(X3) DATE SURVEY

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		IL6005607	B. WNG		C 02/29/2024		
IAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
UTHERA	N HOME FOR THE AGE	800 WES	ST OAKTON STREE	ET			
	IN THE AGE	ARLING	TON HTS, IL 60004	4			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
S 000	Initial Comments		S 000				
	Facility Reported Incident of 2/19/24/IL170357						
S9999	Final Observations		S9999				
	Statement of Licensure Violations						
	300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6)						
	Section 300.610 Res	sident Care Policies					
	procedures governin facility. The written pube formulated by a R Committee consisting administrator, the admedical advisory conformation of nursing and other policies shall comply The written policies sthe facility and shall it	g of at least the visory physician or the mmittee, and representatives services in the facility. The with the Act and this Part. shall be followed in operating be reviewed at least annually ocumented by written, signed					
	Section 300.1210 G Nursing and Persona	eneral Requirements for al Care				1	
	facility, with the partic the resident's guardia	ive Resident Care Plan. A cipation of the resident and an or representative, as elop and implement a					

Electronically Signed

TITLE

(X6) DATE

03/26/24

Illinois Department of Public Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 02/29/2024 IL6005607 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **800 WEST OAKTON STREET LUTHERAN HOME FOR THE AGED ARLINGTON HTS, IL 60004** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 1 comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) The facility shall provide the necessary b) care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision

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and assistance to prevent accidents.

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Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	MBER: A. BUILDING:		COMPLETED					
					С					
		IL6005607	B. WNG		02/29/2024					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
LUTHERAN HOME FOR THE AGED 800 WEST OAKTON STREET										
		ARLINGTO	ON HTS, IL 600	004						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE					
S9999	Continued From page 2		S9999		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
	Based on interview at failed to ensure a resi for one of three reside in the sample of three	were not met evidenced by: nd record review, the facility ident was transferred safely ents (R1) reviewed for safety e. This failure resulted in R1 ical neck fracture (Right								
- 1- 1	The lindings include.									
	shows she was admit 2017 with diagnoses quadriplegia, right and heart disease, low ba spasms. R1's diagnos	ses were updated February ct pain and fracture of upper								
	2024 shows she is co	Set (MDS) dated January 16, gnitively intact and shows taff for showering, toileting,								
	R1's Fall Scale dated she was a moderate r	January 13, 2024 shows risk for falls.								
		ed on June 23, 2023 shows nical lift with two staff and ansferring between								
ž	2024 shows, "On Feb approximately 11:00 A pain in her right shoul the nurse. Family and	eport dated February 19, ruary 19, 2024 at AM, the resident reported der and lower extremity to physician notified with r results received February								

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Illinois Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A BUILDING: C B. WNG 02/29/2024 IL6005607 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **800 WEST OAKTON STREET LUTHERAN HOME FOR THE AGED ARLINGTON HTS, IL 60004** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 59999 S9999 Continued From page 3 19, 2024 at approximately 4:30 PM noting right shoulder view: question subtle impacted fracture of surgical neck." R1's Radiology Results Report dated February 19, 2024 at 4:39 PM shows, "Fracture of the surgical neck. No dislocation of the head. Joint space narrowing. Mild soft tissue swelling." On February 28, 2024 at 9:10 AM, R1 said V4 CNA (Certified Nursing Assistant) came into R1's room with the mechanical lift machine, but said V4 told R1 she wasn't going to use it. R1 said that V4 just picked her up by her hands and underneath her arms to put her in the shower chair. R1 said she kept telling V4 that she could not walk. R1 said she hasn't been able to use her legs for years. R1 said that V4 pushed the shower chair into the bathroom, gave her a shower, then transferred her back into bed in the same manner. R1 said she had a lot of pain. R1 said that V4 was by herself during the transfer. R1 said she felt like V4 was handling her like a "rag doll". R1 said, "This was the first time V4 took care of me. I've been here for almost seven years, and no one has hurt me before. All V4 said when she was done was if I needed a pain pill. I was crying, it really hurt." "I kept telling her that I don't walk. I felt like I was being taken advantage of and she wasn't listening to me. I feel safe here as long as V4 does not come back." R1 had a black sling to her right arm and said the ortho doctor said she is not allowed to use her right arm. V4 was not in the facility during this investigation nor was V4 answering the phone calls made by this surveyor on February 28 & 29, 2024. On February 28, 2024 at 10:07 AM, V5 RN

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PRINTED: 04/09/2024 FORM APPROVED Illinois Department of Public Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 02/29/2024 IL6005607 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **800 WEST OAKTON STREET** LUTHERAN HOME FOR THE AGED **ARLINGTON HTS. IL 60004** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 4 (Registered Nurse) said she gives the CNAs instructions every morning. V5 said she told V4 that R1 uses the full body sling with two staff members for transferring and to call V5 when she was ready to transfer R1. V5 said at about 10:30 AM, V4 came to her and said that R1 needed pain medications. V5 said that R1 was upset when she went into R1's room. V5 said that R1 told her that V4 did not use the lift to transfer R1. V5 said that R1 complained of pain to both of her shoulders, both knees, both hips, and both ankles. R1 told V5 that V4 pulled R1 by her arms and armpits to put her into the chair. V5 said she notified the manager on duty and notified the nurse practitioner which ordered stat x rays on all of R1's joints. V5 said the results showed that R1 had a right shoulder fracture. On February 28, 2024 at 12:35 PM, V7 Unit Manager said V5 called her and reported that R1 wanted to talk to her. R1 told V7 that V4 transferred R1 without using the mechanical lift and now R1 had pain. V7 said she went to talk to V4 and V4 told V7 that she transferred R1 without the lift. V7 said that V4 knew she was supposed to use the lift, but she said she was strong enough to do it without the lift. On February 28, 2024 at 1:14 PM, V6 Nurse Practitioner said she was notified by the nurse that R1 was experiencing pain. V6 said she saw

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using a mechanical lift.

R1 soon after the report. V6 said R1 is alert and oriented and that R1 told V6 that she was held up by her shoulders during a transfer that occurred in the morning. V6 said the x ray came back with a shoulder fracture. V6 said the fracture occurred during the transfer when staff was holding R1 by her shoulders. V6 said R1 should be transferred

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ C 02/29/2024 IL6005607 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 WEST OAKTON STREET **LUTHERAN HOME FOR THE AGED** ARLINGTON HTS, IL 60004 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 5 R1's Nursing Notes dated February 20, 2024 shows, "Resident came back from her ortho appointment with instruction to have the patient wear an arm sling to her right arm at all times. Ice the shoulder for 20 minutes twice per day. No lifting to right arm." V4 signed a Pledge for Transfer Safety document on February 23, 2023. This document shows, "Policies and procedures are written for the safety of residents, patient and myself. I will follow policies and procedures. I understand that I increase the risk to the resident, patient and to myself if I do not follow policies and procedures. I understand that I must use the lifts according to the policy to protect residents, patients, and myself from harm." The facility's Mechanical Lift Policy revised April 27, 2023 shows, "The purpose of this policy is to establish the general principles and procedure of safe lifting using mechanical lifting devices. Two team members are needed to safety move a resident with a mechanical lift with sling: one team member will operate the mechanical sling lift, while the second team member supports the resident. A full body sling mechanical lift is used for residents who are not able to bear any weight or provide support for the transfer." (B)

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