STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005037	A. BUILDING: _____ B. WING _____	C 06/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING BRUWAERT HOUSE	6101 COUNTY LINE ROAD BURR RIDGE, IL 60521

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Investigation of Facility Reported Incident of 4/21/24/IL172569	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710 a) Section 330.710 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. This requirement was not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure resident safety by using gait belts for transfers for 2 of 3 residents (R4, R1) reviewed for safety and supervision in the sample of 5. The findings include: 1. R4's face sheet showed a 94-year-old female with diagnosis of dementia, squamous cell carcinoma of the face, and malignant neoplasm of the skin. R4's physician order sheet showed a 4/19/24 order to admit to hospice.	S9999		

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S9999	Continued From page 1	S9999		

R4's 5/1/24 fall risk assessment showed she was a high risk for falling.

The facility's fall incident log showed a 1/7/24 fall with subsequent skin tears.

R4's care plan showed she was at risk for falls related to gait instability and decline in cognitive function.

R4's care plan showed fall incidents on 10/30/23 and 12/13/23.

On 6/22/24 at 2:10 PM, R4 was seated in a chair in the common area. V7, Certified Nursing Assistant (CNA), and V10, CNA, lifted R4 under both arms and transferred her from the chair to a wheelchair. V1, Administrator, was within view of the transfer.

At 2:58 PM, V1, Administrator, said, "Gait belts are used for the safe transfer of residents. Gait belts should be used to transfer residents who can bear weight."

At 3:22 PM, V10, CNA, said, "The purpose of a gait belt is to make it easier to transfer and to use to avoid injury to both residents and staff. I did transfer R4 without a gait belt, and we are supposed to use them."

The facility's 3/2022 Resident Transfer Policy showed residents are lifted and transferred safely in all incidents. Both the safety of the residents and the staff are protected by the use of proper body mechanics and use of gait belts and mechanical devices. The purpose of the policy was to prevent injury to residents and facility staff. Residents who are weight-bearing and require

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S9999	Continued From page 2	S9999		

assistance (can stand for 4 seconds bearing weight without assistance) are transferred with a gait belt. All members of the nursing staff, nurses and nursing assistants are responsible for using good body mechanics, knowing proper procedures, and properly operating assistive devices.

2. R1's face sheet showed an 80-year-old female with diagnosis of dementia, hypertension, osteoarthritis of the hand, malignant neoplasm of the breast, hypertension, and anxiety disorder.

R1's care plan showed she was at risk for falls due to poor safety awareness related to dementia.

R1's care plan showed she was in the skilled nursing area after a knee replacement and broken leg bone from a fall upon her return after (knee replacement) surgery.

R1's care plan showed she required extensive assistance of two staff to move between surfaces bed to chair.

R1's 4/21/24 fall report showed R1 was standing next to the bed and turned to find her phone. R1 lost her balance and fell to the floor.

The facility's State reported incident showed two staff were present during the transfer.

On 6/22/24 at 11:11 AM, R1 was in her room in a remote-controlled lift chair. R1 was asked if she had a nurse call light available, and she showed this surveyor the remote control for her chair.

On 6/22/24 at 3:22 PM, V9, CNA, said on 4/21/24, she responded to R1's alarm and found

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S9999	Continued From page 3 R1 attempting to transfer from her bed to her wheelchair. V9 said V4, Registered Nurse (RN), responded as well. V9 said V4 attempted to attach R1's wheelchair footrests and had trouble so she moved and attached them. V9 said R1 was standing with a walker in front of her and fell backward falling to her buttocks on the floor. V9 said V4 asked R1 if she had her phone and V4 was next to R1, not behind her when R1 fell. V9 said she should have had a gait belt on R1, and had the chair ready for transfer before R1 was upright. V9 said there was no gait belt on R1, and R1 did not refuse the use of a belt. "It happened very quickly". (B)	S9999		