STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6019723	A. BUILDING: _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEERFIELD CROSSING NORTHBROOK	4101 LAKE COOK ROAD NORTHBROOK, IL 60062

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S 000	Initial Comments Investigation of Facility Reported Incident of August 11, 2023/IL163710 Investigation of Facility Reported Incident of August 20, 2023/IL164185	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b)5) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary 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. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) 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: 6) 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 and assistance to prevent accidents.	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure a resident was safely transferred for 1 of 4 residents (R3) reviewed for safety in the sample of 15. This failure resulted in R3 sustaining a laceration to the right lower leg needing an emergency room visit requiring 33 stitches to the laceration.

The findings include:

R3's electronic medical record accessed on 10/27/23 show R3 is a 94-year-old Russian speaking resident with diagnoses that include weakness, peripheral venous insufficiency, and diabetes.

R3's facility assessment dated 8/19/23 show R3 has severe cognitive impairment. R3 needs maximal assistance for transfers from wheelchair to bed.

R3's Facility Reported Incident (FRI) dated 8/25/23 sent to the state agency as final (date of incident 8/20/23) show, (R3) has received a skin tear from the transfer. R3 was immediately assessed. The right lateral leg was cleansed with normal saline, and a pressure dressing applied ... On 8/20/2023 the two CNAs (agency CNAs) were assisting R3 back to bed. During the stand and pivot, resident knees buckled and the two staff members were able to assist her to a full standing position and pivot her to sitting on side of bed. The injury occurred by the skin rubbing

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against the bed frame and the area of injury aligns and can explain how the injury shape presented. The report also shows that R3's physician gave orders to send R3 to the emergency room (ER.)

R3's Emergency Department (ED) notes dated 8/20/23 show, Large jagged laceration to right lower extremity. Patient- A 94 y/o came in from nursing home for laceration to right lower leg. Per EMS facility reports that her leg got caught on the sharp edge of the bed when she was being moved around. Laceration is actively bleeding.

R3's ED discharge instructions dated 8/21/23 show: large, jagged laceration to right lower extremity. Wound closed with a total of 33 non-absorbent sutures. Wound wrapped in clean gauze. Instructed to follow up in 7 days for suture removal.

On 10/27/23 at 10:15 AM R3 was in the common area. R3 had a dressing to the right lower leg. V6 (Registered Nurse/RN) who can also speak in Russian interpreted for this surveyor. R3 said she was fine and cannot recall what happened to her right lower leg. V6 said R3's wound to her right lower leg was due to an injury from the bed frame while R3 was being transferred by agency CNAs.

On 10/27/23 at 10:30 AM, R3 was in her room. V8 (Wound Nurse) was providing wound treatment to R3. R3's right lower leg wound was irregular and jagged shaped. V8 said R3's right leg wound was a "V shaped" wound measuring 1.5 cm x 3 cm with tunneling 3.0 cm at 10 o'clock. V8 said this wound was from trauma sustained approximately two months ago from R3's bed frame after R3 was being transferred to her bed

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by the 2 agency CNAs. The wound had not healed yet.
V6 (RN) who was also in the room pointed to R3's metal bed frame and said to this surveyor that she had applied paddings to the sharp edges on R3's metal bed frame. R3's metal bed frame was observed. There were missing protective caps of the sharp edges of R3's metal bed frame which was pointed out to V6. V6 said she will be adding more paddings.

On 10/27/23 at 12:15 PM, V7 (RN) said she was R3's nurse on 8/20/23 when the incident happened. V7 said she was called in the room and saw R3's leg bleeding. V7 said she was told that both Certified Nursing Assistance (who were agency CNAs) were in the process of transferring R3. During the transfer, R3 was too close to the metal frame of the bed and that R3's right leg was scraped. V7 said she sent R3 to the local hospital and received sutures to her right leg. The wound has not completely healed. V7 said when transferring a resident, make sure there was enough space and away from the bed's metal frame to prevent injury.

On 10/27/23 at 1:30 PM, V2 (Director of Nursing/DON) said she was the one who completed the investigation of the incident involving R3 and the 2 agency CNAs (V11 and V12). Both V11 and V12 placed R3 who was sitting in her wheelchair at the side of her bed. V11 and V12 did a pivot transfer and R3's legs buckled. R3's right leg skin rubbed against the bed frame and that had caused the injury. V2 (DON) said the bed frames have been padded. V2 stated "the shape of R3's wound perfectly aligned with the shape of the metal frame that would cause the injury. R3 received 33 stitches in the emergency room." V2 said R3 has edema

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S9999	Continued From page 4 and fragile skin and was prone to wounds. V2 said in-services have been provided to V11, V12 and to other staff regarding safe transfers to prevent injuries. On 10/27/23 at 10:40 AM, V9 (Nurse Practitioner) said R3 sustained her right lower wound during transfers. It was an unfortunate incident that could have been avoided. V9 said staff should ensure residents were transferred safely to prevent injuries. "A"	S9999		