STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145661	A. BUILDING _____ B. WING _____	C 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON SQ SKL NRSG & LIVING	**5130 WEST JACKSON BOULEVARD CHICAGO, IL 60644**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Incident Investigation of 06/20/2015/ IL78276 F323 Complaint Investigation: 1583372/IL78170-No Deficiencies	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to ensure that correct transfer interventions were implemented for 1 of 3 residents(R2), reviewed for falls, in a sample of 5. Findings include: R2 admitted to the facility on 05-06-2015 with diagnosis of muscle weakness, cognitive communication, history of falls, pain, paralysis Agitus, Huntington's Cholera, Dementia, Osteoarthrosis and Hemiplegic Affect. MDS(Mini Data Set) May 2015 describes resident requires extensive transfer assist utilizing 1 person for transfer. Incident report dated 6/19/15 indicates that while being transferred from chair to bed by E6(Certified Nursing Assistant), E6 allegedly fell on top of R2 , resulting in R2 complaining of right leg pain. Interview with R2 on 07-02-2015 at 3:15 PM,	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 stated that,"E6 was putting me back to bed from my motorized wheelchair. E6 got me up, my foot slipped resulting in E6 falling on top of me. E6 did not use a transfer belt." Interview with E3 (Fall Coordinator) on 07-07-2015 at 12:00 PM," The certified nurse assistant (E6),involved in the incident was terminated for not using gait belt with transfer an improper transfer." Review of the Safe Patient Lifting Policy on 07-02-2015, the purpose; The Safe Patient Lifting Policy exists to ensure a safe working environment for resident handlers. Process and Procedure bullet 4; Gait belt usage is mandatory for all residents handling with the exception of bed mobility and medical contraindications.	F 323		