STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005607	A. BUILDING: _____ B. WING _____	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME FOR THE AGED	800 WEST OAKTON STREET ARLINGTON HTS, IL 60004

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S 000	Initial Comments Complaint Investigation 2310853/IL155931	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3210t) Section 300.610 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 by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were Not Met as evidenced by: A- Based on interview and record review, the facility neglected to ensure contracted staff reported a fall with a head injury for 1 of 3 residents (R1) reviewed for abuse in the sample of 7. This failure resulted in resident (R1) not being monitored for an hour and a half after the fall occurred. B- Based on interview and record review, the facility failed to ensure the safety of a resident	S9999		

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during care for 1 of 3 residents (R1) reviewed for abuse in the sample of 7.

This failure resulted in R1 falling out of bed, getting a head injury, being sent to a local hospital emergency room, and later to the intensive care unit of the hospital.

The findings include:

The facility's Initial IDPH (Illinois Department of Public Health) Notification of Serious Incident, dated 1/29/23, showed R1 was noted to have a laceration with purplish discoloration to forehead while in bed during nursing rounds at 7:56 PM on 1/27/23. The notification showed 911 was activated and R1 was transferred to a hospital.

R1's Progress Notes, printed by the facility on 1/31/23, showed she had diagnoses including pneumonitis due to inhalation of food and vomit, altered mental status, moderate protein-calorie malnutrition, dysphagia (difficulty swallowing), reduced mobility, weakness, and need for assistance with personal care. R1's Brief Interview for Mental Status Assessment (an assessment to determine cognitive status), dated 1/23/23, showed she was not able to complete the assessment due to "Resident is rarely/never understood." The assessment also showed R1 had a short-term and long-term memory problem. R1's admission Baseline Care plan showed she needed one-person physical assist for eating, personal hygiene, and bed mobility. The care plan showed R1 required assistance of two staff persons for transfers.

On 1/30/23 at 4:50 PM, V16 (R1's daughter) said the incident happened on 1/27/23. V16 said she was at the facility until 11:00-11:30 AM on

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S9999	Continued From page 3 1/27/23. V16 said V3 (Licensed Practical Nurse-LPN) called her around 8:00 PM and said she found (R1) in the bed with an injury to her head. V16 said there is no way (R1) could have made that kind of injury on her head by herself. V16 said "Something happened, either accidental or on purpose." V16 said there is no way (R1) could have fallen out of the bed and got herself back up on her own. V16 said something happened between 11:30 AM and 8:00 PM. V16 said when she went to the emergency room to be with R1, she had "a laceration about the size of your hand" on her head. V16 said R1 was wailing and sobbing and making noises like an animal would make. V16 said R1 was on the critical care unit and was moved to the hospice unit of the hospital on 1/30/23. On 1/31/23 at 9:02 AM, V1 (Administrator) said V5 (Registered Nurse-RN) started his shift at 7:00 PM on 1/27/23. V1 identified V3 (LPN-Agency) as R1's nurse from 7:00 AM-7:00 PM on 1/27/23. V1 said V18 (an RN that works for a company that specializes in vascular access and is contracted with the facility's pharmacy) was in the facility and left "around 6:00ish" (PM). V1 said she spoke with V18, and he said he noticed a bump on R1's head when he was starting the intravenous (IV) line. V1 said she asked V18 if he reported it to the nurse, and he said no. V1 was told by V3 (LPN) that V18 seemed to be in a rush when he was leaving. V1 said V6 (Certified Nursing Assistant-CNA) told her (V1) that about 6:00 PM, she was sitting at a computer and heard R1 yell out. V1 said V6 ran to the doorway of R1's room where she saw a man trying to put both of R1's legs in the bed, like she had her legs off the side of the bed, and he was trying to put them back up on the bed. V1 said V6 asked the man what was going on and he	S9999		

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got out of the room quick. V1 said around 7:00 PM, V6 noticed blood on the sheet by R1's arm. V5 (RN) went into R1's room to check her IV line and that is when the bump on her head was discovered. V1 said V18 came into the facility around 5:00 PM on 1/27/23 and was in R1's room for about 45 minutes to an hour. V1 said during that time, no one went into R1's room to check and see how it was going.

On 1/31/23 at 11:38 AM, V5 (RN) said he worked on 1/27/23. V5 said his shift started at 7:00 PM and he got the shift report from V3. V5 said V3 (LPN) mentioned during report that R1 had a PICC line (a Peripherally Inserted Central Catheter that goes into a vein in the upper arm). V5 said after getting report, he started his medication pass and rounds. V5 said he went into R1's room to check her PICC line and saw bleeding near the PICC line. V5 said he did not notice the injury to R1's head at that time because her hair covered the area and R1 was looking the other way. V5 said he went out and got V20 (Nurse) to come in with him to check R1's PICC line and that is when V20 noticed the bump on R1's head. V5 said V20 asked V5 if he saw the injury on R1's head. V5 said it was probably a little smaller than a golf ball, with blood that was dried and crusted on it. V5 said it was not fresh blood. V5 said he went back out and asked V3 about it and V3 said she did not know anything about it. V5 said V3 told him it must have happened earlier, and no one reported it to her. V5 said V3 took over for R1 after that.

On 1/31/23 at 11:56 AM, V6 (CNA) said she worked on 1/27/23. V6 said she was not assigned to R1. V6 said about 6:00 PM, she was on the computer doing her charting and she heard R1 scream. She ran to R1's room to check on her,

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and she saw a guy bending down to put R1's legs back on the bed. V6 said she asked what happened and the guy said just bring a couple of sheets, maybe she's cold, then he went out of R1's room. She took a couple of sheets to R1 and covered her up. After the guy left R1's room, he went into the dining room and sat at a table for at least 10 minutes doing something on his computer, maybe charting. V6 said about 7:00 PM she went in to take R1's blood pressure and saw blood on R1's right arm and sheet. She ran to inform V5, and he (V5) came back to R1's room with her. V6 said she left R1's room at that time. She went back in to do R1's vitals a little later and that is when she saw the bump on R1's head. V6 said she heard V5 just outside of R1's room telling someone on the phone that she had a bump on her head.

On 1/31/23 at 12:34 PM, V9 (RN/Unit Manager) said he worked on 1/27/23. V9 said he and V10 (Licensed Practical Nurse-LPN/IV Certified) went in to R1's room between 2:30 - 3:00 PM to try to start an IV(Intravenous) access. They were unsuccessful in trying to start the IV for R1, so they put R1's bed back down to the floor (low position) and placed the fall mat next to R1's bed. V9 said he did not see any injuries to R1 at that time. V9 said he and V10 went out and informed V3 that they were not able to start the IV and to call and get an order for someone from (the company that specializes in vascular access and is contracted with the facility's pharmacy) to come in and start the IV.

On 1/31/23 at 12:43 PM, V7 (Certified Nursing Assistant/CNA) said she was assigned to R1 on 1/27/23. V7 said she did not see any bump, bruising or bleeding on R1 during her shift. V7 said after the residents had lunch, she took her

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break and then put R1 into her bed. V7 said she put R1's bed in the low position and placed the mat on the floor next to her bed. V7 said she was moved to another floor at 2:57 PM because someone had to leave.

On 1//31/23 at 12:55 PM, V8 (Physician's Assistant) said she saw R1 around 11:30 AM on 1/27/23. V8 said R1 did not have any injuries to her face at that time.

On 1/31/23 at 1:08 PM, V10 (LPN) said between 2:30-3:00 PM on 1/27/23 she went in with V9 to try to get a peripheral IV started on R1. V10 said they were not able to get the IV started. V10 said R1 was in bed with a sweater and pants on. V10 said R1 did not have any bumps, bruising or bleeding on her forehead when she and V9 were attempting to start the IV. V10 said they let V3 (LPN) know they were unsuccessful and V3 called to get an order for someone from (company that specializes in vascular access and is contracted with the facility's pharmacy) to come in and start the IV. V10 said she (V10) is the one that called the company to have them come in.

On 1/31/23 at 1:18 PM, V1 (Administrator) said she spoke with V18 (RN that works for a company that specializes in vascular access and is contracted with the facility's pharmacy) again and he told her that R1 had fallen out of bed while he was trying to start the IV. V1 said V18 panicked and thought it was something manageable. V1 said V18 told him he changed R1's clothes and placed a gown on her because there was blood on R1's clothes. V1 said V18 told her he did not tell the nurse about the fall, and he knew it was not the right thing to do. He panicked.

On 1/31/23 at 1:29 PM, V3 (LPN) said she was

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R1's nurse on 1/27/23 from 7:00 AM-7:00 PM. V3 said between 5:00-6:00 PM she took the tech (RN that works for a company that specializes in vascular access and is contracted with the facility's pharmacy) to R1's room. V3 said when V18 went to leave the area, he was in a hurry and was not going to provide her with paperwork about the procedure. She had to flag V18 down to get the paperwork from him. V18 handed her the paperwork, said "here," and then left the area. V3 said R1 had been fully dressed when she took V18 to R1's room. V3 said after the injury was discovered, R1 had a gown on. She does not know who put the gown on R1. V3 said it was about 7:20 PM when V5 told her there was blood around R1's IV. V3 said she and V5 were in R1's room a few times tending to the IV and did not notice the injury to R1 because they were focusing on the IV. V3 said she went back out to chart and V5 came up to her asking about the injury to R1. She went back in to assess R1 and then called 911 because it was a bruise that she did not know where it came from and had not been there earlier. On 2/1/23 at 11:26 AM, V3 said she had walked by R1's room some time between 5:00-6:00 PM and R1's door was still closed. V3 said she told another nurse that it seemed to be taking a long time to start the IV. V3 said she did not go in to see what was taking so long. V3 said the injury was discovered some time between 7:30-8:00 PM.

On 1/31/23 at 5:26 PM, V18 said on 1/27/23 he went to the facility to start three IVs. V18 said V3 took him to R1's room. V18 said he saw the mattress on the floor by R1's bed. He introduced himself to R1 and explained why he was there. V18 said he moved the mattress out of the way that was on the floor and raised R1's bed up about six to eight inches. V18 said he lifted R1's

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sleeve and prepared his kit. He applied a tourniquet to her arm and gave R1 lidocaine. V18 said R1 became "squirrely" at that time and was reaching over with her left arm to where he was working with her right arm. He wanted to get R1 more comfortable, so he turned to get more lidocaine from his cart. V18 said he heard a thud. V18 said he turned around and R1's torso and face were on the floor, and her feet were still on the bed. V18 said he panicked and lifted R1 back up into the bed. He did not notice any injury at that time. He asked R1 if she was okay and R1 did not respond. V18 said R1 had not responded when he introduced himself to her either. V18 said he gave R1 more lidocaine and inserted the mid-line. V18 said then he noticed blood on the right side of R1's head. He cleaned up the wound and applied pressure for about five minutes until the bleeding stopped. V18 said he noticed blood on R1's clothes and pillow case, so he removed her clothes and put a gown on her. V18 said he felt comfortable with R1's wound, that it was not bleeding. He was stressed out about what had happened, and he had other jobs to do. V18 said he moved onto the other residents in the facility. V18 said he panicked. He understands he should have reported it. "It was a bad, bad, bad decision not to tell the nurse." When asked why he told V1 when she interviewed him the first time about the incident, V18 said he was scared to say what happened. V18 said he panicked. He was scared not only for her (R1), but for himself-the consequences. V18 said he is beside himself and feels horrible. He had been a nurse for 23 years and had emergency department experience. V18 said it is important to inform the nurse when a resident has a fall because they could have a head injury, a concussion, possible brain-bleed, or broken bones.

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S9999	Continued From page 9 R1's progress note dated 1/27/23 at 7:56 PM, showed "Writer noted resident with discoloration/dry blood to right forehead and lethargic. Writer assessed. Called 911." The progress note dated 1/27/23 at 8:20 PM, showed "Resident via stretcher transported to (local ER) ..." R1's notes from a local hospital show R1 was sent to the emergency department on 1/27/23 and was diagnosed with acute localized area of extra-axial hematoma overlying the lateral left frontal lobe (intracranial hemorrhage). The hospital notes showed R1 was transferred from the emergency department to the ICU unit and a critical care physician was consulted. The facility's Abuse and Neglect of a Resident policy, with a revision date of 12/20/22, defined Neglect as "Failure of the facility, it's associates or service providers to provide goods and services to a resident, necessary to avoid physical harm, pain, mental anguish, or emotional distress. Medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living are necessary to avoid physical harm, mental anguish, or mental illness of a resident. Examples are but not limited to not acting on medical problems, prescribed treatment, or therapies, not calling a physician when necessary..." (A)	S9999		