Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: ______ B. WING ______	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(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 Facility Reported Incident of 03/01/2023/IL157064	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. 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.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: ____ B. WING ____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(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
S9999	Continued From page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to transfer a resident (R2) using a total body lift during bedside care and failed to ensure one resident's (R2) environment was free of hazards. These failures resulted to R2 sustaining a laceration requiring hospital transfer and 25 sutures to R2's right leg. Finding include: R2's face sheet documents that R2 has diagnosis which includes but not limited to: Displaced bimalleolar fracture of left lower leg subsequent encounter for closed fracture with routine healing, type 2 diabetes mellitus without complications, history of falling, unspecified protein calorie malnutrition, hypothyroidism unspecified, hypertensive heart disease without heart failure,	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: ______ B. WING ______	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(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
S9999	Continued From page 2 unspecified atrial fibrillation, chronic kidney disease unspecified, gout unspecified, gastro esophageal reflux disease without esophagitis, major depressive disorder single episode unspecified, polyarthritis unspecified, anemia unspecified, laceration without foreign body right lower leg subsequent encounter, encounter for other orthopedic aftercare, muscle weakness (generalized) dysphagia oral phase, other abnormalities of gait and mobility, and need for assistance with personal care. R2's Brief Interview for Mental Status (BIMS) dated 02/22/2023 documents that R2 has a BIMS score of 00 which indicates that R2 is cognitively impaired. R2's Care Plan dated 01/22/23 documents in part: Focus: R2 has an ADL (Activities of Daily Living) self-care performance deficit secondary to impaired mobility... Transfer: R2 requires a total body lift with transfers. Do not seat the resident next to the bed while the bed is being raised. On 04/10/23 at 11:30 am, R2 was observed awake, alert sitting in a wheelchair and without a total body lift transfer pad underneath R2 in the resident sitting area on the facility's second floor. Surveyor attempted to interview R2 and R2 was not able to answer questions. On 04/10 23 at 11:33 am, V4 (Licensed Practical Nurse, LPN, Agency) stated, R2 had recently sustained an injury to R2's right lower leg that is resolved. V4 was asked regarding R2's transfer status. V4 stated, R2 recently declined and required a total body lift for transfers. V4 also stated, R2 was receiving physical therapy and occupational therapy since 03/08/23.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: ______ B. WING ______	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(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
S9999	Continued From page 3 On 04/10/23 at 2:03 pm, Surveyor requested V7 (Certified Nursing Assistant, CNA) and V8 (CNA) to perform a skin check with R2. V7 stated, "Great! It's time for her (R2) to be changed anyway." Surveyor observed V7 and V8 bring R2 to R2's room and place R2's wheelchair next to R2's bed. Surveyor then observed V7 and V8 place a gait belt around R2's waist while R2 was still sitting in R2's wheelchair next to R2's bed. Surveyor observed both V7 and V8 place one of V7's and one of V8's hands on the gait belt around R2's waist while V7's other hand and V8's other hand was observed underneath R2's arms. Surveyor observed V7 and V8 manually transfer R2 to R2's bed without the use of a total body lift. Surveyor observed R2 in bed and R2's wheelchair without a total body lift pad in R2's wheelchair. Surveyor further observed R2's right and left lower legs skin intact. V7 and V8 were asked regarding R2's transfer status. Both V7 and V8 stated, V7 and V8 did not know R2's transfer status. When V7 and V8 was asked regarding how staff is made aware of a residents transfer status both V7 and V8 both stated that the residents have a circle outside of the residents room that tells the residents transfer status. When surveyor, V7 and V8 went to observe R2's transfer status circle outside of R2's door, surveyor, V7 and V8 observed a red circle that showed "TBL (Total Body Lift)." When V7 and V8 were asked regarding what does the red circle that showed "TBL" meant, both V7 and V8 both stated, "I (V7) and (V8) don't know what TBL means." On 04/10/23 at 2:55 pm, V11 (Restorative Nurse, Wound Care Nurse, Registered Nurse, RN) stated, V12 (Certified Nursing Assistant, CNA) was raising R2's bed to the level of R2's	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: ______ B. WING ______	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(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
S9999	Continued From page 4	S9999		

wheelchair and notice a laceration to R2's right lower leg that R2 was holding. V11 stated, an investigation was conducted regarding R2's injury and concluded that R2 had a sharp piece hanging from the side of R2's bed that injured R2 when V12 was transferring R2 to bed from R2's wheelchair. V11 was asked to read R2's progress notes authored by V13 (Registered Nurse, Agency) from the incident dated 02/14/23. V11 stated, "Oh the progress notes say the CNA stated R2's injury occurred during V12's transferring of R2's from the wheelchair to the bed." When V11 was asked how staff are made aware of residents transfer status, V11 stated there is a circular sticker outside of each residents door with residents transfer status that is determined by the therapy department and placed outside the residents doors by the restorative department to makes staff aware of a residents transfer status. Surveyor asked V11 R2's current transfer status. V11 stated, R2's current transfer status is a total body lift. V11 was asked what could happen if a residents transfer status is not being followed. V11 stated, the resident can be at risk for injury or fall. V11 was asked how staff are educated regarding a residents transfer status. V11 stated, staff are educated at the facility's daily meetings regarding residents transfer status.

On 04/11/23 at 10:00 am, V2 (Director of Nursing, DON) stated R2 sustained a leg injury when V12 (Certified Nursing Assistant, CNA) was transferring R2 from R2's wheelchair to R2's bed a few months ago. V2 stated, R2's bed was examined, and no sharp object was seen coming from R2's bed. V2 stated, there was a metal extension pieced extending from R2's bed that was believed to have injured R2 when V12 was transferring R2 from the wheelchair to the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: ____ B. WING ____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(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
S9999	Continued From page 5	S9999		

V2 was asked how staff are made aware of a residents transfer status. V2 stated, the circle outside of the residents room indicates that residents current transfer status. V2 was asked regarding TBL on the circle outside of a residents room. V2 stated that TBL means "Total Body Lift" and that the resident should transfer with a total body lift and two staff members. V2 was asked if a resident is not transferred properly what could happen to the resident. V2 stated, an injury can occur. V2 also stated, the importance of following the indicated transfer status outside of the residents room is to make sure the resident is safe. V2 explained, residents equipment should always be safe to use and that the nurse or the nursing assistant should monitor the patient equipment before use and report if something is wrong. V2 further stated, it is improper for a nurse or CNA to use equipment that is not safe.

On 04/11/23 at 12:35 pm, V3 (R2's Physician) was interviewed and stated, V3 was called and informed that R2's leg got injured accidentally while transferring a few months ago. V3 stated, R2 was sent out to the local hospital for the injury to R2's leg (unable to recall which leg) and R2 received sutures to R2's injured leg. V3 further stated, V3 treated R2's injured leg with an antibiotic. Surveyor asked V3 how a residents transfer status is determined. V3 stated, the physical therapist, and the nursing staff determine a residents transfer status. V3 also stated that if a resident is not properly transferred the resident can get hurt or fall. V3 was asked regarding what could happen if staff use equipment for the resident that is not safe. V3 stated, "The resident could get harmed or injured".

On 04/11/23 1:10 pm, surveyor attempted to contact V12 (Certified Nursing Assistant, CNA,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: ______ B. WING ______	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(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
S9999	Continued From page 6	S9999		

Agency) and was unsuccessful. V2 (Director of Nursing, DON) stated that V12 is an agency CNA and is no longer able to return to the facility.

On 04/11/23 1:13 pm, surveyor attempted to contact V13 (Registered Nurse, RN, Agency) and was unsuccessful. V2 (Director of Nursing, DON) stated that V13 is an agency nurse and is no longer able to return to the facility.

R2's Facility Reported Incident initial report to state agency dated 02/15/23 at 4:29 pm, documents, in part: "When R2 was being assisted to bed, V12 (Certified Nursing Assistant, CNA) noted a large skin tear on R2's left lower leg (area in question is right lower leg) ... R2 went out to the hospital for evaluation, skin are with sutures and dressing upon return."

R2's Facility Reported Incident final report to state agency dated 02/21/23 at 4:17 pm, documents, in part: "R2's was sitting with right leg next to the bed when the bed was raised, the side rail has an extended piece on the outer aspect at the bottom of the rail. It is presumed that the extended piece from the side rail rubbed across the right lower leg when the bed was being raised and caused the skin tear and open area."

R2's progress report dated 02/14/23 at 18:35 authored by V13 (Registered Nurse, RN) documents, in part that V13 was called by V12 (Certified Nursing Assistant, CNA) about a laceration on R2's right outer lateral leg (11.5 X 0.5 X 0.4) while V12 was transferring R2 to the bed to change (provide incontinence care) R2 ... V12 stated that R2 reached to R2's leg at the injured site after R2 was transferred from R2's wheelchair to the bed ... V3 (R2's Physician) was called and informed, order given to send R2 out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: ______ B. WING ______	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(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
S9999	Continued From page 7 to the local hospital emergency room for suturing. At 21:04 R2 was picked up by transportation company. R2's progress report dated 02/15/23 at 6:38 am, authored by V15 (Registered Nurse, RN) documents, in part R2 returned to the facility with right lower leg repair ... Wound observed with 24 sutures ... Tetanus Toxoid inoculation applied during emergency room visit. R2's hospital record dated 02/14/23 documents, in part: "Procedure orders: Laceration repair ... Physical Exam: ... four-inch curvilinear laceration of lateral right shin with exposed but intact fascia and no active bleeding ... Repair method: Sutures ... Number of sutures: 25." Facility's undated document titled "Resident Handling Policy Limited-Lift" documents, in part: "The Resident handling Policy exist to ensure a safe working environment for resident handlers ... The transfer will be designated into one of the following categories ... TBL: Total Body Mechanical Lift Transfer with two caregivers ... Any transfer with mechanical lift requires two persons assist ... The policy is to be followed at all times." Facility's document presented regarding R2's mobility, devices, ambulation documents, in part: "Mobility, Devices, Ambulation: Transfer: R2 requires total body lift with transfers." Facility undated document titled "Position Description Acceptance and Acknowledgment" documents, in part: "Position Title: Certified Nursing Assistant (C.N.A.) ... When indicated, use mechanical lift with another CNA or nurse and transfer resident."	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING: ______ B. WING ______	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(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
S9999	Continued From page 8 (B)	S9999		