STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016497	A. BUILDING: _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SUBURBAN REHAB CENTER	19000 SOUTH HALSTED HOMEWOOD, IL 60430

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S 000	Initial Comments Complaint Investigation 2497740/IL178465 Facility Reported Incident of September 22, 2024 IL178871 Facility Reported Incident of September 24, 2024 IL178890	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1210 b) 300.3210 t) 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 1	S9999		

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.

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 are not met as evidenced by:

Based on interview and record review, the facility failed to prevent an incident of resident-to-resident physical assault. This affected two of three residents (R9, R10) reviewed for physical abuse. This failure resulted in R10 pushing R9 to the ground unprovoked, and R9 sustaining an extensive intraparenchymal and subarachnoid hemorrhages from hemorrhagic contusions and extensive skull fractures extending from the vertex anteriorly and posteriorly.

Findings include:

R9 was admitted to the facility on 9/13/18, with diagnosis of dementia without behavioral disturbances, hypertension, dysphagia, and cognitive communication deficit.

R9 brief interview for mental status, dated 7/23/24, documents should not be conducted because resident is never /rarely understood.

R10 was admitted to the facility on 1/15/24, with a

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S9999	Continued From page 2	S9999		

diagnosis of dementia without behavioral disturbances, cognitive communication deficit, and major depressive disorder. R10's Brief Interview for Mental Status score, dated 7/8/24, documents a 13/15, which indicates cognitively intact.

R9's facility reportable, dated 9/24/24, documents: R10 was ambulating in the dining room area. R9 was standing in the pathway of R10. R10 pushed R9 out of the way. R9 fell back and hit her head on the floor. A moderate amount of blood was noted from posterior scalp, first aid rendered. R9 denied any pain and level of consciousness within normal baseline. R9 sent to hospital for further evaluation. R9 admitted to hospital for fractured skull. Under resolution: R10 was ambulating in the dining room as she approached two residents standing in her pathway. R10 pushed R9 out of her way. R10 continued to ambulate and sit down at a nearby table. R9 fell back and hit her head on the floor. R9 was sent to local hospital and admitted for fractured skull. R10 was assessed and said she was looking for something. R10 was calm cooperative and easily redirected. One to one monitoring initiated by staff. R9 and R10 had no previous interactions prior to incident. There was no previous behavior noted by R10. Plan of care updated. No concerns noted.

R9's incident report, dated 9/24/24, documents: Resident was standing up when another resident pushed her. The resident fell backwards. Resident was assessed and noted with laceration to the back of her head and two skin tears to the left elbow. Resident alert with confusion. Under statements: V19(Certified Nursing Assistant/CNA) and V22(CNA) I was monitoring the dining room when one resident walked up and pushed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SOUTH SUBURBAN REHAB CENTER	19000 SOUTH HALSTED HOMEWOOD, IL 60430

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S9999	Continued From page 3	S9999		

another resident down. I was unable to stop it. I notified the nurse. Under notes: Resident was standing in dining room when another resident pushed her, she fell down to floor and to the back of her head. No previous behaviors noted from either resident, Resident was sent out to Emergency room and noted with a fractured skull.

R9's hospital record, dated 9/24/24, documents under diagnosis subarachnoid hemorrhage, intraparenchymal hemorrhage of the brain, contusion of cerebrum, closed fracture of the skull. Under history: Patient arrived from nursing home with scalp laceration after witnessed fall when patient was pushed by another resident. Under physical exam: Approximate two-centimeter laceration to posterior scalp, skin tear left elbow. Under CT head impression: Extensive intraparenchymal and subarachnoid hemorrhages from hemorrhagic contusions, intraventricular hemorrhages as described with bilateral frontal lobes from the vertex to the anterior skull base. Extensive skull fractures extending from the vertex anteriorly and posteriorly as described. R9's hospital record, dated 9/25/24, documents: trauma transfer. Glasgow coma scale score of 7 (Severe brain injury). Ambulance run report, dated 9/24/24, documents: crew dispatched to local hospital for subarachnoid hemorrhage. Upon arrival resident was found in supine in bed. Patient is responsive to touch but is non-verbal. Per nurse patient was pushed down at the nursing home resulting in multiple fractures to the head and a subarachnoid bleed. Patient is to be transferred to another hospital for further care and treatment.

R10's progress note, dated 9/25/24, documents: the writer asked resident why she pushed peer and resident stated there was no reason. Writer

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S9999	Continued From page 4	S9999		

informed the resident of the risk of physical aggression.

R9's abuse care plan, dated 10/3/24, documents R9 is at risk for abuse. Interventions, dated 10/3/24, documents: Assess for abuse risk quarterly and as needed; Observe for signs and symptoms of abuse; Report all instances of alleged abuse to the abuse coordinator.

On 10/9/24 at 10:48AM, V19(CNA) said she was in the dining room when incident occurred between R9 and R10. V19 said she saw R10 was at one table and R9 was at another table and staff was getting ready to serve dinner. R10 and R9 had no previous interactions prior to incident. They both got up and were walking towards each other between table and chairs. V19 said there was enough space for both residents to pass each other. R10 just pushed R9 to the ground and did not say anything and kept walking.

On 10/10/24 at 11:59AM, V2(DON) said she spoke to R10 after the incident, and R10 reported she pushed someone but didn't know why, and was looking for something.

On 10/10/24 at 4:25pm, V1 (Administrator) said she reviewed the video footage of R9's incident and said R10 was ambulating towards the window in dining room. There were two other residents standing in path of R10. R9 was standing to the right, and R10 used her hands and pushed R9 out of the way and continued towards the window. R9 fell backwards to the ground.

Facility's abuse prevention policy undated documents: The facility affirms the right to our residents to be free from abuse, neglect,

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	IL6016497	A. BUILDING: _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SUBURBAN REHAB CENTER	19000 SOUTH HALSTED HOMEWOOD, IL 60430

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S9999	Continued From page 5 exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than accidental means. Abuse is the willful infliction of injury with resulting harm, pain or mental anguish to a resident. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. (A) 2 of 2 300.1210 b) 300.1210 d)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. 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.	S9999		

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S9999	Continued From page 6	S9999		

All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure safety measures were in place to prevent avoidable resident accidents. This affected two of three (R7, R8) reviewed for safety. This failure resulted in R7 wheelchair not being secured in a medivan, R7 sliding out of the wheelchair sutaining a comminuted transversely impacted fracture of the right tibial (shin bone) and fibula (long slender bone in the lower leg that run alongside the tibia) requiring surgical intervention and the application of a long leg cast and a left proximal tibia fracture with hemarthrosis (bleed into joint space) requiring aspiration and application of long-leg splint; and facility staff not applying foot/leg support to R8's wheelchair resulting in R8 feet hitting the ground abruptly stopping and falling forward while being pushed by staff. R8 sustained a laceration to the left eye which required four sutures.

Findings Include:

1. R7's progress note, dated 9/9/24, documents: Resident returned from emergency room. Per the previous nurse, resident was sent to the hospital from the dialysis center due to complaint of leg pain. Upon assessment, the right knee looks swollen, and resident complained of pain more to the right leg. Emergency room diagnosis states Acute Pain of both knees. Knee pain of uncertain cause.

Patient Incident Report Form, dated 9/9/24, documents: While transporting R7, V26 turned

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S9999	Continued From page 7	S9999		

around to check on R7, V26 noticed R7 sliding out of the wheelchair. V26 preceded to pull the van over to park safely. V26 went to help position R7 a little better in the chair and moved his leg on the leg rest. The leg rest on his wheelchair was not fully functioning. V26 could only do so much. V26 couldn't fully move him alone. Before proceeding to R7's appointment, V26 asked R7 several times was he ok. R7 responded the first time and said "yes but my leg". V26 asked R7 if he was positioned ok now R7 said "yes". The second time V26 asked him, he said "yes do you have some candy?". V26 chuckled and said "no". Once V26 arrived at dialysis to drop R7 off, V26 asked for someone's help to make sure R7 was sitting up properly before removing R7 from the van. They came to help and brought him inside. When V26 returned for pick up, the front desk told V26 they were getting R7 ready. While in the waiting room thirty minutes went by and the ambulance grabbed R7. V26 was then told R7 was not feeling well and complaining about his leg and V26 can V26 return his wheelchair to the rehabilitation center.

V16's witness statement not dated documents: asked R7 what happened? R7 said the driver didn't strap him in and they almost had an accident and he flew out of his wheelchair.

Fall report, dated 9/9/24, documents: Resident (R7) injury was a result of a fall that occurred during transport to dialysis center.

Pain assessment. dated 9/9/24. documents: pain intensity ten (10) out of ten (10), verbal descriptor scale: severe. Staff assessment for pain documents: non-verbal sounds (e.g., crying, whining, gasping, moaning or groaning), Facial expression (e.g., grimaces, winces, wrinkled

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	IL6016497	A. BUILDING: _____ B. WING _____	C 10/11/2024

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SOUTH SUBURBAN REHAB CENTER	19000 SOUTH HALSTED HOMEWOOD, IL 60430

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S9999	Continued From page 8	S9999		

forehead, furrowed brow, clenched teeth or jaw) and Protective body movements or postures e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement). Frequency with which resident complains or show evidence of pain or possible pain documents indicators of pain (1 to 2 days).

Dialysis noted, dated 9/9/24, documents: Patient (R7) arrived to the center with transportation/ Transporter requested help to get him out of the vehicle, she stated he had moved while in route. Patient complained of leg pain while he was being removed from the van via his wheelchair. Patient complained of leg pain throughout treatment. Will call 911 to route him to emergency department (ED) for evaluation. Transportation crew stated, 'he kinda slipped down in his wheelchair during route so he might have hurt his leg."

Hospital paperwork, dated 9/9/24, documents: R7 presents for bilateral knee pain. Apparently his chair was unlocked and he was rolling around. He denies any trauma. When he presented here he was complained of pain and even more so on the right. Per emergency medical service (EMS) R7 here for bilateral lower extremely (BLE) pain/soreness. EMS reports on the way to dialysis the patient was not locked in and he was rolling around. Pt states he did not hit his legs but has soreness to bilateral lower extremities (BLE.)

Hospital paperwork, dated 9/10/2024, documents: chief complaint: Fall- Other closed fracture of proximal end of right tibia, initial encounter (primary). Per EMS and nursing report, patient fell while being assisted by NH (nursing home) staff who were attempting to get patient into wheelchair. Patient fell to right leg. Musculoskeletal: Positive for joint swelling. XR

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SOUTH SUBURBAN REHAB CENTER	19000 SOUTH HALSTED HOMEWOOD, IL 60430

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S9999	Continued From page 9 TIBIA FIBULA 2 VIEWS RIGHT (Final result) Result time 09/10/24 Multiple views of the right tibia and fibula demonstrates a comminuted, predominantly transversely oriented fracture involving the proximal tibial metadiaphysis. ED Triage Notes Pt from nursing home due to right knee pain and swelling. Per staff, patient was getting into wheelchair with staff assistance and fell onto right knee. R7's Nurse Practitioner Narrative/Physician Assistant progress note, dated 9/10/24, documents: Seen today because of subsequent complaint of right knee pain and swelling. He reports that while on his way to dialysis, he was not securely placed in the transportation cart, and when the driver hit the brakes, he fell forward, injuring his right knee. The patient rates his pain as 5 out of 10 and states that she was prescribed 1000 mg of Tylenol every 6 hours for pain management. Orthopedic Surgery service date 9/17/24 documents: Right proximal tibia fracture closed reduction and application of cast. Preoperative diagnosis: Left proximal tibia metaphyseal fracture. Procedure Performed: right knee proximal tibia fracture closed reduction and application of a long-leg cast. Left knee aspiration of hemartrosis and application of long leg splint for treatment of proximal tibial fracture. Facility reportable, dated 9/18/24, documents: R7 complained of right leg pain during outpatient dialysis. Dialysis nurse called facility to notify of transfer to emergency department. R7 transferred back to facility from ED where he was treated for pain but still complained of pain upon return. Nurse assessed R7, observed right knee swollen warm and pain upon touch. R7 sent to hospital for	S9999		

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	IL6016497	A. BUILDING: _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SUBURBAN REHAB CENTER	19000 SOUTH HALSTED HOMEWOOD, IL 60430

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S9999	Continued From page 10	S9999		

further evaluation. R7 was admitted for tibia fracture of the right knee. Occurrence resolution documents: Investigation revealed that R7 began to slide out of wheelchair during transportation to outpatient dialysis center. Transportation professional pulled over, repositioned resident and removed leg rest from wheelchair. R7 complained of pain to right leg at that time. Hospital records indicated R7 was admitted. X-ray of right knee demonstrates a comminuted, predominantly transversely oriented impact fracture of the proximal tibial matadiaphysis. R7 returned with a cast on right leg.

On 10/09/24 at 10:31am, R7 was assessed to be alert and oriented to name only. R7 was observed with a cast to right lower leg and a leg immobilizer in place to left lower leg. R7 was unable to report what happened to his legs.

On 10/09/24 at 2:56pm, V23 (dialysis nurse) said, "(R7) complained of leg pain. (R7) could not rate his pain level. (R7) always complained of leg pain, but this day was different. (R7) did not want to his leg to be touched. (R7's) legs are usually moved around when he is positioned into the dialysis chair. (R7)is moved from the wheelchair to the dialysis chair via a mechanical lift. (V26, transportation personnel) asked for help with (R7). (V26) reported she was afraid (R7) slipped out of his wheelchair."

On 10/09/24 at 3:07pm, V24 (dialysis clinical manager) said, "(V26) came into the dialysis facility and asked for help with (V7). Dialysis does not usually help transfer residents out of the transportation vehicle. (V26) reported that (R7) was almost out of his wheelchair. I went outside to the transportation vehicle. (R7) was almost out of his wheelchair. (R7's) mechanical sling was all

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S9999	Continued From page 11	S9999		

over the place. (R7's) back was in the middle of the seat portion of his wheelchair. (R7's) buttock was off the wheelchair. (R7) did not have a seat belt or foot rest on his wheelchair. (R7's) legs were pressed against the back of the driver and passenger seats. The seats were holding (R7) up from completely being on the vehicle floor. I believe (R7) slipped from his wheelchair due to having the sling underneath him."

On 10/09/24 at 3:43pm, V2 (Director of Nursing/DON) said, "(R7) was sent to dialysis with the mechanical left sling underneath him so he could be transferred to the dialysis chair via their mechanical lift. (R7) used a wheelchair for mobility. (R7's) wheelchair did not have a seat belt. (R7) was secured to the transportation vehicle by the driver. Facility staff does not secure any resident to transportation vehicles. (R7's) dialysis nurse called to report (R7) was complaining of leg pain more than usual. (R7) would be transported to the hospital from dialysis. (R7) came back from the hospital with pain patches. (R7's) receiving nurse completed a body assessment noting (R7) with a swollen/warm knee. (R7) was sent to back to the hospital. The second hospitalization reported (R7) had fractures in both legs, with one leg requiring surgery." V2 said she was informed by the transportation company that R7 fell in the transportation vehicle in route to dialysis.

On 10/11/24 at 212pm, V26 (transportation driver) said she went to pick up R7 for dialysis, and he was complained of leg pain, which is normal. "(R7's) leg are weak. (R7) could not hold his legs in position. It was hard for (R7) to keep his leg up right on the foot rest which was usual. (R7) was secured to the van." V26 said she drove off, constantly looking back to check on R7, because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SUBURBAN REHAB CENTER	19000 SOUTH HALSTED HOMEWOOD, IL 60430

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S9999	Continued From page 12	S9999		

he normally had an escort with him, but he didn't for dialysis. V26 said she came to a stop, and R7 was sliding out of the wheelchair. V26 said,she was not sure how R7 was sliding out of the wheelchair because she was driving. V26 said she pulled over to reposition R7 back into his chair. "(R7's) legs pop out. (R7) has no control of legs. (R7) was a heavy big man. (R7'a) legs slips off the foot rest all the time." V26 said she asked R7 if he was ok; R7 said he was ok, then R7 said 'but my leg' and asked for some candy. V26 said she was driving and did not see why/how R7 slipped. R7's knee was bent. V26 said she didn't want to say R7's buttock was completely out of the wheelchair, she just remembered getting R7 back into the seat. V26 said, "There is a high step inside the van. (R7's) knees were on the high step. Normally his feet are on the high step."

2. R8 has diagnoses of Alzheimer's disease, anxiety disorder, disorder of muscle, abnormal posture, lack of coordination and unspecified psychosis.

R8's brief interview for mental status dated 8/28/24 documents a score of 3/15 which indicate severe cognitive impairment. Height summary dated 7/9/24 documents: seventy (70) inches lying down.

R8's plan of care, initiated 9/5/24, documents: R8 presents with wandering behaviors, wandering with or without a purpose. On 9/23/24 resident presented with wandering behaviors in evidence by wandering into other residents' rooms. Nurse attempted to redirect resident out of patient's room and the resident was not receptive. Resident pushed his feet into the floor to stop the wheelchair from moving which caused the resident to fall. Interventions: Staff will assess for

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	IL6016497	A. BUILDING: _____ B. WING _____	C 10/11/2024

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SOUTH SUBURBAN REHAB CENTER	19000 SOUTH HALSTED HOMEWOOD, IL 60430

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S9999	Continued From page 13	S9999		

elopement. Date Initiated: 09/05/2024; Staff will provide opportunities for safe wandering throughout the unit. Date Initiated: 09/05/2024; Staff will provide redirection when resident is observed wandering into unsafe areas or situations. Date Initiated: 09/05/2024.

V18's witness statement, dated 9/22/24, documents: Resident(R8) fell out of the chair by placing feet forward and hit head on the floor above his left eyebrow.

R8's progress note, dated 9/22/24, documents: resident observed being mobile down the hallway staff attempted to re-direct resident back to nursing station for close monitoring when the resident fell from chair by placing feet down to stop chair movement and hit his head above left eyebrow. Care rendered to skin injury; laceration about 1 inch noted to the left eyebrow. Ice applied for comfort with gauze to secure bleeding, and tape to secure. Paramedics arrived to transfer resident to hospital further evaluation.

R8's incident report, dated 9/22/24, documents under description: resident observed being mobile down the hallway staff attempted to re-direct resident back to nursing station for close monitoring when the resident fell from chair by placing feet down to stop chair movement and hit his head above left eyebrow. Resident unable to give description. Immediate action: R8 hit head laceration noted to the left eyelid, clean with normal saline, gauze and ice applied with pressure, staff stayed with resident until paramedics arrived. Resident transferred to local hospital for further evaluation. Under injury laceration. Mental status: oriented to person. Predisposing physiological factors: confused, noncompliant with safety guidance. Under

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S9999	Continued From page 14	S9999		

predisposing situation factors: using a wheelchair, wanderer. Under notes: upon investigation, the root cause was related to resident putting his feet down while being pushed in the wheelchair. Referral made to therapy to evaluate for appropriate wheelchair/footrest.

R8's hospital records, dated 9/22/24: R8 presents for evaluation after falling out of his chair at nursing home. He hit his head and caused laceration to left eyebrow. He is alert and oriented x1 at baseline. Under laceration repair left eyebrow, two centimeters length; four sutures.

Facility reportable, dated 9/23/24, documents: R8 was observed wandering down unit hallway attempting to go in other resident's room. When verbally redirected by nurse. R8 was noncompliant. Nurse went to assist R8 back to the nurse's station, while mobilizing R8 in wheelchair he placed both feet firmly on the floor abruptly stopping the wheelchair and falling forward.

R8's physical therapy note, dated 9/25/24: Patient will benefit with a custom wheelchair to provide proper fitting and increase safety during mobility. Patient was using a regular wheelchair which is short/small for his physique. Staff education needed in using wheelchair leg rests if transporting patient secondary to patients decreased ability to maintain knee in extension.

On 10/9/2024 at 10:20am, V17 (Certified Nursing Assistant/CNA) said R8 was able to self-propel in the wheelchair, but required assistance when instructed to go to specific locations. V17 said, "(R8) tends to stick out his leg when being wheeled by staff. If you ask (R8) to lift his legs, sometimes (R8) will lift his legs up, and other

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S9999	Continued From page 15	S9999		

times (R8) will keep his feet planted on the ground."

On 10/9/24 at 10:56am, R8 was observed in bed. A high back specialized wheelchair with no foot rest was observed in R8's room. Foot rest was observed on the floor near R8's wardrobe cabinet. V2 (Director of Nursing/DON) said, "That is (R8's) high back wheelchair." V2 said she was not sure if the foot rest on the floor belonged to R8's new wheelchair. V2 said physical therapy assessed R8 after his fall. R8 was given a high back wheelchair with foot rest. R8 had a standard wheelchair prior to the fall. R8 was given a high back wheelchair due to the way R8 positioned himself in the standard wheelchair with his feet dragging the ground. "(R8) was holding his feet up while being pushed by (V18, Nurse). (R8) put his feet down resulting in a fall. Staff had access to foot rest. (R8) typically self-propels and did not have foot rest on his previous wheelchair when he was being pushed."

On 10/9/24 at 11:06am, V18 (nurse) said, "(R8) was in the doorway of another resident's room on the opposite hall. I went to get (R8) after I heard the other resident scream. I pulled (R8's) wheelchair back out of the doorway, turned, pivoted and pushed (R8's) wheelchair forward. (R8) put his feet down to stop his wheelchair. (R8) fell forward hitting the floor. (R8) had a laceration to the left eye. (R8) should have had foot rest on his wheelchair when he was being pushed."

On 10/9/24 at 2:28pm, V20 (physical therapy) said, "(R8) had a standard wheelchair that was too small and too short for his height. During my assessment, (R8) was asked to raise his legs to assess muscle strength. (R8) was weak. Ideally,

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S9999	Continued From page 16 leg rest should be used when a resident can't propel themselves. (R8) was given leg rest related to his decreased level of cognition, so if staff need to transport or push (R8) in the wheelchair on weak days, it could be done safely." (A)	S9999		