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	IL6005607	A. BUILDING: _____ B. WING _____	C 10/02/2024

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LUTHERAN HOME FOR THE AGED	800 WEST OAKTON STREET ARLINGTON HTS, IL 60004

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S 000	Initial Comments Facility Reported Incident Investigation for incident that occured September 20, 2024/IL178563.	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b)5) 300.1210c) 300.1210d)6) 300.1220b)3) 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 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	S9999		

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care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
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.
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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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S9999	Continued From page 2 These Requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to safely transfer two of two residents (R1, R3) reviewed for safe transfers in the sample of three. This failure contributed to R1 falling forward out of her wheel chair which required a transfer to a local hospital where R1 was diagnosed with a brain hemorrhage. The findings include: 1. R1's Admission Record shows she was admitted to the facility on January 27, 2024 with diagnoses including adult failure to thrive, traumatic subdural hemorrhage, palliative care, glaucoma, dementia, and macular degeneration. R1's Fall Scale dated September 20, 2024 shows she was at a moderate risk of falling. The facility's Incident Report shows on September 20, 2024, R1 had a fall from her wheel chair when she "impulsively and abruptly put her feet down on the floor while being propelled by staff. She landed face down to the floor with right side of face touching the floor. A small cut was noted, the arm of her eyeglasses's was bent." R1 became more confused overnight, labs were ordered and the results were insignificant to R1's mental status change. The doctor was notified by staff regarding the increase in confusion and developing skin discoloration to the right side of her face, prompting an emergency department transfer...care plan updated to reflect use of high back wheelchair with footrests...	S9999		

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R1's local emergency record shows on September 21, 2024 R1's brain cat scan showed "There is subarachnoid hemorrhage overlying the right frontal and temporal lobes. There is a small amount of subarachnoid hemorrhage in the right occipital lobe. Within the left frontal lobe, there is a 1.7 x 1.4 cm intraparenchymal hematoma with a small amount overlying subdural hemorrhage. There is a small amount of hemorrhage within the left lateral ventricle."

On October 1, 2024 at 9:37 AM, R1 was observed in a high back wheel chair with foot pedals on. R1 had some bruising to the right side of her forehead, eye, and cheek area.

On October 1, 2024 at 9:42 AM, V4 RN (Registered Nurse) said she was passing medications when R1 had her fall. V4 said V5 CNA (Certified Nursing Assistant) was wheeling R1 to the bathroom via her wheel chair when R1 put her feet down. V4 said that R1 fell forward on her right side. There was a small cut to R1's right eye from her glasses. V4 said that R1 was able to follow commands and was talking after her fall. V4 said when she came in for her shift the next day, the night nurse (V8-LPN-Licensed Practical Nurse) reported that R1 was more confused than normal and she called the doctor. V8 said the doctor ordered labs to be done. V4 said after breakfast, she called R1's primary doctor and told him about R1's increase in confusion and R1's doctor said to send R1 to the local emergency room. V4 said that if staff are bringing residents off of the unit or staff take residents to the bathroom via their wheel chairs, then foot rests should be applied.

On October 1, 2024 at 10:01 AM, V5 CNA said after R1 finished breakfast, he took R1 to the

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bathroom. V5 said that R1 is able to propel her wheel chair and did not want her foot pedals on the wheel chair. V5 said he was pushing R1's wheel chair and he told R1 to put her feet up. V5 said R1's feet were up. V5 said R1 then put both of her feet down while he was pushing R1's wheel chair and R1 fell forward on her right side. V5 said "it all happened so fast." V5 said that when staff are pushing residents' wheel chairs, staff would normally have foot pedals on for residents' safety. V5 said that R1 kept taking her foot off of the foot pedal so V5 took that as a "sign" that R1 did not want her foot pedals on. V5 said that R1 could not verbally say she did not want her foot pedals on. V5 said that R1 had dementia and R1 would not know to follow V5 to the bathroom by self propelling.

On October 1, 2024 at 12:26 PM, V8 LPN (Licensed Practical Nurse) said she was the night nurse taking care of R1 the night after her fall. V8 said she was making her rounds and noticed R1 not acting how she normally acts, so she called the on call doctor. V8 said the on call doctor ordered blood work to be done and to monitor the resident.

On October 1, 2024 at 9:56 AM, V6 CNA said resident wheel chairs should have foot rests on when staff is pushing them because you don't want the residents to jump and fall.

On October 1, 2024 at 9:58 AM, V7 CNA said when pushing resident's wheel chairs, the foot pedals should be on to help prevent the residents from tipping. V7 said the foot pedals also help the residents to not put their feet down on the ground while getting pushed.

R1's Care Plan initiated April 16, 2024 shows R1

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has impaired cognitive function/dementia or impaired thought processes related to dementia. Initiated January 20, 2024 and revised September 24, 2024 shows R1 is high risk for falls related to gait/balance problems, impulsive behaviors, and dementia. Make sure patient has a footrest on the wheelchair while ambulating her anytime and around the unit was initiated September 20, 2024.

The facility's Wheelchair and Associated Attachments policy last revised January 11, 2024 shows, "Resident requiring transport by wheelchair will have access to the equipment and associated detachable accessories (leg rests) at all times. Transport by wheelchair will be in accordance with safety guidelines for managing such transport equipment. Wheelchair leg rests are to be in position on the wheelchair in the following situation: The resident is propelled by staff, family members, volunteers, therapists, etc. General safety precautions when using wheelchair leg rests: Once the resident is seated in the wheelchair, make certain the foot rests are lowered and secured with the resident's feet in place before releasing the brakes and moving the wheel chair."

2. R3's Admission Record shows he was admitted to the facility on April 17, 2023 with diagnoses including congestive heart failure, secondary malignant neoplasm of bone, malignant neoplasm of prostate, sciatica, low back pain, and osteoarthritis.

R3's Care Plan revised on September 30, 2024 shows R3 is at high risk for falls related to confusion due to dementia, gait/balance problems, history of fall, and generalized weakness.

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S9999	Continued From page 6 On October 1, 2024 at 9:37 AM, V6 CNA pushed R3's wheel chair from the dining room to the activity room. R3 had gripper socks on and R3's feet were sliding against the floor. There were no leg rests to R3's wheelchair. At 9:46 AM, V5 CNA pushed R3's wheel chair to the middle of the hallway. R3's feet were sliding against the floor and R3 still did not have leg rests to his wheel chair. R3 was not self propelling his wheel chair. (A)	S9999		