STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145547	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dekalb County Rehab & Nursing	2600 North Annie Glidden Road Dekalb, IL 60115

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on observation, interview and record review the facility failed to ensure a resident (R2) was transferred safely and in a manner to prevent a resident fall. The facility failed to ensure care-planned, fall interventions were in place for a resident (R2) with a recent fall. The facility failed to ensure a resident (R3) was supervised while being toileted which contributed to a resident fall. These failures apply to 2 of 3 residents (R2, R3) reviewed for safety and supervision in the sample of 3. The findings include: 1. R2's Incident Note dated 12/25/24 showed, CNA (certified nursing assistant) notified me that resident had fallen while being transferred from wheelchair to sit stand (stand mechanical lift). CNA's said resident seem very nervous and anxious and would not stay still. When I arrived to resident room, I saw him on the floor on his side shaking and nervous . Resident is nonverbal so I couldn't ask if he was in pain . During assessment, I noticed resident has long red abrasion on the middle of his back . R2 remained in the facility post-fall and was monitored by facility staff. R2's care plan dated 10/22/24 showed R2 was severely cognitively impaired related to his diagnosis of Alzheimer's disease. The care plan showed R2 did not understand content of task and environment. I don't verbally respond. The plan showed R2 had a communication problem related to me not fully understanding contents of conversation. R2 was at high risk for falls due to his impaired cognition, poor safety awareness, and overestimating his physical abilities. The plan showed, I like to stand up from my wheelchair without staff assistance. R2's fall interventions included R2 was to have a bed or chair alarm in place at all times. R2 required a sit-to stand lift for all transfers. On 1/7/25 at 11:13 AM, R2 was seated in a wheelchair in his room with no staff present. R2 was observed repositioning his bottom forward in his wheelchair and attempted to stand but was unsuccessful. A chair/pad alarm was in place on the seat of R2's wheelchair, however the cord that connected the alarm box to R2's chair/pad was disconnected. The alarm box was turned off and not functioning. This surveyor attempted converse with R2 but got no verbal response from him. On 1/7/25 at 11:41 AM, R2 remained seated in a wheelchair in his room with no staff present. The alarm box remained disconnected from R2's chair/pad alarm. The alarm box was still turned off. (continued on next page)

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.

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: 145547	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2025
NAME OF PROVIDER OR SUPPLIER: Dekalb County Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 2600 North Annie Glidden Road, Dekalb, IL 60115	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/25 at 11:17 AM, V4 Licensed Practical Nurse stated R2 used to try and get up on his own so he has bed and chair alarms in place as fall interventions. On 1/7/25 at 10:48 AM, V8 Certified Nursing Assistant (CNA) stated she and V9 CNA were present when R2 fell on [DATE]. V8 CNA stated, (R2) was in the hall, trying to take his clothes off so we wheeled him into his room to put him into bed. He was anxious. He is always confused. He can't follow directions. He is nonverbal. We positioned the sit-to-stand in front of (R2) while he was seated in the wheelchair. He held onto the stand and was rocking back and forth. He kept shaking the stand with his hands. We didn't even get him strapped into the stand when he pulled himself forward out of the wheelchair onto the floor . On 1/7/25 at 11:30 AM, V3 Assistant Director of Nursing (ADON) stated R2 had a history of scooting forward in his wheelchair. V3 stated, (R2) is hard to redirect due to his cognition. If (R2) was holding onto the stand (sit-to-stand) and sliding forward in his wheelchair, they (V8 and V9 CNA's) should have stopped the transfer. The facility's sit-to-stand lift operator's instruction manual dated 10/24/24 showed patients should be able to bear some weight, have upper body strength and be able to follow simple commands to safely be transferred via a sit-to-stand lift. The manual showed if a patient does not meet each of these three criteria, a total body lift (hoyer mechanical lift) must be used. 2. R3's Incident Note dated 12/9/24 showed R3 was transferred to the toilet by V10 CNA. While on the toilet, R3 asked V10 CNA to get her a tissue for her nose. V10 CNA left R3 alone on the toilet as she walked out of R3's bathroom to retrieve a tissue for R3. The note showed when V10 CNA walked back into R3's bathroom, R3 was lying on the bathroom floor as she had fallen forward off the toilet. R3 was sent to a local hospital for an evaluation on 12/9/24. R3 returned to the facility on [DATE] with no diagnosed injuries as a result of the fall. R3's care plan dated 9/19/24 showed R3 was at high risk of falls due to her impaired mobility related to her diagnosis of CVA (stroke). The plan showed, I have poor safety awareness and lack functional limitations/judgement. I overestimate my physical capabilities. I have a tendency to not utilize my call-light for assistance and attempt self-transfers. I am impulsive and impatient . I frequently refuse the gait belt during transfers and require education on safety . On 1/7/25, three attempts to contact V10 CNA via phone for an interview were unsuccessful. On 1/7/25 at 10:40 AM, V7 Registered Nurse (RN) stated she was the nurse assigned to R3 on 12/9/24. V7 stated, (V10 CNA) came and got me because (R3) had fallen off the toilet. I walked into the bathroom and found (R3) on the floor. (V10) stated she had left (R3) alone on the toilet to go get her a tissue for her nose. When (V10) came back, (R3) was on the floor. I don't know why she didn't just give (R3) toilet paper to blow her nose . V7 stated any resident that is high risk for falls should be supervised when toileted. On 1/7/25 at 11:23 AM, V11 RN stated any resident that is impulsive, has poor safety awareness and has a history of self-transferring should be supervised by staff when toileted.