

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Lutheran Home for the Aged		STREET ADDRESS, CITY, STATE, ZIP CODE  800 West Oakton Street Arlington Hts, IL 60004	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34891</p> <p>Based on interview and record review the facility failed to assess a resident prior to being moved off the floor for 1 of 1 resident (R1) reviewed for safety in the sample of 3.</p> <p>The findings include:</p> <p>R1's face sheet printed on 4/18/24 showed diagnosis including but not limited to aftercare following joint replacement, fracture of right femur neck, sepsis, and urinary tract infection. R1's facility assessment dated [DATE] showed no cognitive impairment and no behaviors. The assessment showed substantial to maximal assistance required for toilet transfers.</p> <p>R1's care plan showed a focus area initiated 3/29/24 for acute pain related to femur fracture. Interventions included: Anticipate the resident's need for pain relief and respond immediately to any complaint of pain.</p> <p>On 4/18/24 at 12:15 PM, V6 (CNA-Certified Nurse Aide) stated he assisted R1 onto the toilet the morning of 4/1/24 around 6:30 AM. V6 said R1 was alert, oriented and had no communication deficits. V6 said R1 was able to stand and pivot onto the toilet with assistance. V6 placed the call light near R1 and exited the bathroom. V6 said he went across the hall and assisted a second resident. He was on his way back to check on R1 when he heard a crash and found R1 sitting directly on the bathroom floor. R1's pants were still down, and his wheelchair was next to the toilet. V6 said he immediately stuck his head out of the room door and called for help. He could see two nurses standing at the nurse station (approximately three rooms away). V6 said it was an agency nurse and a regular staff nurse. V6 stated R1 looked uncomfortable and was trying to scoot himself back up against the wall. R1 was alert and was apologizing for trying to transfer by himself. R1 repeatedly tried to stand and grab at the wheelchair handle to pull himself up. R1 said, I can't stay here on this cold floor. V6 said he told R1 to wait and don't move. R1 was frustrated and continued to pull himself up. V6 stated he continued to stay near R1 and waited for help. V6 said he guessed it was around 10 minutes or less. V6 said he decided to help R1 back into the wheelchair, wheeled him across the room, and continued to wait for nursing staff. V6 said around 7 AM, V4 (Occupational Therapist) entered the room and he told her R1 had fell. V4 exited the room and returned with V5 (LPN). V6 said V4 had to physically go get a nurse at the nurse station to get a response. V6 said the fall event happened right around shift change and he left approximately 10 minutes later.</p> <p>(continued on next page)</p>

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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/18/24 at 11:11 AM, V4 (Occupational Therapist) stated she entered R1's room on 4/1/24 to begin a morning therapy session. R1 was seated in his wheelchair, next to the bed. V6 appeared to be doing vitals and the blood pressure cuff was being removed. V6 told her R1 just fell so he did not know if R1 could do therapy. V4 said she went to the nurse station and told V5 (LPN-Licensed Practical Nurse). V4 and V5 returned to the room together and V5 did an assessment while R1 was seated in the wheelchair.</p> <p>On 4/18/24 at 11:25 AM, V5 (LPN) stated she was notified by V4 that R1 had fell . V5 said she entered R1's room and he was seated in his wheelchair, next to the bed. V5 said R1 was alert and said he tried to transfer himself off the toilet but fell . V5 asked how did R1 get back into the wheelchair. V6 stated he helped R1 off the floor and into the wheelchair.</p> <p>On 4/18/24 at 12:52 PM, V7 (Therapy Director) stated if a resident has a fall they should not be moved until a nurse has assessed them. The assessment ensures there is not any serious injury. There is the potential for more injury if the assessment is not done.</p> <p>On 4/18/24 at 1:00 PM, V3 (Assistant Director of Nurses) stated all unwitnessed falls require the resident to immediately be assessed. Residents should not be moved until the assessment is done. V3 stated it is a nursing expectation that staff report and respond immediately to a resident fall. Waiting or moving a fall resident before the assessment has the potential for more injury to occur.</p> <p>On 4/18/24 at 1:39 PM, V8 (Nurse Practitioner) stated she would expect residents to be assessed before being moved after a fall. The assessment is important to ensure it is safe to move the resident.</p> <p>The facility's Fall Prevention and Post-Falls Management policy last review dated 8/8/23 states under the After a Fall section: 1. If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. 4. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying, or standing position, and then document relevant details.</p>		