STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Home for the Aged	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)
F 0689 Level of Harm - 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** 34506 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 [DATE] 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 . 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. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. R3's Admission Record shows he was admitted to the facility on [DATE] 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. 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.