STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145765	A. Building B. Wing	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Rehab Center	5888 North Ridge Chicago, IL 60660

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** 45000 Based on interview and record review, the facility failed to use extensive assistance of two staff members during a manual bed-to-wheelchair transfer for one resident (R2) out of three residents reviewed for resident injury and falls. This failure resulted in R2 falling in the facility on 09/17/2024, during a manual bed-to-wheelchair transfer, sustaining a head injury and requiring four staples to the head. Findings include: R2s' Facesheet documents R2 has diagnoses not limited to: Diffuse traumatic brain injury with loss of consciousness, muscle spasm, other seizures, history of falling, and weakness. R2's MDS/Minimum Data Set, dated dated [DATE], documents R2 does not score on the BIMS/Brief Interview for Mental Status, and indicates R2 has memory problems. R2s' MDS documents R2 requires substantial/maximal assistance with chair/bed-to-chair transfer and sit to stand transfer. R2s' MDS documents R2 has impairments to upper and lower extremities on both sides. R2s' MDS documents R2 ambulates via wheelchair and is incontinent of bowel and bladder. R2s' care plan, dated 07/06/2024, documents R2 has an ADL/Activities of Daily Living Self Care Performance with Functional Deficit for transfers related to diagnosis of weakness to the upper and lower extremities. Interventions include to use gait belt for safety. R2s' Fall risk assessment, dated 07/27/2024, documents R2 is at high risk for falls. R2s' fall risk assessment documents R2 is unable to independently come to a standing position, R2 exhibits loss of balance while standing, and R2 has a decrease in muscle coordination. R2s' facility reported incident, dated 09/18/2024, documents R2 hit the right side of her head in the facility while being transferred from her bed to her wheelchair. (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Nursing progress note, dated 09/17/2024, written by V6 (Registered Nurse/RN) documents, Writer was informed by the staff that (R2) fell and hit her head on the nightstand. Writer went to see (R2) in the room. A full body was assessment done. Resident noted with a small laceration on the right temple. Writer notified NP (Nurse practitioner) and an order was given to send the resident to the local hospital for medical evaluation. Writer started neuro checks, vitals were taken, and the affected area was clean and covered with dry dressing. Resident was given PRN/as needed for pain as per MAR/medication administration record. Vitals were taken and were normal. Nursing Service and Administrator made aware. At 4:50 PM, writer scheduled ambulance for transportation. At 5:30 PM, R2 was transferred to the hospital. R2 left in stable condition. Nursing progress note, dated 09/18/2024, documents, (R2) returned to the facility from hospital with 4 staples and a bandage above the right eyebrow. Discharge instructions were to provide wound care, keep head elevated, and no limitations on wt./weight bearing. (R2) was placed in bed and safety measures were implemented. Vitals are normal. R2s' hospital records, dated 09/17/2024, documents R2 was evaluated in the hospital on 09/17/2024, and diagnosed with a scalp laceration. R2s' care plan, dated 10/04/2024, documents R2 was sent to the hospital for evaluation and treatment on 9-17-24. R2 returned to facility with 4 staples above the right eyebrow on 9-18-24. On 11/30/2024 at 9:56 AM, R2 was observed fully dressed sitting in a wheelchair inside the second-floor dayroom. R2 was not interviewable and unable to make her needs known. On 11/30/2024 at 2:20 PM, V6 (Registered Nurse/RN) stated on 09/17/2024, she remembers R2 sitting in the second-floor dayroom and needed her incontinence brief changed. V6 stated two CNAs (identified as V9/CNA and V10/CNA) took R2 to her room so they could provide incontinence care for R2. V6 stated, (R2) is a two-person assist with transfers, which is why two CNAs were present to assist (R2). V6 stated she did not witness R2 fall, but was informed V10 was in the shower room and V9 was standing next to R2. V6 stated R2 attempted to stand up and lost her balance, and V9 tried to catch R2. V6 stated, (V9) was unable to catch (R2) from falling on the floor and (R2) hit her head on the nightstand. V6 stated she believes the incident occurred during the process of trying to transfer R2 and transport her back to the day room after they had finished changing R2s' incontinence brief. V6 stated, (R2) has history of falling. (R2) sits on the bed and starts jerking her legs, attempting to wiggle herself out of the bed. V6 stated V10 (Certified Nursing Assistant/CNA) was the CNA assigned to care for R2 on 09/17/2024. V6 stated she was made aware of R2s' injury when V9 (CNA) came to get her in the dayroom and told her R2 fell and hit her forehead. V6 stated she immediately went to assess and assist R2. V6 stated when she arrived, she saw R2 was sitting on the bed and had some bleeding on her head. V6 stated she called the DON/Director of Nursing, the Administrator, and R2s' doctor to make them aware. V6 stated R2s' doctor ordered to send R2 to the hospital for evaluation. V6 stated she then cleaned R2s' wound and applied a dry protective dressing. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/01/2024 at 10:47 AM, V10 (Certified Nursing Assistant/CNA) stated she was responsible for caring for R2 on 09/17/2024. V10 stated R2 was located in the day room on 09/17/2024, and needed her incontinence brief changed. V10 stated R2 is a two-person assist, so V10 asked another CNA (identified as V9/CNA) to assist her with changing R2. V10 stated R2 was transported to her room via wheelchair and placed inside of her room. V10 stated she immediately went to the bathroom to prepare towels and warm the water to provide incontinence care for R2. V10 stated she was inside of the bathroom for approximately six minutes. V10 stated V9 stayed with R2 while V10 was inside of the bathroom. V10 stated once she finished in the bathroom, she went inside of R2s' room and saw R2 on the bed and a little blood on the floor at the bedside. V10 stated she asked what happened, and V9 told her R2 fell . V10 stated she did not witness R2 fall or what occurred, because she was in the bathroom. V10 stated she then stayed with R2 while V9 went to inform the nurse R2 had fall and was bleeding. V10 stated she began to clean the blood up off of the floor and also saw R2 had a little blood on her forehead. V10 stated she never touched R2, did not witness what happened, or why R2 was bleeding. V10 stated once the nurse arrived (identified as V6/RN), V6 examined the cut on R2 and asked what happened. V10 stated she informed V6 that she was not there and did not see what happened. V10 stated V9 informed V6 that R2 fell . On 12/01/2024 at 1:21 PM, V10 (Certified Nursing Assistant/CNA) stated she can't remember exactly who transported R2 to her room, but R2 was transported to her room via wheelchair and placed inside of her room. V10 stated during this time, incontinence care had not occurred for R2 yet, and she went inside the bathroom to prepare towels and warm water. V10 stated when she returned to R2s' room, she saw R2 sitting on the bed bleeding and V10 is unaware of how R2 got onto the bed. On 12/01/2024 at 11:08 AM, V9 (CNA) stated he was not the CNA assigned to care for R2 on 09/17/2024. V9 stated R2 is a two-person assist with transfers, and was asked by V10 (CNA) to assist her with transferring R2 and incontinence care for R2. V9 stated he has provided care for R2 on previous occasions and is familiar with R2. V9 stated he stayed with R2 while V10 went to the bathroom. V9 initially stated he was helping R2 from the bed to the wheelchair, when R2 hit her head on the nightstand. Upon further interview, V9 stated he was positioned directly in front of R2, holding R2 by the shirt, while R2 was sitting on the bed. V9 stated he was waiting for V10 to come back from the bathroom so he could transfer R2 from the bed to the wheelchair. V9 stated, That's when (R2) suddenly reached out to the nightstand and bumped her head on the nightstand. V9 stated R2 got up and tried to reach towards the nightstand. He lost his grip on her and R2 fell . V9 stated it happened all of a sudden because he didn't know that (R2) would do that. V9 stated R2 moves back and forth while in the sitting position and does not sit still. V9 stated V10 entered the room and he and V10 sat R2 on the bed. V9 stated that's when they both realized that R2 was bleeding. V9 stated he then went to report the incident to the nurse (identified as V6/RN). V9 stated sometimes he uses a gait belt to transfer residents, but not every time. V9 stated if he does not have another staff member to assist him right away with a two-person assist and staff are busy, then he uses a gait belt to transfer the residents by himself. V9 stated he does this when the facility is short staffed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/01/24 at 1:54PM, V9 (CNA) stated when he arrived to R2s' room to assist V10, R2 was already inside of R2s' room sitting in her wheelchair. V9 stated he and V10 then transferred R2 from the wheelchair to the bed. V9 stated he and V10 immediately began incontinence care for R2. V9 stated the towels and the water were already located inside of R2s' room, soaking in water inside a bin. V9 stated his role was to take off R2s' diaper, clean her, and assist to transfer her back to the wheelchair. V9 stated V10 was going back and forth to the bathroom exchanging water, washing her hands, and bringing the bin back. V9 stated incontinence care was provided for R2 prior to V10 going to the bathroom for the first time. V9 stated R2 fell after incontinence care was provided and while he was waiting on V10 to return back from the bathroom. V9 stated at this time, R2 was sitting on the bed fully dressed because he and V10 had provided incontinence care and fully dressed R2. V9 stated he was only waiting on V10 so that he could get assistance with transferring R2 from the bed to the wheelchair and take her back to the dayroom. On 12/01/2024 at 11:48 AM, V12 (Restorative Nurse/Fall Coordinator/LPN), stated he is familiar with R2.(R2) is an extensive to total care assist with ADL/Activities of Daily Living care. For transfers, (R2) needs at least a two-person assist due to her history of seizures and traumatic brain injury. (R2) ambulates via wheelchair and should be in a wheelchair when (R2) is not walking. (R2) also has an abnormal posture and muscle spasms. (R2) tends to stand up and has issues with safety awareness. (R2) wiggles around and still thinks she can do everything on her own, but she can't. V12 stated he is aware of the incident involving R2s' head injury. V12 stated he was made aware one of the CNAs (identified as V9/CNA) tried to transfer R2 by themself, and R2 fell and hit her head. V12 stated, (R2) had a wound on her head and was sent out to the hospital for evaluation. (V9) was not supposed to transfer (R2) by himself. (V9) was supposed to ask for help from another staff member to transfer (R2), especially since (V9) has a smaller weight/frame size than (R2). V12 stated a proper bed to wheelchair transfer should be as follows: one staff member standing in front of the resident and places a gait belt on the resident. The other staff member should be positioned on the other side of the resident to help move the resident from the bed to the wheelchair. V12 stated during a two-person transfer procedure, it is not acceptable for one staff member to leave the room. V12 stated R2 has spasms and always requires two people for transfers because of how R2 moves her body. V12 stated R2 is a high risk for falls. Facility policy undated, titled Supervision and Safety documents, 9. Staff to decrease safety risk hazards as much as possible. Facility policy undated, titled Lifting/Transfers documents, Purpose: To promote comfort, maintain good body alignment, decrease the complications related to immobility, and decrease the possibility of injury to the resident. 4. Transferring a resident with injuries, pain or dementia can cause anxiety. The procedure should be done carefully while providing support and reassurance to the resident. Facility policy undated, titled Limited Lifting Resident Handling Policy documents, 9. Use of gait belt for all physical assist transfers is mandatory. Facility policy undated 01/12/2024, titled Fall Prevention Program documents, The Fall Prevention Program includes the following components: 10. Care plan incorporates: a. Identification of all risk/issue. c. Preventative measures. Standard Fall/Safety Precautions for all Residents: 12. Transfer conveyances shall be used to transfer residents in accordance with the plan of care.