STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005607	A. BUILDING: _____ B. WING _____	C 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME FOR THE AGED	800 WEST OAKTON STREET ARLINGTON HTS, IL 60004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 9/20/23/IL165262	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 care needs of the resident. 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.	S9999		

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S9999	Continued From page 2 These Requirements were not met evidenced by: Based on interview and record review the facility failed to ensure a gait belt was used to safely transfer a resident. This failure contributed to R1 falling and sustaining a right femur fracture requiring hospitalization and surgical intervention. This applies to 1 of 5 residents (R1) reviewed for safety/supervision in the sample of 5. The findings include: R1's face sheet shows she is a 89 year old female with diagnoses including: transient ischemic attack, restless leg syndrome, pain in right leg and atrial fibrillation. R1's 9/14/23 facility assessment shows her cognition is intact, and she requires extensive 1 staff assistance with transfers. R1's care plan shows she has an ADL (Activities of Daily Living) self- care deficit due to having a cerebral vascular accident (stroke) with right sided weakness. R1's 8/10/22 fall risk care plan shows she is at a moderate risk for falls related to having weakness and gait and balance problems. R1's 9/20/23 6:00 AM, nursing progress note completed by V5 (Licensed Practical Nurse/LPN) shows that R1 had a fall while being transferred by staff from her wheelchair to the toilet. The note says that R1 indicated to V5 that she felt her knees buckle and she fell forward landing on her knees. After the fall R1 was not able to move her right lower extremity and said she was having a lot of pain to her right knee. R1's 9/20/23 progress notes show after the fall R1 continued to complain of pain to her right leg and was sent to	S9999		

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S9999	Continued From page 3 the local emergency room for evaluation and was admitted with a right femur fracture. R1's Nursing progress notes show she was re-admitted to the facility on 9/28/23 and had a surgical incision and immobilizer on her right leg. R1's hospital records from a local community hospital show she was admitted to the hospital on 9/20/23 after falling at the facility and was found to have a a right peri-prosthetic distal femur fracture. R1 underwent surgery on 9/22/23 for a "complex revision of the right total knee arthroplasty." A final IDPH (Illinois Department of Public Health) notification of serious incident report form completed by V3 (Assistant Director of Nursing/ADON) on 9/21/23 shows that R1 sustained a fall on 9/20/23 during a staff assisted transfer from wheelchair to the toilet. The report describes R1 as alert and oriented with some periods of forgetfulness. The report says that R1 should be transferred by one staff person and a gait belt. On 10/10/23 at 10:03 AM, R1 said "I had a fall while being transferred to the toilet. The aide did not use a gait belt on me like they usually do, and she was rushing me and said come on let's go and next thing I knew I was on the floor. She did not ask me if I was ready to stand like the CNAs (Certified Nursing Assistants) usually do. She was standing beside me and used my pants and arm to try to grab me when my knees buckled and I went down. If she had put a belt on and let me go slow she could have assisted me to transfer and held on to me, because I have been doing really good. Once I hit the floor all I know is I was in a lot of pain on my right knee."	S9999		

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S9999	Continued From page 4 On 10/10/23 at 10:15 AM, V4 (Registered Nurse/RN) said R1 is a stand and pivot transfer with 1-2 staff persons and a gait belt. V4 said she has heard that when R1 had the fall resulting in a fracture, the CNA did not use a gait belt to assist R1 to pivot and turn. On 10/10/23 at 10:23 AM, V6 (CNA) said gait belts are required to transfer all residents. V6 said with R1 you have to go slow, explain to her what you want her to do and let her get going slowly. On 10/10/23 at 11:02 AM, V5 (LPN) said she was notified by the CNA (V8) that R1 had fallen and was on the floor. V5 said she got into the bathroom and R1 was covered in urine and feces and on the floor crying out in pain. She said R1 had her legs out in front of her and complained of pain to her right knee. V5 said R1 did not have a gait belt on her when she arrived to the room and she asked V8 why she didn't use a gait belt to transfer R1 and V8 said something like she had forgotten. V5 said gait belts are required during all resident transfers and had V8 used one during R1's transfer she would have been able to use it to stabilize R1 when her knees buckled. On 10/10/23 at 11:07 AM, V8 (CNA) said she had taken R1 into the bathroom and had pulled her pants down to put her on the toilet. She was standing beside R1 and R1 used her walker to stand up and pivot and then "it happened so fast" her knees buckled and she was on the floor. V8 said she did not use a gait belt during R1's transfer and she was supposed to and usually does. V8 said she felt so bad after R1's fall happened, and she did tell the facility staff that she did not use a gait belt during the transfer and she received "coaching" from the facility about the incident.	S9999		

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S9999	Continued From page 5 On 10/10/23 at 11:18 AM, V9 (Nurse Practitioner) said "It is common sense for a resident of this age to be moved with a gait belt. I think it would have helped the CNA to have something to grab on to instead of the back of the resident's pants to prevent the fall." V9 said the facility should be following their gait belt protocol and this type of fall would be consistent with R1's femur fracture. On 10/10/23 at 11:26 AM, V3 (ADON) said gait belts are required for all resident transfers and V8 was given in-servicing and education after R1's fall occurred. A facility provided document titled "Pledge for Transfer Safety" was signed by V8 on 1/12/23 showing she understood that gait belts are required for all assisted transfers. A facility provided document titled "Gait Belt use Acknowledgement" signed by V8 on 1/12/23 shows it is an expectation of work performance to use a gait belt with proper technique with residents that require assistance with transfers or ambulation and failure to do so may result in disciplinary action. The facility provided Gait Belt/Transfers policy revised on 2/14/23 states, "All staff members who assist resident to transfer will be required to use a gait belt." (A)	S9999		