STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006688	A. BUILDING _____ B. WING _____	C 01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA REHAB & SENIOR CARE	2833 NORTH NORDICA AVENUE CHICAGO, IL 60634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID 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 11/1/22/IL153407	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care 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	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 These requirements were not met as evidenced by: Based on interview and record review, the facility failed to use a gait belt and or walker during transfer from wheelchair to bed for one of three (R1) residents reviewed for safe transfers. This failure resulted in R1 falling to the floor during transfer and sustaining an incomplete fracture to the left medial malleolus (broken ankle). Findings include: R1's MDS (Minimum Data Set of 10.18.2022) documents R1 is a cognitively intact 89-year-old admitted to the facility on 7.16.2021 with diagnoses including but not limited to Metabolic Encephalopathy, Atrial Fibrillation, Arthritis, Osteoporosis, and Heart Failure. R1 is not steady during surface-to-surface transfer (between bed and wheelchair) and is only able to stabilize with staff assistance. Facility's incident report of 11.1.2022 notes in part, the resident transfers with stand by assist, with walker and can transfer from wheelchair to bed. On 10.21.2022 the nursing assistant was helping the resident into bed, the resident stood up from wheelchair, held onto walker and then started to become weak with legs starting to shake. The nursing assistant felt that the resident was about to fall and assisted with sliding down to the floor. On 1.26.2023 at 1:45 PM. R1 said, "I was getting back in bed, I was turning around, apparently I wasn't close enough to the bed, I missed the bed	S9999		

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S9999	Continued From page 2 and fell on the floor." On 1.26.2023 at 2:44 PM, V6 (CNA-Certified Nursing Assistant) said, R1 was in R1's wheelchair. V6 said, "I put the wheelchair close to R1's bed. R1 didn't have a walker to grab onto. R1 said they (R1 and V6) could do it, so I assumed R1 could. I was standing in front R1, holding on to the back of R1's pants. I told R1 to hold onto the railing. R1 was kind of off balance, looked unsteady when R1 got up from wheelchair and R1 started to fall. I got behind R1. R1 started really sliding. I slid R1 down my leg to the floor. I did not know what R1's transfer status was before I attempted to transfer R1. I didn't use a gait belt. I hold back of their (residents) pants, that's how I secure them." On 1.26.2023 at 4:30 PM, V9 (Director of Rehab/Speech Therapist) said R1's walker should have been used during transfer from wheelchair to bed. Progress note of 10.22.2022 at 12:00 PM notes, (R1) states had a fall 2 days ago when transferring from wheelchair to bed with CNA. R1 states was not ready to transfer, felt pushed, lost balance and landed on the floor bedside. Progress note of 10.22.2022 at 2:00 PM notes, resident said (R1) had fallen on Thursday 10/20/22 around noon. Resident said was in (R1's) wheelchair and was going to be transferred to bed with the help of a CNA. (R1) said they (R1 and V6) stood up but before they could stand up completely, the CNA pulled R1 on to the bed which made R1 lose R1's footing and fall to the floor. R1's at risk for falls care plan (initiated 7.16.2021,	S9999		

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S9999	Continued From page 3 revised 10.20.2022) notes, "staff to ensure gait belt is used when transferring resident." Left ankle x-ray report of 11.1.2022 notes incomplete fracture of the medial malleolus. (B)	S9999		