STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145844	A. BUILDING _____ B. WING _____	**07/28/2020**

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

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** Based on interview and record review the facility failed to identify and remove the risk of injury while transferring R1 from the wheelchair to the bed. This failure resulted in R1 sustaining a laceration to the left lower extremity Findings Include: R1 has [DIAGNOSES REDACTED]. R1 was admitted to the facility 12/14/19. R1's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 06 indicating severe cognitive impact. On 07/19/20 R1 was transferred to the hospital due to the laceration to the Left Lower Extremity. On 07/24/20 at 11:17 AM V5 (Certified Nurse Assistant) stated 'I am not aware of any open wounds to R1's leg prior to 07/19/20. On 07/24/20 at 11:23 AM V4 (Registered Nurse) stated on 07/19/20 there was an open laceration to the left leg that was wrapped with a gauze. On 07/18/20 R1 did not have any open wounds on his legs. On 07/24/20 at 11:33 AM V6 (Certified Nurse Assistant) stated on 07/18/20 no open wounds were seen on R1's legs. On 07/24/20 at 11:45 AM V7 (Registered Nurse) stated I took care of R1 once and he did not have any wounds on his body. On 07/24/20 at 12:06 PM V3 (Director of Nursing) stated R1 had no evidence or documented wounds to the left lower extremity. The staff noticed an opening to the left leg over the weekend. Based on the investigation, before transfer to bed his skin was intact and after the transfer he had a wound to his leg. On 07/24/20 at 12:18 PM V8 (Certified Nurse Assistant) stated me and another CNA(Certified Nurse Assistant) and nurse transferred R1 to bed. Me and the nurse lifted his legs into the bed and that is when we saw the blood coming from his leg. The wound looked pretty deep. I cleaned the blood from the floor then left the room. Prior to that I do not know if he had any wounds. Prior to 07/18/20 he did not have any dressings on his legs. On 07/24/20 at 12:29 PM V9 (Licensed Practical Nurse) stated I did not see any open areas to R1 legs. When I came to work 07/18/20 R1 was up in a wheelchair. We pushed him to his room. Me and 2 CNA's transferred him to bed. I was on the right side of him, one CNA was on his left and the other CNA was holding his wheelchair. We helped him stand up and pivot to the bed. He sat on the bed, V8 (Certified Nurse Assistant) and I lifted his legs to put them in the bed. I saw red blood. It might have been 30 cc. Some of it squirted out of the wound. There was an opening at the top of his leg near the calf. There was a thin area 3 cm opening in width. The length went all the way down his leg near his foot. He did not have any wounds to his leg prior, not to my knowledge. It was a gash. There was some blood on the floor next to the bed. On 07/24/20 at 12:48 PM V10 (Medical Director) stated R1 has a vertical skin laceration to lower left leg with exposed muscle. It is a new laceration. Most likely from something pulling up on his leg and tearing his skin. It is 25 cm in length and 1/2 cm in width. It appears something had to be sharp. On 07/24/20 at 12:56 PM V11 (Certified Nurse Assistant) stated R1 was wheeling himself with the rails in the halls. There was no blood on the floor near or around him. He was wheeled into his room, his wheelchair was positioned beside his bed. I was behind the wheelchair. The transfer happened and they put his legs on the bed. There was a pool of blood on the floor. There was a laceration on his leg. On 07/24/20 at 01:38 PM V12 (Assistant Director of Nursing) stated, I worked with R1 Thursday 07/16/20 and Friday 07/17/20. He did not have any wounds to his legs. The laceration to R1 LLE (Left Lower Extremity) measurements 11 cm x 3 cm. There was a long laceration on left lateral side. The lower extremity, in the middle, it was whiter and irregular shaped. It was deep about 1 cm. On 07/24/20 at 02:42 PM V6 (Certified Nurse Assistant) stated on 07/17/20, R1 was given shower and he did not have any open areas on his legs. On 07/24/20 at 02:48 PM V13 (Registered Nurse) stated on 07/18/20 R1's left leg was clearly visible, with no injuries. On 07/28/20 at 08:40 AM V15 (Licensed Practical Nurse) stated I had R1 as a patient on 07/16/20. I do not remember R1 having any open areas to his leg On 07/28/20 at 09:08 AM V2 (Administrator) stated I did the initial investigation. I was on site Sunday 07/19/20 and the ADON told me R1 had a skin tear of unknown origin. He was not aware of how it got there. During my investigation we looked at the wheelchair and bed to see how it transpired. The wheelchair did not have leg rest and the C-shaped part that holds the leg rest is kind of sharp and was exposed. We looked at the bed and there is nothing sharp on it. The wheelchair was right next to the bed. He could have bumped his leg. On 07/28/20 Record review of Progress Note dated 07/18/20 at 2300 reads in part resident skin noted as intact. Progress Note dated 07/19/20 at 02:54 reads in part resident assisted to bed. Resident noted with left lower leg ulcer. Left lower lateral leg with moderate amount of blood. Progress Note dated 07/19/20 at 10:27 reads in part noted open skin area to left lateral lower leg 18 cm x 4 cm with small amount of blood, irregular shape, skin around laceration pinkish/purple in color and hard to touch. Progress note dated 07/19/20 at 19:40 reads in part has a vertical laceration on lateral lower 2/3rd (Two third) of leg with bleeding, wound gaped 1 - 1.5 inch, exposing underlying muscle. Record review of hospital medical records indicate [DIAGNOSES REDACTED]. Wound is deep exposing muscle. Patients' lower leg skin is grayish in color. Left lower extremity to the leg region has a significant laceration from the knee to the ankle exposed with mild bloody oozing likely of lack all the way to the muscle. Patient presents with approximately 14-inch laceration on LLE (Left Lower Extremity). Record review of Treatment Result Report reads in part on 07/18/20 R1 has skin tear/open area to lateral site on left lower leg. R1 was being transferred to bed. The Nurse and CNA (Certified Nurse Assistant) assisted R1 to stand and Pivot from the wheelchair to the bed. After transfer was complete fluid, blood, and skin tear/open area were observed. Records were reviewed and staff were interviewed and there is no evidence of any bruising, skin tear, wounds, etc. (Etcetera) to LLE (Left Lower Extremity) until the identified incident on July 18th. Staff interviews lead to the conclusion that resident sustained [REDACTED]. Policy: Abuse and Neglect Policy and Procedure Reviewed 2019 reads in part an injury should be classified as an injury of unknown source when the source of the injury was not observed by any person or the source of the injury could not be explained by the resident. The injury is suspicious because of the extent of the injury or the location of the injury.

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

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.