STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145806	A. BUILDING _____ B. WING _____	C 08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN PARK HEALTH & LIVING CTR	6700 NORTH DAMEN AVENUE CHICAGO, IL 60645

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaints: 2185720/IL136899 - No Deficiency 2184009/IL134780 - No Deficiency Facility Reported Incident of 8/1/2021/IL137233 - F689 G	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and records review the facility failed to maintain safety measures to prevent falls or accidents, to follow the fall policy on interventions to help prevent falls for 1 (R2) out of 4 residents (R1, R2, R3 and R4) reviewed for fall prevention in the total sample of 4 residents. These failures resulted in R2 falling multiple times and sustaining multiple injuries. R2's 8/1/21 fall injuries included an anterior frontal lobe subdural brain hemorrhage (or subdural hematoma, or bleeding) a right forehead laceration closed with 11 stitches, right eye bruising and a left leg abrasion. Findings include: R2 is 60 years old, originally admitted to the facility on 5/19/17. Medical diagnosis includes Traumatic Subdural Hemorrhage dated 8/3/21	F 689	WARREN PARK HEALTH & LIVING CENTER PLAN OF CORRECTION 08/27/21 SURVEY F 689 The following Plan of Correction shall also serve as the Facility's written credible allegation of compliance that will be achieved by the stated date of completion. Submission of this Plan of Correction does not constitute in any way an admission of any facts and/or conclusions of law reflected in the alleged deficiencies nor does it constitute a waiver of the Facility's right to contest the deficiencies and/or any remedies imposed as a result	9/10/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2021

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F 689	Continued From page 1 due to history of falling. On 8/24/21 at 10:14 AM, R2 was seen in her room alert and verbally able to express her thoughts. R2 stated, "I was having problem falling big and small falls. I mean big because I went to the hospital and the rest are small falls. Twice I fell on the stairwell, I cannot remember the most recent fall on the stairwell because I lost consciousness. It was all so blurred that I cannot recall. But I also fell around 9 to 10 months ago and went to the hospital. I used the stairwell by myself going up and down the 3rd Floor to visit a friend. Yes, I visit R3 on the 3rd Floor. Today I am scheduled to have my stitches out (showing me the staples on her right forehead). Now they told me not to use the stairwell anymore." On 8/24/21 at 10:50 AM, the 2nd floor and 3rd floor were reviewed. On the 2nd floor there were 3 doors that can be used to gain access to the stairwell. North door, middle door, and the south door. All doors have a keypad to disable the alarm when opening the door. The alarm can be silenced easily without using the keypad by pushing a large square button. On the 3rd Floor there are 2 doors that lead to the stairwell. The first door is near the elevator and with alarm keypads. The Second door connects to the middle door on the 2nd Floor. There was no nursing staff stationed on the 3rd Floor. On 8/26/21 at 12:40 PM, on tour with V14 (Social Worker) of the 3rd Floor, the middle door was opened but the alarm was not sounding. When asked, V14 stated that she didn't know why the door was not closed and the alarm was not sounding. Then V14 closed the door and re-opened it again and the alarm still wasn't	F 689	of this or future surveys. The Facility ensures that the resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. I. Corrective action for residents identified in the deficiency. R-2 has been reassessed and Care Plan revised. II. Identifying other residents with potential for being affected and corrective action. All residents who are at risk for falls are potentially affected. The Facility will provide each resident with the level of supervision that he or she needs at any given time. Care Plans will be reviewed and revised as necessary after falls. Door alarm identified in the survey has been repaired. III. Systemic changes to reasonably assure deficiency does not recur. On or before 09/10/21, inservices will be held with nursing staff. Director of Nursing and/or her designee will conduct the inservices. The inservices will include: 1) a review of the requirement that the Facility reasonably assures that residents' environment remain as accident free as possible; 2) a review of the alleged deficiency; and 3) a review of the requirement to follow the Facility's Falls and Fall Risk Management Policy.	

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F 689	Continued From page 2	F 689		

sounding. V14 stated, "Oops, I didn't know the alarm was not working."

On 8/26/21 at 11:10 AM, V2 (Director of Nursing) stated that on R2's recent fall of 8/1/21, R2 was found on the stairwell near the middle door on the 2nd Floor level. R2 went to the hospital and had injuries including a subdural hematoma. V2 was not aware about R2's incident dated 7/24/20 also on the same stairwell. V2 stated that there are no nursing staff stationed on the 3rd Floor and the 1st and 2nd floor nurses were assigned to 3rd floor residents.

On 8/26/21 at 11:31 AM, V6 (Registered Nurse) stated that R2 was a resident on the 3rd Floor before R2 fell on 7/24/20. After the fall R2 was transferred to the 2nd Floor. V6 said that R2 was sent to the hospital due to the fall.

On 8/26/21 at 11:54 AM, V8 (Rehab Nurse) stated that R2 can ambulate by herself but needs redirection. R2 needs monitoring and supervision and that the care plan should have addressed the identified problem of falling on the stairwell.

On 8/26/21 at 12:12 PM, V7 (Licensed Practical Nurse) stated that she was the nurse assigned during R2's fall incident that happened on 8/1/21. V7 stated she heard a loud sound. When checking the stairwell, R2 was found on the 2nd floor level by the middle door with a bad injury to the forehead. R2 was then transferred to the hospital and was admitted. V7 stated that R2 was transferred from 3rd Floor to 2nd Floor to be monitored, since there are no nursing staff stationed on the 3rd floor.The alarm sound cannot be heard on the 2nd floor if it was sounding on the 3rd floor. V7 stated that the 2nd

IV. How corrective actions will be monitored.
Charge Nurses and/or their designees will perform spot checks at least weekly to determine level of staff compliance with residents' care plan interventions. Any irregularities will be corrected and noted on a Quality Assurance report. Director of Nursing and/or her designee will monitor for overall compliance through her general supervision and reports from Charge Nurses and staff compliance.

V. Completion Date: 09/10/21

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floor alarm can be silenced easily by just a single press of the button.

On 8/26/21 at 3:15 PM, V1 (Administrator) was notified about the door on the 3rd Floor that it was left open and that the alarm was not working. V1 stated that he was informed by staff regarding the alarm not working on the 3rd Floor door going to the stairwell. And that he called an outside vendor to fix it by the next day.

On 8/27/21 at 11:35 AM, V16 (Primary Care Physician) stated, "R2's fall was preventable and that it was very unfortunate. R2 should not be in the stairwell. During the most recent fall (8/1/21), R2 sustained subdural hematoma or basically bleeding of the brain. This should not have happened nor should it happen again to R2 or anyone else."

Record review shows R2 had multiple fall incidents, as follows:

Notes dated 2/20/20, at 3:38 PM documents R2 fell in the basement hallway, small bruise was noted on the left knee.

Notes dated 10/28/20, at 12:06 AM documents R2 was observed on the floor next to her bed.

Notes dated 4/17/21, at 10:46 PM documents R2 was found sitting on the floor.

Notes dated 7/24/20, at 12:30 PM documents R2 fell in the stairwell. R2 stated, I lost my balance and tumbled down the stairwell. R2 was transferred to the hospital around 1:30 PM. The 7/25/2020 at 2:25 AM note documents, R2 returned to the facility at 1:35 AM and has a sling

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on her left arm from the hospital.

Hospital records dated 7/24/20 read that R2's reason for the visit was due to fall and shoulder injury.

Notes dated 8/1/21 at 5:00 PM documents R2 was noted at the bottom of the stairwell to door # 3 from the 3rd Floor. R2 was then transferred to the hospital and came back on 8/3/21 were the following injuries were present: right forehead laceration closed with 11 stitches, right eye bruising and left leg abrasion.

Hospital records dated 8/1/21 read that R2, based on a computerized tomography scan (CT Scan) of the head, sustained an acute 4 mm subdural hemorrhage in the anterior frontal lobe or subdural hematoma.

R2's Minimum Data Set Assessment under reads that R2 needs 1 supervision on both walking in the room or corridor. The following activity was not attempted:
The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor) and the ability to go up and down a curb and/or up and down one step due to medical condition of safety concerns.

R2's Morse Fall Scale Assessment dated 10/27/20 results read that resident was low risk for falling although resident has history of multiple falls.

R2's Care Plan history reads that although R2 was still using the stairwell and fell on 7/24/20 on the stairs with multiple falls in between, almost all interventions including reminding R2 to use elevator instead of the stairwell was resolved

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dated 6/4/21. On 8/1/21, R2 fell and sustained an injury of subdural hematoma The care plan intervention does not address R2's risk, accident, or falls related to using the stairwell.

Falls and Fall Risk Management Policy dated 3/2018 reads:

Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.

Resident-Centered Approaches to Managing Falls and Fall Risk

5.If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant.

6.If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable.

Monitoring Subsequent Falls and Fall Risk

1.The staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling.

3.If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current

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F 689	Continued From page 6 interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.	F 689		