STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145382	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee Manor	1301 Lee Street Des Plaines, IL 60018

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41758 Based on interview and record review, the facility failed to follow their Community Privileges and Notice of Resident Rights and Responsibilities policies by not obtaining a doctor's order or consent from the durable Power of Attorney (POA) prior to allowing a resident to leave on pass with a family member. This affected one of three residents (R1) reviewed for pass privilege policy and procedure. Findings Include: R1 was admitted on with the diagnosis of Dementia with Lewy Bodies, Traumatic Brain Injury and Cognitive Communication Deficit. R1's Brief Interview for Mental Status, dated 8/19/24, documents a score of ninety-nine, which indicates the resident was unable to complete the interview with short (recall after five minutes) and long term memory problems. R1's Community survival /risk, dated 8/10/2024, documents: Resident (R1) is new to the facility with Lewy Body and alert times one. It is recommended and agreed upon with her surrogate (V19) that resident is not capable physically or cognitively able to go into the community independently. It is recommended she may go with (V19) (ONLY) with primary care physician (PCP) order. She (V19) is aware that when leaving the property she will need to sign her off the unit and sign her back in on the floor when she returns. Nursing note, dated 10/14/24, documents: R1 accompanied by V19 went out on pass. On 11/12/24 at 2:55PM, V20 (R1's POA) said the facility called and asked when was she going to bring R1 back to the facility. V20 said she had never been to the facility to visit R1 because she lives out of the state. V20 was unable to report who called from the facility. V20 said she never gave permission for anyone to take R1 out on pass. V20 said she feared for R1's safety, and called the police to do a [NAME] being check, because the facility did not know who took R1 out on pass. On 11/13/24 at 11:21AM, V4 (Social Service Director)said, In order for a resident to go out on pass, they must have a doctor order, completed community assessment and be safe to go out. It is the same protocol for Dementia resident, but the Power of Attorney (POA) must be notified as well. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145382	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee Manor	1301 Lee Street Des Plaines, IL 60018

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 12:30PM, V1 (Administrator) said R1 was admitted to the facility by V19 (surrogate decision maker). V1 said, We found out about (V20, R1's POA) on 9/7/24. (V20) sent a copy of the POA paperwork with (V20's) name on it on 9/9/24. (V20) was responsible for (R1). On 11/14/24 at 10:13AM, V10 (Social Service) said she was not aware of V20 until a week after R1's admission. V10 said, In order for a resident to go out on pass, the resident must have a doctor order. (R1) did not have a doctor's order to go out on pass. (V20) was not called either time when (R1) went out on pass with (V19). (V19) did not have (V20's) authorization to take (R1) out on pass. (R1) was not verbal upon admission, and would stare at staff when spoken to. Towards the end of (R1's) stay, (R1) could answer yes or no to basic care needs questions. V10 said she was informed V20 should have been the contact person for R1. R1's physician order sheet did not document an order to go out on pass. Out on pass sign out sheet, dated 10/14/24 and 10/22/24, documents: V19 signed out R1 destination outside. Police report, dated 10/21/24, documents: V20 stated V19 took R1 from the nursing home without V20's permission. V20 stated she is R1's POA. The facility called V20 asking when she was going to bring R1 back to the facility. V20 stated she did not have R1 because V20 lives out of state. V20 asked the employee who took R1, and they stated V19. V20 told the police V19 was not allowed to have access to R1. Durable Power of Attorney, notarized on 7/10/16, documents: appoint (V20) to be my true and lawful agent for (R1) and on my behalf to perform all such acts as my agent in his/her absolute discretion may deem advisable, as fully as I could do if personally present. This Power of Attorney is durable and shall not be affected my subsequent disability or incapacity. Expect as otherwise stated in this Power of Attorney, my Agent is given the fullest powers to act on my half. To authorize my admission to a medical, nursing, residential, or similar facility and to enter into agreement for my care. To make or do any of the following (use this space to list any additional powers you want your agent to have): to rectify situation that affect my physical and/or mental health. This power of attorney shall not expire by reason of lapse of time. This Power of Attorney shall be revoked by my giving my agent written notification on the revocation. Community Privileges policy, dated 9/2005, documents: Out on pass order will be obtained. Notice of resident rights and responsibilities policy no date documents: Should a resident be adjudicated incompetent or identified as lacking decision making capacity, the resident's representative (sponsor) shall act in behalf of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145382	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee Manor	1301 Lee Street Des Plaines, IL 60018

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to determine an injury involving blunt force head injury for one resident. This affected one of three residents (R2) reviewed for injury of unknown injury. This failure resulted in R2 becoming unresponsive, being transferred to the local hospital, and succumbing to her death related to complications of intracranial hemorrhage. Finding include: R2 was admitted to the facility on [DATE], with diagnoses of acute heart failure, anemia, atrial fibrillation, unspecified dementia, kidney disease, hypertension, gout, and abnormality of gait and mobility. R2's progress note, dated 10/19/24, documents: at 10 AM this writer attention was called by CNA (Certified Nursing Assistant) who's taking care of the resident. CNA said (R2) was not feeling well after the shower. Transferred (R2) back to her bed with the help of the CNA. Resident was still awake but not responding to the questions that we asked. Writer called 911. R2's ambulance report, dated 10/19/24, documents: upon arrival crew found (R2) unresponsive, non-reactive to pain, lying supine in bed. Nursing staff advises the crew that a certified nursing assistant found (R2) unresponsive in the shower, got her out and then proceeded to get her dressed before calling 911. Nursing staff advised the crew that her normal mental status is alert and orient x4 and last known normal was approximately 45 minutes ago. Primary impression: stroke Under trauma: cause fall from standing; Mechanism of injury ([NAME]) blunt. Notified:10/19/24 10:09AM; patient contact 10:13AM. On 11/15/24 at 11:59AM, V30 (Emergency Medical Services, EMS) said he was called to the facility for a change in condition. V30 said he recalls staff (unclear who) reported R2 fell in the shower room, CNA found her, got her dressed, and they called 911. V30 remembers this because he thought it was strange that the staff would wait to get resident dressed before calling 911, and that is why he put it in the report. V30 said he does not recall any injury to head. There was no bleeding, and that is why blunt was marked for mechanism of injury ([NAME]). R2's hospital record, dated 10/19/24, documents: (R2) was found unresponsive. Unclear exactly what happened but reportedly patient fell in the shower. Emergency Medical Services had concerns that (R2's) pupils were unequal enroute. Under exam: (R2) unresponsive does not move to any kind of painful stimuli or verbal stimuli. Under head CT (Computed Tomography) scan impression documents: extensive intracranial hemorrhage and edema with mass effect and multifocal herniation. Under findings: Extensive cortical and subcortical hemorrhage is noted throughout the left cerebral hemisphere with significant edema. This consists of a contusion as well as subarachnoid hemorrhage with multifocal intraventricular hemorrhage. R2's death certificate, dated 10/19/24, under cause of death: complication of intracranial hemorrhage due to probable fall. Manor of death it documents accidental. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145382	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee Manor	1301 Lee Street Des Plaines, IL 60018

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/14/24 at 12:30PM, V18(Medical Examiner) said R2's cause of death, after review of medical record, was determined to be intracranial hemorrhage due to probable fall. V18 said he could not say it was due to fall one hundred percent because it was not witnessed, but due to the record documenting fall and being found on the floor, it was attributed to possible fall. V18 said, Review of the CT scan documents extensive cortical and subcortical hemorrhage and a contusion, which would be caused by any type of blunt force trauma. Blunt force trauma would be consistent with hitting a hard surface. In this case, the cause possibly the floor, because it says she was found on the floor. It was not due to stoke or any other medical diagnosis. This injury was acute, probably happened quickly within 24 hours, due to resident being unconscious, extent of hemorrhage, and mass effect, but can not be certain of exact time. (R2's) death was directly related to the injury.