STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145415	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irving Park Living & Rehab Ctr	4340 North Keystone Chicago, IL 60641

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. (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide adequate supervision for one cognitive impaired resident (R2) who is a high fall risk with a history of falls with injury out of a sample of four [R1, R3, R4] residents reviewed for falls. This failure resulted in R2 falling, transferred to the emergency department, and sustained a left eye orbital fracture.Findings Include, R2 ‘s clinical record indicates the following in part: R2 was admitted with hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, essential hypertension, vitamin D deficiency, restlessness, history of falling, type II diabetes, anxiety disorder, depression, and fracture of upper end of left humerus. R2's minimum data set [MDS] Section [C] Brief Interview Mental Status score [11]. Indicates R2 is mildly cognitively impaired. MDS Section [GG] indicates R2 requires maximal assistance with toileting, personal hygiene, and transfers.R2's Facility IDPH Reportable in part:6/3/26 at 7:05 AM, Upon staff rounds observed R2 on the floor at bedside. R2 noted with left eye and forehead discoloration. Neuro checks initiated. Physician gave order to send R2 to the emergency department. R2 was admitted to the hospital for a left orbital wall fracture.R2's Care Plan in part:12/15/25R2 is a high fall risk.R2 is incontinent of bowel and bladder, requires incontinent care. 12/27/25R2 primarily speaks mandarin, understand basic English. R2 is forgetful at times.12/29/25R2 has dementia with impaired decision making.R2 requires the support, care, and services of a long-term care facility. R2 demonstrates symptoms of cognitive impairment.R2 living with chronic psychiatric illness. R2 has ineffective coping modalities, disorganized thought process and mood patterns, delusions, hallucinations, difficulty meeting basic self-care needs. Having reduced insight and judgment related to schizoaffective disorder.R2's Fall Incidents in part:[R2 was admitted on [DATE]]12/16/24, R2 was observed on the floor mat in her bedroom. Intervention: Bed will remain in lowest position, floor mats in place, make sure all needs are met.1/12/25, R2 was observed on the floor in her bedroom lying on the stomach near wheelchair. The wheelchair footrest was on top of R2's calf. R2 was sent to the emergency room and sustained a left arm fracture. Interventions: Monitor for ortho hypertension.1/18/25, R2 was observed on the floor in her room near the closet. R2 said the closet door hit her head. R2 was sent to the emergency room, no injury noted. Intervention: There was no intervention in care plan.2/25/25, R2 was observed siting on the floor in her bedroom, no injury. Intervention: Continue therapy, staff to anticipate needs related to ADL care.Anti-anxiety medications [Power of Attorney refused medications]6/3/25, R2 was observed on the floor in her bedroom. R2 was sent to the emergency room and sustained a left eye orbital fracture. Interventions: [None] R2 did not return back facility.Interviews:On 7/17/25 at 10:20 AM, V13 [Certified Nurse Assistant] stated, On 6/3/25, I was R2's first shift certified nurse assistant. It was around 7:00 AM, I was at the nursing station getting myself together, when I heard a loud noise and heard R2 yell out. I went into her room and looked like she fell out the bed on to the floor. I ran and told the 11PM - 7AM nurse that R2 was on the floor. The nurses assessed R2 and we put her into the wheelchair. Typically, I make rounds when I get to the nursing unit, but I was getting my assignment. R2 has fallen in the past. R2 needs close monitoring all the time. R2 fell during shift change when everyone was at the nursing station, third shift and first shift staff.On 7/17/25 at 10:50 AM, V16 [Certified Nurse Assistant] stated, I was the night shift aide, worked on 6/3/25, when R2 fell. I provided care to R2 around 6:00 AM. Around 7:10 AM, all the first-floor staff was at the nursing station when we heard a noise. I ran into R2's room and she on the floor. R2 left side of her face was discolored dark. R2 needs close monitoring. R2 needs to go to the bathroom frequently and it takes a long time to take her. R2 knows how to place on her call light sometimes, but she does not wait for assistance, she will try to take herself and will fall. Some of R2's fall interventions are, close monitoring, floor mats, low bed and keep the call light in reach. R2 constantly tries to transfer herself all the time.On 7/17/25 at 12:30 PM, V14 [Licensed Practical Nurse] stated, I was R2's third shift nurse. Around 7:05 AM the nursing staff was all at the nursing station. I was giving report to the first shift nurse when we heard a noise came from R2's room. The certified nurse assistance went to her room first to check on the resident. I was called to R2's room I saw R2 on the floor lying on her left side. R2 said she was okay, and after assessing her she was placed into her wheelchair noted with her left side of face was discolored dark. R2 requires constant supervision. Through the night shift the Certified Nurse Assistant sits in a chair outside R2's room to provide one to one monitoring. R2 pulled the call light, but before someone was able to answer her call light, she tried to transfer herself. This happens all the time. I saw her last around 6:00 AM, she was resting in bed. The first shift nurse took over and notified