STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145429	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wentworth Rehab & Hcc	201 West 69th Street Chicago, IL 60621

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 Based upon interview and record review the facility failed to follow policy procedures and failed to develop a comprehensive care plan for one of three residents (R4) reviewed for abuse. Findings include: On 2/20/25, the State Agency received allegations that V7 (Certified Nursing Assistant) has been having an intimate relationship with R4 for the past two months, and this is abuse. R4 was admitted to the facility on [DATE]. R4's comprehensive care plan (received 2/26/25) excludes risk for abuse. On 2/26/25 at 11:32am, surveyor inquired when comprehensive care plans are developed V3 (ADON/Assistant Director of Nursing) stated The initial is on new admission. [R4 was admitted roughly 5.5 months ago]. On 3/3/25 at 12:27pm, surveyor inquired if R4 has an abuse care plan V3 reviewed R4's electronic medical records and responded I (V3) just see that he's (R4) an identified offender. I don't really see a care plan that he's at risk for abuse. Surveyor inquired if abuse should be included in resident care plans due to potential risk for abuse perpetrated by staff, residents and/or visitors V3 replied I'm not really sure. The (11/2017) comprehensive care plan policy states the interdisciplinary team will develop and implement a person-centered comprehensive plan of care. The comprehensive, person-centered plan of care is developed within 7 days of the completion of the required comprehensive MDS (Minimum Data Set). Care plans are comprised of focus statements, goals, and interventions. The comprehensive person-centered care plan will: describe the services that are to be provided to attain or maintain the highest practical physical, mental, and psychosocial well-being. Identify the professional services that are responsible for interventions.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 Based upon record review and interview the facility failed to follow policy procedures and failed to review/revise comprehensive care plans for two of four residents (R1, R5) reviewed for falls and pass privileges. Findings include: On [DATE], the State Agency received allegations concerning resident medical records not being updated to reflect current condition. On [DATE] at 11:32am, surveyor inquired when care plans are required to be reviewed and/or revised V3 (ADON/Assistant Director of Nursing) stated It's every 3 months and if it's a change or something new comes up. R1's care plans include the following: ([DATE]) Risk for falls, Goal Target Date: [DATE] [expired 2.5 months ago]. ([DATE]) Resident has been evaluated to be placed on a level one of the behavioral health pass program, Goal Target Date: [DATE] [expired 2.5 months ago]. On [DATE] at 12:01pm, surveyor inquired about concerns with R1's ([DATE]) fall care plan V3 (ADON) reviewed R1's electronic medical records and stated, I actually don't see anything wrong with this care plan. Surveyor inquired about R1's fall goal target date V3 responded It say [DATE], is the goal target date; today is [DATE]. Surveyor inquired when R1's fall care plan was supposed to be reviewed and/or revised V3 replied It's done every 3 months so that review should have been done [DATE] to [DATE]. Surveyor inquired when R1's behavioral health pass program care plan was last reviewed and/or revised V3 replied The target date say [DATE], it should be reviewed [DATE] to [DATE] and affirmed it was not. R5's ([DATE]) incident report states resident noted with blood at the back of her head, upon assessment, writer observed a cut. Resident unable to give an account of incident. R5's ([DATE]) final report states the facility has determined that the resident endured a fall due to unsteady gait while pulling the windows open. R5's ([DATE]) care plan includes risk for falls however preventive interventions and/or revisions on or about [DATE] are excluded. On [DATE] at 12:13pm, surveyor inquired if R5's fall care plan was reviewed and/or revised on or about [DATE] V3 reviewed R5's electronic medical records and stated No, I don't see it updated for that one. I don't see an intervention for that to reflect [DATE]st. The (,d+[DATE]) comprehensive care plan policy states the interdisciplinary team will develop and implement a person-centered comprehensive plan of care. Assessment of the resident is ongoing and care plans are revised based on the resident condition, preferences, treatments, and goals change. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The (,d+[DATE]) management of falls policy states the facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the residents plan of care in order to minimize the risks for fall incidents and/or injuries to the resident. Review and modify the residents plan of care at least quarterly and as needed in order to minimize risk for fall incidents and/or injury.

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(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** 32819 Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that fall risk assessments are accurate, failed to develop and/or implement preventive interventions, and failed to provide supervision to two of three residents (R2, R5) reviewed for falls. These failures resulted in the following: R5 sustained (12/31/24) fall resulting in intracranial hemorrhage and traumatic head injury requiring 4 staples. R1 sustained (1/10/25) fall resulting in left eyebrow laceration requiring 6 sutures. Findings include: R5 was admitted (11/25/24) with diagnoses which include Alzheimer's disease, glaucoma, (1/8/25) traumatic subarachnoid hemorrhage and fall, subsequent encounter. The fall incident log affirms R5 fell on [DATE], 2/3/25, 2/17/25, and 2/23/25. R5's (2/23/25) post fall risk assessment determined a score of 8 (indicating at risk) however R5 fell 3 times in February [therefore is high risk]. R5's (1/17/25) BIMS determined a score of 5 (severe impairment) with inattention behavior continuously present. R5's (1/17/25) functional assessment affirms resident requires partial/moderate assistance with sit to stand and chair/bed to chair transfer, walking was not attempted due to medical condition or safety concerns. R5's (11/26/24) care plan includes risk for falls related to poor balance, cognitive deficits, poor safety awareness and wandering behaviors. Interventions: (12/8/24) Resident will be within arm length of staff monitoring dining/day room. R5's (12/31/24) incident report states injury of unknown cause: resident noted with blood at the back of her head at about 6:30am at the nursing station. Upon assessment, writer observed a cut. Resident unable to give an account of incident. Resident sent to the hospital for further evaluation. The resident wanders with an unstable gait and is non-redirectable. R5's progress notes state (12/31/24) Writer contacted hospital to follow-up on resident. Resident being admitted with a diagnosis of intracranial hemorrhage. (1/6/25) Received resident back from the hospital. Four staples at the back of her head. R5's (12/31/24) final report states the facility has determined that the resident endured a fall due to unsteady gait while pulling the windows open. On 2/25/25 at 11:13am, surveyor inquired about R5's location V12 (Licensed Practical Nurse) stated She (R5) had a fall, she's in the hospital. She was sent there Sunday (2/23/25). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/3/25 at 12:13pm, surveyor inquired about R5's cognitive status V3 (ADON/Assistant Director of Nursing) responded I would say that she alert and oriented x/times 2. She's oriented to her name and location of her room. Surveyor inquired about R5's (12/31/24) injury of unknown origin V3 replied It happened at 6:30 in the morning, she (R5) came from her room and walked to the Nurse's station. That's when the Nurse observed that she (R5) had a cut on the back of her head [therefore the incident was not witnessed]. She (R5) was unable to give an account of what happened. Surveyor inquired if R5's fall care plan was reviewed and/or revised on or about 12/31/24 to prevent additional falls V3 reviewed R5's electronic medical records and stated No, I don't see it updated for that one. I don't see a intervention for that to reflect December 31st. No, I don't see nothing for an intervention for her falls care plan. On 3/5/25 at 12:37pm, surveyor inquired about potential harm to a resident that sustains an unwitnessed fall V19 (Medical Director) stated Anybody with an unwitnessed fall with a head injury they can have a bleed. Surveyor inquired what type of injury requires staple repair? V19 responded Superficial cuts which are deep enough they will need staples or sutures. Surveyor inquired what the facility should implement post falls V19 replied If the resident falls, then the facility has fall protocols which they can implement. On 2/14/25, the State Agency received allegations that R2 is supposed to have frequent/constant monitoring by staff however fell 3 times in the last 10 months. On 1/10/25, R2 fell and sustained a head wound. The fall incident log affirms R2 fell on [DATE], 5/15/24, and 1/10/25. R2's diagnoses include dementia, hemiplegia/hemiparesis affecting right dominant side, and history of falling. R2's (11/9/21) admission fall risk assessment determined a score of 8 (at risk). R2's (2/10/25) BIMS (Brief Interview Mental Status) affirms short term memory problem and cognitive skills for daily decision making is severely impaired. R2's (2/10/25) functional assessment affirms resident is dependent on staff for sit to stand, and chair/bed to chair transfer, walking was not attempted due to medical condition or safety concern. R2's (1/10/25) incident report states resident in room sitting in her wheelchair. Upon rounds Nurse observed resident in lying position on the floor. Resident has laceration above left eyebrow. Resident non-verbal unable to give description. Predisposing situation factors: ambulating without assist. R2's (1/14/25) progress note states resident has 6 sutures on the left eyebrow. R2's (4/30/24) care plan includes risk for falls due to hypotension, cognitive deficits related to developmental disability, poor balance, poor safety awareness, unsteady gait, impulsivity, and inability to follow instructions. Interventions: placement of call light within reach. Rounding at a minimum of every 2 hours. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/25/25 at 12:08pm, R2 was observed lying in bed and the call light was noted to be on the floor (out of reach). R2's left foot was on the floor and the right foot was near edge of the bed. R2 was alone in the room. On 2/25/25 at 12:10pm, surveyor inquired about R2's fall prevention interventions V13 (Licensed Practical Nurse) stated She has floor mats, her call light, and has her bed in lowest position. V13 subsequently entered R2's room (as requested). Surveyor inquired about the location of R2's call light V13 responded On the floor now. Surveyor inquired if R2 can walk V13 replied No, she's a 2 person assist. She will try to get out the bed on her own that's why we have to keep putting her in the bed then placed R2's left leg on the bed. Surveyor inquired if R2 can communicate V13 stated She's non-verbal. On 3/3/25 at 11:35am, surveyor inquired about R2's (1/10/25) fall V3 (ADON) stated She (R2) was in her room, the nurse made rounds and observed her (R2) on the floor with a laceration to her head. It was a unwitnessed fall. Surveyor inquired about concerns with R2's (1/14/25) post fall risk assessment V3 responded #2 predisposing condition, is supposed to be hypotension, it wasn't marked. That would have gave 2 points if it was marked. The next thing is the mentation, they (staff) put confused but in my opinion, I would have put impaired memory overall it would have been a higher score if they picked impaired memory. The assessment wasn't correct actually it would have been higher. The medication, I'm not sure about that. Surveyor inquired about R2's fall risk score which indicates at risk (instead of high risk) V3 replied It do say 5 which means at risk, but I can say overall it's not correct. Surveyor inquired about R2's fall prevention interventions (post 1/10/25 fall) to prevent additional falls V3 stated She's being supervised like her room is close to the Nurses station. She actually do get out of bed and has a mind of a 2-year-old, so we (staff) try to do what we can to protect her. The (08/2020) management of falls policy states the facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risks for fall incidents and/or injuries to the resident. Complete a fall risk assessment upon admission, re-admission, with significant change, post-fall, quarterly, and annually. Develop a plan of care to include goals and interventions which address resident's risk factors. Risk factors may include but are not limited to the following: contributing diagnoses/disorders/disease processes/active infections/other comorbidities, history of fall incidents, incontinence, medications, assistance required with ADLS, gait/ transfer/ balance issues, behaviors, and/or cognitive status. Review and modify the resident's plan of care at least quarterly and as needed in order to minimize risk for fall incidents and/or injury.