STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145507	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark Manor	7433 North Clark Street Chicago, IL 60626

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39779

Based on observation, interview, and record review the facility failed to a) ensure a residents' self-releasing seat belts (used to keep a resident positioned properly in their wheelchair) were secured in a manner which allowed the residents to freely release the belt, b) failed to complete an assessment for the need of a restraint and c) failed to code the Quick Release Belt in the MDS (Minimum Data Set) as a restraint for 1 (R1) out of 3 residents reviewed for physical restraints.

Findings Include:

R1 was initially admitted to the facility on [DATE] with a readmitted [DATE] with diagnoses not limited to Chronic Kidney Disease, Stage 3, Nephrogenic Diabetes Insipidus, Extrapyramidal and Movement Disorders, Drug Induced Subacute Dyskinesia, Other Specified Forms of Tremor, Diabetes Insipidus, Pain In Leg, Low Back Pain, Drug Induced Secondary Parkinsonism, Schizoaffective Disorder, Bipolar Type, Unilateral Primary Osteoarthritis, Right Knee, History of Falling and Anxiety Disorder. R1's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 12 indicating moderately impaired.

Progress note dated 07/30/24 at 4:57 pm document in part: Restorative Note Text: R1 has been provided a Quick Release Seat Belt to protect her from falls and/or injuries sustained by falls due to poor posture. R1 has tendency to frequently bend over from waist when ambulating or sitting. R1 is currently in a wheelchair and bending over while sitting can cause R1 to fall out of her chair.

Progress note dated 10/09/24 at 7:52 am document in part: Behavior Note Behavior: Observed sitting up in wheelchair with face leaning on table in day room, refused to go to the bed. Refused pillow when offered. List education provided: Quick release belt provided D/T (due/to) resident EPS (Extrapyramidal Symptoms).

Order Summary Report document in part: My have Quick Release Torso Safety Belt Daily when up in wheelchair to reduce risk of fall and/or injury sustained from fall dated 10/29/24.

Document titled Physical Restraint Informed Consent dated 07/30/24 document in part: Method of Physical Restraint Used: Quick Release Safety Belt. The Reason the Physical Restraint is Needed: To Prevent Falls/Injury Sustained from Fall. Times when restraint will be applied: Daily when in wheelchair.

(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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NAME OF PROVIDER OR SUPPLIER Clark Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 7433 North Clark Street Chicago, IL 60626	

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plan document in part: Focus: R1 is at high risk for fall d/t (Due/to) slipping from wheelchair going to the washroom, unsteady gait secondary to dx. (diagnosis) of Cerebral Infarction, delusional episodes, failure to get up from bed slowly and possible side effects from use of anti-psychotic medication. Date Initiated: 02/10/25. Interventions: R1 has tendency to frequently bend over at waist (due to back pain she states when she bends it relieves the pain somewhat) causing poor posture and risk for fall. R1 has been provided a Quick Release Belt for her wheelchair which will help to prevent her falling and/or sustaining injury. This belt should remain in place when she is sitting in her wheelchair to be released only for care and toileting needs. Date Initiated: 07/30/24. MDS Section P - Restraints and Alarms document in part: Physical restraints are any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The coding of 0 not used is documented on the MDS Section P. Facility Matrix indicate R1 has a Physical Restraint. Document titled Side rail/Other Devices evaluation has no restraint devices documented. On 02/25/25 at 12:22 PM V6 (Licensed Practical Nurse) stated R1 has a quick release belt in the chair due to her posture. I can't recall any falls just the quick release. On 02/25/25 at 02:07 PM R1 was sitting in wheelchair in the dining room with the quick release belt in use. R1 was transported to her room in the wheelchair by a staff member. R1 stated they never showed me how to release this belt. If it was an emergency, I would be a goner. It is connected somewhere in the back of the wheelchair. R1 was pulling the quick release belt near the bottom of the belt near the lower area around the abdomen. R1 stated its tight and not giving. R1's quick release belt Velcro was connected at R1 right lower side out of view and reach for R1 to release. On 02/26/25 at 10:40 AM V11 (Restorative Nurse/Licensed Practical Nurse) stated the quick release self-release is considered a restraint because R1 wears it. R1 is able to take it off anytime she wants. R1 is alert and oriented x/times 3. R1 has a tendency to lean forward with her head between her legs and the belt is helping her to understand to sit upright. R1 has had the belt for some months. The resident should be able to get out of the quick release belt. We had a couple of short trails to remove the quick release belt, but we put it back. We don't want R1 to tumble out of the chair. R1 is a high fall risk. I was unaware there is a physical restraint assessment. V11 was shown by the surveyor MDS Section P Restraints and Alarms that indicate R1 has no restraints. On 02/26/25 at 11:33 AM V12 (MDS Coordinator) stated the restorative nurse is in charge of restraints. The restorative nurse will assess and do the care plan because they are in charge of the order. We divide the MDS, the restorative nurse fills out section P. The quick release belt would be considered as a trunk restraint. The MDS is indicating the resident has no restraints because it is coded as zero. The MDS section P was incorrect meaning there were no restraints in use. I believe there is and assessment or evaluation that is done for restraints. On 02/26/25 at 01:23 PM R1 was in wheelchair in the dining room with the quick release belt in use. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/25 01:24 PM V13 (Certified Nurse Assistant) stated R1 leans forward in the wheelchair and the quick release belt is released every 2 hours. I put the quick release belt on R1 when I get her up. On 02/26/25 at 01:49 PM V2 (Assistant Administrator) stated R1 leans forward so we see the quick release belt for support. On 02/26/25 at 04:03 PM V19 (Licensed Practical Nurse) stated we put on the quick release belt to prevent R1 from falling. When in the wheelchair R1 will lean forward. If R1 takes the quick release belt off by herself R1 will be getting up and fall. On 02/27/25 at 10:15 AM V20 (Director of Rehabilitation) stated R1 is unable to sit at the edge of the bed. According to the physical therapy evaluation it does not have any indication that R1 cannot sit up in a wheelchair. R1 had a sitting and standing instability. The physical therapist usually put recommendations in the discharge note. The quick release belt is for safety, so R1 does not fall and hurt herself. The more R1 sits upright, it helps her with her trunk control. That is nursing not therapy to reevaluate R1. On 02/27/25 at 10:37 AM V20 (Director of Rehabilitation) stated Physical Therapy was working on R1's lateral trunk stability, sitting up. Weight shift dynamic stability and facilitation of anticipatory postural adjustments to pull herself up. If R1 was leaning forward, conscious enough to pull herself back. There was training, limit balance and R1's trunk technique to facilitate proprioception and adjustment of center of mass over base of support improving proactive sitting balance training. This was in July 2024 when R1 was discharged from physical therapy R1 has made progress with skilled interventions. There were no recommendations other the restorative nursing program for ambulation and range of motion. On 02/27/25 at 11:19 AM V2 (Assistant Administrator) stated regarding the vest for R1 we gave R1 and the staff education. On 02/27/25 at 11:22 AM R1 was in the dining room in a wheelchair with the quick release belt in use. On 02/27/25 at 11:23 AM R1 was transported to her room in the wheelchair by a staff member. R1 stated they said the belt is to keep me from sliding out of the chair. The chair is low so where am I to go to. I can sit up; they don't give me enough time to demonstrate I can you sit up straight. R1 was sitting in the wheelchair with the left shoulder strap of the quick release belt hanging off of the left shoulder. R1 was leaning to the right side with her right arm hanging near the wheel of the wheelchair. When asked can she (R1) sit up straight in the wheelchair, R1 readjusted herself and sat upright in the wheelchair. R1 stated I don't feel the belt is helping, it is unnecessary and don't make sense. They put this belt on me every day when they get me up. They showed me how to take the belt off today. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/27/25 at 12:29 PM V4 (Direction of Nursing) stated R1 has improved a lot. The restorative nurse recommended the quick release belt. We have to assess and evaluate if they need that quick release belt, get an order, consent, and monitor if they are okay with that one. We did the in-service yesterday. Document titled In-Service Topic and Attendance Sheet dated 02/26/25 Topic: Quick release Torso Support. Summary of In-Service Topic: Use of Quick Release Torso Support for Poor Trunk Control. Attachments: (Two Pictures of the Posey Torso Support for Wheelchair). Policy: Titled Restraints reviewed 08/19/24 document in part: It is the facility's policy to ensure that each resident is not restrained for the purposes of discipline or convenience. The facility will utilize non- restraining interventions first before trying restrain-type devices which will be considered as last resort. Physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that. A) attached or adjacent to the resident's body. B) that the individual cannot intentionally removed easily, and C) restricts freedom of movement or normal access to one's body. Procedures: 1. In the event that resident's condition warrants the use of restraint, a restraint device assessment will be done to determine if the device is appropriate for the resident. 2. Once the assessment determines that the device or intervention is a restraint, a physician order will be obtained indicating the type of device to be used. The order may be accompanied by the indication/reason for the device, the duration of use, and how often it is supposed to be released. If this information is not reflected in the POS (Physician Order Sheet), these should be specified in the device assessment, in the Progress Notes, or in the care plan. 5. T use of the restraining device may be assessed and reduced at least quarterly. 9. Any device including mobility alarms that may have a restraining effect on a resident should be assessed and evaluated to determine it is a restraint or an enabler.