STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145648	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Nursing Home	2450 North Central Avenue Chicago, IL 60639

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067 Based on observations, interviews, and record reviews, the facility failed to provide timely nail trimming and care for one resident (R1) in the sample of three residents (R1, R2, R3) when reviewed for activities of daily living (ADL) care. Findings include: R1's Admission Record documents, in part, diagnoses of moderate intellectual disabilities, acute kidney failure, major depressive disorder, hypertensive heart disease without failure, anxiety disorder, schizoaffective disorder, and scabies. R1's Minimum Data Set (MDS) dated [DATE], documents in part a Brief Interview of Mental Status (BIMS) score of 15 which indicates that R1 is cognitively intact. R1's Functional Abilities and Goals for Self-Care documents, in part, that for shower/bathe self is coded as partial/moderate assistance where helper does less than half the effort, and for personal hygiene as the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands is coded as supervision or touching assistance where assistance may be provided throughout the activity or intermittently. On 9/30/24 at 12:34 pm, this surveyor entered R1's room with R1 laying in bed and observed R1 holding an unopened milk carton (8 fluid ounces). R1 observed struggling to open the milk carton by R1's self. R1's fingernails observed long on all fingers with debris noted under the nails. R1 asked for assistance with opening the milk carton from this surveyor. Surveyor called staff to come to help open R1's milk carton. (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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/24 at 12:36 pm, V3 (Registered Nurse, RN/Wound Care Nurse, WCN) answers R1's call light. R1 observed asking V3 for help opening milk with slight shaking to R1's hands. R1 stated, I (R1) can drink it, but I don't want to spill it. V3 and V14 (Licensed Practical Nurse, LPN) assisted to reposition R1 up in the bed and elevated R1's head of the bed. R1's arms and legs observed with small scabs on arms and legs from R1's healing rash. V3 then took the milk carton from R1's hands with long fingernails, opened the milk carton and assisted R1 with positioning milk carton with a straw so R1 can drink the milk. After staff left R1's room, R1 stated that R1 has had R1's skin rash to hands, arms, and legs for a few months, but it's healing. R1 held up R1's hands to show this surveyor all R1's fingernails are long with yellow, brown, and black debris under the nails. R1's right 4th fingernail and left pinky (5th) fingernail are very long with the fingernail tips being curved down back towards the tip of R1's fingers. This surveyor asked about R1's fingernail length and if R1 has been offered to have R1's fingernails cut or trimmed by staff. R1 stated, Yes. I have. I want them done. They should be cut. I don't know if they (staff) are too busy. On 10/1/24 at 10:05 am, R1 observed in bed in R1's room with R1's fingernails remaining long with yellow, brown, and black debris under the nails (unchanged from 9/30/24). On 10/1/24 at 10:17 am, V16 (Certified Nursing Assistant, CNA) called into R1's room by this surveyor. When asked about the care that R1 received today from V16 since 7:00 am today. V16 stated that V16 feed R1 breakfast, gave R1 a shower, changed R1's fitted sheets, shaved R1, and got R1 dressed. V16 stated that V16 washed all R1's body during shower and combed R1's hair afterwards. V16 stated that V16 offered R1 grooming care in shaving R1's face. This surveyor pointed out to V16 R1's fingernails, long with debris under them. V16 stated that R1 did say that R1 wanted R1's fingernails cut. V16 stated that R1 has no fingernail clippers and that they are kept with the nurse. V16 then observed going to V7 (LPN) who retrieved fingernail clippers from the locked medication cart. On 10/1/24 at 12:36 pm, V3 (RN/WCN) stated that R1 has received treatment in the facility for intrinsic eczema and tinea [NAME] to R1's bilateral hands, arms, and legs. V3 stated that R1 was educated not to scratch at the body rash, and that they (staff) keep nails short so long nails won't open up R1's skin. When asked about V3 assisting R1 with care, drinking from the milk carton on 9/30/24 and seeing R1 hands, V3 stated that V3 did not remember seeing R1's fingernails. This surveyor informed V3 of 9/30/24 and 10/1/24 observations of R1's long fingernails with yellow, brown, and black debris under the nails. V3 stated that nail care is provided by staff as needed for R1; and that staff should be cleaning under R1's fingernails to decrease the risk of infection if R1 is scratching R1's body. On 10/2/24 at 12:46 pm, V2 (Director of Nursing, DON) stated that R1 was being treated by the wound care team for intrinsic eczema and that staff make sure that (R1's) fingernails are trimmed. When asked why is that important for R1 having a skin rash, V2 stated, So it will prevent the nail from making skin tears, make the skin not intact. When asked how often fingernail should cleaned and trimmed, V2 stated, I (V2) always tell them (staff) when you get up residents, clean and change them, shave them and clip their nails. Check every time during care. Daily, it is supposed to be daily. I tell them imagine if that's you, take care and clean them when you get them up. Shave and keep nails clipped. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan, date initiated 9/20/24, documents, in part, that R1 has a focus of impairment to skin integrity, upper and lower extremities-rash/pruritus, bilateral hands and palms-other pruritis dermatitis with an intervention of education of R1 of causative factors and measures to prevent skin injury. R1's Care Plan, date initiated 1/7/21, documents, in part, that R1 has a focus of self-care deficit related to inability to comb hair, inability to brush teeth, inability to wash/dry face, inability to wash perineum, bilateral arms and torso with an intervention of provide supervision, verbal cues and physical assistance. R1's Care Plan, date initiated 5/8/19, documents, in part, that R1 has a focus of fluctuating ADL self-care deficit R/T (related to) disease process, impaired balance and limited ROM (range of motion) with interventions of inform of tasks to be perform and allow sufficient time to perform ADL tasks. On 10/2/24 at 3:21 pm, V2 stated that there is no facility policy specific for grooming/nailcare, and grooming/nailcare for residents is included in the ADL policy already provided to the surveyor. Facility policy titled Policy and Procedure: Activities of Daily Living and dated 1/6/23 documents, in part, Residents are given routine daily care and HS (hour of sleep) care by a C.N.A or a Nurse to promote hygiene, provide comfort and provide a homelike environment. ADL care is provided throughout the day at intervals that are coordinated between the care giver and the resident. ADL care of the resident includes: Assisting the resident in personal care such as bathing, dressing, eating. Facility job description dated 3/24/22 and titled Certified Nursing Assistant documents, in part, Summary: The Certified Nursing Assistant (CNA) is responsible for provide resident care and support in all activities of daily living and ensures the health, welfare and safety of all residents. Essential Duties and Responsibilities: . Provide assistance in personal hygiene . Assist (Assist) with ADL Care . Adhere to professional standards, company policies and procedures, and all federal, state, and local requirements. Facility job description dated 3/25/16 and titled Registered Nurse (RN) documents, in part, Summary: The RN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is maintained at all times.

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F 0689 Level of Harm - Minimal harm or potential for 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** 40067 Based on observations, interviews, and record reviews, the facility failed to implement fall prevention interventions for high fall risk residents; failed to supervise high fall risk residents; and failed to perform quarterly fall risk assessments which affected two residents (R2 and R3) in the sample of three residents when reviewed for improper nursing care. Findings include: 1) R2's Admission Record documents, in part, diagnoses of Parkinson's disease without dyskinesia, hemiplegia and hemiparesis following cerebral vascular accident (CVA) affecting right dominant side chronic obstructive pulmonary disease, heart failure, peripheral vascular disease, hypertensive heart disease, schizoaffective disorder, anxiety disorder, Alzheimer's disease, psychosis, dementia, osteoarthritis, seizures, mood disorders, anemia, syncope and collapse, and gastritis without bleeding. R2's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview of Mental Status (BIMS) score is not conducted due to R2 rarely/never understood. Therefore, R2's Staff Assessment for Mental Status indicates that R2 has a short-term and long-term memory problems, and R2's Cognitive Skills for Daily Decision Making is coded as moderately impaired - decisions poor; cues/supervision required. R2's Behaviors include delusions and wandering (which occurs 1 to 3 days a week). R2's Functional Abilities and Goals for Safety and Quality of Performance documents, in part, that for sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed) is coded as partial/moderate assistance where helper does less than half the effort, and for walking 10 feet is coded as supervision or touching assistance where helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently. On 9/30/24 at 12:22 pm, V11 (Escort) observed supervising R2 in the dining room. R2 observed in a reclining wheelchair, dressed, and wearing regular white socks which are not skid proof. This surveyor spoke to R2 to ask R2 about recent fall incident in the facility, and R2 nodded yes, but did not nod yes or no to further questions or verbalize details of R2's fall incident on 9/16/24. R2 observed with a yellow/purple color fading bruise behind R2's left ear down to R2's neck. On 9/30/24 at 12:25 pm, V4 (Certified Nursing Assistant, CNA) stated that V4 is the assigned CNA for R2. When asked what care has V4 provided to R2 since beginning of the day shift, V4 stated, I (V4) dressed (R2) and waited for sitter. V4 stated that R2 is a fall risk resident. On 10/1/24 at 9:58 am, R2 observed sitting in R2's reclining wheelchair inside the nurse's station past the swinging half door separating the nurse's station from the hallway, and V15 (RN) observed sitting inside the nurse's station on the telephone. This surveyor inquired about R2 today, and V15 stated that R2 is fine, calm. When asked why is R2 inside the nurse's station, V15 stated, I (V15) have to wait for the sitter to come, (R2's) a fall risk. (continued on next page)

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	145648	A. Building B. Wing	10/03/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at 3:54 pm, V9 (CNA) stated that V9 was R2's assigned CNA on 9/16/24 on the 3:00 pm to 11:00 pm shift. V9 stated, (R2) had a fall at the end of the shift on 9/16 (2024). (R2) was with the sitter. She (the sitter) leaves and (R2) sat at the nurse's station. When asked what time the sitter left on 9/16/24, V9 stated, It was before 11 pm, around 8 pm. V9 stated, (R2) tries to get up. (R2) gets up and moves on (R2's) own. We don't want (R2) to fall. That's why (R2's) at the nurse's station till I (V9) put (R2) down to sleep. V9 stated, I saw (R2) on the floor one time. I instantly got the nurse (V10, Licensed Practical Nurse). When asked what time was R2's fall on 9/16/24, V9 stated around 9 to 10 pm, almost time to go. When asked where the nurse (V10) was, V9 stated that V10 was towards the back (of the floor). V9 stated that V9 walked away from R2 who was on the floor in the nurse's station to inform V10, and then V9 and V10 both walked back to the nurse's station. V9 stated that V9 did not witness R2 falling on 9/16/24, and R2 was laying on (R2's) side on the floor already when I came back to nurse's station. When asked were there any staff members present at the nurse's station when V9 returned to the nurse's station seeing R2 had fallen on the floor, V9 stated, No, nobody was there. V9 stated that R2's head was down, (R2) was alert, and (R2) was on the floor grabbing to lift self-up. V9 stated that R2 was sitting in R2's reclining wheelchair before V9 left R2 unsupervised at the nurse's station. When asked if R2 is a high fall risk resident, V9 stated, Yes, that's why (R2) sits at the nurse's station, so someone is around to watch (R2) and not leave (R2) unattended. We are sitting watching (R2). When asked about V9 leaving R2 unattended at the nurse's station on 9/16/24, what about V9 supervising R2, and V9 stated, All staff are helping to watch (R9). On 10/1/24 at 12:01 pm, V10 (LPN) stated that that R2 is alert, oriented times 1 to 2, confused and ambulates around with monitoring. V10 stated that R2's gait is not that stable and that R2 is forgetful. When asked if R2 is a fall risk resident, V10 stated, No, not that really. (R2) walks around. We (staff) monitor everyone, to see where they are. When asked how is R2 prevented from having falls, V10 stated, The only thing we can do is just monitor (R2) all the time. All the staff. When asked about R2's fall incident on 9/16/24, V10 stated that V10 was R2's assigned nurse on the 3:00 pm to 11:00 pm shift. V10 stated that on 9/16/24 at 11:00 pm, I (V10) got report that (R2) had a fall, (R2's) on the floor. V10 stated that V10 was making rounds by going to the dining room to direct any resident to their room for sleep, and V9 (CNA) came into the dining room to notify V10 that R2 was on the floor in the nurse's station. V10 stated that V9 and V10 then went back to the nurse's station, and V10 stated, When I got to (R2), (R2) was laying on (R2's) back. V10 stated that R2's chair was in the middle of the nurse's station and where I find (R2) laying down was closer to the door that leads out by the crash cart. V10 stated that R2 was alert, had no injury (no skin tear, no cut, no bruise, no discoloration, and no bleeding) and could not tell V10 what happened. V10 stated that V10 last saw R2 at 10:00 pm in the nurse's station only with V9 present. V10 stated that V10 documented this fall incident for R2 in the facility's incident report documentation. In R2's Fall Incident report dated 9/16/24, V10 (LPN) documents, in part, At 2300 (11:00 pm), the C.N.A (V9) reported to the writer that the resident (R2) is on the (floor) in the nursing station. On getting to the nursing station (V10) observed (R2) lay on (R2's) back, beside the wheelchair; faced the ceiling in no apparent distress . (R2) noted with unbalance gait . head to toe assessment was done. No noted skin tears, bruise or bleeding. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at 7:30 am, V19 (Registered Nurse, RN) stated that V19 worked from 9/16/24 11:00 pm to 9/17/24 7:00 am shift. V19 stated that V19 was informed by V10 of R2's fall incident around 11:00 pm. V19 stated that around 5:30 am, V19 performed a follow up neurological assessment of R2 post fall and observed a small bruise the size of 2 quarters and dark purple in color behind R2's left ear, and R2 denied pain with palpation of area. V19 stated that V19 notified V17 (Attending Physician) who ordered for continued monitoring with neurological checks. In R2's Health Status Note dated 9/17/24 at 6:59 am, V19 (RN) documents, in part, that R2 was noted with discoloration of back of (R2's) L (left) ear post fall. R2's Fall Risk Assessment, dated 9/17/24 and titled Fall Scale, documents, in part, Instructions: Fall Risk is based upon Fall Risk Factors, and it is more than a Total Score. Determine Fall Risk Factors and Target Interventions to Reduce Risks. Complete on admission, quarterly, at change of condition, and after a fall with R2's score as 100 which indicates that R2 is a high fall risk (Fall Scoring: High Risk 45 and higher). R2's Fall Risk Assessment, dated 8/15/24 (score of 55) and dated 7/12/24 (score of 95), indicate that R2 has been a high fall risk. R2's Care Plan, initiated 4/17/19, documents, in part, a focus of R2 is at high risk for falls r/t (related to) gait/balance problems, psychoactive drug use, Parkinson's disease, Unaware of safety needs, history of Syncope, history of fall, Impulsive behavior, altered thought process, resident overestimate (R2's) ability with interventions of ensure that (R2) is wearing appropriate footwear and anticipate and meet (R2's) needs. R2's Care Plan, initiated 1/7/2020, documents, in part, a focus of R2 with impaired mobility as evidence by inability to ambulate independently and requires assistance with verbal cues and supervision with a focus of provide physical assistance when ambulating. 2) R3's Admission Record documents, in part, diagnoses of cerebrovascular vasospasm and vasoconstriction, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus (DM), seizures, schizoaffective disorders, hyperlipidemia, vitamin D deficiency, hypertensive heart disease without heart failure, psychosis, acute peptic ulcer, gastrostomy status, seborrheic dermatitis, weakness, lack of coordination, abnormalities of gait and mobility, history of falling, pulmonary fibrosis, dysphagia, and long term use of oral hypoglycemic drugs. R3's MDS, dated [DATE], documents, in part, a BIMS score is not conducted due to R3 rarely/never understood. Therefore, R3's Staff Assessment for Mental Status indicates that R3 has a short-term and long-term memory problems, and R3's Cognitive Skills for Daily Decision Making is coded as severely impaired - never/rarely made decisions. On 9/30/24 at 11:55 am, R3's room door is observed closed. This surveyor entered R3's room observing R3 laying in bed with 2 dark blue floor mats not on the floor on R3's sides of bed. One floor mat is observed propped up against the wall away from R3's bed, and the second-floor mat is folded in half leaning against R2's bed and is in contact with privacy curtain in between R2 and R3's bed. There is a chair and a bedside table noted at the foot of R3's bed. R3 observed laying with R3's head towards the foot of R3's bed and is holding a cellular phone which is playing a cartoon. This surveyor is asking R3 questions; however, R3 is intently watching the phone and not answering this surveyor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/24 at 12:00 pm, an alarm goes off loudly coming from the cellular phone, and R3 begins leaning over the side of the bed, towards R2's bed. On 9/30/24 at 12:03 pm, this surveyor comes to the doorway to call out for staff assistance. V3 (Registered Nurse, RN/Wound Care Nurse, WCN) enters R3's room, removes the alarming cellular phone from R3, and R3 is saying, I want. I want. I want. V3 stated, The nurse (V5, RN) was watching (R3). V3 assists R3 with repositioning in the bed, and R3 is resistive to care. V3 stated to other staff, Can you get the sitter? On 9/30/24 at 12:25 pm, V4 observed sitting in a chair inside R3's room with both fall mats now down on the floor on both sides of R3's bed. V4 stated that V4 is the assigned CNA for R3. When asked if R3 is a fall risk resident, V4 stated no. When asked does R3 have any fall prevention interventions, V4 stated that R3 has fall mats. When asked where the fall mats to be placed, V4 stated, On floor next to the bed for a fall. When asked how does V4 know which residents are high fall risk residents, V4 stated, The nurse will tell me most of the time. I can tell by the mats seen on both sides of the bed. Some people (residents) have a fall risk band on their wrist. On 9/30/24 at 12:17 pm, when asked if R3 is a fall risk resident, V5 (RN) stated, No. I (V5) have never seen him fall. When asked what fall precaution interventions are in place for R3, V5 stated, bed in lowest position and that R3 is bed bound. This surveyor informed V5 that there are floor mats near R3 folded up away from R3's bed. When asked where floor mats are to be placed, V5 stated, on both sides on the floor. When asked the purpose of this, V5 stated, So if (R3) goes to the floor, (R3) won't land on hard floor. Have a cushion if (R3) rolls out of bed. When asked about seeing a table and chair in R3's room, V5 stated that V5 was recently in R3's room supervising R3, but V5 stepped out when R3 was sleeping. On 10/1/24, this surveyor requested from V2 (Director of Nursing, DON) the last two (most recent) fall risk assessments for R3. On 10/2/24, V2 provided this surveyor with R3's last two fall risk assessments, dated 3/27/24 and 6/8/24. R3's Fall Risk Assessment, dated 6/8/24 and titled Fall Scale, documents, in part, Instructions: Fall Risk is based upon Fall Risk Factors, and it is more than a Total Score. Determine Fall Risk Factors and Target Interventions to Reduce Risks. Complete on admission, quarterly, at change of condition, and after a fall with R3's score as 75 which indicates that R3 is a high fall risk (Fall Scoring: High Risk 45 and higher). R3's Care Plan, initiated 3/14/24, documents, in part, a focus of R3 is at high risk for falls r/t COPD, DM, HTN (hypertension), history of fall with interventions of Floor mats/Floor pads at bedside and anticipate and meet (R3's) needs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 12:46 pm, when asked how the facility is preventing residents from falling, V2 (Director of Nursing, DON) stated that residents are assessed when admitted to the facility, they are assessed for falls. V2 stated that fall risk assessments are then done quarterly if the resident has a fall or there is a significant change. V2 stated that quarterly means every 3 months. V2 stated that the fall risk assessment will determine if the resident is a low or high risk for falling which will then drive the fall precaution interventions to be in place. V2 stated that nurses communicate to CNA staff in report who the high fall risk residents are, and we (staff) make sure extra staff are there to gather them in the dining room so somebody will watch them. V2 stated that R2 is a high fall risk resident and tries to get up and walk at times. V2 stated that V2 tries to have staff with R2 as much as possible. When asked if R2 is awake inside the nurse's station, is there to be a staff member watching R2, and V2 stated, Yes. When asked how staff find out who is a fall risk resident, V2 stated that the nurse will check the care plans and will let the CNAs know. When asked about a fall risk wrist band, V2 stated that the facility does not use this as a fall risk identifier, and that a few residents still have these wrist bands when they return from the hospital. V2 stated that floor mats should be placed on both sides of the bed on the floor. When asked the purpose of fall mats, V2 stated, To prevent injury. On 10/2/24 at 2:51 pm, V2 stated that the staff nurses (RN, LPN) are responsible for performing the quarterly fall risk assessments. When this surveyor showed R2's most recent fall risk assessment (6/8/24) being over 3 months, V2 stated that the MDS nurse will give V2 a list of residents with required assessments, and nurse gets busy. V2 stated that V2 participated in the intradisciplinary team (IDT) meeting for R2's 9/16/24 fall investigation. V2 stated asked why did V9 leave R2 alone in the nurse's station. V2 stated V9 went to the bathroom when R2 was sitting calm. On 10/2/24 at 4:33 pm, when asked what footwear should R2 be wearing when R2 is out of bed, V2 stated, Shoes, sturdy shoes or the non-slip socks. When asked what's the purpose for this, V2 stated, You don't want (R2) to slip and fall. We even put non-slip socks on when (R2's) in bed just in case (R2) would stand up from bed. V2 stated that the sturdy shoes and non-slip socks provide R2 with traction when standing so R2's feet won't slip upon standing causing R2 to fall. On 10/2/24 at 2:06 pm, V13 (Restorative Nurse) stated that V13 participates in intradisciplinary team (IDT) meeting whenever a resident has a fall occurrence to investigate how the fall occurred and what individualized intervention is to be put in place to prevent another fall incident. V13 stated that V13 remembered R2's 9/16/24 fall incident investigation. V13 stated, CNA (V9) went to the bathroom for a minute. And that's when (R2) fell . (R2) was being monitored. When asked the root cause of R2's fall on 9/16/24, V13 stated, The CNA not handing (R2) over to another staff member. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145648	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Nursing Home	2450 North Central Avenue Chicago, IL 60639

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 - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Fall Prevention Program and dated 12/31/23 documents, in part, Policy: It is the policy of this facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary . Standards: 1. A Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool with incorporate current clinical practice guidelines. 2. A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. 3. Safety interventions will be implemented for each resident identified at risk using a standard protocol. 4. The admitting nurse and assigned CNA are responsible for initiating safety precautions at the time of admission. All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained . Standard Falls/Safety Precautions for All Residents: 1. All staff will be oriented and trained in the Fall Prevention Program . 16. All nursing personnel will be informed of residents who are at risk of falling. The fall risk classification will be identified on the care plan . 19. Footwear will be monitored to ensure the resident has proper fitting shoes and footwear is non-skid. Facility job description dated 3/24/22 and titled Certified Nursing Assistant documents, in part, Summary: The Certified Nursing Assistant (CNA) is responsible for provide resident care and support in all activities of daily living and ensures the health, welfare and safety of all residents. Essential Duties and Responsibilities: . Assist (Assist) with ADL Care . Adhere to professional standards, company policies and procedures, and all federal, state, and local requirements . Performs other duties as assigned. Facility job description dated 3/25/16 and titled Registered Nurse (RN) documents, in part, Summary: The RN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is maintained at all times. Essential Duties and Responsibilities: Direct the day-to-day functions of the nursing assistants. Meet with your assigned nursing staff, as well as support personnel, in planning the shift's services, programs and activities. Make written & oral reports/recommendations concerning the activities of the shift as required. Facility job description dated 4/1/17 and titled Licensed Practical Nurse (LPN) documents, in part, Summary: The LPN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing to ensure that the highest degree of quality care is maintained at all times. Essential Duties and Responsibilities: Direct the day-to-day functions of the nursing assistants. Meet with your assigned nursing staff, as well as support personnel, in planning the shift's services, programs and activities. Make written & oral reports/recommendations concerning the activities of the shift as required.