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	04/25/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49666 Based on interview and record review, the facility failed to follow their fall clinical protocol for one (R1) resident out of four residents reviewed for falls in a total sample of five residents. Findings include: On 04/22/2025, at 11:38 AM, V3 (Registered Nurse/Nursing supervisor) states that upon checking on R1 at 9:30 AM, he was eating breakfast by himself. Staff did the rounds again. Staff has the 72 hours post fall procedure, because he fell at 6:30 AM, I think. We are going to recheck again what happened. V2 stated when I saw him around 10:00 am, I (V3) saw that his (R1s) left side was getting a little bit weaker, because that's his strong side. His right-side is usually the weak side. V3 stated, I (V3) checked his vital signs immediately. I think R1s oxygen saturation became low. V3 stated I (V3) documented in the electronic medical record, in the nurses' note, and documented the vital signs. I (V3) asked someone to be with R1 and I called 911. V3 stated I (V3) informed the doctor and the daughter as well. V3 states that the policy and procedure for an unwitnessed fall is if we see the resident on the floor, we immediately assess vital signs, complete a head-to-toe assessment, check the range of motion, assess changes in level of consciousness, and do a pain assessment. If the resident is alert, staff asks them if they hit their head. V3 stated that if a resident is not alert and cognitively able to answer questions, then we need to check the head-to-toe assessment, check head for bumps, and skin (redness, skin tears). After the assessment, if there no injuries, staff will safely get them back to their bed or wheelchair. It depends on where they fell . V3 continues we will inform the doctor regarding what happened and the assessments. Then, staff will see if there are new orders and inform the family too. On 4/22/2025, at 12:50 PM, V5 (Licensed Practical Nurse) reported it is important to review medications especially if the resident is on a blood thinner. I would call the doctor, let them know, and make them aware of the medications that they are on. V5 stated sometimes I can convince the doctor, based on his medications that he is taking. For example, if they are on blood thinners, this places the resident at risk for internal bleeding. V5 stated that the complications of internal bleeding are death and/or brain damage. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/2025, at 1:35 PM, via telephone V6 (Registered Nurse) stated that when V6 was rounding and starting her medication administration pass, one of the CNA (certified nursing assistant) notified her that R1 was found sitting on the floor next to his bed. V6 states I went in there immediately. All of his vital signs were normal. Staff assisted him back to his bed. Five minutes later he was back on the floor again. V6 reported that R1's vital signs were taken. R1's doctor and family were notified. V6 states that she reported to V13 (R1's primary physician) that R1 had an unwitnessed fall. Staff assessed R1 immediately and vital signs normal. We kept monitoring him closely. V6 reports that she does not know if R1 hit his head because it was an unwitnessed fall. V6 reports that R1 was able to respond to his name or where he was. V6 asked him if he hit his head. R1 stated no and denied any pain. On 4/23/2025, at 10:36 AM, via telephone V7 (Certified Nursing Assistant) stated the nurse came to help me get him up off the floor. I don't know what happened. When I got to his room, I saw him sitting on the floor. V7 states that R1 did not have any visible injuries. V7 stated that R1 was assessed by V6 (Registered Nurse). I just helped R1 back to bed. V7 stated that R1 fell around 6:30 in the morning. On 4/23/2025, at 2:59 PM, via telephone V13 (R1's primary physician) states staff can do neuro checks. But if he (V13) was informed that the resident is taking antiplatelet medication and had unwitnessed fall, and we do not know if he hit his head or not, R1 would need to have a CT (brain) scan. Even if it was reported to V13 that R1's vital signs were stable. V13 reports that V13 would order for R1 to be sent out with this information. V13 states that the nurses should be following the facility's policies and procedures. R1's face sheet documents that R1 is a [AGE] year-old male with diagnoses not limited to: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia following cerebral infarction, dysarthria and anarthria, hyperlipidemia, unspecified, type 2 diabetes mellitus without complications, depression, unspecified, cerebral infarction, unspecified, long term (current) use of oral hypoglycemic drugs. R1's MDS/Minimum Data Set, dated dated dated [DATE], documents that R1 has a BIMS/Brief Interview for Mental Status score of 04/15, indicating that R1 is severely cognitively impaired. R1's care plan documents in part the resident is at risk for falls r/t (related to) dx/hx (diagnoses/history) of CVA (Cerebrovascular accident) with right hemiparesis. R1's health status note dated 3/28/2025, 9:24 AM, documents 6:30 AM staff reported that resident was found sitting on the floor, next to his bed. Resident (R1) was assessed immediately, with no complaints of pain or discomfort at this time. Vital signs were obtained, 130/70, P (pulse):76, RR (respirations):18, Temp (temperature):96.4, O2 (oxygen):97%. Family and MD (medical doctor) notified. Will continue to monitor. R1's health status note dated 3/28/2025, 10:13 AM, documents in part 9:55 AM Observed resident with left sided weakness. Vital signs taken. Head of bed elevated, placed on oxygen. Called 911. V13 (R1's primary physician) notified. Daughter made aware. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility document dated 09/01/2024, titled falls- clinical protocol documents in part, the nurse shall assess and document/report the following: all current medications, especially those associated with dizziness or lethargy; and all active diagnoses. The physician will identify medical conditions affecting fall risk and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant.