| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145654 | A. Building<br>B. Wing | 04/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lakeview Rehab & Nursing Center | 735 West Diversey<br>Chicago, IL 60614 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304<br><br>Based on interview and record review the facility failed to follow their policy and procedure for resident assessment and documentation after a fall/incident for 1 resident (R1) of 3 residents reviewed for improper nursing care.<br><br>The findings include:<br><br>R1's health record documented admitted on 10/10/2023 with diagnoses not limited to Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right non-dominant side, Obstructive sleep apnea, End stage renal disease, Dependence on renal dialysis, Heart failure, Malignant neoplasm of bladder, Benign essential microscopic hematuria, Other abnormalities of gait and mobility, Weakness, History of falling, Unspecified sequelae of cerebral infarction, Personal history of transient ischemic attack, and cerebral infarction without residual deficits, Unspecified ptosis of left eyelid, Facial weakness, Dysarthria and anarthria, Conversion disorder with seizures or convulsions, Fistula, left shoulder, Anxiety disorder, Depression, Essential (primary) hypertension, Anemia, Disorder of thyroid, Bipolar disorder, Hyperlipidemia.<br><br>On 4/7/24 at 10:00am R1 was transferred to the hospital.<br><br>On 4/7/24 at 10:48am V6 (Licensed Practical Nurse/LPN) said nurses are doing 12-hour shifts. V6 stated R1 was transferred to hospital this morning. V6 said R1 had self-reported incident and reviewed R1's electronic health record (EHR). V6 said R1 claimed he had a fall on 3/24/24 early morning. V6 said R1 was interviewed and stated R1 fell on the floor and got up by himself and reported the incident to the CNA (Certified Nursing Assistant). V6 stated she does not know if it was reported to the nurse.<br><br>On 4/7/24 at 12:25pm V7 (Certified Nursing Assistant / CNA) said on 3/24/24 between 4-5am, R1 told her that he fell on the floor but got up by himself. V7 stated she informed V5 (Registered Nurse/RN) and the other nurse (V9) overheard it and V9 said she is the assigned nurse and proceeded to check on R1. V7 said she went to R1's room to make sure R1 was okay. R1 told V7 that V9 will be coming back to R1's room. V7 stated she did not check R1's vital signs. V7 said that the nurse (V9) will check his vital signs and do assessment.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145654 | A. Building<br>B. Wing | 04/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lakeview Rehab & Nursing Center | 735 West Diversey<br>Chicago, IL 60614 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/7/24 at 1:40pm Observed R1 sitting on the side of the bed, can ambulate with steady gait, alert, and oriented x 4, verbally responsive. R1 stated he came back from hospital around 1:30pm. R1 said on 3/24/24 early morning, while sleeping in bed he rolled over, fell on the floor, got up by himself and went back to bed. R1 stated the call light was activated and V7 (Certified Nursing Assistant / CNA) responded. R1 asked for cup of ice and informed V7 that he fell on the floor but no big deal. R1 said the nurse came in, he did not know her name and asked him if he was okay. R1 replied, I fell on the floor but I'm fine. R1 said the nurse walked out of the room, did not assess him, or check his vital signs. R1 said another nurse (V5) came into his room and asked him if he wanted to go to the hospital and R1 said, No, I'm fine.<br><br>On 4/7/24 at 2:40pm V2 (Director of Nursing / DON) said after a fall incident she expects the nurse to complete an incident report, document in resident's electronic health record (progress notes), perform comprehensive assessment, check vital signs and ROM (range of motion). V2 said nurses should follow up documentation every shift x 72 hours to monitor or assess resident for any injury post fall. V2 said documentation is done in resident's electronic health record under progress notes.<br><br>MDS dated [DATE] showed R1's cognition was intact. R1 needed supervision/touching assistance with eating, oral, toileting and personal hygiene, shower/bathe self, upper and lower body dressing, chair/bed and toilet transfer. MDS showed R1 was always continent of bowel and bladder.<br><br>R1's Nursing Progress Note dated 3/24/2024 documented in part: The resident (R1) reported that he fell during the night to the Physical therapist. R1 stated the fall happened around 4 am this morning. R1 reported this fall to the therapist around 10AM. Fall was unwitnessed. The resident (R1) stated he woke up in the middle of the night on the ground lying in a prone position on the right side of his bed. R1 reported that once he woke up on the ground, he quickly got himself off the floor and back into his bed. R1 stated he reported the fall to a night shift CNA.<br><br>Care are plan dated 10/24/2023 documented in part: R1 at Risk for Falls as evidenced by the following risk factors and potential contributing Diagnosis: General Weakness, H/O or S/P CVA with Hemiparesis or Hemiplegia.<br><br>o Nursing Staff will complete a Fall Risk Assessment per Facility Fall Protocol.<br><br>o Follow the facility Fall Protocol.<br><br>R1's electronic health record reviewed, no nursing documentation of R1's physical and mental status on 3/26/24.<br><br>No immediate comprehensive assessment and incident report found in R1's EHR completed by nurse on duty on 7pm -7am shift.<br><br>Facility's accident incident reporting policy dated 4/15/13 documented in part:<br><br>- If a resident is involved in an accident / incident an immediate assessment of the resident will be completed.<br><br>- The nurse responsible for the oversight and care of the resident will complete an incident / accident report.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145654 | A. Building<br>B. Wing | 04/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lakeview Rehab & Nursing Center | 735 West Diversey<br>Chicago, IL 60614 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Documentation of the resident's physical and mental status will be completed each shift following the incident for a minimum of 72 hours. |