

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145767	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Paul House & Health Cr Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 North California Avenue Chicago, IL 60618	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>15301</p> <p>Based on interview and record review, the facility failed to ensure that an overbed table was maintained in good working condition for one of three residents (R2) reviewed for accidents in the sample of four. This failure resulted in R2 sustaining a fall after the overbed table top she was leaning on detached from the table base.</p> <p>R2's incident report of 1/1/2025, documents in part, resident was sitting in the hallway by the nurses' station in 2E. She was leaning on the bedside table in front of her when the table broke. R2 fell on the floor hitting her right side.</p> <p>1/21/2025, at 3:20 PM, V4 (LPN-Licensed Practical Nurse) said I was in a resident room with a resident when R2 fell . After I got through with my patient, V3 (Assistant Director of Nursing) told me she (R2) fell ; the fall was witnessed by a CNA (Certified Nursing Assistant) and physical therapy. V4 told me R2 was lying with her head down on an overbed table, the table gave way, and resident fell to floor. V4 added, I went to look at the overbed table and the tabletop was not connected to the base.</p> <p>1/22/2025, at 9:45 AM, V6 (Maintenance Director) I saw the table after the fact. The tabletop detached from the base. The screws were no longer attached to the tabletop, but it still attached to the base. Those tables are meant for food, not for naps or to lean on, they're just not strong enough. There was no preventative maintenance completed prior to the incident, I wasn't checking them unless it was brought to my attention. After the incident, I looked through most of the tables and threw out a whole bunch. Moving forward, I will probably do an in-service with nurses/CNAs (Certified Nursing Assistants) to inform them that these tables are not meant for napping, food only.</p> <p>1/22/2025, at 12:17 PM, V8 (Restorative Aide) said when R2 fell , the resident may have been pushing and leaned over on the overbed table. I'm not sure how it happened, R2 fell , and the tabletop was no longer attached to the base.</p> <p>1/22/2025, at 12:42 PM, V9 (Physical Therapy Assistant) said he heard a commotion but did not see R2 fall. V9 said I saw R2 on the floor; the overbed table was on the floor, the tabletop was no longer connected to the base.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/22/2025, at 2:39 PM, V3 (Assistant Director of Nursing) said R2 was sitting near the Nurses Station on 2East, resting her head on the overbed table, the table gave way, and R2 fell to the floor. V8 (Restorative Aide) and V9 (Physical Therapy Assistant) witnessed the fall as well.</p>