

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  03/06/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45196</p> <p>Based on observation, interview, and record review the facility failed to answer a residents (R3) call light timely who is dependent for care. This failure affected 1 out 3 residents reviewed for call light response.</p> <p>Findings include:</p> <p>On 02/27/25 at 12:55 pm, R3 was observed sitting in a wheelchair in R3's room, awake, alert and able to communicate needs. When R3 was asked regarding staff responding to R3's call light. R3 stated that a few weeks ago R3 was in R3's bed, began to have chest pain, and activated R3's call device. R3 stated that no staff responded to R3's call light after 10 minutes so R3 phoned V2 (Director of Nursing, DON) on R3's cellular phone. R3 explained that V2 stated that V2 would send a nurse to R3's room. R3 explained once R3 hung up from speaking to V2 a few minutes later a nurse came into R3's room to assist R3. R3 then explained that R3 was sent to the local hospital and was treated for having a heart attack. Surveyor then requested to perform a call device response check with R3 and R3 pulled R3's call device cord and at 1:00 pm, and at 1:11 pm, V8 (Restorative Aide) responded to R3's call device.</p> <p>On 02/27/25 at 1:12 pm, V8 stated that V8 did not know who R3's CNA (Certified Nursing Assistant, CNA) was and that V8 was the facility's restorative nurse. V8 explained that any staff member can respond to a residents call light. V8 stated that if a residents call light is not answered the resident can possibly fall and hurt themselves.</p> <p>On 03/03/25 at 12:10 pm, R3 was observed in R3's bathroom attempting to transfer from R3's wheelchair to the toilet without assistance. Surveyor questioned R3 regarding asking staff to assist R3 to the toilet and R3 stated that R3 asked V12 (Licensed Practical Nurse, LPN) for help to the bathroom and V12 informed R3, that R3's CNA (Certified Nursing Assistant) was on break. R3 then stated that R3 asked R3's nurse V22 (LPN) for assistance and V22 informed R3 that V22 would let R3's CNA know when R3's CNA returned from break. R3 then stated that R3 had been waiting 20-30 minutes when R3 decided to transfer herself to the toilet. Surveyor then instructed R3 to activate R3's bathroom call light device for assistance at 12:13 pm. Surveyor observed R3 pull R3's call light cord in R3's bathroom with the red light on R3's bathroom call device activated and flashing. At 12:33 pm, Surveyor and R3 remained in R3's bathroom awaiting staff assistance. Surveyor then observed R3's call device outside of R3's room door not functioning, not showing activated (without a flashing light or indicator of R3 signaling for help in R3's bathroom).</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/03/25 at 12:33 pm, Surveyor pushed the call box button for help in R3's room and at 12:40 pm, V8 (Restorative Aide) responded to R3's call device button. Surveyor questioned V8 regarding R3's call device cord in R3's bathroom functioning and V8 stated that R3's call device cord was able to light up for assistance in R3's bathroom but was not activated and signaling in the hallway above R3's door. V8 explained that only R3's call box was functioning. V8 stated that V8 was not R3's assigned CNA and that V8 was just responding to R3's call light.</p> <p>On 03/03/25 at 12:41 pm, V22 (Licensed Practical Nurse, LPN) was asked regarding responding to R3's call device V22 stated that R3 was in bed 1 hour ago and pulled R3's call device from R3's bed and asked V22 if R3 could go to therapy and V22 informed R3 that R3's CNA was on break and would assist R3 when she returned. V22 stated, It is not the nurses responsibility to get the residents dressed. That's the CNA's job. When V22 was asked regarding V22 being aware that R3 was inside of R3's bathroom pulling R3's call device requesting for help V22 stated, I did not know that R3 was in the bathroom calling for help. Her (R3) call device was not on. She (R3) should not be trying to transfer herself. She (R3) requires assistance from staff for transferring. She (R3) could have hurt herself.</p> <p>On 03/04/25 at 10:26 am, V2 (Director of Nursing, DON) denied any knowledge of R3's having complaints of R3's call light not being answered in a timely manner or R3's call light device not functioning. V2 also denied knowledge of R3's call light not being answered when R3 had complaints of chest pain a few weeks ago. V2 stated that R3 called V2 on V2's cell phone and notified V2 that R3 was having chest pain and that V2 immediately went to R3's room to address R3's chest pain. When V2 was asked regarding what can happen if a resident's call light is not answered timely or if a residents call light is not functioning and V2 stated that if a residents call light is not answered timely the staff would not be able to tend to the resident and the resident can go into distress. V2 explained that any staff can respond to a residents call light device, and the nursing staff should be checking the residents call lights daily during rounds to ensure the call light is functioning. V2 also explained that resident call lights that are not functioning properly should be immediately reported to the maintenance department for repair.</p> <p>R3's face sheet shows that R3 has a diagnosis included but not limited to: Parkinson's disease without dyskinesia without mention of fluctuations, spinal stenosis lumbar region without neurogenic claudication, osteoporosis with current pathological fracture vertebrae subsequent encounter for fracture, wedge compression fracture of third lumbar vertebra, bilateral primary osteoarthritis of the knee, and chronic kidney disease stage 3b.</p> <p>R3's Minimum Data Set (MDS) dated [DATE] section C shows that R3 has a BIMS score of which indicates that R3 is cognitively intact. R3's MDS section GG shows that R3 requires substantial maximal assistance with toileting.</p> <p>R3's Call Light Ability Screen dated 02/12/25 documents in part: IV. Conclusion: A. Resident is able to use the call light after the screening process.</p> <p>The facility's undated document titled Answering Call Lights documents in part. Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines: 4. Be sure the call light is plugged in and functioning at all times . 7. Report all defective call lights to the nurse supervisor promptly.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45196</p> <p>Based on observations, interviews, and record review, the facility failed to provide a functioning call device for a dependent resident (R3) who requires assistance from staff. This failure affected 1 out of 4 residents reviewed for resident call system.</p> <p>Findings include:</p> <p>On 03/03/25 at 12:10 pm, R3 was observed in R3's bathroom attempting to transfer from R3's wheelchair to the toilet. Surveyor questioned R3 regarding R3 asking staff to assist R3 to the toilet and R3 stated that R3 asked V12 (Licensed Practical Nurse, LPN) for help to the bathroom and V12 informed R3, that R3's CNA (Certified Nursing Assistant) was on break. R3 then stated that R3 asked R3's nurse V22 (LPN) (R3's assigned nurse) for assistance and V22 informed R3 that V22 would let R3's CNA know when R3's CNA return from break. R3 then stated that R3 had been waiting 20-30 minutes when R3 decided to transfer herself to the toilet. Surveyor then instructed R3 to activate R3's bathroom call light device for assistance at 12:13 pm. Surveyor observed R3 pull R3's call light cord in R3's bathroom with the red light on R3's bathroom call device activated and flashing. At 12:33 pm, Surveyor and R3 remained in R3's bathroom awaiting staff assistance. Surveyor then observed R3's call device outside of R3's room door not functioning, not showing activated (without a flashing light or indicator of R3 signaling for help in R3's bathroom).</p> <p>On 03/03/25 at 12:33 pm, Surveyor pushed the call box button for help in R3's room and at 12:40 pm, V8 (Restorative Aide) responded to R3's call device button. Surveyor questioned V8 regarding R3's call device cord in R3's bathroom functioning and V8 stated that R3's call device cord was able to light up for assistance in R3's bathroom but was not activated and signaling in the hallway above R3's door. V8 stated that V8 did not know how long R3's call light was not functioning properly.</p> <p>On 03/03/25 at 12:47 pm, V23 (Maintenance Director) assessed R3's bathroom call device that was not alarming in the 2nd floor hallway and stated, It may just need a bulb. Surveyor and V23 both went to the 2nd floor nurses station to assess the call box at the nurse station and observed that R3's call light was not alarming at the nurses station either. V23 stated, I think replacing the bulb will make it sound and fix it. When V23 was asked regarding performing call device functioning checks for the facility V23 stated, I (V23) don't perform call device checks. The staff has to make me aware that the call device is not functioning. When V23 was asked regarding the importance of the call device for resident to be functioning in the residents rooms and bathrooms and V23 stated, To alert someone they need help in the bathroom. When V23 was asked regarding what could happen if a call device is not functioning and V23 stated, Various things. A resident could fall.</p> <p>On 03/04/25 at 10:35 am, V2 (Director of Nursing, DON) explained that it is the nursing staff responsibility to check to ensure that the call lights are functioning and if the call device is not functioning staff should notify the maintenance. V2 stated that if a resident call device is not functioning staff would not be able to tend to the resident and the resident can go into distress. V2 stated if a residents call device is not working and a resident who requires maximum assistance for toileting attempts to transfer themselves the resident can fall.</p> <p>(continued on next page)</p>		

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