Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145806	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Park Health & Living Ctr	6700 North Damen Avenue Chicago, IL 60645

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45002 Based on interview and record review, facility failed to follow their policy to report the appearance of suspicious bruise, lacerations, or other abnormalities as unknown origin as soon as it is discovered for one (R1) out of three residents reviewed for reporting of unknown injury. Findings include: R1 is a [AGE] year-old female. R1's medical diagnoses are but not limited to schizophrenia, bipolar disorder, unspecified psychosis not due to a substance or known physiological condition, seizures, and rectal prolapse. R1's BIMS (Brief Interview for Mental Status) dated 03/14/2024, notes interview for mental status was not conducted because R1 is rarely or never understood. R1's care plan documents that R1 had a fall on 2/16/2023 and 4/17/2023. On 06/04/2024 at 11:18 AM, V3 (Nurse Practitioner) stated that she was R1's nurse practitioner when R1 was here. V3 stated that R1 hurt her head a while back due to a fall. V3 stated that R1 fell on [DATE]. R1 refused to go to the hospital. R1 is alert and oriented x2. V3 stated that R1 had a contusion to her head. V3 stated that a CT (Computerized Tomography) scan was never done. V3 stated that R1 was sent to the hospital on May 21st, 2024 due to lethargy, low oxygen saturation, altered mental status. R1's oxygen saturation was 80% on room air. V3 stated that on May 21st, 2024, she noticed a new hematoma on the side of R1's head. V3 stated that R1's nurse was with her doing the assessment when she noticed that hematoma. V3 stated that no one knew how she received the new hematoma. V3 stated that R1 was impulsive and that she did not adhere to fall precautions. V3 stated that she has no idea how she fell the first time. R1 is not the most reliable historian. She continues to forget. On 06/04/2024 at 11:50 AM, V5 (Licensed Practical Nurse) stated she was the nurse taking care of R1 when she was sent to the hospital. V5 stated that R1 was sent to the hospital because she had altered mental status and R1's oxygen saturation was down. V5 stated that R1 was okay and talking in the morning. V5 stated, When I was doing my morning rounds, R1 was not responding to me. V3 (Nurse Practitioner) was also there that morning. We did the assessment together. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/04/2024 at 12:10 PM, V1 (Administrator) stated that she has been the administrator for the past two years. As the abuse coordinator I oversee all the internal investigations. If there is any falls with injury we are expected to report that. Any injury of unknown origin we are expected to report that to (State Agency) within 24 hours. V1 pointed to the reportables binder and stated, These are all the reportables for the past 6 months. V1 stated that she is familiar with R1. V1 stated that she fell about two months ago. V1 stated that in April R1 was praying and she fell while praying. She fell in her room. V1 stated that R1 did sustain injuries from this fall. She had a laceration on her head. It was a laceration that was treated in house. V1 stated that R1 refused to go to the hospital. V1 stated she did not speak to V3 so she was not aware of any new bruising. V1 stated that she was not even aware R1 even had an injury. V1 stated that if she had known about it and R1 was not able to tell her what happened, she would have reported it because it would have been an injury of unknown origin. R1's progress note by V3 (Nurse Practitioner) on 05/21/2024 documents in part: SKIN: contusion on head healing, new hematoma left forehead, about 1 inch in diameter. pt (patient) with recent falls R1's progress note by V3 (Nurse Practitioner) on 05/21/2024 documents in part: The resident was admitted to the hospital with the diagnosis: Fracture of the Cervical Vertebrae. Facility's Abuse Prevention Program policy (10/2022) documents in part: The nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. Following the discovery of any suspicious bruises, lacerations or other abnormalities of an unknown origin, the nurse shall complete a full assessment of the resident for other bruises, lacerations or pain. For resident injuries involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an 'injury of unknown source'. An injury should be classified as an 'injury of unknown source' when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. If classified as an 'injury of unknown source' the person gathering facts will document the injury, the location, time it was observed, any treatment given and notification of the resident's physician, responsible party. The Department of Public Health will be notified.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 45002 Based on interview and record review, facility failed to appropriately assess and evaluate residents that are high risk for falls and implement interventions related to the resident's specific risks and causes to try to prevent the resident from falling for one (R1) out of three residents reviewed for falls. This failure resulted in R1 being sent out to the hospital with diagnosis of fracture of the cervical vertebrae and an acute subdural hematoma. Findings include: R1 is a [AGE] year-old female. R1's medical diagnoses are but not limited to schizophrenia, bipolar disorder, unspecified psychosis not due to a substance or known physiological condition, seizures, and rectal prolapse. R1's BIMS (Brief Interview for Mental Status) dated 03/14/2024, notes interview for mental status was not conducted because R1 is rarely or never understood. R1's care plan documents that R1 had a fall on 2/16/2023 and 4/17/2023. On 06/04/2024 at 11:18 AM, V3 (Nurse Practitioner) stated that she was R1's nurse practitioner when R1 was here. V3 stated that R1 hurt her head a while back due to a fall. V3 stated that R1 fell on [DATE]. R1 refused to go to the hospital. R1 is alert and oriented x2. V3 stated that R1 had a contusion to her head. V3 stated that a CT (Computerized Tomography) scan was never done. V3 stated that R1 was sent to the hospital on May 21st, 2024 due to lethargy, low oxygen saturation, altered mental status. R1's oxygen saturation was 80% on room air. V3 stated that on May 21st, 2024, she noticed a new hematoma on the side of R1's head. V3 stated that R1's nurse was with her doing the assessment when she noticed that hematoma. V3 stated that no one knew how she received the new hematoma. V3 stated that R1 was impulsive and that she did not adhere to fall precautions. V3 stated that she has no idea how she fell the first time. R1 is not the most reliable historian. She continues to forget. On 06/04/2024 at 11:40 AM, V4 (Restorative Nurse) stated that she is familiar with R1. V4 stated that R1 fell last was in April. Last time she went out for medical reasons. She went out the beginning of May. Any time there is a fall in the facility, I am the one who investigates it. The last time R1 had a fall, she slipped and she bumped her head on the frame of the bed. She did have an opening on the forehead. I believe they tried to send her out, but she refused. So, they did a dressing in house. Her care plan is updated. V4 stated that residents are assessed for fall risk every time they have a fall. I don't remember R1 having anymore falls after the one she had in April. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

On 06/04/2024 at 11:50 AM, V5 (Licensed Practical Nurse) stated she was the nurse taking care of R1 when she was sent to the hospital. V5 stated that R1 was sent to the hospital because she had altered mental status and R1's oxygen saturation was down. V5 stated that R1was okay and talking in the morning. V5 stated, When I was doing my morning rounds, R1 was not responding to me. V3 (Nurse Practitioner) was also there that morning. We did the assessment together. We gave her oxygen. After we gave her oxygen, her oxygen saturation level was low. V5 stated that R1 did not have a fall at that time but prior to being sent out there was something on her forehead. V5 stated that R1 fell in April and that they tried to send her out for that, but she refused. She didn't go. That was the only fall she had. The intervention that was added was to her care plan. V5 stated that R1 does not remember too well.

On 06/04/2024 at 12:10 PM, V1 (Administrator) stated that she has been the administrator for the past two years. As the abuse coordinator I oversee all the internal investigations. If there is any falls with injury we are expected to report that. Any injury of unknown origin we are expected to report that to (State Agebcy) within 24 hours. V1 pointed to the reportables binder and stated, These are all the reportables for the past 6 months. V1 stated that she is familiar with R1. V1 stated that she fell about two months ago. V1 stated that in April R1 was praying and she fell while praying. She fell in her room. V1 stated that R1 did sustain injuries from this fall. She had a laceration on her head. It was a laceration that was treated in house. V1 stated that R1 refused to go to the hospital.

On 06/04/2024 at 1:01 PM, V2 (Director of Nursing) stated R1 moves around in a wheelchair. V2 stated that she is impulsive. Her last fall was on 04/17/2024. V2 stated that R1 did not tell the nurse what happened. The doctor saw her but she did not order any CT or X-ray for her. We are trying to constantly monitor her. Our CNAs (Certified Nursing Assitant) watch her round the clock. Whenever I come into work, I watch her.

Surveyor asked, How is it after constant monitoring, that she fell ?. V2 responded, I cannot answer how she fell . V2 stated that they could have added a more specific intervention after her fall on 4/17/2024 to prevent R1 from falling again. V2 stated that the fall coordinator and herself complete fall assessments to assess whether residents are high risk for falls. V2 stated that a fall risk assessment is completed upon admission quarterly and after a fall.

Surveyor asked V2 to show him where the fall assessments were for 2/16/2024 and 4/17/2024. V2 looked on R1's electronic medical record and stated that there were no fall risk assessments completed for resident after fall on February 19th, 2024 and April 18th, 2024.

Surveyor asked V2, if R1 was a high fall risk upon admission. V2 stated that R1 was a high fall risk upon admission. Surveyor then showed V2 R1's Initial admission fall risk assessment asked V2 to read assessment results. V2 stated that R1 was a moderate fall risk and then became a high fall risk. V2 stated that x-ray and radiology scans can be done in the facility if there is a doctor's order. V2 stated that after R1's last fall on 4/17/2024 no orders for x-ray or scans were put in by the doctor. V2 stated that this would have helped identify any injuries that have occurred internally.

Reviewed R1's care plan. No new interventions updated after fall on 4/17/2024.

R1's progress note by V3 (Nurse Practitioner) on 05/21/2024 documents in part: SKIN: contusion on head healing, new hematoma left forehead, about 1 inch in diameter. pt with recent falls

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's progress note by V3 (Nurse Practitioner) on 05/21/2024 documents in part: The resident was admitted to the hospital with the diagnosis: Fracture of the Cervical Vertebrae. Reviewed R1's physician order sheet. No order for X-ray or CT were documented. Reviewed R1's assessments. No fall assessment done after fall on 2/19/2024 and 4/18/2024. Reviewed R1's MDS Section C for 3/14/2024: Unable to conduct interview with R1 due to resident being rarely/never understood. Reviewed R1's MDS Section C for 5/21/2024. Unable to attain BIMS score for R1 due to R1 not being understood. R1's hospital record (5/21/2024) documents in part: CT of the head on 5/21/2024 results in an acute subdural hematoma along the right side of the interhemisperric fissure measuring up to 5mm, Acute subdural hematoma along the right side of the tentorium measuring up to approximately 7 mm. Acute subdural hematoma right cerebrum temporal lobe region measuring approximately up to 3.5 mm. Facility's Falls and Fall Risk Managing Policy (3/2020) documents in part: If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions.