

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/26/2025
NAME OF PROVIDER OR SUPPLIER Norwood Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 6016 North Nina Avenue Chicago, IL 60631	

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 - 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>45110</p> <p>Based on interviews and record reviews, the facility failed to provide adequate supervision for one resident [R5] who is a high fall risk out of three residents reviewed for falls. This failure resulted in R5 experiencing an unwitnessed fall and sustaining an acute nondisplaced fracture of the L5 superior endplate with extension to the left L5 transverse process (Lumbar Fracture).</p> <p>Findings Include,</p> <p>R5 clinical record indicate in part; R5 is a sixty-nine year old with the Medical diagnosis includes but not limited to malignant neoplasm of right main bronchus, secondary malignant neoplasm of brain, severe protein calorie malnutrition, atrial fibrillation, osseous and subluxation, major depressive disorder, wedge compression fracture of fifth lumbar vertebra, subsequent encounter for fracture with routine healing, muscle weakness, difficulty in walking, need for assistance with personal care, malignant neoplasm of unspecified part of unspecified bronchus or lung , adult failure to thrive, and presence of left artificial hip joint. R5's minimum data set section [C] dated 11/27/24 indicates R5 is cognitively impaired.</p> <p>R5's care plan documents in part:</p> <p>11/27/24, R5 has anemia, metastatic small cell lung cancer. Intervention: Complete fall risk assessment and increase vigilance for falls.</p> <p>11/27/24, R5 needs a safe environment with a working and reachable call light.</p> <p>11/27/24, R5 requires maximum staff assist with transfers.</p> <p>12/9/24, place R5 by the nurse station for closer monitoring.</p> <p>R5's hospital document dated 12/9/24, indicates: R5 was brought in for unwitnessed fall at the nursing care facility. CT scan results: Acute nondisplaced fracture of the L5 superior endplate with extension to the left L5 transverse process.</p> <p>R5's progress notes documented in part:</p> <p>V7 [Registered Nurse] Note:</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>12/9/24 at 9:01 AM, Note Text: R5 has been anxious this morning trying to get out of bed. Writer and CNA [V11-Certified Nurse Assistant] redirected R5 multiple times as she kept dangling her legs off the bed. Writer and CNA [V11] on duty transferred the resident to the wheelchair so that she could be supervised at the nurse's station.</p> <p>V7 [Registered Nurse] Note:</p> <p>12/9/2024 11:16 am Nurses Notes</p> <p>Note Text: Writer hears yelling coming from R5's and quickly went in to assess the scene and found R5 laying supine position on the floor next to her bed. R5's head was facing towards the foot of the bed, and her feet were facing towards the head of the bed. The R5 began to adjust her arms and bend her knees to try and get up, and the writer and another RN on duty assisted the R5 off the floor back into the wheelchair. The R5 began pointing to her head where the writer observed a small hematoma on the right side of the rear of her head. RN assessed the resident for additional injuries and the assessment was within normal limits. Vital signs: BP (blood pressure) 111/74, HR (heart rate) 79 BPM (beats per minute), 99%O2 (oxygen) saturation, 97.1F temperature, and respirations 22. Parties notified: AM supervisor, director of nursing, physician, and family. Carried out doctor's orders to send the resident to the hospital emergency department for evaluation.</p> <p>12/10/2024 04:34 am Nurses Notes</p> <p>Note Text: R5 admitted to hospital with L5 Vertebral fracture.</p> <p>R5's Illinois Department of Public Health Report Notification dated 12/10/24, indicated:</p> <p>On 12/9/24 at 11:12 AM, R5 was noted laying on the floor in her room. Noted with elevated area to the back of R5's head.</p> <p>On 1/25/25 at 12:41 PM, V11 [Certified Nurse Assistant] stated, I was R5's certified nurse assistant on 12/9/24 day shift. R5 is alert but confused and needs close monitoring. When I came in to work and observed R5 trying to get out of bed and anxious. I assisted R5 with ADL (activities of daily living) care and dressed. R5 was transferred out of bed into her wheelchair. Then R5 was taken nurse's station for close monitoring. At 11AM, I told V7 [Registered Nurse] I was going to lunch and to monitor R5 at the nurse station. Upon my return back from lunch, V7 told me that R5 fell , when I left for lunch.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/25/25 at 1:30 PM, V7 [Registered Nurse] stated, I was R5's nurse on 12/9/24, day shift. R5 is alert but confused and is a high fall risk resident. R5 has diagnosis of lung and brain cancer. R5 needed close monitoring and supervision especially when she becomes anxious. Early that morning, I noticed R5 was anxious trying to get out of bed. Multiple times I redirected R5 to place her legs back into the bed so she would not fall. I assisted V11 in transferring R5 into the wheelchair so she could be monitored and supervised closely at the nursing station. A little past 11AM, I was in the hallway and heard yelling from R5's room, I observed R5 laying on the floor on her back. R5 started to move and was trying to get herself up, after me and another registered nurse assessed R5 then we assisted her up off the floor back into her wheelchair. At that time R5 pointed to her head and noted a hematoma. R5's physician gave an order to send R5 to the emergency department for further evaluation. I did not see when R5 left the nursing station, I had other residents to give medication and assistance. Around 11AM I started the noon medication pass and checking blood sugar levels during that time. I do not remember if V11 told me she was going to lunch around 11AM. I did not notify the director of nursing that I needed assistance to monitor R5.</p> <p>On 1/26/25 at 11:25 AM V12 [Nurse Practitioner] stated, I am familiar with R5, I been working at the facility for several years. R5 is alert and confused due to lung cancer that spread to her brain. R5 requires close supervision and monitoring due to her confusion and brain cancer diagnosis. I made rounds and saw R5 on 12/9/24. R5's pain was managed well. R5 needed to supervise and monitored closely due to the fact R5 needed frequent queuing and redirection for her safety. R5 was able to stand and walk but with a weak unstable gait. However, due to R5's brain cancer she did not have safety awareness, not to walk, therefore needed close supervision. R5 had an unwitnessed fall on 12/9/24 and sustain a L5 fracture.</p> <p>On 1/25/25 at 2:40 PM V3 [Director of Nursing/Fall Coordinator] stated, R5 is alert but confused and is a high fall risk resident. R5 has diagnosis of lung and brain cancer. R5 needed close monitoring and supervision. During my investigation related to R5's fall on 12/9/24, V7 [Registered Nurse] observed R5 being restless and trying to get out of bed. R5 was dressed and transferred to the wheelchair and taken to the nurse's station for close monitoring. When V11 [Certified Nurse Assistant] notified V7 that she was leaving the unit for lunch, V7 should have monitored R5 closely. If V7 had to take care of other residents, then V7 should have notified me so I could have assisted in making sure R5 was supervised closely. R5 fell and sustained a fracture that could have been avoidable due to lack of supervision.</p> <p>Policy documents in part:</p> <p>Fall Prevention dated 6/15/24.</p> <p>Residents assessed at risk for falls will be closely observed.</p> <p>Residents will be free from falls and Injury.</p> <p>Diagnosis is evaluated for those that may predispose a resident.</p> <p>Residents exhibiting mental or physical changes are evaluated for the increased risk of falls.</p>		