STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146013	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkeley Nursing & Rehab Center	6909 West North Avenue Oak Park, IL 60302

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41758 Based on interview and record review, the facility failed to follow their change in condition policy by not calling advance life support services (911) for two hours after R48 who was found with an altered mental status and verbally unresponsive. This failure resulted in R48 immediate intubation by emergency medical service and mechanical ventilation for 1 of 1 residents reviewed for change in condition. Findings Include: R48 has the diagnosis of Atrial Fibrillation, Lack of coordination, abnormalities of gait and mobility, need for assistance with personal care and Adult Failure to Thrive. R48's physician order summary dated 2/7/25 documents: Rivaroxaban (antithrombotic/prevent blood clots) fifteen milligrams given by mouth at bedtime for atrial fibrillation. Medication administration record dated 2/1/25-2/28/25 and 3/1/25 documents: R48 received Rivaroxaban as prescribed. Fall risk review dated 2/28/25 documents: R48 was at high risk for falls. Is resident receiving a medication that affects awareness, judgement or safety (e.g. anti-anxiety, antibiotics, anticoagulants) yes. Ambulation with assist. Gait Balance: balance problem while standing/walking. Requires use of assistive device. On 4/1/25 at 10:34am, V3 (Complainant) said, he was called to the facility for a fall. R48 had signs of a severe brain bleed (hemorrhage). R48 had a fall the previous day, was not assessed or sent to the hospital. R48 presented with his arm flexed, hyper-extended, leg stiff, and toes pointed. V3 said, he was not sure how long R48 was in that position. R48 had a decrease level of consciousness and a pulse oxygen saturation of 83% on room air. R48 was breathing at ten breathes per minutes which was irregular. R48 was started on oxygen, high flow non-breather mask, which did not adjust R48's rate/oxygenation. R48 was sedated for intubation to establish an airway. On 4/2/25 at 10:04pm, V15 (Nurse) said, she was informed by V18 (Certified Nursing Assistant/CNA) that R48 was on the floor. R48 was assessed and denied hitting his head. R48 was not wet and had a urinary catheter in place. V15 said, R48 was alert and orient times 1-2 at the time of the incident. That was R48 baseline. V15 said, if a resident has an unwitnessed fall and is taking anticoagulants that resident should be sent to the hospital at the time of the incident to rule out possible brain bleed. Statement dated 3/1/25 documents: CNA reported the resident (R48) was on the floor. Immediately responded. Observed resident on his left side laying on the floor. V18's statement dated 3/1/25 documents: I saw resident in room three on the floor informed the nurse (V15). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Progress note dated 3/1/25 documents: 5:30pm (V18) CNA reported that resident (R48) is on the floor. Immediately responded. Observed resident on his left side laying on the floor. Assessment done. No visible injuries noted, no change of level of consciousness or range of motion, no complain of pain or discomfort at this time. Assisted resident back to bed via two person assist. Incident report dated 3/1/25 documents: CNA reported that resident is on the floor. (R48) stated he wanted to go to the bathroom when asked what he was trying to do. Predisposing environmental factors: wheelchair/recliner, medical equipment (IV pole, etc). Predisposing Physiological Factors: Fragile/sensitive skin, recent change in medication, medication affecting blood coagulation, recent illness, weakness/fainted, high risk for significant injury: use of anticoagulants and decrease strength/endurance. Predisposing situation factors: Incident during self-transfer from bed. On 4/2/25 at 1:49pm, V8 (CNA) said, she saw R48 on 3/2/25 in the bed around 7:00am. V8 said, she reports to work early at 6:30am to complete her resident rounds. V8 said, R48 was not yelling which was his baseline. V8 said, R48 was in bed sleeping when she saw him. V8 said, she took R48 his breakfast tray between 8:00am - 8:30am. V8 said, she called R48's name. R48 did not respond. V8 said, she shook R48 to get him to wake up, but did not respond. V8 said, she informed the nurse. V8 said, R48 needs help ambulation to the bathroom. R48 was shaky/unsteady when he stood up. V8 said, she did not get any report about R48 from the off-going CNA/Nurse. Facility Final Incident report form dated 3/6/25 document: R48 was observed on the floor next to his bed. No one witnessed R48 falling. The following morning, R48 was observed with a change in condition. Physician was notified with order to transfer resident to the hospital for further evaluation. On 4/4/25 at 2:46pm, V16 (Nurse) said, when she completed her morning rounds, nothing was out of ordinary with R48. V16 said, she completed a second round on R48. V16 said, R48 was observed not his normal self. R48 was usually very verbal, out spoken, making jokes and could make his needs known. V16 said, she was use to R48 speaking to her. V16 said, she called out R48's name with no reply. V16 said, R48 was breathing with his eye's open but wasn't as verbal per usual. V16 said, R48 did not eat his breakfast which was not normal. V16 said, she notified the doctor who gave orders to discharge R48 to the hospital. V16 said, she called basic life support ambulance service (BLS). V16 said, when emergency medical technician (EMT) from the basic life support ambulance arrive they stated that 911 should have been called. V16 said, when the EMT did their assessment, they felt R48 should have gone out 911. V16 said, she did not notice anything different with R48 after the EMT assessment that different from V16's initial assessment. V16 said, the EMT never shared why they felt R48 should have been discharged to the hospital via 911 instead of BLS. V16's progress note dated 3/2/25 at 9:22am documents: During rounds notice resident hasn't ate breakfast. Observed altered mental status. Nurse practitioner ok to send out to the hospital. Contacted ambulance states 30 (thirty) minute estimate time of arrival (eta.) Progress note dated 3/2/25 at 10:12am documents: BLS ambulance arrived 2EMTs with stretcher. After assessment (BLS) has decided to send resident out 911. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Ambulance Run report dated 3/2/25 documents (10:08AM): Provider's Primary Impression: Unspecified Altered Mental Status. Initial Patient Acuity: Critical (Red) Basic life support unit called to the scene for R48 with chief complaint of altered mental status. Upon arrival to patient (R48), patient was found in the supine position. Patient was alert and oriented time one baseline was alert and oriented time four and would open his eyes to verbal stimulus. CSS was attempted but unable to be completed because patient was unable to respond to verbal. Slurred speech inconclusive. Arm lift inconclusive and no facial droop notices. Med control was contacted per trauma systems of care and advised to contact 911 for advance life support (ALS) upgrade. 911 was contacted. Fire department report dated 3/2/25 documents: Patient contact (10:35AM).Emergency medical service was greeted by a basic life support crew who had been called to transport the patient, but determined that patient needed advance life support intervention. EMS was informed the patient had been found down on the ground yesterday at 5:00pm, it was unwitnessed fall, and was unknown if the patient had loss of consciousness. This morning during checks around 9:00am staff at the nursing home reported finding the patient was altered level of consciousness (ALOC) and was having issues rousing him. Staff reported the patient was normally CAOx4 (Conscious. Alert and Oriented times four means a patient is fully aware and can accurately identify who they are (person), where they are (place), what time it is (time) and what is happening around then (situation) with a Glasgow Coma Scale (GCS) of 15. Pt was taking blood thinners. As EMS entered the room they found the patient laying supine in bed with decerebrate posturing (an abnormal body posture characterized by involuntary extension of the arms and legs with the head and neck arched backward) hyper-extension of the upper extremities. Patient was found to have irregular bradypnea (abnormally slow breathing), with ALOC, presenting with a GCS of 7 (score 7 indicated a severe head injury, often associated with a come and high risk of mortality), responsive to painful stimuli and pinpoint pupils. Patient was lifted and place on the cot and secured. Patients vital were obtained. A 4- lead ECG was obtained showing a-fibrillation (heart (atria) beats irregularly and rapidly, instead of contraction in a coordinated rhythm). EMS established intravenous access and place the patient on high flow oxygen. An inbound patient care report was called into the hospital emergency department via phone. Hospital recommended EMS attempt intubation of the patient. Patient was pre-oxgenated with a bag-value mask (BVM). Pt was intubated. Progress note dated 3/2/25 documents: Writer spoke with nurse at hospital that is caring for resident, Nurse inform writer that he is currently being intubated. Progress note dated 3/4/25 documents: R48 was diagnosis with fractured ribs. Hospital paperwork dated 3/2/25 documents: Patient brought in to Trauma A via Fire Department. Alerted Mental Status (AMS) after fall yesterday at 1700 (5:00pm). Positive + blood thinners. Patient was sating 90% on non-rebreather and posturing. Patient arrived EMS bagging. Patient found down at nursing home on 3/1/25. EMS called for AMS on 3/2/25. Patient was intubated for inability to protect airway. Transferred to ICU for ventilator management. Patient with left 8, 9 rib fracture, Covid and Pneumonia. Patient remains on vent. Patient not waking up. GSC 3 (lowest possible level of consciousness, suggesting deep unconsciousness or coma and is associated with very poor prognosis often indicating a high mortality rate) in trauma bay. Change on condition policy not dated: documents: During medical emergencies such as unstable vital signs, respiratory distress, uncontrolled bleeding and unresponsiveness 911 will be notified for transport to the hospital.