STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146185	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Sisters of the Poor	2325 North Lakewood Avenue Chicago, IL 60614

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 0689 Level of Harm - Actual harm Residents Affected - Few	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** 32819 Based upon observation, interview, and record review the facility failed to ensure that (R1's) care plan was congruent with the fall risk assessment, failed to implement fall prevention interventions and failed to provide supervision to three of three residents (R1, R2, R3) reviewed for falls. These failures resulted a laceration to the left lower leg from R1's 6/25/24 fall. These failures also resulted a laceration, abrasion, and bruises to the forehead, bridge of nose, and both arms along with a C1 fracture from R1's 7/13/24 fall. Findings include: 1.) The facility's fall incident log affirms R1 fell on [DATE] and 7/13/24. R1's (6/25/24) incident report states Unwitnessed Fall. Called to resident room by CNA (Certified Nursing Assistant). Upon entering resident room noted sitting on her bottom with both legs extended out in front of her, with hands palm side down with upper body erect next to closet. Noted moderate amount of blood from open old wound on lower inner left leg. Resident states she was getting her walker and lost her balance, states I hit my leg on my walker when I fell . Injury: laceration to inner lower left leg. Predisposing factors: gait imbalance, improper footwear, using wheeled walker. R1's (7/13/24) incident report states Unwitnessed Fall. Resident was sitting behind the door close to the closet. Blood was dripping from her forehead. Injury: open area top of scalp. Predisposing factors: confused, gait imbalance, ambulating without assist, improper footwear. R1's (7/13/24) final injury investigation report states resident returned from hospital with fracture of C1. Resident also noted with laceration, abrasion, bruises to forehead, nose bridge and both arms. R1 is [AGE] years old with diagnoses include bilateral hearing loss, atrial fibrillation, chronic kidney disease and osteoarthritis. R1's (7/22/24) functional status affirms resident is dependent on staff for chair/bed to chair transfers and toilet transfers. R1's (6/20/24) admission fall risk assessment determined a score of 10 (high risk). (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's care plan states resident is a medium risk for falls [R1 is high risk - per fall assessment] due to impaired balance, osteoarthritis, chronic shoulders contracture related to torn rotator cuff and history of falling. (6/25/24) Resident fell and sustained laceration to left leg. Interventions: Re-educated to call and wait for help. Staff educated to place call light within reach and remind resident to call for help. (7/13/24) Fall with injury to forehead and nose. Returned from ER (emergency room) with cervical fracture. Interventions: Nursing staff will continue to check on resident frequently especially when she's in her room. Bring resident to the Nurse's station area for close observation during morning/evening shift change and as needed. On 8/27/24 at 12:15pm, V3 (CNA) affirmed that she's assigned to R1. Surveyor inquired about R1's fall prevention interventions. V3 stated She (R1) stays supervised in the glass room here (pointing to the glass enclosed room - adjacent the Nurse's station) or in the dining room. If she's in bed she has the call light and there's regular rounds. R1's (7/22/24) BIMS (Brief Interview Mental Status) determined a score of 11 (moderate impairment). On 8/27/24 at 12:21pm, V4 (CNA) was observed seated next to R1 in the dining room. Surveyor inquired about R1's fall prevention interventions. V4 stated We (staff) just round on her (R1). Surveyor inquired if R1 can walk. V4 responded She (R1) uses the wheelchair. R1 was noted to be wearing a neck brace, a large dressing was covering her forehead, and bruises were observed across the bridge of the nose and cheeks. Surveyor inquired how R1 fell . R1 stated I don't remember. When did I fall? V4 responded You (R1) fell I think in July [6 weeks prior]. She (R1) looks much better now. She looked bad when she came back from the hospital. On 8/27/24 at 2:49pm, surveyor observed R1 (alone) in the (1st floor) glass enclosed room adjacent the Nurse's station. R1 was seated in a recliner watching television however a call light was not observed in the room. On 8/27/24 at approximately 2:51pm, surveyor inquired if the glass enclosed room (where R1 was placed) has a call light available. V3 (CNA) stated We do not. On 8/28/24 at 12:05pm, surveyor inquired about R1's (7/13/24) incident. V2 (Director of Nursing/DON) stated She (R1) just moved in not too long ago. She told us she fell on ce before coming here from home. I try to allow her to do things without limiting her too much and she had a fall. Surveyor inquired what fall prevention interventions were implemented post R1's fall. V2 responded We did invite her to activities to see what she likes doing, CNAs monitor her quite closely. Surveyor inquired what staff are required to do prior to leaving R1 in a room. V2 replied We just keep an eye on her and if she uses the call light, we go in her room. Surveyor inquired how dependent residents can request help if they are not provided a call light. V2 stated They (residents) have a call light. They all have a call light right next to them. Surveyor inquired if there's a call light in the (1st floor) glass room. V2 responded There's no call light in the glass room. 2.) The facility fall incident log affirms R2 fell on [DATE] in the bedroom. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's (6/29/24) incident report states Unwitnessed Fall. CNA called Nurse to resident. Noted resident on his knees next to the bed with both arms on the bed and the wheelchair behind. Resident said, I was trying to get in bed and fell on my knees. Noted slight redness at the right knee. Predisposing factors: gait imbalance, impaired memory, during transfer. R2 is [AGE] years old with diagnoses which include dementia, cognitive communication deficit, generalized muscle weakness, lack of coordination, abnormalities of gait/mobility and history of falling. R2's (5/28/24) functional status affirms substantial assistance is required for chair/bed to chair transfer and toilet transfer. R2's (6/4/24) fall risk assessment determined a score of 8 (moderate risk). R2's (11/14/18) care plan states resident is high risk for falls related to gait/balance problems, history of fall with right hip fracture, alert/oriented x 1-2 with periods of forgetfulness, has tendency of transferring/toileting self without calling for help. Intervention: (6/29/24) Bring resident to his room when ready to go to bed. Resident has an ADL (Activities of Daily Living) self-care performance deficit related to impaired balance, lack of coordination and cognitive communication impairment. Intervention: Low bed due to risk for injury secondary to tendency to get up from bed without calling for help. R2's (5/28/24) BIMS determined a score of 5 (severe impairment). On 8/27/24 at 1:47pm, R2 was observed alone in the room lying in bed. R2's bed was not in low position. Surveyor inquired how R2 fell on [DATE]. R2 stated I fell down and got back up. I stepped off a curb to get across the street. The sole of my shoe got loose, and it tripped me. Surveyor inquired if R2 was injured when he fell . R2 responded Yeah, I hurt my arm. On 8/27/24 at 1:51pm, surveyor inquired about R2's cognitive status. V6 (Registered Nurse/RN) stated, He's alert times 2 and at times he's confused. Surveyor inquired if R2 can walk. V6 responded No, he's in the wheelchair and needs assistance. Surveyor inquired about R2's fall prevention interventions. V6 replied I think bed in lowest position and assist with transfer. Surveyor inquired what staff should implement when R2 is placed in bed. V6 stated When he's in bed, the bed should be in the lowest position with the call light in reach. On 8/27/24 at 1:54pm, surveyor inquired if R2's bed was in low position prior to V3 (CNA) entering the room. V3 stated No, it was mid-way about. 3.) The facility fall incident log affirms R3 fell on [DATE] in the bedroom. R3 is [AGE] years old with diagnoses which include vascular dementia, age related osteoarthritis, psychotic disturbance, mood disturbance and anxiety. R3's (5/20/24) BIMS determined a score of 6 (severe impairment). R3's (5/20/24) functional status affirms substantial assistance is required for chair/bed to chair transfer and toilet transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's (5/20/24) quarterly fall risk assessment determined a score of 16 (high risk). R3's care plan includes unwitnessed falls on the following dates: 12/13/23, 12/27/23, 1/2/24, 1/10/24, 3/25/24, 4/11/24, 4/19/24, 5/8/24, 5/15/24, and 7/12/24. Interventions: (1/2/24) Nursing staff members will take turns every 30 minutes and sit with resident in her room from 8pm to 10pm for close observation to help assist with her needs. R3's (7/12/24) incident report states (8:40pm) writer called to resident room by CNA. Resident observed sitting upright on floor between the wheelchair and the bed. Resident states she just slid off the bed while trying to get into her wheelchair to go to the bathroom. No visible injuries observed. Resident reminded to use call light for assistance. Predisposing factors: gait imbalance during transfer. [Per R3's care plan - Nursing staff were supposed to be sitting with resident from 8pm-10pm]. On 8/27/24 at 1:42pm, R3 was observed alone in the room lying in bed asleep however the bed was not in low position. The height of R3's bed frame was noted to be near the seat of the wheelchair (which was adjacent the bed). On 8/27/24 at 1:44pm, V5 (CNA) affirmed she's assigned to R3. Surveyor inquired about R3's fall prevention interventions. V5 stated We check on her every 2 hours. Sometimes we just sit her (R3) up here (Nurse's station) with us (staff) so we can monitor her and take her to the bathroom. We (staff) make sure her (R3's) bed is lowered to the floor. The falls prevention program (revised 08/2017) states the resident care plan will alert the staff to the following: enhanced direct observation of resident. Ensure that the call light is always within reach for those who comprehend its use as documented on the care plan.