FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6005227 B. WING 03/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 735 WEST DIVERSEY **LAKEVIEW REHAB & NURSING CENTER** CHICAGO, IL 60614 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) S 000 **Initial Comments** S 000 Annual Licensure and Complaint 2281559/IL143981 S9999. Final Observations S9999 Statement of Licensure Violations (1 of 3): 300.610a 300.690c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.690 Incidents and Accidents c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Department representative who confirms over the

Office by phone only" means talk with a

incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional

TITLE

Attachment A

Itatement of Licensure Violations

(X6) DATE

	Illinois I	Department of Public	Health		£	FOR	RM APPROVE	ED
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		phone that the requirements by: Based on interview a failed to implement the death of a reside	irement to notify the Regional is been met. If the facility is the Regional Office, it shall ent's toll-free complaint registry shall send a narrative exportable accident or incident within seven days after the end record met as evidenced and record review the facility their policy by failing to report ent after a fall, to the Illinois	39999				
	I I I I E	or three residents re- Findings include: R2's Fall Report date documents in part, incident Description: Writer alerted by sou- counding and observe Per resident, "I fell ar mmediate Action Tak Body assessment con	ed 01/05/2022 at 4:30 PM and of resident's voice during ed resident lying on the floor. and I can't get up." seen: mpleted and resident was					
	In unit of the second s	noted with visible bloomable to move lower njuries Report Post In welling, right iliac creates Nursing Progress 100 AM notes in part of the unresponsive, rangement noted. Reseptived at 3:00 am.	od in peri area. Resident extremities. ncident:					

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED IL6005227 B. WING 03/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAKEVIEW REHAB & NURSING CENTER 735 WEST DIVERSEY CHICAGO, IL 60614 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 said, R2's fall incident should have been reported to IDPH (Illinois Department of Public Health) Facility's undated policy "Incidents/Accidents/Falls" documents part, Policy: "The facility will ensure that incidents and accidents that occur involving residents are identified, reported, investigated and resolved." Procedure: 13. "Any incident/accident/fall that meets the reporting criteria of the state/federal regulations will be reported timely and accurately, to include the initial as well as the follow up report." (no violation) Statement of Licensure Violations (2 of 3): 300.610a) 300.1210a) 300.1210b) 300.1210d)2)3)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part.

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The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed

PRINTED: 05/05/2022

Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED IL6005227 B. WING 03/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **LAKEVIEW REHAB & NURSING CENTER** 735 WEST DIVERSEY CHICAGO, IL 60614 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician.

	Illinois	Department of Public	Health				FORM	APPROVED	
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		resident's condition, emotional changes, determining care refurther medical eval made by nursing staresident's medical resident's medical resident seven-day-a-week be enters the facility wit develop pressure so clinical condition densores were unavoidal pressure sores shall services to promote and prevent new president of a facility services to a facility services to promote and prevent new president. (Section 2-Based on observation review the facility fails treatment documental sacral pressure injury plan for 1 (R1) out of pressure injury prevent includes lack of monit pressure injury was fill Stage 3. And for lack ordered by physician for the facility fails treatment documental sacral pressure injury was fill Stage 3. And for lack ordered by physician for the facility fails treatment documental sacral pressure injury was fill stage 3. And for lack ordered by physician for the facility fails treatment documental sacral pressure injury was fill stage 3. And for lack ordered by physician for the facility fails treatment documental sacral pressure injury was fill stage 3. And for lack ordered by physician for the facility fails treatment documental sacral pressure injury was fill stage 3.	n to prevent and treat t rashes or other skin practiced on a 24-hour, asis so that a resident who hout pressure sores does not res unless the individual's nonstrates that the pressure ible. A resident having receive treatment and healing, prevent infection, ssure sores from developing. Duse and Neglect e, administrator, employee chall not abuse or neglect a 107 of the Act) n, interview and record ed to follow policy on tion per physician order of and failed to follow care 4 residents reviewed for						

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: __ COMPLETED IL6005227 B. WING 03/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 735 WEST DIVERSEY **LAKEVIEW REHAB & NURSING CENTER** CHICAGO, IL 60614 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 5 S9999 Findings include: Facility's policy on Wound Cleansing and Dressings reads: It is the policy of this facility to cleanse all wounds to clear exudates, bacterial contamination, and debris from the wound bed. Optimal wound healing cannot proceed until inflammation producing substances are removed from the wound bed. Wound cleaning is completed as indicated in the physician's order by the licensed nurse. Under documentation: Documentation of the dressing change is completed on the Treatment Administration Record (TAR). Additional documentation may be completed in the nurse's notes. R1's care plan on wound was documented that resident (R1) intervention for sacral wound treatment was to provide treatment as order by Medical Doctor (MD). Per weekly wound evaluation: R1 has pressure iniury on the sacrum that was facility acquired and was first identified on 1/28/2022 as Stage 3. As documented on 1/28/2022 R1's sacral pressure injury was staged as a 3. Measurement was as follows: Length 3.0 centimeters, Width 1.0 centimeter and Depth 0.0. On 2/5/2022 R1's sacral pressure injury was still stage as 3. Measurement was as follows: Length 1.2 centimeters, Width 1 centimeter and 0.4 centimeter. On 2/17/2022 R1's sacral pressure injury was increased to stage 4. Measurement was as follows: Length 2.5 centimeters, Width 1.6 centimeters and Depth 1.1 centimeters. Sacral pressure injury depth increased from 0 on 1/28/2022 to 0.4 centimeter on 2/5/2022 to 1.1 centimeters on 2/17/2022. There was an increased on R1's sacral pressure injury depth

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from 0.4 to 1.1 centimeters.

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED IL6005227 B. WING 03/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 735 WEST DIVERSEY **LAKEVIEW REHAB & NURSING CENTER** CHICAGO, IL 60614 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 6 S9999 On 3/2/2022 at 11:26 AM. V7 (Wound Care Nurse /Licensed Practical Nurse) stated, that when she assessed R1's sacral pressure injury it increased from stage 3 to stage 4 because the bone and muscle are exposed. V7 said, "Yes, R1 has a pressure injury on her sacral, and it increase from stage 3 to stage 4 because during my assessment bone and muscle were exposed. I work weekdays only and during week end we did not have any treatment nurse before. Yes, there was no treatment nurse designated during weekend. But now the facility hired treatment nurse assigned for the weekend. But still nursing staff working on the floor must do the dressing when there is no treatment nurse. And dressing change or treatment should be signed by the nurse performing the treatment on the TAR (Treatment Administration Record). I know that if it is not documented, it means it is not done. And as I said, we don't have treatment nurse during weekend. In my notes I charted that R1's pressure injury on her sacral has an odor that is why I asked wound doctor for Daikins solution because it helps with the odor." On 3/2/2022 at 1:38 PM. R1 was seen in her room by writer with V7. R1 sacral pressure injury was seen with bone and muscle on the sacral area were visible that fits the definition of Stage 4 pressure injury. On 3/3/2022 at 10:08 AM. V2 (Director of Nursing) stated that in the event there is no wound care nurse on the floor it is the responsibility of the nurse that is working on the floor to do dressing change or treatment. And after each dressing change or treatment, TAR (Treatment Administration Record) must be signed or documented.

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		Dor Dillo Manuel A		Ì			:
		Injury was identified	sessment: Sacral Pressure	ĺ			1 6
	ı	order for foam dres	on 1/28/2022 with physician sing every Tuesday, Thursday				
		and Saturday, order	r date 1/29/2022 and	:			1
		discontinued on 2/5	/2022. No treatment was				
		documented as don	e for the above order until				
		2/1/2022 of 5 days a	after R1's sacral pressure				
		injury was identified.	. Then R1's sacral pressure				
		injury was changed on 2/5/2022 to Calcium Alginate after cleansing with Dakins Solution per					
		physician order and should be performed daily					
		Per Treatment Admi	inistration Record (TAR) of R1				
		It was not signed as	done on the following dates:		1		1
2/		2/13/2022 and 2/20/	2022 that both falls on				
	Sunday although it was ordered as daily.			i.			
		Per R1's Nurse's No	tes dated 2/22/2022 was		Å.	30	
		documented by V7 re	eads: Noted odor from sacral			371	
		pressure injury.	and a sacrification occording		i i		
33		(B)	ĺ				
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		Statement of Licensi	ure Violations (3 of 3):				
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		300.610a)					
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	- 13	300.3240a)					- 1
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	а	a) The facility shall ha	ave written policies and	1			
	l p	rocedures governing	all services provided by the				1
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	D	e formulated by a Re	esident Care Policy				
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	o	f nursing and other s	ervices in the facility. The				

Illinois Department of Public Health **FORM APPROVED** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: ___ COMPLETED IL6005227 B. WING 03/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 735 WEST DIVERSEY **LAKEVIEW REHAB & NURSING CENTER** CHICAGO, IL 60614 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 8 S9999 policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

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c medical record luding but not lind Penis, Palliative ness, Abnormalianxiety Disorder. Fort dated 01/05/2 part, iption: "Writer a eduring rounding on Taken: Body resident was no ea. Resident un juries Report Po liac crest (front) rogress Note (di in part, Upon rousive, no up and	nited to: Malignant Care, Acute Kidney ities of Gait and 2022 at 4:30 PM lerted by sound of g and observed resident, "I fell and v assessment oted with visible able to move lower st Incident: " raft) 1/6/2022 at and resident was down chest				
COMPANIE THE STATE OF CAPACITATION OF THE	IL6 UPPLIER NURSING CENTI MARY STATEMENT OF FICIENCY MUST BE FORY OR LSC IDENTIFY from page 9 r, licensee, admin facility shall not ection 2-107 of the erviews and reco to follow facility paresident was ad r one (R2) of three falls. The facility R2 after falling or pronounced dear r found unrespond ude: c medical record cluding but not lin Penis, Palliative kness, Abnormali Anxiety Disorder. ort dated 01/05/2 part, ription: "Writer a ce during roundin on the floor. Per tion Taken: Body d resident was no rea. Resident und juries Report Po iliac crest (front). Progress Note (dr in part, Upon rou nsive, no up and ed. Resident was ed. Resident was	IL6005227 UPPLIER STREET A NURSING CENTER 735 WES CHICAG MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION) From page 9 T, licensee, administrator, employee a facility shall not abuse or neglect a ection 2-107 of the Act) erviews and record reviews, the to follow facility policy and failed to a resident was adequately monitored or one (R2) of three residents falls. The facility failed to assess R2 after falling on 01/05/22 at 4:30 pronounced dead on 01/06/2022 at r found unresponsive. Ide: C medical record (EMR) documents bluding but not limited to: Malignant Penis, Palliative Care, Acute Kidney kness, Abnormalities of Gait and Anxiety Disorder. Ort dated 01/05/2022 at 4:30 PM part, ription: "Writer alerted by sound of the during rounding and observed on the floor. Per resident. "I fell and	CIES IN INTERPLIER (X1) PROVIDER/SUPPLIER (X2) MULTIF A BUILDING IL6005227 B. WING UPPLIER STREET ADDRESS, CITY, 735 WEST DIVERSEY CHICAGO, IL 60614 MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION) From page 9 Try, licensee, administrator, employee a facility shall not abuse or neglect a ection 2-107 of the Act) The facility policy and failed to a resident was adequately monitored a rone (R2) of three residents falls. The facility failed to assess R2 after falling on 01/05/22 at 4:30 pronounced dead on 01/06/2022 at round unresponsive. The facility failed to: Malignant Penis, Palliative Care, Acute Kidney kness, Abnormalities of Gait and Anxiety Disorder. The during rounding and observed on the floor. Per resident, "I fell and it resident was noted with visible rea. Resident unable to move lower appries. Report Post Incident: iliac crest (front)." Progress Note (draft) 1/6/2022 at in part, Upon round resident was pronounced and on the sport post Incident: iliac crest (front)."	CIES IN IN PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER IL 6005227 STREET ADDRESS, CITY, STATE, ZIP CODE TOTAL MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL ORRY OR LSC IDENTIFYING INFORMATION) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TOTAL PROVIDER'S PLAN OF COLOR TO THE DEFICIENCY TOTAL PROVIDER'S TOTAL TO THE DEFICIENCY TOTAL PROVIDER'S PLAN OF COLOR TO THE DEFICIENCY TOTAL PROVIDER'S PLAN OF COLOR TO THE DEFICIENCY TOTAL PROVIDER'S PLAN OF COLOR TO THE DEFICE TO THE DEFICIENCY TOTAL PROVIDER'S PLAN OF COLOR TO THE DEFICIENCY TOTAL PROVIDER'S	CIES N (X1) PROVIDERSUPPLENCUA DENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING: IL6005227 B. WING 03) UPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE T35 WEST DIVERSEY CHICAGO, IL 60814 ARX STATEMENT OF DEFICIENCIES FICIENCY WIST BE PRECEDED BY PULL PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Tom page 9 S. J. G. C.

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6005227 B. WING 03/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LAKEVIEW REHAB & NURSING CENTER 735 WEST DIVERSEY CHICAGO, IL 60614 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 10 S9999 On 03/02/2022 at 11:25 AM, V11 (Registered Nurse) said, "(R2) was transitioning. I tried to keep an eye on (R2). I found him unresponsive, (R2) expired. I don't know anything about a fall. (R2) didn't fall on my shift. The nurse (doesn't know who off-going nurse was) didn't say anything to me about a fall. If (R2) fell, I should have been informed during report. I don't know anything about any blood." V17's (Hospice Nurse) Hospice Progress Note (Handwritten "Routine Nursing Visit Assessment") of 1/6/22 at 12:30 AM, documents in part, "Pt (patient) had fall, whereas (R2) slid OOB (out of bed) per FN (Facility Nurse). Care was provided and (patient) returned to bed. (Facility Nurse) reports at start of shift (R2) was ok but when they came to reposition, during rounds (patient) had blood on pillow from either nose or mouth." V17's Progress Note (Typed, electronically signed on 1/6/22 at 2:42 AM) documents in part, call received from V11 states R2 had blood nose or mouth, wasn't sure. V11 notes at start of shift (R2) was fine, talkative, usual self, but when V11 completed rounding and was checking (R2), found dark blood on pillow and (R2) is slow to respond. Requested visit. On 3/2/2022 at 2:39 PM and on 3/9/2022 at 11:47 AM. V17 said, I was notified on 1/6/22 by facility that resident was having nose bleeding. V11 didn't tell me (R2) fell. I went out there to see (R2). Of course they (facility staff) cleaned (R2) up. There was no blood on (R2's) face, just a little blood on the pillow. I don't recall seeing any bruising (to the face), (R2) was unable to speak (transitioning, unable to get vital signs other than respiratory rate). I don't remember if I looked at R2's peri area.

Illinois	Department of Public	c Health			FORM	MAPPROVED
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	[/V2) DAT	T 01151
		IDENTIFICATION NUMBER:		:	CON	E SURVEY PLETED
****		IL6005227	B. WING		03/	04/2022
NAMEOF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, 9	STATE, ZIP CODE		- 112022
LAKEVI	EW REHAB & NURS	ING CENTER 735 WES	T DIVERSEY			
		CHICAGO), IL 60614			
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT	CTION	0.5
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	Mar Dec	(X5) COMPLETE
				DEFICIENCY)	ROPRIATE	DATE
S9999	Continued From pa	age 11	S9999			
	(R2) wasn't sent to	the hospital because I figured				
	(R2) was at the end	of life, (R2) had a DNR (Do	3.1			
	Not Resuscitate), I	believed (R2) was				d s
	transitioning. We de	on't send them out /to	1			10
	hospital), it's under	stood (R2's) going to get to the				
	point of transitioning	g, we make sure (R2's)				
	comfortable. If the f	family had decided send (R2)	- 1			1 8
	out, we would have	abided by that decision and	4			
	sent (R2) out. I don	't recall family requesting that	-			
	(RZ) be sent to the	hospital. I would have called the	1			
9	the purse had provide	d seen anything additional or				
- 1	witer asked 1/17 #4	ded anything additional. This				
1	mile asked VIVIII	there was any policy or when a resident should be				
	sent to the hospital	V11 said, "from experience I				1
-	was seeing a patien	t who was transitioning.				
- 1		¥ ()				
1	On 03/02/2022 at 3:	08 PM, V14 (Licensed				
1.	ractical Nurse) said	d, "I heard beating on the				
	table, yelling that (R)	2) had fallen, me and two				
	(R2's) room, (R2) wa	sing Assistants) went to				1
	essessed (R2) got r	nechanical lift, and (with the				
	assistance of two CN	VAs) put (R2) back in bed. I		AV EG		
(called hospice. I spo	ke with both V16 (Hospice	7			3
Į į į	vurse) and V17 (Hos	Spice Nurse). Linformed both	1			3
ι	nat resident had falle	en. I spoke with	1			
l n	nanagement team (\	V18. Former Infection	1		1	- 1
. ij ⊩	'reventionist) and re	sident's family to let them	1			1
- ∣ K	now that (R2) had a	fall. I put neuro checks in				1
. ↓ p	lace. Vve document	neuro checks on naner				
ti	ney re not in the syst	em (EMR). I completed a fall	- 1			1
a	ssessment, i was in	Structed by V18 to do a fall i				- 1
f d	anily and bassics a	ro checks in place, notify				1
re	esident. I did inform	nd check frequently on				100
W	ould have had to co	V11 that (R2) fell, (V11) ntinue the neuro checks.				
R	equested R2's neuro	o check short on			0 10	
0:	3/02/2022 at 3:30 PM	M and 4:45 PM. Document	-			1
W	as presented to this	writer on 03/03/2022 by V1	7		13.10	
-		THE OF COLOGIZOZZ DY VI			10	

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If continuation sheet 13 of 13

AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
94	H-	IL6005227	B. WING		02/	04/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	103/	04/2022
LAKEVII	EW REHAB & NURSIN	NG CENTER 735 WES	T DIVERSEY D, IL 60614			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	Dec	(X5) COMPLETE DATE
	Incomplete, that is to checks were not sig completed them. Vocompleted unsigned V1 why V11 completed V11 had informed who fR2's fall. V1 said, Neuro check sheet (documents "R2 was extremities." Fall assessment (1/5 not have any falls will lace the facility's undated pole. Incidents/Accidents/Procedure: 9. Neuro checks will strauma as well as after (even if the resident shead) as per policy. 10. The occurrence is to shift as part of the stabilize(d).	cumentation was noted to be o say, the last three neuro ned off by staff member that 1 stated V1 assumed V11 documentation. Writer asked ted neuro checks on R2 when riter that V11 was not aware "maybe V11 forgot." initiated 1/6/22 at 4:30 PM) able to move all four 6/2022) documents, R2 did thin the last three months.	S9999			
ois Departm	ent of Public Health					

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