Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: ______ B. WING ______	C 01/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2380522/IL155518	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690b) 300.690c) 300.1210b) 300.1210c) 300.1210d)6) 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 b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: ______ B. WING ______	C 01/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

Continued From page 1

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable 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 Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: ______ B. WING ______	C 01/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

following and shall be practiced on a 24-hour, seven-day-a-week basis:

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.

These requirements were not met as evidenced by:

Based upon observation, interview and record review the facility failed to provide supervision to (R2, R4) and failed to implement appropriate fall prevention interventions for three of four residents (R2, R3, R4) reviewed for falls. These failures resulted in R2 sustaining (1/5/23) fall with facial injury and (acute) right tibia & fibula fractures. The facility also failed to to submit a narrative summary of incident involving fractures which includes a thorough investigation and/or root cause to IDPH (Illinois Department of Public Health) for one of four (R2) residents reviewed for falls.

Findings include:

R2's diagnoses include Alzheimer's disease, repeated falls. (8/17/22) fracture of shaft of left fibula and (9/8/22) fracture of shaft of right tibia.

R2 was transferred to the hospital (1/11/23) and did not return to the facility.

R2's (11/23/22) BIMS (Brief Interview Mental Status) determined a score of 5 (severe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: ______ B. WING ______	C 01/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3 impairment). R2's (11/23/22) functional assessment affirms (2 person) physical assist is required for bed mobility and transfer. R2's (11/23/22) fall risk evaluation states right lower extremity is weak with tendency to go externally with non-mixed minimal foot drop. (Left) lower extremity is with limited movement related to fracture of the fibula with tendency to internally rotate. Extensive assist of 2 on mobility. (High risk for fall). R2's initial FRI (Facility Reported Incident) includes type of incident: unwitnessed fall (with injury). Location of incident: Bedroom. On 1/5/23 at 6:45 pm, resident was observed lying on the floor. Resident was observed with a bump on the left side of the head. Resident was sent to hospital for further evaluation. On 1/27/23 at 8:32 am, surveyor inquired about R2's (1/5/23) fall V3 (Family) stated "She (R2) was 88 years old. I don't know how she (R2) would fall because she's bed bound. They (Facility) said that she (R2) fell face down on the floor and couldn't give me a direct answer on how it happened." Surveyor inquired about R2's fall prevention interventions prior to (1/5/23) fall V3 responded they (Facility) don't have any mats on the floor, they didn't have anything." R2's (8/17/22) care plan states resident is at risk for falls related to medication use, poor safety awareness, unsteady gait and disease process. Side rails to prevent rolling out of bed. Use assistive device during ambulation to prevent falls. Keep call light within reach when in bedroom or bathroom. [Floor mats were excluded prior to	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: ______ B. WING ______	C 01/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

1/5/23 fall].

On 1/28/23 at 3:08 pm, surveyor inquired about R2's cognitive and functional status. V2 (Director of Nursing) stated, "She's alert and oriented times one and I believe she has dementia as well. She's totally dependent (2 person assist) as far as bed mobility and self-performance." Surveyor inquired if R2 was ambulatory. V2 responded, "She's bed bound." Surveyor inquired about R2's fall prevention interventions prior to (1/5/23) fall. V2 replied, "Resident was categorized as a high risk for falls so the call light is within reach, she was in therapy for mobility and strength, bed in the lowest position and after the fall the intervention was the floor mats."
On 1/28/23 at 3:08 pm, surveyor inquired about the regulatory requirement for reporting incidents with serious injury V2 (Director of Nursing) stated "We are required to submit to IDPH within 24 hours for the initial and for the final we need to submit it within 7 days." Surveyor inquired about R2's (1/5/23) fall investigation and root cause of the incident. V2 responded, "Prior to the fall the daughter was there, I don't know how long ago it was though. Based on the conclusion that we have resident has poor safety awareness resident may have rolled from the bed. She does have Alzheimer's as well that could cause the fall."

On 1/29/23 at 11:40 am, surveyor inquired about R2's (1/5/23) fall. V10 (Agency Registered Nurse) stated, "I was in the middle of an admission. She was found on the floor they (staff) came and told me. When I got there, she (R2) was face down in the prone position (beside the bed)." Surveyor inquired if R2 was ambulatory. V10 responded, "She's bed bound she can't walk." Surveyor inquired if fall preventive interventions were in place prior to falling (1/5/23). V10 replied, "I think

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: ______ B. WING ______	C 01/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

there was rails raised on the bed." Surveyor inquired how R2 fell from the bed if the rails were in use. V10 stated, "We don't know why she fell."

On 1/29/23 at 11:40 am, surveyor inquired about R2's (1/5/23) fall V10 (Agency Registered Nurse) stated "I was in the middle of an admission. She (R2) was found on the floor they (staff) came and told me. When I (V10) got there, she (R2) was face down in the prone position (beside the bed)." Surveyor inquired if R2 was ambulatory. V10 responded, "She's bed bound, she can't walk." Surveyor inquired if fall preventive interventions were in place prior to R2 falling. V10 replied, "I think there was rails raised on the bed" and affirmed that she (V10) was unsure.

R2's (1/5/23) hospital progress notes state patient is 88 years old admit after a fall with multiple injury to face and right lower leg fracture.

R2's (1/6/23) right ankle x-ray includes comminuted fracture through the distal tibia and fibula.

R2's (1/6/23) history & physical states patient fell at nursing home and had acute pain. Workup shows (acute) tibia/fibula fracture on the right.

R2's (1/5/23) post fall investigation states resident was observed lying on the floor on a prone position near left side of the bed. She (R2) was alert and oriented x1 and unable to describe the incident, with side rails up [therefore likely did not roll from the bed as stated].

R2's final FRI submitted to IDPH (1/12/23) states x-ray of the right femur and ankle was performed and reveals close tibia and fibula fracture. There is a diffuse osteoporosis. Depression of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: ______ B. WING ______	C 01/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

lateral tibia plateau consistent fracture of indeterminate age. Resident returned to the facility on 1/8/23 with ace wrap to the right ankle as family deferred casting as recommended by ortho. Medical records reviewed, resident had a previous fracture of the right and left ankle prior to admission to the facility. Also, hospital record reveals a subsequent encounter of a close fracture of the right tibia and fibula with delayed healing. Care plan reviewed, and fall interventions updated as appropriate. [An investigation including witness statements and/or root cause analysis of R2's fall are excluded].

On 1/29/23 at 2:26 pm, surveyor inquired about potential harm to a resident that sustains an unwitnessed fall V13 (Medical Director) stated "It could be anything." Surveyor responded what type of injuries could be sustained? V13 replied, "I'm sorry I cannot exactly recall any type of injury." Surveyor inquired about potential harm to a resident post fall (in general) like skin impairment, fracture, or subdural hematoma. V13 stated, "Patients could have injuries after falls, it could be something it could be nothing. It could be something small it could be something large it could be anything." Surveyor inquired what "anything" entails. V13 responded, "We have a whole set of procedures I couldn't get into the details right now because every case is individualized" and refrained from answering the questions directly.

R4's diagnoses include dementia with mood disorder, anxiety disorder, cognitive communication deficit and difficulty in walking.

R4's (11/21/22) BIMS determined a score of 4 (severe impairment).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: ______ B. WING ______	C 01/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7 R4's (11/21/22) functional assessment affirms (2 person) physical assist is required for bed mobility and transfer. R4's (1/21/23) fall risk assessment determined a score of 15 (high risk). R4's (11/17/22) care plan states resident is at high risk for falls related to periods of anxiety. Provide me with activities to minimize the potential for falls while providing diversion and distraction while in the activity room specially in the morning while waiting for breakfast. Toilet me every 2 hours and as needed to prevent unassisted attempts to go to the toilet. R4's incident reports include (12/26/22) & (1/21/23) falls. On 1/28/23 at 12:56 pm, surveyor inquired about R4's fall prevention interventions. V9 (Licensed Practical Nurse) stated, "We usually making sure when she's in the bed it's in the low position, the floor mat in place we also give her the call light within reach and all her personal belonging close to her for reach. Remind her that if she need anything to call, she can use the call light. Also, we do the frequent rounding to check on her. She cannot walk. We do have CNA's (Certified Nursing Assistants) who is usually watching them, we have some other patients too needing watched." Surveyor inquired about R4's (1/21/23) fall. V9 responded, "The patient was in the dining room. Activity (staff) just called me and said she (R4) was on the floor. She (R4) was lying on her right side next to her (Brand name wheelchair). It was unwitnessed fall so I'm not really sure what happened to her or how she end up on the floor." Surveyor inquired if the dining room is supposed to be supervised when residents are placed	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: ______ B. WING ______	C 01/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

there. V9 responded, "Yes, we have like two (2) activity aides and one (1) CNA (Certified Nursing Assistant) in there."

On 1/27/23 at 12:55 pm, R4 was observed (in the dining room) seated in a modified wheelchair (reclined position) with both legs dangling over the arm of the wheelchair and arms flailing about. R4 was also noted to be wearing a (soft collar) neck brace. V5 (Activity Aide) attempted to place pillows next to R4 to no avail because R4 was restless, removed the pillows and would not follow redirection. Surveyor inquired about R4. V5 stated, "When she's done eating already, she wants to just keep on moving. She's the same language and dialect as me so I can communicate that you're gonna fall or that one." Surveyor inquired about R4's fall preventions interventions V5 replied "We just watch her one on one with her pillows." Surveyor inquired why R4 was attempting to get out of the wheelchair. V5 stated, "She's just only trying to move, she don't say anything to me." V5 made no attempt to provide a diversion, distraction and/or activity [as directed per care plan].

R3's diagnoses include dementia and morbid obesity.

R3's (1/16/23) BIMS determined a score of 9 (Moderate Impairment)

R3's (1/16/23) functional assessment affirms (2 person) physical assist is required for bed mobility and transfer.

R3's (1/16/23) fall risk assessment determined a score of 13 (high risk).

R3's (3/13/20) care plan states resident is at risk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: ______ B. WING ______	C 01/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9 for falls related to incontinence, forgetfulness, and bilateral lower extremity weakness. Follow the facility fall protocol. The resident needs a safe environment with a working reachable call light and bed in low position. On 1/27/23 at 12:37 pm, surveyor observed R3 (from the hallway) lying in bed and the bed was in high position. On 1/27/23 at 12:42 pm, surveyor inquired about R3's fall prevention interventions. V4 (Registered Nurse) stated, "We have the bed set in lowest position and the call light is within reach. She's alert and oriented." Surveyor inquired about the current height of R3's bed. V4 subsequently observed R3 and responded, "The bed just need to lower it a little more because it's not in the lowest position." Surveyor entered the room and affirmed that the height of R3's bed was thigh level. The call light button was observed near R3's right elbow however R3's right hand was splinted. Surveyor inquired about R3's call light access, R3 struggled to access the call light button due to placement (near elbow), right hand splinted and left hand severely contracted. Surveyor inquired if R3 was able to activate the call light. R3 was unable to push the button with her fingers and/or thumb therefore activated the button by hitting herself with the device (on the forehead) multiple times before able to do so. Surveyor inquired about concerns with R3's handheld call light. V4 responded. "She has to put it on her head, she needs like a push button." The fall occurrence policy (reviewed 5/17/22) states those identified as high risk for falls will be provided fall interventions. The call light policy (reviewed 7/27/22) states be	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013684	A. BUILDING: ______ B. WING ______	C 01/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY NURSING & REHAB CENTER	3919 WEST FOSTER AVENUE CHICAGO, IL 60625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10 sure call lights are placed within reach of residents who are able to use it at all times. If a call light is not functional, evaluate and provide another means in order for the resident to call for assistance. The incident reporting policy (revised 7/28/22) states any serious injury sustained by a resident that is not an expected outcome of the disease process will be reported to IDPH Regional Office. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days. (A)	S9999		