STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002851	A. BUILDING: _____ B. WING _____	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRVING PARK LIVING & REHAB CTR	4340 NORTH KEYSTONE CHICAGO, IL 60641

(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: 2382779/IL158318 FRI of (2/12/23) IL157115	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1210b) 300.1210d)6) 1/2 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 a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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. 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 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	S9999		

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S9999	Continued From page 2 care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care 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: 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: 1) Based upon record review and interview the facility failed to document a serious injury (rib fractures) in the progress notes, failed to ensure that designees are aware of the regulatory requirement for reporting serious injuries to IDPH (Illinois Department of Public Health) and failed to report an incident resulting in serious injury to IDPH within regulatory requirements for one of 3 residents (R1) reviewed for falls. 2) Based upon observation, interview and record review the facility failed to provide fall prevention interventions on two of three residents (R1, R8) care plans, failed to ensure staff were aware of (R1, R5, R8) fall prevention interventions and failed to implement fall prevention interventions for two of three residents (R1, R8) reviewed for falls. These failures resulted in R1 sustaining acute rib fractures on the left from a fall on 2/12/23. Findings include:	S9999		

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S9999	Continued From page 3 1.R1's diagnoses include absence of right leg below knee. R1's (2/9/23) fall evaluation determined a score of 60 (high risk). R1's (2/12/23) incident report states patient fell on the floor in her room during transfer. R1's (2/24/23) Physical Therapy Evaluation & Plan of Treatment states patient requiring SUP (Supination) for slide board transfers. Chair/bed to chair transfer = Dependent. R1's (3/2/23) functional assessment affirms (2 person) physical assist is required for transfers. R1's (3/2/23) BIMS (Brief Interview Mental Status) determined a score of 15 (cognitively intact). R1's (9/17/20) care plan includes risk for falls related to right leg below knee amputation however interventions exclude SUP for slide board transfers and/or 2 persons assist during transfers. R1's (2/12/23) initial incident report states patient fell on the floor in her room during transfer before staff could get to her. On 2/17/23, facility received report from the hospital indicating an acute fracture of the left ribs. IDPH was notified 2/17/23 (5 days after the incident) via smartsheet. R1's (2/13/23) Abdomen & Pelvis CT/Computed Tomography (received from the facility) includes acute rib fractures on the left (printed 2/15/23). R1's progress notes state (2/12/23) resident has had a recent fall [pain and/or injuries are	S9999		

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S9999	Continued From page 4	S9999		

excluded]. Follow-up with hospital, notified that resident was being evaluated and would be kept for observation regarding pain level and low BP and to rule out internal injuries [reason for pain and or injuries are excluded]. (2/13/23) Resident admitted to Hospital for UTI (Urinary Tract Infection), dehydration, possible sepsis, and AKI (Acute Kidney Injury). [Rib fractures and/or 2/17/23 progress notes are excluded].

On 4/10/23 at 1:56pm, R1 stated, : It was inquired if a gait belt was in use during (2/12/23) transfer. "I was on my bed, and they (2 staff) went to help me get in the chair. They (staff) tried and then they (staff) dropped me. There was one (staff) on each side by my arm. Four (4) of my ribs got fractured when I fell on the floor." A gait belt was inquired in use during (2/12/23) transfer. R1stated, "No, I have a sliding board" and affirmed a sliding board was also not in use.

On 4/10/23 at 2:24pm, V4 (Certified Nursing Assistant) affirmed she was currently assigned to R1. V4 stated, "She calls when she needs assisted. She has a slide board. She has slip resistant socks and a boot that helps her balance." V4, stated "Half go on the wheelchair, half on the bed and one side on the wheelchair let up." V4 inquired how many staff are required to transfer R1. V4 replied, "One person." [R1 requires 2 persons assistance].

On 4/11/23 at 1:30pm, V13 (Registered Nurse) stated, "The CNA (Certified Nursing Assistant) was about to transfer her (R1). I asked her (CNA) to step away and before I stepped next to her (R1) she (R1) had fallen over. It happened essentially as soon as the CNA stepped away." V13 stated, "I thought it would be quicker for me to transfer (R1) and the CNA to assist another

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S9999	Continued From page 5	S9999		

resident needing help." V13 inquired if R1 transfers by himself. V13 replied, "Yes." V13 stated, "I don't recall if there's an order to be transferring her (R1) with two (2) individuals or using a lift." V13 reviewed R1's care plan and stated "Nope, nothing about a slider board."

On 4/12/23 at 11:52am, V17 (Minimum Data Set Coordinator) stated, "The intervention when she came back (from the hospital) was to make her a mechanical lift." V17 stated, "It will show up on their care plan in PC (electronic program)." V17 stated, "The DON (Director of Nursing) will usually let the staff know if there's something new."

On 4/12/23 at 2:11 pm, V 21 (Medical Director) inquired about potential harm when a resident falls, V21 stated, "It could be anything it can be something small it can be something big. I don't have a crystal ball I can't say for sure." V 21 stated, "There could be no injury there could be a large injury potentially anything could be possible. A scrape to anything it could be anything." V 21 stated, "Right away the patient should be assessed and sent out for evaluation. If there's head trauma, we have to send them right away it depends on the assessment."

On 4/12/23 at 3:10pm, V12 (Registered Nurse) affirmed he was (prior) Director of Nursing at the facility. V12 stated, "Whenever there's an incident or accident that requires sutures, stitching's, fracture or injury of unknown origin I have to report it. The initial report I have to send to IDPH." V12 inquired about the required timeframe for reporting serious incidents/accidents to IDPH V12 responded "I think its within 72 hours for incidents and abuse is within 48 hours." V12 stated "we did not get the

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S9999	Continued From page 6	S9999		

information about the fracture until the 17th." V12 inquired why R1's fractures (identified via CT on 2/13/23) were reported on the 17th (4 days later). V12 stated "Usually when the patient goes out, we check on them through the liaison, it was on the 17th that we found out about the status of the patient."

R1's (2/13/23) Abdomen & Pelvis CT (Computed Topography) includes acute rib fractures on the left.

The (11/28/12) Incidents and Accidents policy states the Director of Nursing, Assistant Director of nursing, or Nursing supervisor must notify the following if an actual injury occurs: The Illinois Department of Public Health, by phone, within 24 hours of the occurrence. Documentation in Nurses' notes is to include: a description of the occurrence, the extent of injury (if any), the assessment of the resident, vital signs, treatment rendered, and parties notified.

2. R5's diagnoses include morbid obesity and unsteadiness on feet.

R5's (2/6/23) fall risk assessment determined a score of 80 (high risk).

R5's (3/20/23) functional assessment affirms set up is required for transfers and locomotion (uses walker).

R5's (12/16/22) care plan includes risk for falls.

On 4/10/23 at 2:24pm, V 5 (Agency Nurse) affirmed he was currently assigned to R5. V 5 stated, "I could find out but the system is down so I can't" and affirmed he was unaware. V 5 advised that the facility phone and Internet were

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S9999	Continued From page 7 not working. R5's (3/20/23) BIMS determined a score of 15 (cognitively intact). On 4/10/23 at 2:26 pm, R5 stated, "I did have a couple falls, they (staff) tell me four (4)." 3. R8's diagnoses include abnormalities of gait and mobility. R8's (3/21/23) functional assessment affirms (2 person) physical assistance is required for transfers. R8's (3/21/23) fall risk evaluation determined a score of 36 (moderate risk for falling). R8's (3/21/23) BIMS determined a score of 13 (cognitively intact). R8's comprehensive care plan excludes risk for falls and/or fall prevention interventions. On 4/10/23 at 2:44 pm, R8's was lying in bed while in high position. R8's call light was tied to the side rail however dangling below the mattress. R8 attempted to locate the call light and stated, "Uh oh, I think I dropped it. It's not there." R8 stated, "No, I'm not able to walk. They (staff) need like 2 people to put me in the wheelchair." R8 stated, "Oh yes, I've had a few falls. I fell in the room and shortly after that I fell again going to the door to get some money. I got dizzy, collapsed and fell on the floor." On 4/10/23 at 2:55 pm, V5 (Agency Nurse) affirmed he was currently assigned to R8. V5 stated, "Off the top of my head I don't know but usually they'll put a pad on the floor and the bed	S9999		

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S9999	Continued From page 8 will be at the lowest level, but I can't really see because the system is down." R8's bed was inquired to V5. V5 responded, "I would say the bed is all the way up." R8's call light inquired to V5. V5 replied, "It should be clipped on her." V5 stated, "No floor mats were besides R8's bed. V5 states to R8, "I'm going bring your bed down because it should be low and going to give you a call light because it should be by you." R8 responded, "Ok." The Fall Prevention Program (revised 11/22/22) states care plan incorporates identification of all risk/issue. Addresses each fall. Interventions are changed with each fall, as appropriate. Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan. Safety interventions will be implemented for each resident identified at risk. All assigned Nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained. The bed will be maintained in a position appropriate for resident transfers. (A) 2/2 300.610a) 300.1210b) 300.1210d)1) 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	S9999		

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S9999	Continued From page 9 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 300.1210 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. Section 300.1210 General Requirements for Nursing and Personal Care 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. These regulations were not met as evidenced by: Based upon record review and interview the facility failed to ensure that three of three residents (R1, R5, R8) reviewed for medication administration were free from significant medication errors. This failure resulted in R1 and R5 sustaining critical high (above 300) blood	S9999		

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S9999	Continued From page 10 sugars. Findings include: R5's diagnoses include type II diabetes mellitus with hyperglycemia. R5's (3/20/23) BIMS (Brief Interview Mental Status) determined a score of 15 (cognitively intact). On 4/10/23 at 2:26pm, R5 stated, "About a week ago Saturday we had no Nurse on the floor (2nd floor) for all 3 shifts. They (Nurse) did my blood sugar the following day and it was 500 because I didn't get my medication." On (4/7/23) R1's blood sugar was 551 (critical high) at 7:30am. R5's POS (Physician Order Sheet) includes but not limited to (12/17/22) Glipizide (Oral Hypoglycemic) 10mg (milligrams) twice daily, Metformin (Oral Hypoglycemic) 1,000mg twice daily, Humalog (Insulin) 10 units before meals and Lantus 58 units at bedtime. R5's (April 2023) MAR (Medication Administration Record) affirms scheduled medications were not documented on 4/4 and 4/7. R5's (4/7/23) Humalog and/or blood sugar were not documented at 4:00pm, Metformin & Glipizide were not documented at 6:00pm, and Lantus was not documented at 9:00pm (as scheduled). — R1's diagnoses include diabetes mellitus. R1's (4/2/23) POS includes but not limited to Lantus (Insulin) 10 units every morning and at	S9999		

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S9999	Continued From page 11 bedtime for diabetes. R1's (3/2/23) BIMS determined a score of 15. On 4/11/23 at 1:57pm, R1 denied medication administration concerns however R1's (April 2023) MAR affirms scheduled medications were not documented on 4/2, 4/3 and 4/8. On 4/2/23 & 4/3/23, R1's Lantus is not documented at 6:30am and 9:00pm. R1's (6:30am) blood sugars were 347 (critical high) on 4/2/23 and 349 (critical high) on 4/3/23. R8's diagnoses include schizoaffective disorder, depressive type. R8's (3/21/23) BIMS determined a score of 13 (cognitively intact). On 4/10/23 at 2:44pm, R8 stated, "There was a problem with them not giving me enough Clozapine so I let the Administrator know, he (Administrator) said he would take care of it." R8's POS includes but not limited to (12/21/22) Clozapine (Antipsychotic) 300mg at bedtime and Clozapine 25mg once daily. R8's (April 2023) MAR affirms scheduled medications (including Clozapine) are not documented 4/7, 4/8, 4/9 and 4/10. On 4/18/23 at 12:07pm, V30 (Physician) stated, "Both of them could cause some problems. They (residents) could get hyperglycemia or other problems like mental status not being controlled if they're not receiving medication." The (undated) Medication Administration policy	S9999		

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S9999	Continued From page 12 states medications are administered in accordance with written orders of the prescriber. The resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration. (B)	S9999		