

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/28/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARREN PARK HEALTH & LIVING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NORTH DAMEN AVENUE CHICAGO, IL 60645
---	---

(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 1687036/IL90402	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

01/17/17

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WARREN PARK HEALTH & LIVING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NORTH DAMEN AVENUE CHICAGO, IL 60645
--	---

(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	<p>Continued From page 1</p> <p>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>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:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/28/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARREN PARK HEALTH & LIVING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NORTH DAMEN AVENUE CHICAGO, IL 60645
---	---

(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	<p>Continued From page 2</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to eliminate fall hazards, failed to ensure appropriate footwear, failed to follow fall policies, and failed to accurately document a fall assessment in the MDS (Minimum Data Set) for one resident (R1) reviewed for falls. These failures resulted in R1 falling and sustaining a hip fracture that required surgical repair.</p> <p>Findings include:</p> <p>On 12/22/2016 at 11:40am, R1 was sitting on a wheelchair and stated that she had surgery and pointed to surgical incision on right hip. R1 stated that she had some breakfast and fell downstairs and tripped by the doorway. At 12:44pm, E9 (Certified Nursing Assistant/CNA) wheeled R1 to the basement and showed the surveyor where R1 fell. R1 stated in part that her sandal got caught because there should be tape or something there on the floor so that she doesn't trip and fall. The surveyor noted a gap from the new flooring and old flooring between the basement hallway and entryway of the dining/activity room where R1 pointed to where R1 fell. On 12/22/2016 at</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN PARK HEALTH & LIVING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NORTH DAMEN AVENUE CHICAGO, IL 60645
---	---

(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	<p>Continued From page 3</p> <p>1:01pm, E5 (Maintenance Supervisor) stated that they started remodeling the floors about six months ago. E5 pointed to the same entryway to the basement activity/dining room and stated that there should be no gaps on the floor, and there should be a threshold so that the floors are even. E5 stated that he will call the company right away to fix the floors as soon as possible.</p> <p>On 12/22/2016 at 4:01pm, E1 (Administrator) measured the gap at the entryway of the basement dining/activity room that measured 43 inches in length and approximately 5 inches in width. There were two grooves to the floor tile that each measured approximately 1/16 inch in depth. (The grooves on the floor tile is where R1 previously stated her sandal got caught in causing her to trip and fall).</p> <p>R1's progress notes reads in part: 11/29/2016 7:49am - incident note: Resident noted coming out of activity room post breakfast. Resident had a fall that was witnessed by staff in the lower level basement hallway. Resident noted with sandals on and hallway floor wet with caution signs visible. Resident assisted to sitting position then to a chair by staff. Resident noted with no injury at this time and verbalizes no pain. Resident is able to move lower extremities with no distress or discomfort noted. Staff able to take sandals off of resident and replace with gym shoes with grip for traction. Resident educated on importance of wearing shoes with grip to prevent falls. Resident able to ambulate with steady gait. Resident's MD (medical doctor) will be notified for any orders. Resident has no emergency contact to notify of incident. 12/6/2016 - Resident came to writer with complaints of pain to the right hip area. Upon assessment resident noted with bruising to right</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/28/2016
NAME OF PROVIDER OR SUPPLIER WARREN PARK HEALTH & LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NORTH DAMEN AVENUE CHICAGO, IL 60645		
(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 hip area. Resident had a recent fall noted in area of bruising. MD (medical doctor) notified of resident's complaint of pain and bruising. 12/12/2016 11:24pm - Resident x-ray on right hip was done. Right hip x-ray was received and relayed to physician with an order to transfer resident to [local] hospital for medical evaluation due to right femoral neck fracture. On 12/22/2016 at 2:35pm, Z1 (Attending Physician) stated he was notified of [R1's] fall the day he ordered the first x-ray [12/6/2016]. Z1 stated that the facility should have told him [R1] fell when they were aware of the fall. Z1 stated that he saw [R1] a few days later [12/10] and [R1] still had pain, so the first x-ray didn't make sense and ordered another one which showed a fracture. The first x-ray may have not caught the fracture depending on the location. [R1] has osteopenia, and that causes the bones to break easily, but osteopenia does not cause a hip to break. [R1's] hip fracture is from the fall. On 12/22/2016 at 2:24pm, E6 (Licensed Practical Nurse/LPN) stated in part that she witnessed [R1's] fall. [R1] had flip-flops on, not much grip on the floor, and the floor was wet because housekeeping finished mopping the floors and there were signs around. [R1] was on the cell phone and just got done eating breakfast. [R1] was leaving the activity/dining room and slipped and fell because the floor was wet. [E6] stated when she got to [R1], [R1] was still talking on the cell phone. E6 stated that the floor nurse called the doctor, she didn't. R1's Incident/Accident Unusual Occurrence report filled out by E6 reads in part: 11/29/16 7:35am- Brief description - Resident	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN PARK HEALTH & LIVING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NORTH DAMEN AVENUE CHICAGO, IL 60645
---	---

(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	<p>Continued From page 5</p> <p>noted coming out of activity room. Hallway noted wet with floor signs visible. Resident asked what happened and stated, "My sandal got caught there (pointing to floor by activity room door) and I fell." Resident's fall witnessed by staff. Resident fell on right side. Resident assisted to sitting position and staff brought gym shoes down from room. Resident noted with no injury at this time. Resident has no complaints of pain at this time and is able to ambulate with steady gait. Physician [Z1] notified 11/29/16 8a. Immediate intervention - Resident's sandals changed to gym shoes with grip. Resident educated on importance of wearing gym shoes for better traction.</p> <p>R1's Morse Fall Scale dated 9/27/2016 shows moderate risk for falling, weak gait, and overestimates or forgets limits.</p> <p>On 12/22/2016 at 3:03pm, E7 (Restorative Nurse) stated in part that she's in charge of the falls program and [R1] was at moderate risk for falls. E7 also stated that flip-flops were not appropriate footwear and she educated [R1] to wear gym shoes instead. E7 stated that the nurse who filled out the incident report calls the doctor and that the doctor should be notified of the incident within the same day.</p> <p>On 12/22/2016 at 11:58am, E4 (LPN) stated that she was the floor nurse assigned to [R1] the day [R1] fell in the basement. E4 stated she did not call the doctor or write a progress note on 11/28, but that [E6] did because [E6] witnessed the fall. E4 stated that the doctor [Z1] was notified on 12/6 when [R1] had complaints of pain and an x-ray was done. E4 stated that [Z1] saw [R1] on 12/10, ordered a repeat x-ray and when the results came, [Z1] ordered for [R1] to go to the hospital</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/28/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARREN PARK HEALTH & LIVING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NORTH DAMEN AVENUE CHICAGO, IL 60645
---	---

(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	<p>Continued From page 6 on 12/12.</p> <p>R1's MDS (Minimum Data Set) with Assessment Reference Date (ARD) of 12/12/2016 reads in part: 1 for number of falls since prior assessment, A. no injury, and supervision for locomotion off unit and dressing.</p> <p>On 12/27/2016 at 10:09am, E7 stated in part that she should have "clicked on C. for major injury."</p> <p>R1's MDS with ARD of 9/27/2016 shows that R1 has no cognitive impairment, needs supervision and setup help only for locomotion off unit and dressing.</p> <p>R1's radiology reports reads in part: 12/6/2016- Examination: Hip unilateral w (with) pelvis. Results: No fracture or dislocation identified. Subtle irregularity noted at femoral head neck junction but no fracture plane seen. Conclusion: Fracture is not identified, if persistent pain of high suspicion for fracture recommend CT (computed tomography). 12/12/2016- Examination: Hip unilateral w (with) pelvis. Results: There is a right femoral neck fracture with modest displacement. The joint shows no dislocation. Pubic rami are intact. There is osteopenia. Conclusion: Acute appearing right hip fracture as described above. The fracture is not visible or new compared to prior exam dated 12/6/2016.</p> <p>R1's hospital discharge instructions (12/16/2016) reads in part: 12/13/2016 - Problem List: Closed displaced fracture of right femoral neck Procedure: Right hip hemiarthroplasty</p> <p>The facility's policy and procedure titled "Incident/Accident Reporting Fall Management Program" with revision date 12/2015 reads in</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008262	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/28/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WARREN PARK HEALTH & LIVING CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 6700 NORTH DAMEN AVENUE CHICAGO, IL 60645
---	---

(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	<p>Continued From page 7</p> <p>part: 6. Notification to the Physician/Health Care Provider and Family will be done promptly and recorded.</p> <p>The facility's policy and procedure titled, "Fall Risk" with revision date of 11/2013 reads in part: 7. The staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout. 8. The staff and Attending Physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable. These policies were not followed.</p> <p>(B)</p>	S9999		
-------	--	-------	--	--