STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001796	A. BUILDING: _____ B. WING _____	C 01/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK MANOR	7433 NORTH CLARK STREET CHICAGO, IL 60626

(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 Investigation of Facility Reported Incidents of: 12-25-2022/IL154993 12-27-2022/IL154761	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b)4) 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 300.1210 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	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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 Regulations are not met as evidenced by: Based on interviews, and records review, the facility failed to provide adequate fall prevention and monitoring for one resident (R2) of 3 residents reviewed for falls. This failure resulted in R2 sustaining a fall with injuries requiring R2 to receive stitches on the forehead and R2 sustaining a fracture on the right hand. Findings include:	S9999		

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S9999	Continued From page 2 Facility reported incident report dated 12/25/2022 documents: on 12/25/2022 at 02:35am, floor nurse heard a noise coming from the east shower room. Staff went to investigate and observed R2 on the shower room floor, face down. R2 was observed to have a laceration to the forehead with minimal amount of bleeding and a small cut to the left upper lip area. R2 stated "I fell and hit my head." R2 was assessed R2's physician was notified and R2 was sent to a nearby hospital for further evaluation. R2 is a 74-year-old admitted to the facility on 01/28/1999. R2's Brief Interview for Mental Status (BIMS), dated Oct 28, 2022, document R2's BIMS as 15/15. R2's Functional Status dated Oct 26, 2022, document R2 needs limited assistance with bed mobility, locomotion on unit, personal hygiene, toilet use, and R2 needs extensive assistance with walking in room and corridor, with one person assist. R2's medical diagnoses includes but not limited to multiple sclerosis, restless legs syndrome, history of falling, presbyopia, age related nuclear cataract, bilateral, unspecified mononeuropathy of right lower limb, diplopia, mild cognitive impairment of unclear or unknown etiology. On 01/07/2023 at 11:53am V6 (Assistant Director of Nursing-ADON) stated that residents have shower days and shower times, and residents are not supposed to be showering on the 11pm-7am shift for safety and supervision reasons. V6 stated shower schedules are from 7am to 3pm and from 3pm to 11pm, depending on a resident scheduled shower time. V6 stated R2 was taking a shower on 12/25/2022 at 02:35am, without staff supervision or knowledge when R2 fell trying to	S9999		

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S9999	Continued From page 3 reach for something on the floor of the shower. V6 stated R2 was sitting on the shower chair and the chair tipped over. V6 stated R2 did not call for assistance but staff heard a noise coming from the east shower room. V6 stated staff went to check and found R2 on the bathroom floor, face down. V6 stated R2 was bleeding and had a laceration on the forehead, and R3 complained of right shoulder pain. V6 stated R2 gait is unstable and uses a wheelchair because R2 has multiple sclerosis. V6 stated none of the three staff members (2 CNAs and 1 nurse) saw R2 wheel herself (R2) from R2 room all the way to the east side shower room. V2 stated R2 passed by the nursing station as R2 went to the east side shower room, but no staff member saw R2. V2 stated staff should always monitor residents to keep them safe. V6 stated staff should have seen R2 as R2 wheeled self to the east side shower. V6 stated R2 was taken to the hospital and had 5 stitches on forehead and a right-hand fracture. Hospital records dated 12/25/2023 at 09:45am document: on 12/25/2022 R2 was at the hospital related to fall with head laceration. R2 was diagnosed with closed displaced fracture of the surgical neck of the right humerus, unspecified fracture morphology, and facial laceration. On 1/07/2022 at 12:48pm V2 (Director of Nursing-DON) stated V2 was not here when R2 fell. V2 stated R2 fell at 02:35am on Christmas day. V2 stated "maybe staff were taking care of other residents when R2 fell. V2 stated R2 should have been given health teaching and education on how to use the call light if R2 needed to shower. V2 stated the nursing station where the nurses do documentation faces the side wall and cannot see residents as they pass by. V2 stated the nurses might not have heard or seen R2 as	S9999		

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S9999	Continued From page 4 R2 was passing by the nursing station. Nursing notes dated 12/25/2022 at 0:35am document: writer heard a noise coming from the shower room and ran to see what happened and R2 was seen on the floor face down. R2 stated "I fell and hit my head." R2 observed with laceration on the Lt (left side) of the forehead and two small cuts on Lt (left side) upper lip with moderate amount of bleeding. On 1/7/2023 at 13:34pm, V7 (Licensed Practical Nurse-LPN) stated if resident who needs assistance with showering or activities of daily living/ADL care, the CNA is supposed to assist. V7 stated if a resident insists on showering in the middle of the night, the staff should monitor that resident as the resident showers to make sure the resident is safe, because anything can happen, and staff should be on the lookout to assist if the resident needs help. V7 stated residents should be monitored 24 hours a day in the facility to keep them safe. V7 stated the CNAs (certified nurse's assistants) are supposed to be on each side of the hallway monitoring residents. Facility fall policy titled: Fall Occurrence, dated 7/28/2021 documents: -It is the policy of the facility to ensure that residents are assessed for risk for falls and interventions are put in place to prevent them from falling. -Those identified as high risk for falls will be provided interventions to prevent falls. (B)	S9999		