Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055681	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE NURSING CENTER	**4314 SOUTH WABASH AVENUE , CHICAGO, Illinois, 60653**

(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) COMPLETION DATE
S0000	Initial Comments Annual Licensure and Certification Survey	S0000		09/19/2025
S9999	Final Observations SECTION 300.690 - DPS - Citation(s) 300.610a) 300.690a) 300.690b) 300.690c) 300.1210b) 300.1210d)6 Licensure Violation 1 of 3: 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 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.	S9999		09/19/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. 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: 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 on observation, review of records and interviews facility failed to comply with reporting requirement to the State for serious injuries sustained by 1 out of 1 resident (R6). These failures affected 1 resident (R6) when facility failed to investigate and determine cause of accidents / falls that can help prevent repeat of similar incidents. Findings include: On 09/02/2025 at 10:56 AM, R6 seen alert but had a hard time elaborating when questions asked. R6 stated he had recent fall and went to hospital by nodding his head and short statements when asked. R6 was seen with bed about 2 feet high. R6 was not able to move both extremities well more on right side grimacing upon slight movement. R6’s head was positioned opposite of the wall far from bedside table where items out of reach.	S9999		

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S9999	Continued from page 2 Review of R6 fall clinical notes and care plan documents multiple falls: R6 had an actual fall (1/30/25) with no injury R6 had an actual fall (1/31/25) with no injury R6 had an actual fall (3/15/25) with no injury R6 had an actual fall (5/21/25) with injury R6 had an actual fall (6/02/25) with no injury R6 had an actual fall (06/12/25) with injury R6's clinical notes related to falls with injury are as follows: Dated 05/21/2025 by V16 (Licensed Practical Nurse), R6 fell on the bathroom. Transferred to hospital admitted with closed right humeral fracture. R6 now uses right cast/wrap mold and sling. Dated 06/12/2025 by V31 (Registered Nurse) documents that R6 fell in his bedroom in front of his wheelchair. After two days on 06/14/2025 V32 (Licensed Practical Nurse) clinical notes reads right hand with large swelling, pain 9 out of 10. V34 (Nurse Practitioner) medical notes dated 06/14/2025 documents that R6 wearing soft cast on right arm / hand with pain and swelling, X-Ray pending. The same date 06/14/2025, V33 (Licensed Practical Nurse) noted X-Ray done with result of right fracture of the fifth metacarpal. R6 was sent to hospital. On 09/03/2025 at 2:05 PM, V20 (Restorative Nurse / Registered Nurse) after review of R6 clinical records confirmed that R6 have multiple falls. V20 stated that all falls of R6 were not addressed in his plan of care. V20 stated that most current intervention for R6 was dated 04/21/2025 which does not address repeated falls on 05/21/2025, 06/02/2025 and 06/21/2025 which R6 sustained injuries. V20 stated that R6 sustained closed right humerus fracture due to fall on 05/21/2025 and right 5th metacarpal (finger) due to fall on 06/12/2025. V20 stated that interventions needed every time R6 fall to prevent R6 from recurrent falls. V20 stated that care plan interventions should be based on assessments that needs to be reviewed from time to time to prevent falls to reoccur. Requested to V20 report to State agency for fall incidents dated 05/21/2025 and 06/12/2025 resulting to injuries and hospitalization. V1 responded via email	S9999		

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S9999	Continued from page 3 dated 09/04/2025 - Incident was deemed non-reportable because it was an old healing fracture with no hospital intervention. Based on R6 clinical records both fractures were new and related to falls. R6 was hospitalized on both fractures. On 09/04/2025 at 09:49 AM, V2 (Director of Nursing) denies any knowledge that R6 have fractures. V2 said, “I don’t know if there was history of fracture.” V2 stated that there needs to have fall interventions because interventions are there to prevent falls. V2 stated that when there is an incident of fall, it needs to be reported to the State when there is an injury like fracture. Decline of R6’s functional abilities were noted based on Minimum Data Set (MDS) assessment dated 05/16/2025 compared to 06/04/2025). 05/16/2025 assessment documents that R6 needs partial moderate assistance on transfers and ambulation. 06/04/2025 assessment after the fall dated 05/21/2025 when R6 sustained fracture injury. R6’s MDS assessment documents dependent on transfers where facility staff needs to help R6 totally and unable or not attempted to walk due to medical condition or safety concerns. Per clinical notes dated 09/02/2025 by V20, R6 was transferred to hospital due to uncontrolled pain with highest pain score of 10 out of 10 and swelling of right arm. Fall Program Policy dated 03/2021 does not provide guidance related to reporting of incidents to the State Agency. (B) Vaccinations: Licensure Violations 2 of 3 SECTION 300.1060 VACCINATIONS 300.1060e) 300.1060f) 300.1060g) _____ Section 300.1060 Vaccinations e) A facility shall distribute educational information provided by the Department on all vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (available at:	S9999		

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S9999	Continued from page 4 https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf), including, but not limited to the risks associated with shingles and how to protect oneself against the varicella-zoster virus. The facility shall provide the information to each resident who requests the information and each newly admitted resident. The facility may distribute the information to residents electronically. (Section 2-213(e) of the Act) f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and (HIV), and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act) g) All persons determined to be susceptible to the hepatitis B virus shall be offered immunization within 10 days after admission to any nursing facility. (Section 2-213(c) of the Act) This requirement was NOT met as evidenced by: The facility failed distribute educational information risk associated with shingles, Based on interview and record review, the facility failed to provide evidence that they educated residents and their representatives regarding the risks associated with shingles and how to protect the residents against the varicella-zoster virus, failed to screen and document risk factors associated with hepatitis B, hepatitis C, and Human Immunodeficiency Virus (HIV), and document whether or not the resident was immunized against hepatitis B, and failed to offer immunization within ten days after admission for residents who are susceptible to hepatitis B for five (R5, R16, R17, R116, R122) out of five residents reviewed for immunizations. These failures could potentially affect all 144 residents residing in the facility. Findings include: On 9/2/2025 at 10:00 AM, surveyor requested from V3 (Infection Preventionist/IP Nurse) for R5, R16, R17, R116, R122's shingles education or shingles vaccine information, hepatitis and HIV screenings, and hepatitis B immunization information. Facility did not provide the requested documents. V3 stated, "The facility does not screen residents for hepatitis and HIV, nor the facility does not offer immunizations for shingles and hepatitis vaccines."	S9999		

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S9999	Continued from page 5 On 9/4/25 at 9:55 AM, V1 [Director of Nursing] stated, “I been a director of nursing for five years, and I never heard that residents need to be screened or educated on shingles, Hepatitis B, C or HIV. The facility has not screen residents for hepatitis and HIV, nor we have not offered immunizations for shingles and hepatitis vaccines.” R5, R16, R17, R116, R122's immunization history in their electronic health records did not include shingles and hepatitis B vaccines information/education. R5, R16, R17, R116, and R122's electronic health records have no documentation to show that the facility screened them for hepatitis B, hepatitis C, and HIV. (Policy) The facility did not provide policy and procedure related to shingles, hepatitis B, hepatitis C, HIV immunizations and screening protocols for residents. (B) Licensure Violation 3 of 3 300.610a) 300.1210b) 300.1210d)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 300.1210 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	S9999		

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S9999	Continued from page 6 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. These Rrequirements were NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to (a) provide treatment or services, equipment or device and (b) develop comprehensive care plan to address contractures for two (R4 and R34) of two residents reviewed for limited range of motion in sample of 29. This failure resulted to left hand contracture of one (R34) resident admitted with full range of motion and / or mobility status. R4's admission record showed admit date on 5/7/24 with diagnoses not limited to Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Dysarthria following unspecified cerebrovascular disease, Personal history of traumatic brain injury, Pain in left upper arm. On 9/2/25 at 11:35AM Observed R4 sitting on the side of the bed, alert and oriented x 3, responsive, nonverbal, communicate through gestures, nodding and shaking head. Observed with left hand contractures, no device in place. R4 was shaking his head side to side indicating no or he was not wearing device or splint, and range of motion exercises were not provided for his left-hand contracture. MDS (Minimum Data Set) dated 8/12/25 showed R4's cognition was intact. He had functional limitation ROM (Range of Motion) or impairment on one side of upper and lower extremities. R4 needed supervision or touching assistance with eating, oral and personal hygiene, shower / bathe self, upper and lower body dressing, chair / bed and toilet transfer; Partial / moderate assistance with toileting hygiene. MDS showed R4 received restorative nursing program for dressing and / or grooming, Communication. OT (Occupational Therapy) evaluation note dated 5/10/24 showed R4's LUE (Left upper extremity) ROM (Range of Motion) assessment was Impaired. R4's OT discharge summary dated 6/7/24 showed recommendations not limited to Restorative range of	S9999		

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S9999	Continued from page 7 motion program. Functional abilities and goals assessment dated 8/13/25 showed R4 had Impairment on one side of the upper extremity ROM. Restorative observation and planning assessment dated 8/12/25 showed R4's LUE (Left upper extremity) ROM (Range of Motion) deficit. Restorative programs: Communication, Dressing / Grooming. R4's EHR (Electronic Health Record) did not reflect R4 was provided with restorative nursing program for ROM. Reviewed R4's care plan, did not reflect plan of care for left hand contracture. R34's admission record showed initial admit date on 3/21/24 with diagnoses not limited to Peripheral Vascular Disease, Thrombosis of atrium, Hypertensive heard disease, Acquired absence of left leg below knee, Human immunodeficiency Virus (HIV) disease, Unspecified mental disorder. On 9/2/25 at 11:42AM Observed R34 sitting up on wheelchair, alert and oriented x 3, verbally responsive, with left below knee amputation. Observed left hand contracture, not able to open middle, ring and little fingers on left hand. No device or splint on left hand. R34 said he has been residing in the facility for over a year, and he developed contracture on left hand about 6 months ago while residing in the facility. He said left hand contracture started when he had a fracture from a fall incident in the facility. MDS admission assessment dated 3/28/25 showed R34's cognition was severely impaired. R34 had no functional limitation in ROM or no impairment on both upper extremities. MDS dated 7/10/25 showed R34's cognition was moderately impaired. He had functional limitation in ROM or impairment on one side of the upper extremity. He needed supervision or touching assistance with eating, upper body dressing; Substantial / maximal assistance with oral, toileting and personal hygiene, shower / bathe self, lower body dressing, chair / bed and toilet transfers. MDS showed R34 received restorative nursing program for Active ROM and dressing and / or grooming. OT (Occupational Therapy) evaluation and plan of treatment report dated 3/22/24 showed R34's left upper extremity ROM was within functional limits or no impairment.	S9999		

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S9999	Continued from page 8 OT evaluation and plan of treatment report dated 4/22/24 showed R34's left upper extremity (LUE) ROM was impaired, no contracture. R34's OT discharge summary report dated 7/17/24 showed recommendations not limited to restorative program for LUE PROM (Passive Range of Motion) and RUE AROM (Active Range of Motion). R34's EHR reviewed, no documentation found that PROM (Passive Range of Motion) to LUE was provided to R34. OT evaluation and plan of treatment report dated 10/16/24 showed R34's left upper extremity (LUE) ROM was impaired, left-hand contracture (middle, ring and little finger). R34's OT discharge summary report dated 11/26/24 showed recommendations not limited to: Restorative program for left hand PROM. Splint and brace program. Left hand contracture cushion to be worn daily (evening) or as tolerated. R34's EHR (electronic health record) reviewed, no documentation found that PROM and splint or brace to left hand were provided to R34. OT evaluation and plan of treatment report dated 6/16/25 showed R34's LUE ROM was impaired, left-hand contracture. R34's OT discharge summary report dated 7/11/25 showed recommendations not limited to: Restorative ROM program. PROM to left hand. R34's EHR reviewed, no documentation found that PROM to left hand was provided to R34. Care plan reviewed, no plan of care found to address or focus R34's left hand contracture. Functional abilities and goals assessment dated 7/19/24 showed R34's ROM had no Impairment. Functional abilities and goals assessment dated 7/11/25 showed R34's ROM had Impairment on one side of the upper extremity. On 9/3/25 at 2:42PM V20 (Restorative Nurse, Registered Nurse / RN) stated she started working in the facility in July 2025. She said if resident has limited ROM or contractures, should provide restorative programs such as AROM / PROM or rehab evaluation and treatment if	S9999		

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S9999	Continued from page 9 appropriate. V20 said the goal is to maintain resident's functional mobility, prevent contractures or further contractures. She said if resident has hand contracture, palm protector / splint could be provided. V20 said care plan should be developed for limited ROM or Contracture so staff would know the plan of care or what to focus on the resident. She said the purpose of splint or brace is to prevent further contracture or possible injury. V20 said resident's care plan should be individualized to address concern / problem and would include goals, interventions / approaches. Stated does not know if R4 and R34 have limited ROM or contracture because she is new to the facility. Surveyor reviewed R4 and R34's EHR with V20. She said R4 is on restorative program for communication and dressing / grooming. She said if there is limited ROM / Contracture, PROM or AROM could be provided to resident. V20 was not able to find documentation if AROM / PROM was provided to R4's LUE impairment. Stated she could not find care plan for R4's LUE impairment or left-hand contracture. V20 said R34 has limited ROM / impairment on one side of the upper extremity. She is not sure if R34 has left hand contracture. V20 said could not find care plan for left hand contracture on R34's EHR. Stated she does not know if PROM or splint was provided to R34's left hand because she is new to the facility and she was not able to find documentation in R34's EHR. On 9/4/25 at 10:21AM Surveyor and V20 checked R4 and R34. V20 said R4 and R34 have contractures to left hand, no device / splint in place to affected area. On 9/4/25 at 10:34AM V30 (CEO of ARC Rehab, OT / Occupation Therapist) was interviewed via phone and reviewed R4 and R34's EHR. She said R4's last OT evaluation and treatment was on 5/10/24 until 6/7/24. V30 said per documentation R4's LUE ROM was impaired, with contractures. She said R4's treatment goal was splinting on LUE / left hand. V30 said R34's initial OT eval and treatment was on 3/21/24 to 4/3/24. She said R34 was evaluated by OT on 3/21/24, documentation showed both upper extremities ROM within functional limits, no impairment on right and left UE, No contracture. V30 said R34 had another OT eval and treatment on 10/2024 to 11/2024. She said R34's LUE with impairment and contracture to left hand. V30 said treatment goal included donning and doffing of splint on the left hand and wearing hand splint finger contracture and decreasing pain. She said R34 last OT eval and treatment was on 6/16/25 to 7/11/25. V30 said R34 had LUE impairment or left-hand contracture. Stated R34's treatment goal included wear palm roll or hand splint on left hand.	S9999		

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S9999	Continued from page 10 On 9/4/25 at 11:25AM V2 (Director of Nursing / DON) stated if there are limited ROM / contractures, resident should have Restorative nursing program like ROM as appropriate. She said it should be a team effort and what is best for the resident. V2 said the goal is to maintain resident's ROM, prevent contractures or further contractures, if possible, by giving or providing resident with necessary or appropriate services or care best for the resident. On 9/4/25 at 12:08PM V27 (MD / Medical Doctor) was interviewed via phone and stated contractures could be preventable by giving resident necessary services such as hydration, nourishment, therapy, restorative nursing programs. Stated he knows R34, and he is the attending physician. V27 said R34 has multiple comorbidities, he has HIV and muscle weakness / wasting that could possibly lead to limited ROM or contractures. He said the goal is to prevent contracture or further contracture by giving appropriate services or care needed for the resident. Facility's Restorative Nursing policy dated 3/2021 showed in part: The facility shall ensure that restorative care approaches and principles aimed at improving, preventing decline or maintaining a resident's functional level and quality of life are integrated into the individualized plan of care. If therapy department determines that skilled therapy is not indicated, Restorative nursing recommendations will be forwarded to the Restorative Nurse. The Restorative Nurse will initiate individualized goals and objectives based on therapy recommendations and monitor the implementation of the plan of care. Care plan will be individualized and specific to the resident needs. Evaluation and reevaluation fo the resident's status is ongoing and at least quarterly. (B)	S9999		