

Illinois Department of Public 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 03/16/2026	
NAME OF PROVIDER OR SUPPLIER COMMUNITY CARE NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			S0000			
	Complaint Investigation						
	2682918/IL2800907-300.690 a) b) c) cited.						
S9999	Final Observations			S9999			
	Statement of Licensure Violation:						
	300.690a)						
	300.690b)						
	300.690c)						
	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.						
	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. 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.						
	This requirement is not met as evidenced by:						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 Based on interview and record review, the facility failed to notify the Regional Office (IDPH-Illinois Department of Public Health) of a serious incident for one of three residents (R1) in the sample of six. Findings include: 3.15.2026 at 3:41 PM, V5 (LPN-Licensed Practical Nurse) said I was informed by staff that R1 was on the floor. I assessed R1, she had a small laceration to her forehead. She couldn't tell me what happened. She was kind of confused. R1 has a seizure almost every day. She was sent to the hospital (for evaluation and treatment); she returned with sutures. 3.15.3036 at 3:46 PM, V3 (ADON-Assistant director of Nursing) said R1 went to the hospital for a seizure. She did get sutures. An incident report was not sent to IDPH because R1 had a minor injury. 3.15.2026 at 3:52 PM, R1 said I can't tell you what happened. I was in bed and woke up on the floor. I had a cut to my forehead. I went to the hospital. I got five stitches. 3.16.2026 at 3:32 PM, V1 (Administrator) raised his voice to this writer and said: "I knew you were going to write it. I knew you were going to write a tag. I've read the tag." V1 repeatedly demanded that this writer provide him with the definition of a serious incident. V1 said: "what's a serious incident? Tell me, what is the definition of a serious incident?" This writer referred V1 to the Administrative Code and his corporate consultant. He said: "no, I'm asking you what's the definition of a serious incident. I read the regulation before I came in here, it's not a serious incident." V1 said: "R1's case manager has called this in before (to IDPH complaint hotline). It's been investigated. There were no findings." This writer asked for information related to prior investigation(s). V1 did not provide requested information. V1 said: "their (CMS) definition of a serious incident is something more than a laceration that requires (liquid adhesive) or couple of sutures. The resident did get sutures but returned to the facility, she wasn't admitted." V1 said: "Fine, I'll report every single incident, every scrape, every abrasion to IDPH. I'll tell them that (this writer) said that I should report everything." This writer said: "that's untrue, I did not say that." V1 insisted that that's what he would do. 1.22.2026 at 10:40 AM, R1's fall incident documents, in part: writer notified by staff resident had an open area to forehead. Resident states she was sitting on			S9999			

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S9999	Continued from page 2 the bed, she took her helmet off. Resident then stated, "the next thing I know I was on the floor and felt blood". When asked, did you have a seizure or any loc (loss of consciousness), resident stated, "I don't remember". Wound cleansed with n/s (normal saline), (wound closure strips) applied with pressure dressing. Post-fall assessment and neurological monitoring were completed, and (R1) was re-educated on helmet compliance. 1.22.2026 at 10:59 AM, R1's Health Status Note documents, in part: "Writer was notified by staff resident was in her room with small lac (laceration) post unwitnessed fall. Writer arrived to room to find resident on bed, stated "I was sitting on my bed and when I came alert, I was on the floor." Writer asked if resident had a seizure or just fall? "Resident couldn't remember. NP (Nurse Practitioner) notified, order to send for evaluation at (local hospital). Writer cleansed lac with ns (normal saline), applied (skin closure strip) and pressure dressing." 1.22.2026 at 11:25 AM, R1's Daily Note documents, in part: "Resident transferred to (local hospital) via ambulance in stable condition." 1.22.2026 at 6:25 PM, R1's Daily Note documents, in part: Resident returned from (local hospital) with 5 sutures confirmed by co-worker and will return to the emergency department in a (week) to remove them. Per (local hospital) emergency room nurse, resident signed AMA (Against Medical Advice) and did not want to wait for her lab results. Incident-Accident Reporting policy (effective date 3.2021) does not define what a serious incident is, when an incident should be reported or to what entity an incident should be reported. Only page one of two was presented to this writer. V1 said (in aforementioned interview): "there is nothing on page two." (C)			S9999			