STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008262	A. BUILDING: _____ B. WING _____	11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN PARK HEALTH & LIVING CTR	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 Annual Licensure and Certification Survey Investigation of Facility Reported Incident of 10/20/23/IL165630	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.230a) 300.230d) Section 300.230 Information to Be Made Available to the Public by the Licensee a) Every facility shall conspicuously post for display in an area of its offices accessible to residents, employees, and visitors. Source: Amended at 45 Ill. Reg. 1134, effective January 8, 2021 d) All Cook County facilities with Colbert Class Members shall conspicuously display, in a public and accessible location, a Department-provided poster informing residents of their right to explore or decline community transition, and their right to be free from retaliation, regardless of their decision on transition. This poster shall include a telephone number for reporting retaliation to the Department and shall include the steps a resident should take if retaliation does occur. The display of the poster will be included as a compliance measure in the Department's survey process. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to display the William	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Colbert Retaliation Hotline poster for the residents at the facility. This failure has the potential to affect all 120 Medicaid residents residing in the facility. On 11/12/23 around 10:00 am, facility tour was conducted, and surveyors were unable to locate any postings for the William Colbert Retaliation Hotline poster on the second and third floor. On 11/14/23 at 9:55 am, V30 (Admissions) was asked by the surveyor to locate the postings for the Williams Colbert Retaliation Hotline poster on the second floor. V30 stated, "It is not posted they should be on every floor, their normally by the elevators, I (V30) don't see it." On 11/14/23 at 10:15 am, V1 Administrator stated, the William Colbert signs should be posted on every floor. Surveyor asked the importance regarding the displaying the Williams Colbert Retaliation Hotline poster. V1 stated, so the residents will know they can go back into the community with this program. On 11/14/23 at 10:45 am, V28 SSD (Social Service Director) stated, the William Colbert posters should be on every floor. The posters are normally posted by the elevator. I (V28) did not realize the posters were gone. Facility's document dated (11/15/23) documented current residents on the William Colbert Program, listed five residents currently in the program and seven residents pending. (Administrative Warning) Statement of Licensure Violations 2 of 2: 300.610a)	S9999		

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S9999	Continued From page 2 300.1210b) 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 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	S9999		

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S9999	Continued From page 3 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 interview and record review, the facility failed to ensure that a resident was free from physical abuse which affected one (R70) in the sample of 58 residents reviewed for abuse. This failure caused harm to R70 who was physically struck, fell, and suffered a laceration to R70's left forehead which required 4 sutures as treatment in the hospital. Findings include: On 11/12/23 at 11:14 am, R70 observed in wheelchair propelling self out of R70's room using R70's right arm to move the wheelchair wheel and right foot to move on floor. R70's left arm laying on R70's lap. This surveyor noted a healed, pink laceration, approximately 3 centimeters (cm) in length. When asked about the laceration, R70 stated, "I (R70) fell and hit my head." R70 stated, it was in the basement in the dining room by the vending machine (on 10/12/23). R70 said R49 and R70 were in the dining room with no one else there. R70 said, R70 doesn't remember exactly what R49 said to R70 but that "all of a sudden, I (R70) fell and hit my head." R70 said, R70 yelled, and the nurses and CNAs came and helped R70. R70 stated, "I (R70) was bleeding from above my eye" pointing to R70's left eyebrow. R70 stated, "I (R70) went to hospital and got stitches." R70's Admission Record documents, in part, diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left	S9999		

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S9999	Continued From page 4	S9999		

non-dominant side, pseudobulbar affect, schizophrenia, hypertension, chronic obstructive pulmonary disease, unsteadiness on feet, lack of coordination and reduced mobility.

R70's Minimum Data Set (MDS), dated 10/5/23, documents, in part, a Brief Interview for Mental Status (BIMS) score of 15 which indicates R70 is cognitively intact.

In R70's hospital records, V38 (Emergency Hospital Physician) documents, in part, R70 "presenting to the emergency department with forehead laceration after a fall. Per EMS (emergency medical system), (R70) was in physical altercation with another member (R49) of nursing home. (R70) was pushed and fell onto the ground. (R70) hit (R70's) head on the ground and sustained a laceration of (R70's) left forehead" and "(R70) has left-sided deficits from prior stroke." R70's hospital records indicate that R70's laceration repair to the left forehead, 3-centimeter laceration was performed with 4 sutures.

On 11/13/23 at 12:26 pm, R49 observed in room, dressed, groomed, and ambulatory. Surveyor asked about an incident with R70 on 10/12/23. R49 said, R49 was by R49's self in basement by the vending machine with R70. R49 stated, "I (R49) was just doing this" as R49 is demonstrating that R49 was smacking on R70's forearm when R70 was in the wheelchair in front of the vending machine. R49 said, then R70 "hit me (R49) on my face," and R49 hit R70 "to the point that (R70) fell." R49 showed this surveyor again that R49 hit R70 on the left arm.

R49's Admission Record documents, in part, diagnoses of type 2 diabetes mellitus, asthma,

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S9999	Continued From page 5 paranoid schizophrenia, bipolar disorder, heart failure, hypertension, acute kidney failure, major depressive disorder, altered mental status, and cognitive communication deficit. R49's MDS, dated 10/4/23, documents, in part, a BIMS score of 12 which indicates R49 has moderate cognitive impairment. Facility document undated and titled "Emergency Codes," documents, in part, that a "Code White" is for "resident is alert but has fallen." On 11/14/23 at 1:40 pm, V33 (Receptionist) stated, while monitoring the video camera footage of the facility from the receptionist front desk, V33 observed (on 10/12/23 after lunch) R70 on the floor in the basement dining room with R49 off to the side of the room. V33 stated, V33 called the code white on the overhead paging system to alert staff to attend to R70. On 11/14/23 at 12:39 pm, V18 (Psychotropic Nurse, Licensed Practical Nurse, LPN) stated, R70 is oriented times 2 to 3 (person, place, and time) and R70 uses a wheelchair to be mobile due to left sided weakness. V18 stated, R49 is oriented times 2 to 3, is ambulatory and can be "feisty" with being "verbally aggressive with peers." V18 stated, on 10/12/23 in the afternoon, V18 was in the office in the basement hallway and heard "that commotion "coming from the basement dining room; so V18 went running to see what was happening. When asked what V18 was hearing, V18 stated, V18 heard R70 "screaming." V18 stated, on V18's way in the basement hallway, V18 heard the "Code White" to the lower-level dining room announced on the overhead paging system. V18 stated, a code white is when a resident has fallen but is still alert,	S9999		

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S9999	Continued From page 6 and V33 (Receptionist) was the staff member who paged the code white. V18 stated, "As I (V18) got closer (to the basement dining room), I heard (R70) screaming. I didn't hear (R49) at all." V18 stated, V18 observed no other residents or staff in the basement dining room or coming from the basement dining room. V18 stated, V18 observed R70 "face down" on the floor with "blood on the floor coming from (R70," and R49 was "walking away from (R70)." V18 stated, R49 went to sit on a bench in the basement dining room, and R70 was on the floor, laying the middle of the room in front of the vending machine with R70's wheelchair behind R70. V18 stated, R70 was saying, "my arm, my arm," because R70 was laying on R70's left weak arm (from the hemiplegia). V18 stated, other staff then arrived and retrieved gauze dressings for V18 to provide initial first aide to R70's facial laceration. Facility document titled "Resident/Employee Statement" signed by V18 and dated 10/12/23, V18 documents, in part, "I (V18) arrived to the main dining room in basement because I heard yelling. When I entered dining room, I saw (R70) on the floor face down. When I approached (R70), I saw (R49) walking away from (R70). I saw blood coming out of (R70) left eye brown and on opening. I applied pressure to opening and other staff assisted me to get (R70) to seated position then lifted to be seated in wheelchair." On 11/14/23 at 9:47 am, surveyor asked about the incident on 10/12/23 with R49 and R70. V23 (Psychological Rehabilitation Services Coordinator, PRSC) stated, V23 was present in the facility and responded to the basement dining room. V23 stated, "Basically, (R70) was using the vending machine and (R49) asked for soda and they had an altercation together." V23 stated,	S9999		

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S9999	Continued From page 7 when V23 arrived to the dining room, R49 and R70 were the only two residents in there. V23 stated, V18 was present tending to R70 and that R70's eyeglasses were broken on the floor with R70 bleeding from R70's face with blood on the floor around R70's head. V23 stated, R70 was "face down" with body on the floor with R70's wheelchair by R70. On 10/12/23 at 2:30 pm, V23 (PRSC) documents, in part, in R70's progress notes, "(R70) made contact with (R49) in the basement dining area. Staff immediately intervened and separated residents." On 10/12/23 at 2:45 pm, V23 (Psychological Rehabilitation Services Coordinator, PRSC) documents, in part, in R49's progress notes, "(R49) made contact with co-peer in basement in the dining area." On 11/14/23 at 11:28 am, V21 (Registered Nurse, RN) stated, V21 was R70's nurse on 10/12/23 for the day shift. V21 stated, V21 heard the code white to the lower level called overhead on the paging system, and V21 responded immediately. V21 stated, when V21 entered the basement dining room, R70 was bleeding from R70's face and R49 moved away from R70 in the dining room. V21 stated, R70 didn't want to talk about what had just happened with R49 as V21 was tending to R70's care. V21 stated, when R70 was brought upstairs, V21 talked to R70, and R70 said, "I (R70) was pushed and (R49) started it." R70 said, R49 pushed R70 out of the wheelchair. R70's incident report, prepared by V21 (RN), documents, in part, "Nursing Description: (R70) was in physical altercation with (R49). (R70) with the receiver in the contact, at the lower-level	S9999		

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S9999	Continued From page 8 dinning (dining) hall." On 10/12/23 at 3:11 pm, V21 (RN) documents, in part, in R70's progress notes, "Responded to code white in the dinning (dining) room, (R70) found on the floor, noted with laceration on upper left lid, (R70) assisted back to wheelchair, wheeled back to (R70) room for further assessment. (R70) stated, "I (R70) got tired of being bordered by (R49), told (R49) to stop and we got in a fight". On 10/12/23 at 2:30 pm, V21 (RN) documents, in part, in R49's progress notes, "(R49) was in a physical altercation with (R70). (R49) initiated the contact, at the lower-level dinning (dining) hall. No injuries on (R49)." R49's Care Plan, dated 10/12/23, documents, in part, a focus of "(R49) has potential to be physically aggressive towards others, such as hitting others ... history of harm to others ... (R49) made contact with (R70) in basement dining area." On 11/14/23 at 2:19 pm, V2 (Director of Nursing, DON) stated, V2 was not a witness or did not respond to the code white called in the facility on 10/12/23 for R49 and R70's physical altercation due to V2 responding to another code white incident (in a different location in facility) that occurred near the same time on 10/12/23. V2 stated, with reports from staff and R70's hospitalization records, V2 stated, R70's "fall was a result from the physical altercation. (R70) came back with sutures. That is a serious injury." On 11/15/23 at 3:00 pm, when asked what are V37's (Medical Director) expectations of the facility staff to ensure that residents are safe from	S9999		

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S9999	Continued From page 9	S9999		

physical harm. V37 stated, residents should have a safe environment in the facility, and residents must be "free from abuse." When speaking to V37 about R49 and R70's incident on 10/12/23 with R70 falling from a wheelchair after physical hitting from R49 and suffering a forehead laceration requiring suture repair in the hospital, V37 stated, "That's a serious injury." When asked how staff are to ensure that residents don't experience physical harm from other residents, V37 stated, "An altercation like this should never happen. Of course, they (staff) should be watching the residents. And they should know who starts to fight."

Facility policy dated 10/2022 and titled "Abuse Prevention Program," documents, in part, "Policy: This (facility) affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: ... Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment; identifying a current says and patterns of potential mistreatment ... Implementing says stones to prompt away and aggressively investigate all reports in allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment ... Abuse: Abuse means any

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S9999	Continued From page 10 physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury ... Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking." (B)	S9999		