STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005375	A. BUILDING: _____ B. WING _____	C 02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR LIEBERMAN	9700 GROSS POINT ROAD SKOKIE, IL 60076

(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 Facility Reported Incident Investigation of 1-22-22/ IL 143605	S 000		
S9999	Final Observations Facility Reported Incident Investigation of 1-22-22/ IL 143605 STATEMENT OF LICENSURE VIOLATIONS: 300.1210b) 300.1210d)6) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 These regulations were not met as evidenced by: Based on interview and record review the facility failed to monitor and provide supervision for a resident known to be at risk for falls. This affected 1 of 4 (R5) residents reviewed for fall. This failure resulted in R5 falling and hitting his head requiring treatment at the local hospital for forehead laceration and a subdural hematoma. Findings include: On 2-18-22 at 9:37 AM, V2 (DON) said R5 is alert and oriented x 1. Unable to make needs known due to advanced dementia and Alzheimer's. R5 has poor safety awareness. R5 is a high fall risk due to unsteady gait, history of fall at facility, and history of dementia without behaviors. R5 requires close supervision due to history of falls, unsteady on feet, and requires redirection. R5 had an observed fall by CNA. CNA was in 20 feet when R5 fell and CNA was unable to prevent the fall due to being 20 feet away. R5 fell and was noted with laceration to right forehead. R5 was sent 911 to local hospital and received diagnosis of subdural hematoma. On 2-18-22 at 11:01 AM, V9 (CNA) said R5 is not very alert. R5 is confused. R5 is unable to make his needs known. R5 is impulsive. R5 is a fall risk. V9 was not aware of previous falls at the facility. R5 does not requires assistance getting up. R5 does not require assistance with walking. V9 was assigned to observe R5 in common area when another resident called for help. V9 went to assist another resident when R5 got up by himself and fell. V9 could not prevent R5's fall. On 2-18-22 at 10:42 AM, V4 (RN) said R5 ambulates but need to be assisted due to	S9999		

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S9999	Continued From page 2	S9999		

unsteady gait. He wanders and needs to be supervised. R5 has poor safety awareness and is impulsive. R5 is a fall risk because of unsteady gait and bumps into things and needs redirection. R5's fall occurred in common area of D wing. R5 was supervised by CNA. CNA is responsible for watching and monitoring residents especially residents who are risk for falls. The CNA should be close to the resident to monitor and prevent falls. The CNA was unable to prevent R5's fall. When a CNA is assigned to a resident for monitoring the CNA should provide close supervision to prevent accident. If another resident needs assistance, CNA can call another staff member to watch specified resident or tend to other resident who needs assistance.

On 2-18-22 at 9:16 AM, V8 (Restorative Nurse) said R5 has poor safety awareness, unable to make needs known, and requires redirection. R5 is high fall risk because of history of falls, advanced Alzheimer's, and psychotropic medications. R5 is placed in common area for supervision due to high fall risk. R5 was walking in the common area and the CNA was approximately 20 ft away. R5 lost his balance and CNA was unable to prevent the fall. Shuffling gait would make him unsteady on his feet and would make his risk for falls. CNA was assigned to watch R5. The CNA was unable to prevent the fall due to not being close enough to R5. Restorative would actively engage resident this would be more of a safety measure.

R5's MDS (ARD 1-14-22) documents BIMS Score: 00, Wandering behavior occurred 4-6 days, Self transfers require extensive assistance, Support transfers require 1 person, Self walking requires extensive assistance, Support walking requires 1 person, Surface to surface transfers

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S9999	Continued From page 3 require staff assistance, Diagnoses (not limited to): Alzheimer's Disease, Non-Alzheimer's Dementia, Psychotic Disorder, History of Falling, R5 had 1 fall since admission to facility. R5's Hospital Record (dated 2-9-22) documents reason for admission: subdural hematoma and Subarachnoid hematoma, without loss of consciousness. (B)	S9999		