STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009856	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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 Complaint Investigation: 2483512/IL172762	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)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 300.1210 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009856	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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
S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009856	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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
S9999	Continued From page 2	S9999		

These Regulations are not met as evidenced by:

Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that staff are aware of resident fall prevention interventions, failed to implement appropriate fall prevention interventions, and/or failed to provide supervision for three of three residents (R1, R2, R3) reviewed for falls. These failures resulted in R1 sustaining a fall that resulted in laceration and sutures to R1's left eyebrow.

Findings include:

On 5/21/24 at 1:32pm, surveyor inquired about resident fall prevention interventions (post fall). V10 (Restorative Nurse) stated "We want to put in an intervention based off of what we observed to prevent this from happening again or prevent injury. The intervention is in the care plan, we update the care plan." Surveyor inquired how staff are made aware of resident fall prevention interventions. V10 responded "We have report papers, the Nurse gives the CNA (Certified Nursing Assistant) the papers and it says who we (facility) have that falls and what we (staff) do."

R1's diagnoses include dementia, hemiplegia/hemiparesis (affecting right side) and history of falling.

R1's (11/9/21) admission fall risk assessment determined a score of 8 (at risk).

R1's (4/11/24) functional assessment affirms resident is dependent on staff for chair/bed to chair transfer.

The facility fall log affirms R1 fell on 4/12/24 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009856	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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
S9999	Continued From page 3	S9999		

5/15/24.

R1's (4/5/24) care plan states resident is at risk for falls due to cognitive deficits related to developmental disability, poor balance, poor safety awareness, unsteady gait, impulsivity, and inability to follow instructions. Interventions: (4/12/24) Send resident to hospital for further evaluation and treatment status/post fall. (5/16/24) Bed in lowest position and floor mats down.

R1's (5/15/24) progress notes state staff observed resident attempting to stand up from wheelchair, staff immediately went to assist. Before staff could reach resident, resident fell. Skin tear noted above left eyebrow. Resident taken to (Hospital) for further evaluation.

R1's (5/15/24) initial incident description states resident returned to facility (from emergency room) with 4 sutures to the left eyebrow.

On 5/21/24 at 1:43pm, surveyor inquired about R1's (4/12/24) fall V10 stated "While she (R1) was in the room and provided ADL (Activities of Daily Living) care, she had a fall. She was injured, she hit her head." Surveyor inquired if R1's care plan interventions were revised on or about (4/12/24) V10 responded "Yes" and affirmed that "Send resident to hospital for further evaluation and treatment status/post fall" was documented. Surveyor inquired if sending R1 to the hospital would prevent additional falls V10 replied "No." Surveyor inquired about R1's (5/15/24) fall V10 stated "That one happened in the dining room; it was witnessed. She did cut her left eyebrow when she fell, and she did get 4 stitches." Surveyor inquired if R1's care plan was revised post (5/15/24) fall V10 affirmed that low

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009856	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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
S9999	Continued From page 4	S9999		

bed and floor mats were added.

R1's (4/11/24) BIMS (Brief Interview Mental Status) states resident is rarely/never understood. Cognitive skills for daily decision making are severely impaired.

On 5/21/24 at 12:49pm, V7 (Licensed Practical Nurse) affirmed that she's assigned to R1. Surveyor inquired about R1's cognitive and functional status V7 stated "She (R1) is bed bound, she's not oriented and she's non-verbal." Surveyor inquired about R1's fall prevention interventions V7 responded "Bed in lowest position, frequent monitoring and that's all I can remember" [floor mats were excluded].

On 5/21/24 at 12:51pm, sutures were observed on R1's left eyebrow. R1 was lying in bed (low position) however only one (1) floor mat was adjacent to the bed (neither side of R1's bed was against the wall). R1 was noted to be flailing her arms and legs and aimlessly moving about the bed. Surveyor inquired if R1 was trying to get out of bed however R1 did not respond.

On 5/21/24 at 12:54pm, V8 (CNA) affirmed that she's assigned to R1. Surveyor inquired how R1 sustained the left eyebrow injury V8 stated "I believe she had a fall." Surveyor inquired about R1's fall prevention interventions V8 responded "We normally have pads on the floor and make sure her bed is low at all times." Surveyor inquired why only 1 floor mat was adjacent to R1's bed V8 replied "I think that they (staff) came in here earlier to mop the floor and I think they were letting it dry." V8 subsequently removed a floor mat (from behind the dresser) and placed it next to R1's bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009856	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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
S9999	Continued From page 5	S9999		

On 5/23/24 at 1:20pm, surveyor inquired about fall prevention. V11 (Medical Director) stated "We (facility) have to have general precautions for those (residents) that fall. If somebody falls, we (facility) will put fall precautions in place, so they (residents) don't fall again." Surveyor inquired about potential harm to a resident that falls V11 responded "They can have fracture, they can have abrasion if the head is hit on the ground, or they can have a subdural hematoma." Surveyor inquired if implementing one (1) floor mat is appropriate if neither side of the bed is against the wall V11 replied "If the space by the bed is not near the wall you need a mat on that side. If both sides have a space, then both sides need a mat."

R3's diagnoses include vascular dementia, weakness, unsteadiness on feet and fracture of sacrum/coccyx (on admission).

R3's (4/15/24) admission fall risk assessment determined a score of 4 (at risk).

R3's (4/23/24) BIMS determined a score of 11 (moderate impairment).

R3's (4/23/24) functional assessment affirms substantial/maximal assistance is required for chair/bed to chair transfer.

The facility fall log affirms R3 fell on 5/9/24 and 5/10/24.

R3's (5/9/24) incident report states resident was observed attempting to get out of bed and slid onto her buttocks at the side of the bed. Resident verbalized that she was going home.

R3's (5/10/24) incident report states resident observed sitting on the floor outside her room. No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009856	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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
S9999	Continued From page 6	S9999		

witnesses found.

R3's (4/15/24) care plan states resident is at risk for falls. Interventions: (5/9/24) Keep bed in lowest position. Floor mat (door side) while in bed.

On 5/21/24 at 1:08pm, R3 was lying in bed (low position) however only one (1) floor mat was present (neither side of R3's bed was against the wall). Surveyor inquired if R3 recently fell R3 stated "I fell 5 times right in here in this place." Surveyor inquired if R3 was able to walk R3 responded "I can't walk, when I get up, I need someone holding me." Surveyor inquired about R3's fall prevention interventions V9 (Physical Therapy) stated "Usually we lower the bed, call light close to the patient, and make sure the bed is locked" [floor mat was excluded]. Surveyor inquired if there were two (2) floor mats adjacent to R3's bed V9 responded "No."

On 5/21/24 at 2:24pm, surveyor inquired about R3's (5/9/24) fall. V10 stated she (R3) was observed attempting to get out of bed when making rounds, when they (staff) went to go get her, she slid down on her bottom." Surveyor inquired about R3's fall prevention interventions, V10 responded "For 5/9, I did put one floor mat for her (R3) near the door side because she's always favoring the door side." Surveyor inquired if implementing only one (1) floor mat was appropriate knowing that neither side of R3's bed was against the wall (therefore R3 could fall from either side). V10 replied "I was just thinking like when she'll try to get up its always because of the door, she wants to come to the door, and she doesn't have in her head (due to impaired cognition/dementia) to use the call light."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009856	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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
S9999	Continued From page 7	S9999		

R2's diagnoses include bilateral open angle glaucoma, vascular dementia, impulse disorders, muscle weakness and abnormalities of gait/mobility.

R2's (10/23/21) admission fall risk assessment determined a score of 5 (at risk).

R2's (3/25/24) BIMS affirms disorganized thinking is present, fluctuates.

R2's (3/25/24) functional assessment affirms resident requires substantial/maximal assistance with toileting and chair/bed to chair transfer.

The facility fall log affirms R2 fell on 5/19/24.

R2's (5/19/24) incident report states upon making rounds resident observed laying on the floor by his bed. No witnesses found. Resident stated, "I was getting out bed."

R2's (10/23/21) care plan states resident is at risk for falls related to muscle weakness, poor balance, poor safety awareness and visual impairment. Interventions: (5/19/24) Floor mats while in bed.

On 5/21/24 at 2:20pm, surveyor inquired about R2's (5/19/24) fall. V10 stated "The Nurse was making rounds and he (R2) was observed next to his bed" affirming the fall was unwitnessed. Surveyor inquired about R2's cognitive status V10 responded "He has dementia and he's not cognitive enough to say what happened." Surveyor inquired if interventions were added to R4's care plan post (5/19/24) fall V10 replied "I did put floor mats in for him." [R2's balance, cognition, vision is impaired, and the fall was unwitnessed however supervision is excluded].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009856	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENTWORTH REHAB & HCC	201 WEST 69TH STREET CHICAGO, IL 60621

(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
S9999	Continued From page 8 On 5/21/24 at 12:35pm, V4 (Registered Nurse) affirmed that she's assigned to R2. Surveyor inquired about R2's cognitive and functional status V4 stated "He (R2) transfers with assistance. He's vision impaired and up in a wheelchair." Surveyor inquired about R2's fall prevention interventions V4 responded "Bed in lowest position. He's vision impaired so he wouldn't be able to use the call light" [floor mats and/or supervision were excluded]. Surveyor inquired how staff are made aware of resident fall prevention interventions V4 replied "Fall preventions are in the communication book." Surveyor requested the resident fall prevention interventions V4 searched the "communication book" (binder) 3 times and stated I don't know if I'm overlooking it, I'm still looking" then searched the communication book (again) to no avail. V4 affirmed "Sometimes things get misplaced, it should have been here." The (08/2020) management of falls policy states the facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions and revise the resident's plan of care in order to minimize the risks for fall incidents and/or injuries to the resident. Procedure: Develop a plan of care to include goals and interventions which address resident's risk factors. Assess and monitor resident's immediate environment to ensure appropriate management of potential hazards. Review and/or modify the resident's plan of care at least quarterly and as needed in order to minimize risk for fall incidents and/or injury. (B)	S9999		