STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057943	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRVING PARK LIVING & REHAB CTR	4340 NORTH KEYSTONE , CHICAGO, Illinois, 60641

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S0000	Initial Comments Complaint Survey: 2585598/IL194919	S0000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 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	S9999		

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

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S9999	Continued from page 1 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 EVIDENCED BY: Based on interviews and record reviews, the facility failed to provide adequate supervision for one cognitive impaired resident (R2) who is a high fall risk with a history of falls with injury out of a sample of four [R1, R3, R4] residents reviewed for falls. This failure resulted in R2 falling, transferred to the emergency department, and sustained a left eye orbital fracture. Findings Include, R2 ‘s clinical record indicates the following in part: R2 was admitted with hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, essential hypertension, vitamin D deficiency, restlessness, history of falling, type II diabetes, anxiety disorder, depression, and fracture of upper end of left humerus. R2’s minimum data set [MDS] Section [C] Brief Interview Mental Status score [11]. Indicates R2 is mildly cognitively impaired. MDS Section [GG] indicates R2 requires maximal assistance with toileting, personal hygiene, and transfers. R2’s Facility IDPH Reportable in part: 6/3/26 at 7:05 AM, Upon staff rounds observed R2 on the floor at bedside. R2 noted with left eye and forehead discoloration. Neuro checks initiated. Physician gave order to send R2 to the emergency department. R2 was admitted to the hospital for a left orbital wall fracture. R2’s Care Plan in part: 12/15/25 R2 is a high fall risk. R2 is incontinent of bowel and bladder, requires incontinent care.	S9999		

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S9999	Continued from page 2 12/27/25 R2 primarily speaks mandarin, understand basic English. R2 is forgetful at times. 12/29/25 R2 has dementia with impaired decision making. R2 requires the support, care, and services of a long-term care facility. R2 demonstrates symptoms of cognitive impairment. R2 living with chronic psychiatric illness. R2 has ineffective coping modalities, disorganized thought process and mood patterns, delusions, hallucinations, difficulty meeting basic self-care needs. Having reduced insight and judgment related to schizoaffective disorder. R2's Fall Incidents in part: [R2 was admitted on 12/13/24] 12/16/24, R2 was observed on the floor mat in her bedroom. Intervention: Bed will remain in lowest position, floor mats in place, make sure all needs are met. 1/12/25, R2 was observed on the floor in her bedroom lying on the stomach near wheelchair. The wheelchair footrest was on top of R2's calf. R2 was sent to the emergency room and sustained a left arm fracture. Interventions: Monitor for ortho hypertension. 1/18/25, R2 was observed on the floor in her room near the closet. R2 said the closet door hit her head. R2 was sent to the emergency room, no injury noted. Intervention: There was no intervention in care plan. 2/25/25, R2 was observed siting on the floor in her bedroom, no injury. Intervention: Continue therapy, staff to anticipate needs related to ADL care. Anti-anxiety medications [Power of Attorney refused medications] 6/3/25, R2 was observed on the floor in her bedroom. R2 was sent to the emergency room and sustained a left eye orbital fracture. Interventions: [None] R2 did not return back facility. Interviews:	S9999		

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S9999	Continued from page 3 On 7/17/25 at 10:20 AM, V13 [Certified Nurse Assistant] stated, “On 6/3/25, I was R2’s first shift certified nurse assistant. It was around 7:00 AM, I was at the nursing station getting myself together, when I heard a loud noise and heard R2 yell out. I went into her room and looked like she fell out the bed on to the floor. I ran and told the 11PM – 7AM nurse that R2 was on the floor. The nurses assessed R2 and we put her into the wheelchair. Typically, I make rounds when I get to the nursing unit, but I was getting my assignment. R2 has fallen in the past. R2 needs close monitoring all the time. R2 fell during shift change when everyone was at the nursing station, third shift and first shift staff.” On 7/17/25 at 10:50 AM, V16 [Certified Nurse Assistant] stated, “I was the night shift aide, worked on 6/3/25, when R2 fell. I provided care to R2 around 6:00 AM. Around 7:10 AM, all the first-floor staff was at the nursing station when we heard a noise. I ran into R2’s room and she on the floor. R2 left side of her face was discolored dark. R2 needs close monitoring. R2 needs to go to the bathroom frequently and it takes a long time to take her. R2 knows how to place on her call light sometimes, but she does not wait for assistance, she will try to take herself and will fall. Some of R2’s fall interventions are, close monitoring, floor mats, low bed and keep the call light in reach. R2 constantly tries to transfer herself all the time.” On 7/17/25 at 12:30 PM, V14 [Licensed Practical Nurse] stated, “I was R2’s third shift nurse. Around 7:05 AM the nursing staff was all at the nursing station. I was giving report to the first shift nurse when we heard a noise came from R2’s room. The certified nurse assistance went to her room first to check on the resident. I was called to R2’s room I saw R2 on the floor lying on her left side. R2 said she was okay, and after assessing her she was placed into her wheelchair noted with her left side of face was discolored dark. R2 requires constant supervision. Through the night shift the Certified Nurse Assistant sits in a chair outside R2’s room to provide one to one monitoring. R2 pulled the call light, but before someone was able to answer her call light, she tried to transfer herself. This happens all the time. I saw her last around 6:00 AM, she was resting in bed. The first shift nurse took over and notified the physician, family, and administration. “ On 7/17/25 at 2:00PM, V15 [Registered Nurse] stated, “I was R2’s nurse on 6/3/25, working first shift. I was at the nursing station waiting to get nurse report. Certified Nurse Assistant came and said R2 was on the	S9999		

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S9999	Continued from page 4 floor. Everyone ran into R2's room. R2 was lying on the floor with a bruise to her left side of her face. R2 said she was okay. R2 vital signs were with in normal range, and I started neuro checks. R2's physician gave an order to send R2, to the emergency department. Later, the hospital called and said R2 had a left eye orbital fracture. I notified the administration. R2 needs frequent supervision and monitoring. When R2 places on the call light, you have to answer call light immediately or R2 will try to take herself to the bathroom and fall." On 7/16/25 at 11:00 AM, V2 [Director of Nursing/ Fall Coordinator] stated, "I been working here since 1/16/25 as the Director of Nursing and Fall Coordinator. On 6/3/25, during shift change, staff heard a noise, went to R2's room and observed her laying on the floor and noted with left side facial discoloration. R2 was sent to the emergency department and R2 was diagnosis with a left orbital eye fracture. R2 had a total of five falls with two falls resulted in an arm fracture and then a left orbital eye fracture. R2 needs supervision, close monitoring, practically one to one supervision. The facility is not able to provide R2 with a one-to-one sitter all the time. R2's fall interventions should be patient centered for each fall to assisted in preventing another fall. On 7/18/25 at 11:00AM, V18 [Physician] stated, "R2 is very confused with left sided weakness and need close supervision. R2 has anxiety and needed antianxiety medication. R2's power of attorney refused for R2 to take antianxiety medication. During the examination of R2, it takes two staff members to assist me, because R2 is always trying to get up. R2 had an arm fracture from a fall, and recently a left eye orbital fracture. The falls were avoidable, if R2's power of attorney would have allowed R2 to take antianxiety medication to help her." Policy documents in part: Falls and Fall Prevention: To ensure a fall prevention program will include measures which will determine the individual need of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices as indicated based on assessment. Resident will be reassessed quarterly and after each fall.	S9999		

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S9999	Continued from page 5 Immediate change in intervention that were successful. Documentation as indicated. Resident fall risk intervention will be identified on the care plan. The frequency of safety monitoring will be determined by the resident's risk factors and care plan. Resident care plan intervention will be as indicated. IDT [Team] to discuss post incident/accident and or fall incident to ensure prevention from reoccurring. "B"	S9999		