STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145806	A. BUILDING _____ B. WING _____	12/19/2012

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) COMPLETION DATE
F 500	Continued From page 24 reach an agreement. E1 stated that he attempted to obtain a written agreement with the outpatient dialysis center, but agreement had not yet be reached on the language of the agreement.	F 500		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1230a) Section 300.1230 Staffing a) Staffing shall be based on the needs of the residents, and shall be determined by figuring the number of hours of nursing time each resident needs on each shift of the day. This determination shall be made separately for both licensed and non licensed personnel. This regulation was not met as evidenced by the following: Based on observation, record review and interview the facility failed to meet the required staffing requirements. Findings include: Upon entry in the facility on December 16, 2012, at 9:05 a.m., E20 (Marketing Director) stated that she was the supervisor for the day and there were two nurses in the building. During the entrance conference on December 16, 2012 at 9:30 a.m. with E1 (Administrator), a copy of the staffing schedule for 2 weeks was requested.	F9999		

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F9999	Continued From page 25	F9999		

During the initial tour of the facility on the first floor at 9:45 a.m., E5 (Licensed Practical Nurse) was asked about the nursing staff on the floor. E5 stated that there was only one nurse assigned on the first floor and that she was the nurse on duty for 7-3 shift. E5 was the only nurse observed working on the first floor.

During the initial tour of the facility on the second floor at 9:50 a.m, E6 (Licensed Practical Nurse) was asked about the nursing staff on the second floor. E6 also stated that there was only one nurse assigned on the second floor and she was the nurse on duty for 7-3 shift. E6 was the only nurse observed working on the second floor.

During the initial tour of the facility on the third floor at 9:40 a.m., there was no nurse on the floor. E6 stated that the residents on the third floor come down to the second floor to get their medications.

The facility provided the survey team with documentation of the last 2 weeks census including breakdown of residents receiving skilled and non-skilled care.

Staffing schedule for the same last 2 weeks were reviewed. Based on the calculations for staffing requirements for 2012, the facility did not meet such requirements. According to the calculations, the facility has an average of 6 residents that are receiving skilled care and 110 residents receiving intermediate care. The number of Registered Nurse required would be 1 Registered Nurse(RN) for every shift. The facility did not have an RN scheduled on December 16, 2012. The facility also did not have an RN

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F9999	Continued From page 26 scheduled on all the Sundays during the 7-3 shift on November 18 and 25 of 2012, or December 2, 9,16, of 2012 on the nursing staff schedule presented to the survey team. (B) 300.1210d)6) 300.3240a) 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not met as evidenced by the following: Based on observation, record review and	F9999		

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F9999	Continued From page 27 interview the facility failed to safely turn and maintain correct position of siderail for 1 resident (R3) out of 5 residents reviewed for falls in a sample of 24. This failure resulted in R3 sliding from the bed while receiving care, sustaining fractured femur. The facility also failed to ensure that resident environment remains free of hazards and that residents receive adequate supervision for 11 residents (R4, R5, R6, R7, R8, R11, R12, R15, R18, R19, R20) in a sample of 24 and 7 residents (R25, R26, R27, R30 to R33) in the supplemental sample reviewed for accidents. Findings include: 1. An incident report dated 9/7/12 at 2:45 PM indicated R3 slid from bed and sustained a laceration to his right eyebrow. R3 was transported to the hospital for evaluation. Per Nurses Notes dated 9/8/12 at 4:00 AM, R3 received one suture and was returned to the facility. An Addendum to the incident report and Nurse's Notes dated 9/8/12 at 2:00 PM indicate the facility was notified that x-rays taken at the hospital on 9/7/12 reveal a right femoral fracture. R3 was transported back to the hospital for treatment of the fracture on 9/8/12 and returned to the facility 9/13/12. The Fall Risk Assessment Tool for R3 completed 9/3/12 indicates a score of 14 and no use of side rails. A risk score of 14 or greater indicates risk for falls. On 12/6/12, the risk score was 17. No notation was made regarding use of side rails. A Care Plan dated 9/11/12 regarding fall risk reads "Keep call light within [R3's] reach at all times." A Care Plan dated 9/13/12 regarding risk for fracture reads "Resident slid from bed to floor during ADL care." On 12/18/12 at 9:20 AM, R3 told state surveyor	F9999		

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F9999	Continued From page 28	F9999		

and the ambulance emergency medical technicians that staff "forgot to put the rails up. She was in such a hurry she didn't put up the rail before turning me."
On 12/18/12, the facility presented a new care plan dated 12/17/12 addressing Rolling to the Side that reads "Make sure call light is attached to right or left side as preferred by the Resident, where he can reach it with his left hand." A physician's order dated 12/17/12 reads "Resident to have both cephalad half rails on for mobility, positioning."
On 12/18/12 at 9:05 AM, E2 (Director of Nursing) was performing wound care with a CNA positioned on R3's left side of bed and E2 on the right side of the bed. Both upper side rails were down. Upon completion of the dressing change at 9:15 AM, both staff left the room without raising the side rails. The call light was not in reach. E2 had stated the CNA and nurse would return to help transfer R3 to a stretcher for transport to a medical appointment. R3 stated he can't reach the call light with the rails down and that staff don't know what they are doing. "One day they're up, then they're down." Staff returned at 9:20 AM.
On 12/19/12 at 9:15 AM, R3 was sleeping in bed with both upper half rails elevated.
On 12/19/12 at 2:45 PM, R3 was observed in bed with both side rails lowered and the call light cord clipped to the upper corner of the bed sheet, above R3's right shoulder. R3 stated he was in pain and wanted medication. R3 could not locate or reach the call light and was assisted by his roommate to turn on the call light. A CNA entered to ask R3 what was needed and reattached the call light cord to the middle of the mattress length along the right side of the bed.

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F9999	Continued From page 29 The side rails remained down. On 12/19/12 at 2:50 PM, R3 stated he was told the facility could not keep the side rails up "because of the law", but R3 stated he would like the half railings up to reach his call light, help him adjust slightly in bed and as a sense of security, since he previously fell from bed. Cognitive assessment for R3 on the Minimum Data Set listed his scores as 15 out of 15 on 5/11/12 and 14/15 on 11/2/12, indicating normal/good cognition and recall. (B)	F9999		