STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510512	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF LAKEVIEW	3535 NORTH ASHLAND AVENUE CHICAGO, IL 60657

(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
A 000	Initial Comment Complaint Investigation: IL 176890/ 2486575- Unsubstantiated IL 177758/ 2487212- Unsubstantiated Entity Reported Incident: IL 180410- Substantiated	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development.	A4010		

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A4010	Continued From page 1 d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). f) Based on the physician's assessment, the service plan may provide for the disconnection or removal of any kitchen appliance. (Section 15 of the Act) g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; B) dietary needs, if the establishment provides therapeutic diets; and C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; 4) Any risk being negotiated; and 5) Whether the resident requires medication	A4010		

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A4010	Continued From page 2 reminders, supervision of self-administered medication, or medication administration. h) The service plan shall include all support services provided or arranged for by the establishment. i) Nothing in this Part limits a resident's ability to direct his or her own care and negotiate the terms of his or her own care. Residents have the right to refuse certain services or approaches that would otherwise be recommended based on the physician's assessment if the resident has received clear information regarding the risks and benefits of such a choice and the choice does not put other residents or staff at risk. Disclosure of the risks of refusing services or approaches must be documented in the service plan. These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to update service plan to include fall interventions to mitigate fall for one (R1) resident who was a high risk for fall and has history of falls with injury. This deficient practice has the potential to affect all residents. Findings include: R1 is 87 years old. R1's diagnoses include but not limited to Dementia, Hyperlipidemia and Hypertension. R1's Fall Risk Assessment score dated 10/3/24 was 11 indicating-High Risk. At the time of survey, R1 was not in the establishment. R1 was sent to the hospital on 10/25/24. R1's progress notes and Incident Report forms were reviewed. There were 3 episodes of fall incidents with injuries documented:	A4010		

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A4010	Continued From page 3 8/23/24 11:56PM: Resident had an unwitnessed fall on 8/23/24 at 9:45pm... saw resident in sitting position by his dresser...Per CP (Care Partner) he found resident lying on the floor ...Abrasion noted to resident back 2cm, left shoulder abrasion also noted...both abrasions bleeding. Small bump noted to the top of his head toward left side ... R1's Incident Report Forms: 9/29/24 1925pm: Observed outside room in hallway. with laceration to right eyebrow and left hand skin tear. resident stated he tripped over his own feet Unable to provide further details. Injury: Right eyebrow, left hand, Right Zygomatic Arch Fracture. Final Outcome: Resident found to have Zygomatic Fracture and Hyponatremia. 10/28/24 6:57AM: Resident had a fall in his room when getting up to go to the bathroom. CP heard the fall and responded .... Resident hit his head and has bump on head 911 called.... Further documentation on R1's progress notes indicated; CT scan result showed brain bleed. 10/31/24 progress notes stated, per hospital nurse: "Subdural hematoma is subacute and NOT related to fall on 10/28/24. Writer spoke with (Z2-Son) who confirms bleed is not acute and not in any way related to incident." On 11/19/24 at 1:09pm, E6 (Licensed Practical Nurse), nurse on duty at the time of incident said, R1 walk independently. A week before the fall, Physical Therapy recommended the use of cane, but due to Dementia, R1 was hardly compliant. On 11/20/24 at 10:26am, E10 (Care Partner) staff who found R1 on the floor said, she did not witness R's fall. E10 said it was change of shift. R1 told E10 he was going to the bathroom. E10 described R1's gait as "a little bit wobbly". E10	A4010		

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A4010	Continued From page 4 said R1 was given walker about a month after the fall, but R1 was non-compliant. On 11/19/24 at 10:30am, Z2 (Son) said, prior to the fall on 10/28/24, Z2 took R1 out to get some fresh air, upon return R1 needed wheelchair. Z2 was also informed by staff that "something was wrong with (R1)", the next day Z2 was informed R1 had a fall. Z2 said, R1 was diagnosed of (subdural) hematoma, attributed to the fall on 9/29/24 impacting his balance. On 11/19/24 at 2:10pm, E2 (Health and Wellness Director), said the fall on 9/29/24 was due to Hyponatremia. E2 said the interventions in place was documented on a separate form, this for titled "Fall Tracker" was provided for review. It indicated the intervention for this fall was to monitor Sodium, increased NaCl (Sodium Chloride) to 1g (twice a day), PT/OT eval. E2 indicated that there was a delay in the Physical Therapy consult due to R1's insurance issue and not due to referral. R1 was unable to use in house PT. E2 also said about the brain bleed identified post 10/28/24 fall, the brain bleed was not a direct result of that fall but it is reasonable to believe it could have happened on 9/29/24 fall, however the CT scan at that time was negative for brain bleed. E2 said, service plan is updated when there is a change in condition, fall ... On 11/19/24 at 12:43pm, Z6 (Care Manager). "I observed the resident (R1) grossly unbalanced ..." Physical Therapy was consulted for R1. R1's Physical Therapy Discharge notes dated 10/1/24 stated; Functional Status at Discharge: Patient requiring standby assist with sit and	A4010		

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A4010	Continued From page 5 transfers from bed, chair, toilet. Contact guard assist needed ambulating without device for functional distances within facility. Post Discharge Instructions: fall precautions. This assessment was signed by Z4 (Physical Therapy). On 11/20/24 at 10:11am, Z4 said at the time of assessment, R1's gait was unsteady. "He could benefit from using a walker." Z4 acknowledged that fall precautions needs to be in place. Additional PT Evaluation dated 10/18/24 signed out by Z5 (Physical Therapy) stated Gait unsteady without A/D, Walking with HHA x1 person ...patient tendency to hold on to railing and furniture, needs ST cane for safety at this time. R1's Service plan (Assessment -V3- Tiers) dated 7/17/24 was reviewed. Fall Risk: Low score <5. Ambulation and Transfer Assistance was not needed. Despite changes in gait/mobility, transfer requirements as assesed by Physical Therapy, observed changes in gait, history of fall, high fall risk assesment, R1's service plan remained unchanged. Establishment's Service Plan/Agreement Policy and procedure stated in part; Policy: A service plan/agreement will be developed for each resident prior o move-in, with a change in resident needs and the at least 6 months. The service plan/agreement is developed to include services for medical/physical/ functional needs as identified during the assessment process.	A4010		

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A4010	Continued From page 6 Procedures: 3. Service plan/agreement should provide guidance on all services to be provided, the frequency, the amount of assistance needed, and by whom. The service plan was not updated to include fall interventions and reflect PT assessments.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment; 3) The right to retain and use personal property, unless such use infringes on the health, safety, or welfare of other individuals, and a place to store personal items that is locked and secure; 4) The right to designate any individual to	A6000		

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A6000	Continued From page 7 participate with the resident or in the resident's name in the development of the written service plan; 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; 6) The right to direct his or her own care and negotiate the terms of his or her own care; 7) The right to refuse services unless such services are court ordered or the health, safety, or welfare of other individuals is endangered by the refusal, and to be advised of the consequences of that refusal; 8) The right to exercise free choice in selected activities, schedules, and daily routine; 9) The right to exercise free choice in selecting a primary care provider, pharmacy, home health provider, or other service provider and to assume responsibility for any additional costs incurred as a result of such choices. However, an establishment may specify how medications are packaged by a pharmacy if the resident receives administration of medication; 10) The right to request to relocate or refuse to relocate within the facility based upon the resident's needs, desires, and availability of such options; 11) The right to the free exercise of religion and to participate or refuse to participate in religious, social, recreational, rehabilitative, political or community activities;	A6000		

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A6000	Continued From page 8 12) The right to be free of chemical and physical restraints; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; 14) The right to confidentiality of the resident's medical, financial, or other records. The release of a record shall be by written consent of the resident or the resident's representative and shall specify the circumstances under which each individual record may be released, except as specified by law; 15) The right to privacy in financial and personal affairs; 16) The right of access and the right to review and copy the resident's personal files maintained by the establishment, during normal business hours or at a time agreed upon by the resident and the establishment; 17) The right to privacy with regard to mail, phone calls, and visitors; 18) The right to uncensored access to the State Ombudsman or his or her designee, and the right to refuse access to a State Ombudsman or Department reviewer; 19) The right to be free of retaliation for or constraint from criticizing the establishment or making complaints to appropriate agencies or any agency or individual; 20) The right to 24 hour access to the establishment and all common areas of the establishment;	A6000		

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A6000	Continued From page 9 21) The right to a minimum of 30-day notice of any change in a fee or charge or the availability of a service; 22) The right to a minimum of 90-day notice of a planned establishment closure; 23) The right to a minimum of 30-day notice of an involuntary residency termination, except where the resident poses a threat to himself or others, or in other emergency situations, and the right to appeal such termination; 24) The right to a 30-day notice of delinquency and at least 15 days right to cure delinquency. (Section 95 of the Act) b) Nothing in this Part is meant to limit a resident's right to choose his or her health care provider. (Section 75(h) of the Act) These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to ensure fall interventions are in place to mitigate fall for one resident (R1) who was assessed as high fall risk and has history of fall with injury. Findings include: R1 is 87 years old. R1's diagnoses include but not limited to Dementia, Hyperlipidemia and Hypertension. R1's Fall Risk Assessment score dated 10/3/24 was 11 indicating-High Risk. At the time of survey, R1 was not in the establishment, R1 was sent to the hospital on 10/28/24. R1's progress notes and Incident Report forms	A6000		

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A6000	Continued From page 10	A6000		

were reviewed. There were 3 episodes of fall incidents with injuries documented:
8/23/24 11:56pm: Resident had an unwitnessed fall on 8/23/24 at 9:45pm. Per CP (Care Partner) he found resident lying on the floor ...Abrasion noted to resident back 2cm, left shoulder abrasion also noted...both abrasions bleeding. Small bump noted to the top of his head toward left side ...

R1's Incident Report Forms:
9/29/24 1925pm: Observed outside room in hallway. with laceration to right eyebrow and left hand skin tear. resident stated he tripped over his own feet Unable to provide further details. Injury: Right eyebrow, left hand, Right Zygomatic Arch Fracture.

10/28/24 6:57am: Resident had a fall in his room when getting up to go to the bathroom. CP heard the fall and responded .... Resident hit his head and has bump on head 911 called....
Further documentation on R1's progress notes indicated; CT scan result showed brain bleed. 10/31/24 progress notes stated, per hospital nurse: "Subdural hematoma is subacute and NOT related to fall on 10/28/24. Writer spoke with (Z2- Son) who confirms bleed is not acute and not in any way related to incident."

On 11/19/24 at 1:09pm, E6 (Licensed Practical Nurse), nurse on duty at the time of incident said, R1 walk independently. A week before the fall, Physical Therapy recommended the use of cane, but due to Dementia, R1 was hardly compliant.

On 11/20/24 at 10:26am, E10 (Care Partner) staff who found R1 on the floor said, she did not witness R1's fall. R1 told E10 he was going to the bathroom. E10 described R1's gait as "a little bit

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A6000	Continued From page 11	A6000		

wobbly". E10 said R1 was given walker about a month after the fall, but R1 was non-compliant.

On 11/19/24 at 10:30am, Z2 (Son) said, prior to the fall on 10/28/24, Z2 took R1 out to get some fresh air, upon return R1 needed wheelchair. Z2 was also informed by staff that "something was wrong with (R1)", the next day Z2 was informed R1 had a fall. Z2 said, R1 was diagnosed of (subdural) hematoma, attributed to the fall on 9/29/24 impacting his balance.

On 11/19/24 at 2:10pm, E2 (Health and Wellness Director) said about the brain bleed identified post 10/28/24 fall, the brain bleed was not a direct result of that fall but it is reasonable to believe it could have happened on 9/29/24 fall, however the CT scan at that time was negative for brain bleed. E2 said, service plan is updated when there is a change in condition, fall ...

On 11/19/24 at 12:43pm, Z6 (Care Manager). "I observed the resident (R1) grossly unbalanced ..."

Physical Therapy notes was reviewed. Notes indicated the following:
R1's Physical Therapy Discharge notes dated 10/1/24 stated;
Functional Status at Discharge: Patient requiring standby assist with sit and transfers from bed, chair, toilet. Contact guard assist needed ambulating without device for functional distances within facility. Post Discharge Instructions: fall precautions.
This assessment was signed by Z4 (Physical Therapy).
On 11/20/24 at 10:11am, Z4 said at the time of assessment, R1's gait was unsteady. "He could benefit from using a walker." Z4 acknowledged

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A6000	Continued From page 12 that fall precautions needs to be in place. Additional PT Evaluation dated 10/18/24 signed out by Z5 (Physical Therapy) stated; "Gait unsteady without A/D, Walking with HHA x1 person ...patient tendency to hold on to railing and furniture, needs ST cane for safety at this time." Despite changes in gait/mobility, transfer requirements as assesed by Physical Therapy, observed changes in gait, history of fall with injury, high fall risk assesment, R1's service plan remained unchanged. R1's Service plan (Assessment -V3- Tiers) dated 7/17/24 was reviewed. Fall Risk: Low score <5. Ambulation and Transfer Assistance was not needed. No interventions for the change mobility function and R1's non compliance to the use of assistive device. After the fall on 10/28/24, R1 has not been back to the facility (as of 11/19/24).	A6000		