STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004550	A. BUILDING: _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF PALOS PARK	12220 SOUTH WILL COOK ROAD PALOS PARK, IL 60464

(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 Survey: 2397257/IL163732	S 000		
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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. These Requirements were not met as evidenced by: Based on interviews and records reviewed the facility failed to have an effective plan to monitor/supervise resident identified to be high risk for falls This affected one of three residents (R1) reviewed for falls and fall prevention. This failure resulted in R1 falling from bed and sustaining a non-displaced transverse fractures demonstrated on the right side at the C6 and C7 levels. Findings include: R1 has diagnosis including but not limited to Displaced Fracture of Seventh Cervical Vertebra, Difficulty in Walking, Fracture of Neck, Dysphagia, Cerebral Infarction, Hypertension, Dementia, and Depression. R1's cognitive assessment dated 7/5/23 indicates R1 is severely impaired. R1's bowel and bladder assessment dated 7/5/23 states R1 is always incontinent of urine. R1's functional status states she requires extensive assistance with bed mobility, dressing, and personal hygiene. R1 is	S9999		

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S9999	Continued From page 2 total dependent on staff for toileting assistance. R1 was initially admitted to the facility on 7/1/23. On 9/5/23 at 1:26PM V3, Certified Nursing Assistant (CNA), said I kind of know who is at risk for falls from working here. On 9/6/23 at 5:19PM V15, Nurse, said I don't remember R1. The surveyor read off portions of the admission document to V15. V15 could not remember R1 specifically. V15 said we used to use leaves for all risk people, but no longer. V15 said if we get an admission in the evening, often times we don't know about it ahead of time, and we are hunting for floor mats and other equipment needed. V15 said CNAs are verbally told who is a fall risk. V15 said the night nurse would be responsible to notify the night CNA, because second shift ends before the night shift arrives. On 9/6/23 at 10:52AM V5, Restorative Nurse, said I was on vacation from 7/3-7/11/23. V5 said I assess a patient for abilities I document on the form or progress note. V5 said I don't have any documentation prior to 7/5/23 for R1's transfer status. On 9/6/23 at 4:34PM V13, CNA, said on 7/4/23 the nurse called me to get R1 up, I was not the first to see R1 on the floor. V13 said the nurse called me while I was in another room. V13 said the nurse, another aid, and I got R1 off the floor using the mechanical lift. V13 said I had not changed R1, yet. V13 said no one gave me report when I started my shift. V13 said I knew she was a new patient, but I didn't know she was a fall risk. V13 said if I had known R1 was a fall risk, I would have checked R1 often. V13 said R1 is incontinent of bowel and bladder. V13 said I don't	S9999		

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S9999	Continued From page 3 know if the new company uses a fall program. On 9/6/23 at 4:48PM V14, CNA, said we know who is a fall risk from working there and people talking. V14 said we do not always get report from the nurses at the start of a shift. V14 said it is possible a new admission comes in and no one tells us about them. On 9/6/23 at 10:04AM V2, LPN, said the Aid reported R1 was on the floor along the bed. When I entered the room, I saw R1 along the side of the bed on the floor. V2 said R1 said she was trying to get up out of bed. V2 said R1 had just been admitted. V2 said I had not worked with R1 and I was not aware of her behaviors. Report was that she was alert and oriented x 2-3, able to make her needs known, and she was long term. V2 said R1 had some confusion, dementia and behaviors. V2 said R1's bed was lower, I can't recall how low. V2 said R1's bed did not go to the floor it was not on the floor. On 9/6/23 at 1:30PM V12, Wound Nurse, said the day R1 fell one of her feet might have been hanging from the bed. V12 said R1 was not able to turn side to side when she first came in. On 9/6/23 at 1:23PM V17, Former DON, said she investigated R1's fall on 7/4/23. V17 said R1 was trying to reposition herself in the bed. V17 said R1 had progression in dementia and her poor safety awareness was the root cause of the fall. V17 said R1 had only been at the facility for a few days. V17 said I am not sure if R1 had a fall prior to 7/4/23. Review of 7/2/23 Physical Therapy evaluation documents impaired strength to legs.	S9999		

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S9999	Continued From page 4 Incident report reviewed, report has no root cause documented and none in the progress notes. R1's Admission Clinical Evaluation dated 7/1/23 includes Risk Alerts Falls. Fall risk assessment dated 7/1/23 states R1 is unable to independently come to standing position and has decreased muscle coordination and a final score of 14. R1's care plan initiated on 7/1/23 states R1 is at high risk for falls. Progress Notes dated 7/4/23 at 11:55PM state R1 had an unwitnessed fall. Progress notes dated 7/5/23 document at 9:00AM the family requested R1 be sent to the hospital for evaluation. R1's CT Cervical Spine dated 7/5/23 reads Findings: Probably non-displaced transverse fractures demonstrated on the right side at the C6 and C7 levels. R1's hospital History and Physical dated 7/5/23 states closed fracture of C6 and C7. Suspected to be due to trauma from fall. The facility Fall Prevention and Management policy dated 1/2023 states the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. A score of 10 or greater indicates a high risk (B)	S9999		