STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012611	A. BUILDING: _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF HOMEWOOD	940 MAPLE AVENUE HOMEWOOD, IL 60430

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S 000	Initial Comments Complaint Investigation: #2490582/IL169002 Facility Reported Incidents of: 1/03/2024/IL168486 1/03/2024/IL169277	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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	S9999		

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S9999	Continued From page 1 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. 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to have effective fall interventions in place for a resident assessed to be at risk for falls and failed to provide two staff assist when providing assistance with Activities of Daily Living (ADL) per the resident's plan of care. This failure applied to one (R3) of three residents reviewed for falls and resulted in R3 sustaining a fall while being provided with care from one staff and resulted in R3 being transferred to the hospital and diagnosed with a subdural hematoma measuring 2mm. R3 subsequently returned to the facility with a neck collar and gastrostomy feeding tube (G-Tube).	S9999		

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S9999	Continued From page 2 Findings include: R3 is an 88-year-old female who has resided at the facility since 2022, with past medical history including, but not limited to Chronic obstructive pulmonary disease, dementia, heart failure, hypertension, hypothyroidism, etc. Fall risk assessment dated 3/29/2023 and 4/22/2023 score R3 as a 13, indicating that resident is at risk for falls. Facility minimum data set (MDS) assessment dated 8/3/2023 section C (Cognitive) documented a BIMS score of 7 for R3, section G (functional) of the same assessment coded R3 as requiring extensive assistance with two-person physical assist for all ADLs. Fall care plan initiated 1/29/2022 states the following: Resident is a high fall risk due to decreased mobility and strength, potential medication side effects, history of falls, etc. Interventions include: encourage to transfer and change positions slowly, provide assist to transfer and ambulate as needed, provide two persons assist during bed turning for hygiene, Bed in low position, etc. Progress note dated 1/3/2024, documented by V21 (LPN) states: Certified Nurse Assistant (CNA) informed writer that resident rolled out of bed while lying on right side during care. Resident was reaching toward dresser then stated I'm falling CNA could not catch her. Upon assessment writer noticed raised area to top of head on left side. Hospital record dated 1/3/2024 states in part, 88-year-old female with history of COPD,	S9999		

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S9999	Continued From page 3 Dementia, history of heart failure... Presenting to hospital after falling out of bed in her nursing home. Patient was found to be more altered, and CT of the head was notable for a small traumatic subdural hematoma measuring 2mm. On 1/19/2024, V16 (RN) documented the following: Readmitted 88-year-old... from hospital via ambulance and two paramedics, resident arrived wearing a cervical collar that must remain in place for 6 to 8 weeks, g-tube placed 01/17, resident is NPO. On 2/29/2024 at 2:45PM, V16 (RN) said that R3 was a very sweet lady, she was bedridden but makes her needs known to staff, she will always ask staff to open her candy and place them on her bedside table, R3 cannot reach further than her bedside table, she cannot reach her drawer, always ask staff to get the candy from her drawer and open them. Prior to the fall R3 does not move and was dependent on staff for ADLs, staff always need assistance to turn and hold her, will say that R3 requires 2-person assistance for ADLs to be on the safe side. R3 came back from the hospital with a G-Tube, a cervical collar and was not doing good, just went downhill. On 2/29/2023 at 1:43PM, V13 (LPN) said that she recalls R3, she was alert and oriented x2, incontinent of bowl & bladder, and non-ambulatory. Resident did not have a G-Tube before the fall, she cannot do much for herself, staff must feed her, resident cannot use her hands and cannot reach to her drawer to get anything. V13 said she would use 2-person assist with R3 for ADLs due to her weight, it depends on the CNA but most of them ask for help. On 2/29/2024 at 1:55PM, V14 (Restorative CNA)	S9999		

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S9999	Continued From page 4	S9999		

said that R3 requires mechanical lift for transfers, she does not get out of bed, she needed 2 people to help her turn, V14 came to work after the resident was sent out to the hospital after she fell. V14 has done range of motion exercises with resident, she came back from the hospital with a neck brace and a G-tube. V14 stated that R3 requires two people to turn her, and she has assisted other CNAs in providing ADL care to R3. R3 did not have any floor mat prior to her fall.

On 3/4/2024 at 11:55AM, V19 (LPN/Restorative) said that she oversees fall care plans, the initial fall assessment is done upon admission, quarterly and when there is a fall. R3 requires extensive assistance with ADLs, she was a high fall risk and had interventions like low bed, resident does not have a floor mat before the fall, and there were no additional interventions after the fall.

On 3/4/2024 at 4:13PM, V22 (LPN) said that R3 was alert x 1 to 2, she can tell you what she wants and can refuse some stuff sometimes. V22 was not present but was told that staff rolled resident away from her, resident started to reach to her drawer for candy and staff could not pull her back. V22 stated that she in-serviced the CNA about compliance to resident's care plan. R3 was a two-person assist at that time as indicated in her care plan. CNA stated that she was not aware, but resident's level of care is also listed in the Kardex patient information sheet that is available to the CNAs and it is their responsibility to know the type of care a resident requires.

On 3/4/2024 at 3:24PM, V21 (LPN) said that she recalls R3, she was a total care. V21 is not sure if R3 is a fall risk, resident returned from the hospital with a G-tube after the fall, R3 does not

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S9999	Continued From page 5 get out of bed and did not have any interventions before the fall, resident did not have a floor mat before the fall. On 3/4/2024 at 1:58PM, V20 (CNA) said that she recalls R3, she was a total care, incontinent of bowel and bladder and she has always taken care of her by herself, never called anyone to assist her with the resident. V20 said that she was taking care of R3 the day she fell, she was in the middle of changing resident when she started asking for a candy that the family brings for her. V20 said she had gloves on and told resident to wait for her to finish, resident started reaching to her drawer for the candy and V20 could not reach her to pull her back on the bed. V20 said that she was told that R3 was a two person assist and that it was in her care plan but at the time she was not aware of that. V20 stated that she was in-serviced after the fall on getting another staff for assistance and resident fall risk. On 3/5/2024 at 12:53PM, V26 (Attending Physician) said that R3 came back from the hospital with a G-tube and cervical collar, resident was alert to self prior to the fall and denies pain, compliant with medications and dependent on staff for ADLs. V26 was asked if R3 declined after the fall and he said, "definitely, with a cervical collar and subdural hematoma, resident declined." Fall prevention and management policy revised 1/2024 states in general that the facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan preventive strategies, and facilitate as safe an environment as possible. All	S9999		

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S9999	Continued From page 6 resident falls shall be reviewed, and the resident's existing care plan shall be evaluated and modified as needed. Under guidelines, the policy states in part: 1. A fall risk evaluation will be completed on admission, readmission, and quarterly, significant change and after each fall. 2. Residents at risk for falls will have fall risks identified on the interim plan of care with interventions implemented to minimize fall risk. (A)	S9999		