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 _____	05/17/2024

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ALIYA OF PALOS PARK	12220 SOUTH WILL COOK ROAD PALOS PARK, IL 60464

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S 000	Initial Comments Annual Certification and Licensure Survey Facility Reported Incidents: FRI of 4/6/2024/IL172107- F776 FRI of 4/6/2024/IL171786- F776 FRI of 3/19/2024/IL171563- F689 FRI of 3/31/2024/IL171566- F689 FRI of 3/31/2024/IL171785- F689 Complaint Investigations: 2493038/IL172045 - F689	S 000		
S9999	Final Observations Statement of Licensure Findings 1 of 3 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	S9999		

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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 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 interview and record review, the facility failed to supervise one resident while sitting in the dining room unattended who was identified as a high fall risk and has a diagnosis of Dementia, syncope, and a history of falls. This failure resulted in R401 having an unwitnessed fall from her wheelchair sustaining a left hip fracture. The facility also failed to utilize a leg rest during a transport for a wheelchair bound resident. This failure resulted in R61 having a fall from the wheelchair sustaining a right forehead hematoma. These failures affected two of three residents reviewed for falls in a total sample of 26.

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Findings Include:
R401 was diagnosed with Dementia, Syncope and Collapse. Minimal data set Section GG (functional abilities and goals) dated 3/31/24 documents: R401 required partial/moderate assistance for sit to stand (the ability to come to a standing position from sitting in a chair. Helper lifts, holds or support trunk or limbs but provides less than half the effort). Comprehensive restorative assessment dated 3/28/24 documents: History of falls in the past 1-6 months, S/P Fall and/or Fracture in past 6 months. Fall Risk Scoring: Add up the numbers of the responses above twenty-two. Fall risk scoring: ten or above: high fall risk.

On 5/14/24 at 1:01PM, V4 (restorative nurse) said R401 had an unwitnessed fall. V22 (CNA) saw R401 on the floor. No staff was in the dining room when R401 fell. Staff should have been in the dining room monitoring R401.

On 5/15/ 24 at 12:51PM, V22 (cna) said she saw R401 on the floor after a resident mentioned R401 had fallen. V22 said R401 used a rollator walker to assist with ambulation. V22 said she saw R401's walker unlocked after the fall. V22 said at the time of R401's fall no staff was in the dining room. Staff was moving residents from the dining room to the television room. V22 said no staff was monitoring R401 when R401 fell.

Nursing note dated 03/31/24 documents: V47 (nurse) was called to the dining room by a CNA at 1:15pm stating resident fell on the floor and was laying on her left side. Fall was unwitnessed. R401 observed laying on the floor on her left side. When asked what occurred R401 stated in broken English, stood up, lost balance. R401

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complained and was rubbing area of left hip/leg stating it hurts. R401 was assisted onto her rollator walker with staff assist. POA was called to try to translate R401's pain and what occurred. R401 with Dementia diagnosis. M.D called and order was obtained to send to emergency room (ER) for evaluation. POA (power of attorney) requested call 911. 911 called, Paramedics arrived and transferred R401 to a stretcher and departed facility at 1:50 PM to Hospital per POA request for evaluation.

Care Plan Initiated on 03/28/2024 documents: R401 is at high or increased risk for falls, R401 is at risk for injury from falls related to diagnosis of Dementia, Syncope, decreased physical mobility, generalized weakness, and history of falls. R401 is positive for recent and frequent falls at home.

Hospital record dated 03/31/24 documents: Patient (R401) presented to emergency department via emergency medical service after fall out of wheelchair. R401 complained of left hip pain. Positive external rotation and shortening. X-ray dated 03/31/24 documents: Left Femur (hip) Findings: Comminuted intertrochanteric fracture of the proximal LEFT femur with displacement of the lesser trochanter fragment and medial angulation of the distal femur shaft.

Fall prevention and management policy dated 1/2024 documents: The facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all fall is not possible, the facility will identify and evaluate those resident at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible.

R61 was diagnosed with Dementia, Alzheimer's

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disease and Anxiety. Minimal data set section GG (functional abilities and goals) dated 01/05/24 documents: manual wheelchair. R61 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident complete activity. Assistance may be provided throughout the activity or intermittently. R61's care plan dated 3/12/24 documents: actual fall. Slid to front of wheelchair and slid out of chair. Intervention: staff to encourage R61 to sit back in wheelchair, assist to reposition as indicated.

On 5/14/24 at 1:01PM, V4 (restorative nurse) said, R61 was being transported in her wheelchair without leg rests. R61 was holding her feet up off the ground. R61 dropped her feet at some point. R61 had on anti-skid foot wear. R61's foot gripped on the floor leading to a fall forward out of the wheelchair. Residents who use wheelchairs for mobility should not be pushed without leg rests. Leg rests were available at the time of R61's fall.

On 5/14/23 at 3:37PM, V13 (cna) said, R61 was in a wheelchair. R61 asked him to push her to the dining room. V13 said, R61 did not have any leg/foot rest on her wheelchair. R61 usually self-propel. V13 said he pushed R61 and her right foot got stuck on the floor. V13 said R61 fell forward onto the floor landing on the right side of her body. V13 said at the time of the incident, R61 reported she hurt her right side and her back. R61 laid on the floor until the emergency medical technicians arrived.

Nursing note dated 03/19/24 documents: around 0745 CNA observed assisting resident (R61) to the dining room. Nurse observed resident (R61) leaning forward in the wheelchair and fell to the

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floor. R61 left in position, during assessment, R61 was observed with a small lump to the right side of her forehead. R61 complained on right arm pain. R61 was observed with swelling to right lower leg without shortening of extremity. 911 called.

Fall event dated 03/19/24 predisposing physiological factors documents: gait imbalance, impaired memory, decrease vision or hearing; predisposing situation factors: using wheelchair and leaning.

V13's witness statement dated: 03/19/24 documents: during breakfast resident (R61) asked CNA (V13) if he can push her to the dining room. While pushing R61 her foot got stuck to the floor causing R61 to fall forward.

In-service dated 03/19/24 topic of education: propelling residents without foot rest. Please report to nursing when residents ask for assistance propelling. Resident may need to be evaluated for the need of leg rest.

R61's kardex dated 3/19/24 documents: safety: staff education to only propel wheelchairs with footrest on them.

Facility reportable incident dated 3/20/24 documents: Patient name: R61, describe incident/accident: while being assisted to dining area resident fell forward from the wheelchair. She (R61) complained of pain to her right arm and leg.

Hospital record dated 3/19/24 documents: She (R61) leaned forward and fell out of her wheelchair. R61 has hematoma to right forehead.

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S9999	Continued From page 6 Fall prevention and management policy dated 1/2024 documents: The facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all fall is not possible, the facility will identify and evaluate those resident at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. (A) Statement of Licensure Violations 2 of 3 300.1210b) 300.1210d)2 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 shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. These Requirements were NOT MET as evidenced by:	S9999		

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S9999	Continued From page 7 Based on interview and record review, the facility failed to have a system to track requests for diagnostics services to ensure timely x-ray services are provided to residents. This failure resulted in R5 being transported to the hospital after waiting over 30 hours for x-ray service and being diagnosed with multiple rib fractures for one of one reviewed for diagnostic services in a total sample of 26. Findings include: R5 was admitted to the facility on 10/14/21 with a diagnosis of syncope, unsteadiness on feet, orthostatic hypotension, restless leg syndrome, unspecified dementia and anxiety disorder. R5's minimum data set dated 4/3/24 documents brief interview for mental status is 12/15 which indicates cognitively intact. On 5/14/24 at 3:10 PM, R5 who was alert and oriented to self, place and time at time of interview said he was in his room, was putting on a jacket when he lost his balance and fell backwards hitting his left side on the heating/air conditioning wall unit and windowsill. The next day he was having pain and told staff. R5 said he was having pain in his left side 9/10. R5 pain was worse with movement and it hurt when breathing in. R5 facility reportable dated 4/6/24 documents: R5 informed nurse on duty that he fell two days ago, but did not report it, but now has pain in his left arm and left side. R5 was noted with a scrape to left side of his back. Nurse on duty notified doctor and received order for chest x-ray. Power of attorney made request for resident to go to emergency room. R5 returned on 4/8/24 with multiple rib fractures.	S9999		

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R5's progress notes dated 4/6/24 at 12:32PM documents: Resident informed writer that he fell 2 days ago while putting on his shirt. Resident states that he didn't think it was a big deal, so he didn't tell anyone but now he is experiencing pain from his left shoulder to his abdomen. Upon assessment writer noted a scrape to left side of back. MD made aware. MD ordered chest x-ray.

R5's progress notes dated 4/7/24 at 11:57AM documents: Resident alert verbally responsive. Breathing even unlabored. Denies pain and discomfort at this time. Resident and daughter inquired about estimated time of arrival of X-ray service. Writer placed call to x-ray company, informed that technician is en route. Resident and family made aware of estimated time of arrival status. Will continue plan of care.

R5's progress notes dated 4/7/24 at 21:00PM documents: Per report AM nurse contacted x-ray company with estimated time of arrival and the company claimed they were en route. Resident's family concerned with timeliness of x-ray technician. Writer called x-ray services again and was unable to reach anyone. Per family's request resident sent out to local hospital.

On 5/14/24 at 3:46PM, V12 (Nurse) was assigned to R5 on day he reported fall. V12 said she called the doctor who ordered an x-ray. X-ray called in and requisition completed. X-ray usually comes within 24 hours. They said they would be there the next day. V12 said she put in report but was not assigned to R5 after that day.

On 5/15/24 at 12:03pm, V2(DON), said x-rays should be completed within 24 hours. If x-ray is not completed the doctor should be notified and any further orders followed.

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S9999	Continued From page 9 On 5/15/24 at 1257PM, V26 (Xray tech) said they received an x-ray order for R5 on 4/6/24 at 2:44PM and staff said the x-ray was to be done on 4/7/24. V26 said there was no other documentation from the facility that they called for follow up about x-ray. Technician arrived at 9:40PM on 4/7/24 but resident was already at the hospital. On 5/16/24 at 10:15AM , V32 (MD) I would expect an x-ray to be completed within 24 hours or be notified if not completed within 24 hours. I would not necessarily send the resident to hospital for pain because it's not an emergency and rib fractures are hard to see on x-rays. There really isn't much treatment. There can be pain with movement or breathing but I would not prescribe narcotics for pain. The x-ray is more of a legality, to show that fracture occurred at that time. On 5/17/24 at 10:12AM, V2(DON) said they track diagnostics services by when staff enter the order into electronic medical record under orders. Staff communicate through report when waiting for an x-ray to be conducted. Requested physician order and communication for R5's x-ray and no documentation received. R5's physician order sheets for April did not document any order for a chest xray. R5's hospital record dated 4/7/24 documents R5 arrived in emergency room at 21:54. At 22:36 Pain score of 8. Under history: R5 with mild dementia present to emergency room for evaluation of left sided back and shoulder pain. Patient states that approximately 2 days ago, he was reaching for his jacket in the middle of the	S9999		

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night, when he slipped and fell off the bed possibly striking a shelf near his bed. Patient was able to get himself up, and nursing noticed the injuries and recommended a chest x-ray that is yet to be done. Patient states that he has been noticing increasing pain with movement on the left side and standing and finally called 911 and was brought to the emergency room. Patient denies any headache, neck pain, low back pain, chest pain, shortness of breath, cough, fevers or chills, bowel or bladder changes. Patient feels some fullness along the left upper quadrant extending from his injury in the left lower thoracic area. Patient is unaware of the pain medicine they have been given at the nursing home but states it has been only mildly helping him. Under Xray results documents: Acute left lateral seventh and eighth rib fractures.

X-ray services facility in-service packet undated documents under ordering procedure: All non stat orders are performed same day, unless requested to be done another day. If the results cannot be provided same day as the procedure, you will receive them early the next day.

(A)

Statement of Licensure Violations 3 of 3

Section 300.615 e)
Section 300.615 f)

Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information

e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a

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resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)

f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.

This requirement was NOT MET as evidenced by:

Based on interview and record review, the facility failed to perform criminal history background checks within 24 hours of admission for one of five residents (R81) reviewed for criminal history background checks in a sample of 26 residents.

Findings include:
On 05/15/2024 at 10:50AM during record review, R81 was noted with an admission date of 03/14/2024 and a CHRIP was initiated on 03/19/2024. Illinois Sex Offender and Illinois Department of Corrections background check

On 05/15/2024 at 11:30AM during interview with V1(Administrator) and V5 (Admission) both stated background checks should be completed with 24 hours of a resident's admission.

Review of R81's Face Sheet indicated R81 was

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S9999	Continued From page 12 admitted in the facility on 03/14//2024. Facility policy dated 11/2022 Titled Pre-Admission Screening of Potential Residents-Illinois Only reads; The facility shall check the criminal background for any residents seeking admission to the facility to identify previous criminal conviction. The facility will: " Request a criminal background check within 24 hours after admission of a new resident ... " Check for the resident's name on the Illinois Sex Offender Registration Web site. www.isp.state.il.us " Check for the resident's name on the Illinois Department of Corrections sex registrant search page. www.idoc.state.il.us (C)	S9999		