STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006662	A. BUILDING: _____ B. WING _____	C 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA PLACE LIVING & REHAB	6300 NORTH CALIFORNIA AVENUE CHICAGO, IL 60659

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S 000	Initial Comments Investigation of Facility Reported Incidents of: 1/27/25/IL188522 3/4/25/IL188523	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 well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999		

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S9999	Continued From page 1	S9999		

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 were not met as evidenced by:

Based on interviews and record review, the facility failed to ensure the safety of one resident (R3) as two Certified Nurse Assistants prepared to transfer resident from chair to bed. This failure resulted in R3 falling and sustaining a laceration to the forehead requiring hospitalization and stitches.

Findings include:

R3 is 81 year old with diagnosis including but not limited to: history of falling, presence of artificial right hip joint, other osteoporosis and fracture of unspecified part of right femur.

During investigation on 3/24/25 at 12:53 PM, R3 was observed lying in bed with a scar on her

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forehead.

On 3/24/25 at 12:53 PM, V7 (CNA/ Certified Nurse Assistant) said that R3 had fallen from her geri-chair (geriatric chair) while she (V7) and V6 (CNA) were preparing to transfer R3 to her bed. V7 said, "V6 (CNA) and I were working together to transfer her (R3) because she is a total care patient. R3 was sitting up in her chair by the bed and I went to go and get the mechanical lift. V6 was standing on the other side of the bed at that time when R3 leaned forward and fell. I (V7) could not try to catch her (R3) because I was too far from her."

On 3/24/25 at 12:55 PM, V6 (CNA) said that she (V6) was on the side of the bed when R3 fell and could not reach her (R3) in enough time to stop her from falling from the chair.

At that time, V6 pointed to the side of R3's bed near the window and said that this is where she (V6) was standing during R3's fall.

V6 then pointed to the position where R3 was sitting at the time of her fall, which was at the foot of R3's bed.

Surveyor asked if R3 was reclined or sitting up in the geri chair at the time of her fall.

On 3/24/25 at 12:55 PM, V6 (CNA) said that at the time of R3's fall, R3's chair was not reclined, yet in an upward position.

Surveyor asked if a staff member should be standing close to R3 in preparation to transfer R3 from her geri chair to the bed.

On 3/24/25 at 1:18 PM, V5 (RN/ Registered

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Nurse) said, "R3 has poor trunk support and usually leans from side to side in the geri (geriatric) chair. R3 also sometimes slides in the chair and is unable to sit up straight. It is unsafe for her (R3), which is why she is usually reclined in her geri chair. If a staff member was with R3, the fall may have been prevented."

On 3/24/2025 at 2:30 PM, V8 (Restorative Nurse) said, R3 has a tendency to slouch and slide in the chair because she has poor trunk control. Upon inquiry of the process of transferring from bed to chair, V8 said, "One person should be with R3 and applying the slings or guiding the patient, the other CNA is controlling the lift. Once the patient is in the sling during the transfer, one CNA is guiding the patient and the other CNA is maneuvering the machine."

Surveyor asked if was safe for R3 to sit upward in a geri chair alone. V8 said that if a CNA (Certified Nurse Assistant) was standing near R3 prior to the transfer, it would decrease the chances of her falling due to R3's poor trunk control.

On 3/26/25 at 3:15 PM, V14 (CNA) said that during a patient transfer to bed, a CNA should be within arms reach of the patient for safety and to prevent the patient from falling.

Surveyor asked if it would be easier for a patient to lean forward in a geriatric chair if the chair is not reclined.

On 3/27/25 at 12:55 PM, V12 (NP/ Nurse Practitioner) said, "a patient with poor trunk control can definitely sit up and lean forward in a geri- chair depending on how weak or strong the patient is."

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Surveyor asked if a fall with head injury may be detrimental to a geriatric patient.

On 3/27/25 at 12:55 PM, V12 (NP) said, "Sure, yes it can."

R3's Care plan documents, R3 uses reclining wheelchair for proper body alignment, comfort and positioning due to poor trunk control; R3 is at high risk for falls; staff instructed to use tactile cueing, holding on R3's shoulder when R3 is seated on geri chair during showers days, to lower risk of R3 rocking forward.

Section GG- Functional Abilities assessment documents, R3 is dependent on staff for chair to bed transfers.

Facility Incident Report dated 3/4/25 documents, R3 had an observed fall with injury in resident's room; CNA reported to the Nurse on duty that R3 leaned forward and fell on the floor; CNA was unable to reach R3 to stop her from falling; R3 was taken to the hospital and returned to the facility with ten sutures on the right frontal head.

R3's Hospital visit summary dated 3/4/25 documents, diagnosis: Fall, injury of head and facial laceration.

Facility policy titled Mechanical lift transfers documents, there will always be two staff to assist the resident. One staff will control the lift as the other will guide resident and support back and neck to transfer surface.

"B"