STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003008	A. BUILDING: _____ B. WING _____	C 04/17/2025

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ZAHAV OF BERWYN	3601 SOUTH HARLEM AVENUE BERWYN, IL 60402

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S 000	Initial Comments Complaint Survey: 2593091/IL189815	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210c) 300.1210d)6 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. 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.	S9999		

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S9999	Continued From page 1 These Requirements were NOT MET as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement effective individualized fall interventions to prevent fall incidents and fall incidents with injury for residents identified as high risk for falls, with severe cognitive impairment and assessed with poor awareness. This affected two (R2 and R5) of three residents reviewed for incidents/accidents. This failure resulted in R2 having multiple falls with self-transfer attempts and R5 with history of wandering behavior, had a fall and found by the third floor exit door on 4/10/25. R5 transferred to local hospital for evaluation and returned with new diagnosis of closed nondisplaced fracture of proximal end of left humerus. Findings Include: R2 admitted in the facility on 9/16/24 with diagnoses of but not limited to: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Generalized Muscle Weakness, Abnormal Posture, Hypertension, Depression, Insomnia, Restlessness and Agitation, Cognitive Communication Deficit, History of Falling, Type 2 Diabetes, Muscle Wasting and Atrophy on Right Lower Leg and Abnormalities of Gait and Mobility. Section C of MDS (Minimum Data Set) dated 3/16/25, BIMS (Brief Interview for Mental Status) of 6/15, indicates severe cognitive impairment. Fall Risk Review dated 11/7/24 was 17 and 3/15/25 score was 20. R2 is High Risk for Fall.	S9999		

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R2 is care planned for High Risk for falls related to current condition, medication use, Poor Safety Awareness, Unsteady Gait, Disease Process dated 1/23/25.
Fall incident reviewed from January of 2025. R2 had multiple fall incident. One on 3/4/25 and another one on 3/15/25.

R2's 3/4/25 fall incident at 1700, reads in part: R2 noted lying in-between bed and wheelchair on right lateral side. R2 tried to self-transfer from bed to wheelchair. R2 requires assistance with transfer. R2 stated R2 was trying to go to the living room to watch television.

R2's 3/15/25 fall incident at 22:15, reads in part: Walking to the nurses station and heard R2 yelling, hey hey and upon entering room, R2 observed trying to transfer self from bed to wheelchair and slide down off the bed, landing in a sitting position on buttocks.

On 4/15/25 at 11AM, observed R2 sitting in bed. Wearing AFO brace on right foot (white plastic brace with no socks or any footwear on bilateral feet. Feet touching the floor as R2 seats on his bed.

On 4/16/25 at 9:30AM, R2 observed in bed, wearing gown and wearing regular socks.

On 4/16/25 at 9:30AM, V7 (Restorative Aide/CNA) confirmed with V7 that R2 is currently wearing regular socks and not the non-skid socks. V7 stated that AFO brace is used at night, when he is in bed. "R2 was able to put the AFO brace by himself, and that was the brace you have seen R2 was wearing yesterday. We are now keeping the brace in the bottom drawer, so R2 will not be able to put the brace on his own.

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R2 is not supposed to wear it during day time. For his safety". R2 requires minimal staff assist with transfer, can stand pivot safely with staff present.

On 4/17/25 at 11:00AM, V2 (DON) stated that R2 should have and wear non-skid socks for safety because R2 is High Risk for Fall and history of fall with self-transfer. R2 wear AFO brace during night time and not during day time. AFO brace was recommended by outpatient therapy and we are in the process in getting more information into when and now long R2 needs to utilize it. CNA informed V2 that R2 puts on the AFO by himself, and so CNA working with R2 removes the brace and place it in the bottom drawer for resident safety.

R5 admitted in the facility on 2/1023 with diagnoses of but not limited to: Fracture of Upper End of Left Humerus, Protein Calorie Malnutrition, Type 2 Diabetes, Hypertension, Fracture of Neck Left Femur, Mild Cognitive Impairment, Dementia, and History of Falling.

Section C of MDS (Minimum Data Set) dated 3/17/25, BIMS (Brief Interview for Mental Status) of 4/15, indicates severe cognitive impairment.

Fall Risk Review dated 3/17/25 was 10 and 4/10/25 score was 13. R5 is High Risk for Fall.

R5 is care planned for at risk for falls related to: type 2 diabetes, history of falling, essential primary hypertension, dementia, and UTI, with a revision date of 11/18/24.

R5 is care planned for Displays behavioral symptoms of unpredictable verbal aggression outburst towards peers with delusional statement of abuse, related to diagnosis of dementia, with a

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revision date of 3/17/25.

R5's Wandering Risk Careplan dated 4/25/23 and revision date of 11/4/24, reads in part: R5 demonstrates movement behavior that may be interpreted as wandering, pacing and roaming. Pacing, roaming or wandering in and out of peers' rooms. R5 is a new admission and not familiar with her environment. R5 no longer exhibiting with behavior as of 11/4/24 and through this annual review period.

R5's Social Services notes on 3/17/25, reads in part: R5 presents to be Alert & Oriented x1 with periods of confusion, disorientation, poor awareness, short-term memory loss, and/or forgetfulness. She has no challenges with the expression and comprehension of information at times when expressed to her to her understanding and knowledge.

R5's Risk Management Fall Documentation dated 4/10/25 at 1400, reads in part: writer heard the alarm sound and immediately went to the door, upon observation writer noted resident alert and verbally responsive in the supine laying on the stairwell. 911 called due to anticoagulant therapy. Writer noted skin tear to left lower extremity.

R5's Hospital record reviewed dated 4/10/25, reads in part: X-ray Left Shoulder: Comminuted fracture of left proximal humerus with varus impaction at the surgical neck. X-ray Left Humerus: Comminuted sub capital fracture with superior subluxation of distal fragment. Emergency Department diagnosis: closed nondisplaced fracture of proximal end of left humerus.

On 4/16/25 at 9:40AM, V8 (LPN) stated R5 is

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high risk for fall due to R5's wandering behavior. R5 has a behavior of wandering the 3rd floor unit, baseline routine of R5 was up and uses her wheelchair as a mode of locomotion. Able to propel wheelchair with her hand on her own, but not now due to the left arm brace R5 is wearing now and the fracture on left arm. Staff usually redirect R5 when observed with wandering behavior. Staff would ask if R5 needs something, at times R5 would say R5 is looking for her room. V8 stated that V8 worked on 4/10/25, and was working the north side unit on the 3rd floor. Heard code yellow announced in the intercom. V8 stated he checked his unit for all his residents and after V8 went to 3rd floor south side unit. V8 heard an alarm coming from the south side exit door, there were already staff present at the exit door when he arrived in the area. V8 observed R5 outside the exit door, two steps away from the door, with R5 laying on the stairs floor, face up with the head towards two stair steps downward and feet placed upward, foot facing towards the door (body diagonally positioned) and wheelchair located at the middle part of the stairways.

On 4/16/25 at 9:45, V8 demonstrates in opening the exit door. V8 pushed the door, loud alarm went off, however unable to open door for another 15 secs, as it is required to re-push for it to open. Need key for the alarm to stop sounding.

Observed signage on the exit door stating "push until alarm sounds, door can be opened in 15 seconds".
R5 used to be on (3rd floor) south side unit by the exit door, passing an open area used to store unused wheelchair, Geri chair and mechanical lift, parked against the wall.

On 4/16/25 at 12:25PM V9 (CNA) stated that R5

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normal morning get up. R5's baseline routine in the unit, normally when V9 gets here R5 is usually already up in the dining room. Waiting for breakfast to come. Will do activity at times after and sometime will lay back down in her bed after the breakfast. Sometimes she needs redirecting as she forgets which side of the floor her room is on sometimes. Depend on her mood if she stays in the dining area after meals. "When I redirect her, I will then take her to her room, when R5 seems kind of lost and can't find her room".

On 4/16/25 at 12:50PM, V10 (CNA) stated that R5 gets up in the morning and that night shift get R5 up. R5 would be already ready be waiting for breakfast in the dining room. When too many people in the dining area, R5 sometimes would ask if she can go to her room. Most of the time R5 will ask. And there will be times, R5 will go in her room on her own. "At times I see her and I will take her to her room. Sometimes R5 is confused and will not find her room. Sometimes she remembers her room number and sometimes she gets confused".

On 4/16/25 at 1:05PM, V11 (CNA) stated R5 usually stays in the dining room for activity. R5 is fall risk, so R5 stays in the dining room, so staff would be able to monitor R5. To prevent fall and for her safety. One of the reason R5 stays in the dining room, so we can assist her at all times if R5 needs to go to the bathroom. R5 at times would try to go to the washroom and not able to find it unless assisted by the staff. Need assistance with staff in finding her room also.

On 4/16/25 at 1:30PM, V12 (Wound Nurse), "I was on the 2nd floor, Heard the alarm went off from the third floor. I ran south side stair exit coming from the 2nd floor. Office right by the 2nd

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floor exit door". When V12 went upstairs, observed R5 laying on the floor. On the first level, before the first two steps. Body started to continue to slide down further and so V12 assisted R5 further down the step, V12 does not recall the position of R5's head at the time. "I do not recall where her wheelchair was. R5 was screaming and I was paying more attention to R5 at the time. People started coming maybe because of the alarm sounding at the time". 911(Emergency Response) was called and V12 stayed with R5 along with the other staff until taken by paramedics. V12 noted Skin tear on R5's Left leg lower shin area with partial skin flap. It was approximately 3x4 cm. STERI strips placed prior to the ambulance arriving in the facility and V12 was able to control the bleeding. Scant amount of bleeding.

On 4/17/25 at 11:00AM, V2 (DON) stated that R5 was seen in her room prior to her fall. It just happened R5 fell trying to exit, R5 does not have an exit seeking behavior prior to this fall. Upon her returned in the facility, we placed her in a room closer to the nurse's station, and placed her in close monitoring. We are not aware of her wandering behaviors, management are all new in the facility.

Fall Prevention and Management Policy with a review date of 8/2024, reads in part: This facility is committed to maximizing each residents' physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for fall, plan for preventative strategies and facilitate as safe as environment as possible. All residents fall shall be reviewed, and resident's existing plan of care shall be evaluated and modified as needed.

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S9999	Continued From page 8 A fall risk evaluation will be completed on admission readmission, quarterly, significant change and after each fall. Resident at risk for falls will have fall risk identified on the interim plan of care and the ISP with interventions implemented to minimize fall risk. A fall risk evaluation is completed by the nurse. A score of 10 or greater indicates the resident is at "high risk" for falls, a score of less than 10 indicates "at risk" for fall. Care plan to be updated with new interventions based on root cause analysis after reach fall occurrence. (A)	S9999		