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 03/07/2023

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ALIYA OF HOMEWOOD	940 MAPLE AVENUE HOMEWOOD, IL 60430

(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 Investigation: 2391071/IL156181 2390973/IL156069 2390685/IL155717	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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. 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 requirments are not met as evidenced by: Based on interview and record review, the facility failed to supervise and implement effective interventions to prevent or reduce the risk of falling for cognitively impaired residents. This affected 2 of 3 residents (R2, R5) both reviewed for falls and fall prevention. This failure resulted in R2 being sent to the local hospital post fall. R2 was assessed with a subdural hematoma. R5 has been involved in at least 5 unwitnessed fall incidents. Findings include: R2 was admitted to the facility on 11/15/22 with a diagnosis of dysphagia, hypertension, venous insufficiency, pleural effusion, acute respiratory failure, and Alzheimer's. R2's brief interview for mental status dated 11/21/22 s score 1/15 which indicates severe cognitive impairment. R2 section	S9999		

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S9999	Continued From page 2 G dated 11/21/22 documents one person assists for bed mobility, transfer, walk in room, dressing eating, toilet use and personal hygiene R2 progress note dated 11/16/22 documents: resident observed climbing out of bed, making unsafe transfer. Redirected but not successful, assisted to wheelchair brought to hallway for close monitoring. R2's progress note dated 11/17/22 at 1:30 documents: Resident observed climbing out of bed, making unsafe transfer. Redirected but not successful. Assisted to wheelchair and brought to hallway for monitoring. R2's progress note dated 11/17/22 at 5:29 documents: Resident requested to get back onto bed. Assisted back to bed by CNA. Bed in low position and locked, call light within reach. R2's progress note dated 11/17/22 at 5:40 documents: Resident observed sitting on the floor, next to her bed. Bed in low position. Resident brought to the hallway for close monitoring. Resident educated on the use of call light and waiting for help. R2's incident report dated 11/17/22 documents under investigation report: R2 is alert and oriented x1, requires staff assist with most activities and activities of daily. She has poor safety awareness. Resident noted sitting on the floor next to the bed after several attempts to stand due to dementia. R2 progress note dated 11/23/22 by V18 (Nurse) documents: resident had witnessed fall in bedroom without injury. MD notified with no new orders.	S9999		

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S9999	Continued From page 3	S9999		

R2 fall assessment dated 11/24/22 documents time of fall 11/23/22 at 17:20. Under physical limitations: impaired balance; musculoskeletal problem; gait problem. Under disease and conditions: impulsivity or poor safety awareness.

On 3/1/23 at 420PM, V3 Assistant Director of Nursing (ADON) and V29 (Unit Manager) said R2's fall interventions were effective because R2 could use a call light. When asked if R2 was able to understand the need of when to push the call light and not just being physically able to push the call light, V29 said at times she knows and other times she does not know. When asked about the resident cognition, V29 said R2's brief interview score for mental status indicate severe impairment but that could vary on day and time. When asked how reenforce need to call for assistance is an effective intervention for a resident with cognitively impairment? V3 said she did not fall again.

On 3/2/23 at 4:38PM, V2 Director of Nursing (DON) said R2 needed one to one supervision to prevent falls. Staff would take turns monitoring her, but we do not provide one to one and depends on staffing.

R2's progress note dated 12/7/23 documents transfer to the hospital due to change in condition and lethargy.

R2's plan of care dated 11/15/22 documents at risk for falls due to impaired balance. Interventions dated 11/15/22 document: provide assist to transfer and ambulate as needed; refer to therapy plan of treatment; therapy evaluation and treatment. Interventions dated 11/17/22 document: bed in low position; diagnostic labs;

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S9999	Continued From page 4 evaluate medications if patient demonstrates changes in mental status, Activities of daily living function, appetite, neurologic status; scoop mattress. Interventions dated 11/24/22 documents reenforce need to call for assistance. Local hospital record dated 12/7/22 documents: new right parietal convexity 8mm thickness subdural hematoma with layering hyperdensity posteriorly concerning for ongoing bleeding, no midline shift or herniation. R2 progress note dated 11/23/22 by V18 (Nurse) documents: resident had witnessed fall in bedroom without injury. MD notified with no new orders. R2 fall assessment dated 11/24/22 documents time of fall 11/23/22 at 17:20. Under physical limitations: impaired balance; musculoskeletal problem; gait problem. Under disease and conditions: impulsivity or poor safety awareness. On 3/1/23 at 5:49PM, V18 said she did not witness R2's fall and unable to recall who or any other details from R2's fall. R2 progress note dated 11/28/22 documents: patient with increased anxiety and restlessness. Seen by Nurse practitioner, new orders noted. On 3/2/23 at 4:38PM, V2 said the facility is unable to provide any incident or other documents related to R2's fall on 11/23/22. V2 said they are unable to determine who witnessed R2 fall, or any other information related to the fall except for what was written in the nursing note. There is no documentation if resident hit her head, just that there were no visible injuries. If it's a witnessed fall staff are expected to conduct a head-to-toe	S9999		

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S9999	Continued From page 5 assessment, which is documented in the incident report. It is the policy of the facility if they hit their head they are sent to the hospital for evaluation. Facility post fall evaluation dated 11/21 documents: Falls are a common source of patient injury. Identifying fall risk factors is an important nursing evaluation process that occurs throughout a patients stay. In the event of that a patient does experience a fall, a comprehensive clinical evaluation by the nurse supervisor is important to determine the extent of the injury and need for additional intervention. The licensed nurse's evaluation of the patient condition after a fall, identification of changes in condition and recognition of emergent situations is critical to achieving positive outcomes. The licensed nurse is responsible for completing this evaluation and reporting changes in condition to the attending physician whenever any symptom, sign or apparent discomfort is sudden in onset, a marked change in relation to usual symptoms or unrelieved by initial interventions. Documentation of change in condition is completed using the SBAR process. R2's admission hospital record dated 10/29/22 documents under CT scan of head documents: No acute intra cranial hemorrhage, acute transcortical infarct or mass effect. On 3/2/23 at 3:01PM, V32 (MD) said a subdural hematoma is usually caused by a fall. V32 said the subdural hematoma could possibly be from the fall on 11/23/22. On 2/28/23 at 2:26pm, V14 (CNA)said R2 was a fall risk. R2 was confused and tried to get up all the time. We would redirect her. She had a scoop mattress but that did not stop her, and she could	S9999		

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S9999	Continued From page 6 still get out of bed. R2 had a lot of falls on the second shift. R2 had more than 2 falls. Local hospital record dated 12/7/22 documents: new right parietal convexity 8mm thickness subdural hematoma with layering hyperdensity posteriorly concerning for ongoing bleeding, no midline shift or herniation. Local hospital record dated 12/19/22 documents: patient likely has multifactorial encephalopathy related to infectious and metabolic etiologies. Since she has risk factors, I will rule out acute neurologic event like stroke or subclinical seizures. According to Medline plus, a subdural hematoma is a collection of blood between the covering of the brain (dura) and the surface of the brain. Under causes: a subdural hematoma is most often the result of a severe head injury. This type of subdural hematoma is among the deadliest of all head injuries. This often results in brain injury and may lead to death. Subdural hematomas can also occur after a minor head injury. The amount of bleeding is smaller and occurs more slowly. This type of subdural hematoma is often seen in older adults. These may go unnoticed for many days to weeks and are called chronic subdural hematomas. Some subdural hematomas occur without cause. (A) 2 of 2 300.610a) 300.1210b)4) 300.1210d)6)	S9999		

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S9999	Continued From page 7 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living	S9999		

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S9999	Continued From page 8 shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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 effectively monitor and ensure adequate hydration was provided to prevent dehydration. This affected 2 of 3 (R5 and R1) residents reviewed for dehydration. This failure resulted in R5 being found tachypneic, tachycardic and with tongue hanging to the side of her face. R5 was sent to the local hospital and diagnosed with dehydration and hypernatremia. R1 was sent to the local hospital and diagnosed with hypernatremia. Findings Include: R5 had the diagnosis of Vascular Dementia, Chronic Kidney Disease, Metabolic Encephalopathy, Hypercalcemia and Hypertension. Brief interview for mental status dated 10/6/22 documents a score of seven which indicates severely impaired. Section G (functional status) documents: R5 requires extensive assistance with one person physical assist with eating. Physician order sheet dated 12/01/22	S9999		

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S9999	Continued From page 9 documents: Pureed diet and nutritional shake. On 3/2/23 at 12:34pm, V22 (Medical Doctor) said, R5's fluid volume was down. Dehydration can cause no urine based on low volume intake. On 3/2/23 at 3:10pm, V32 (Medical Doctor) said, R5 was on furosemide which usually keeps sodium levels down. Dehydration is caused by not enough fluids. R5 was not on dialysis. Nutrition note dated 10/5/22 documents: R5 averages only ~ 50% meal consumption since admission. Lab results dated 12/19/22 at (1621/4:21pm) documents: Sodium 149 High (H) - (normal range 138-147). Progress note dated 12/20/22 at (2106/9:06pm) documents: lab reviewed, new order intravenous (IV) fluid times one liter, contact pharmacy for fluid and (IV) pump. EMAR and skilled nursing note dated 12/21/22 at (0611/6:11am) awaiting arrival from pharmacy. R5 to start IV fluids when arrives from pharmacy (0618/6:18am). Medication Administration record dated 12/21/22 documents one liter of sodium chloride was given at (2050/8:50pm). Lab results dated 12/23/22 documents: Sodium 151 High (H) - (normal range 138-147). R5 electronic record dated 12/23/22 did not document any interventions. Physician order sheets dated 12/1/22 did not document any ordered related to the sodium level. Medication Administration record dated 12/23/22 did not documents any interventions related to the 12/23/22 sodium level.	S9999		

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S9999	Continued From page 10 Physician note dated 12/30/2022 documents: Seen R5 after nurse stated she did not seem like herself. Assessed patient (R5) was lethargic, not responding. R5 was visibly tachypneic although saturating well, and tachycardic. R5 was in bed, tongue was hanging to the side of her face, and she was not opening eyes not responding to voice, or touch. Hospital paperwork dated 12/30/22 documents: Sodium 160 High (H) - (normal range 135-145). Intervention altered mental status since 12/28/22 subdual non-verbal (off baseline), hypernatremia, electrolyte abnormalities, dehydration, very dry mucous membranes treated with bolus of 0.9 normal saline. Hydration Management Guidelines dated 1/22 did not apply. R1 had the diagnosis of Dementia and failure to thrive. Section G functional status dated 1/24/23 documents: R1 requires extensive assistance with one person physical assist with eating. Physician order sheet dated 2/1/23 enhanced pureed diet with house shakes three times a day. On 3/1/23 at 2:22pm, V22 (Medical Doctor) said, staff should have to give R1 water to prevent the dehydration. On 3/1/23 at 5:30pm, V30 (Nurse) said, R1 was dehydrated from not drinking a lot. On 3/2/23 at 11:30am, V2 (DON) said, I am not able to provide reports from R1 speech session. On 3/2/23 at 12:34pm, V22 (Medical Doctor) said, dehydration can cause no urine based on low volume intake.	S9999		

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S9999	Continued From page 11 . Surveillance note date 1/26/23 document: Appetite poor, family states R1 did not urinate today. R5 states burning with urination. CNA reports, R5 did urinate. Bladder scan 23ml seen in bladder at this time. Service Log dated 2/6/23 documents: R1 was seen by speech on 1/20/23, 1/22/23, 1/27/23 and 1/28/23. Lab report dated 1/30/23, 1/31/23 document sodium 150 (normal range 138- 147) note dated 1/30/23 documents: Sodium 150, oral fluids encouraged. BMP will be repeated. Lab report dated 2/1/23 document sodium 152. Progress note dated 2/1/23 documents: D5 1 liter infusing. Lab report dated 2/3/23 document sodium 150. No intervention documented. Run sheet dated 2/4/22 documents: services were called for R1 for abnormal labs indication sodium level of 150. Nurse reports R1 has not been eating or drinking since admission date of 1/18/22. Sodium levels have stayed in 150 for the past four days, attempted saline bag with no change in condition. Hospital paperwork dated 2/4/23 documents: Chief complaint: abnormal lab. Hypernatremia. Hydration Management Guidelines dated 1/22 did not apply. Hydration policy dated 2/2023 documents: This policy allows for each resident to be provided with sufficient fluid intake to maintain proper hydration	S9999		

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