STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014831	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA ON 87TH	2940 WEST 87TH STREET CHICAGO, IL 60652

(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 FRI of 8/22/2023/IL163974	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 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. 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 werenot met as evidenced by: Based on interview and record review the facility	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

failed to safely transfer a resident to prevent a fall for one of three residents (R1) reviewed for falls. Staff failed to utilize a gait belt during transfer from toilet to wheelchair. This failure resulted in R1 sustaining a subarachnoid hemorrhage (bleeding in the space that surrounds the brain) and a left zygomaticomaxillary complex fracture (fracture involving the cheekbone and the surrounding bones).

Findings include:

R1's medical record (Face Sheet) documents R6 is a 93-year-old admitted to the facility on 8.2.2023 with diagnoses including but not limited to: Metabolic Encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), Difficulty in Walking, Acute Kidney Failure, Repeated Falls, Weakness and Chronic Kidney Disease.
R1's MDS (Minimum Data Set dated 8.9.2023) documents the following:
-BIMS (Brief Interview for Mental Status):3 of 15 (severely cognitively impaired)
-Functional Status: Toilet use: 3/2 (Extensive assistance/ One-person physical assist), Moving on and off toilet-2 (not steady, only able stabilize with staff assistance

Facility's Final Incident Report (8.29.2023) documents in part: "On 8.22.2023 at 6:40 AM the nurse entered the room on the request of staff and observed the patient lying supine on the floor next to the toilet. When questioned, the patient was unable to explain how the fall occurred. The patient was noted with a skin tear to her left eyebrow. 911 was contacted and the MD and family were made aware of the fall and subsequent transfer to the hospital. While in the hospital the patient was diagnosed with a

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S9999	Continued From page 2 subarachnoid hemorrhage and a left zygomaticomaxillary complex fracture. Interview with the assigned nursing assistant revealed that while helping the resident to the bathroom the resident fell while completing the toileting task. During the IDT (Interdisciplinary Team) meeting it was determined that the fall was caused by the patient's ongoing delirium and impulsiveness." Hospital Progress Note (electronically signed on 8.23.2023 at 7:25 AM) documents in part: "This is a 93-year-old female with past medical history of CKD, dementia, hypertension, hyperlipidemia who presents for fall. Clinical impression: 1. Fall, 2. Subarachnoid hemorrhage, 3. Closed fracture of left zygomaticomaxillary complex. CT Brain Final Result (8.22.2023 at 9:09 AM) documents in part: Indication: Head trauma. Fell at nursing home. Impression: 1. Tiny subarachnoid hemorrhage noted in the right sylvian fissure, likely posttraumatic in nature. 2. Left zygomaticomaxillary complex fracture. On 10.24.2023 at 1:35 PM, V2 (LPN/Nurse Case Manager/Fall Nurse) said, V4 (CNA-Certified Nursing Assistant) was interviewed but never said how R1 fell during transfer. V2 said a resident should never fall during a transfer. On 10.26.2023 at 10:07 AM, V2 (LPN/Nurse Case Manager/Fall Nurse) said, V4 said while transferring the patient, the resident fell. The IDT completed the investigation (V1, V2-Director of Nursing, and V6-Administrator). We determined that there was some error in the transfer that resulted in the resident falling. On 10.26.2023 at 2:51 PM via telephone, V1 (DON-Director of Nursing) said, we (IDT)	S9999		

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S9999	Continued From page 3 discussed R1's fall. To our knowledge and after speaking with the CAN (V4), the resident lost her footing when the CNA was getting the resident off the toilet. They (CNAs) should use gait belts when completing transfers. We did ask her (V4) if she used a gait belt (during the transfer) and she said "no". V4 (CNA-Certified Nursing Assistant) was not available for interview. (A)	S9999		