Illinois Department of Public Health

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 12/18/2023

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 10/28/2023/IL166481 & FRI of 10/16/2023/IL166489	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 were not met as evidenced by:	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1	S9999		

1. Based on observation, interview, and record review, the facility failed to supervise ten residents (R2, R9, R10, R11, R12, R13, R14, R15, R16, R17) in the sample. This failure also affected R2 who had an unwitnessed fall which resulted in R2 sustaining a fractured nose. This failure has the potential to affect all residents on the first and second floor of the facility.
The facility failed to ensure that the emergency cart on the 3rd floor was safely locked when not in use and failed to ensure that a full oxygen tank for the emergency cart was stored securely in the oxygen rack. These failures have the potential to affect all the resident on the 3rd floor.

Findings include:

R2's admission records documented admission date as 10/30/23 with diagnosis that includes but not limited to End Stage Renal Disease, Fracture of nasal bone, Fluid overload, Anxiety Disorder, Unspecified Dementia, Dependence on Renal Dialysis and Other specified Diabetes Mellitus.

R2's MDS (Minimum Data Set) dated 11/09/23 scored R2's BIMS as 07 indicating that R2 is cognitively impaired.

R2's plan of care initiated 05/03/23 showed R2 has a wanderer behavior with goal R2's safety will be maintained.

According to facility investigation report incident date 10/28/2023 and time of incident 8:44pm. R2 was observed lying on the floor in the dining area none of the staff knows what happened to R2 on 10/28/23. Upon assessment R2 was noted with a skin alteration on the nose and complained of pain to right shoulder.

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S9999	Continued From page 2 R2's medical record progress note dated 10/28/2023 22:02 (10:02pm) V8 LPN (licensed Practical Nurse) identified as the nurse assigned to R2 documented in part Writer (V8) sitting at nursing station charting and heard resident in dining room yelling help. Writer went into dining room and noted resident laying on the floor with bloody nose stating someone pushed him out his w/c (wheelchair), no staff present in the dining room when writer arrived at the dining room. Resident stated someone pushed him out his w/c. Writer assessed resident for injuries, no visible injuries noted, small laceration on the bridge of nose, area cleansed with NS, V/S obtained, myself and another nurse on the unit assisted resident into w/c. Pt c/o pain 7/10, Writer called third eye and spoke with (V28) and informed her of incident that occurred and that fall was unwitnessed, and neuro checks are in place also requested orders for pain medication, orders rec'd for Tylenol 650mg p q6 hours prn for pain, (family)made aware, Writer called Elite ambulance for p/u dispatch stated they have no availability, writer then called ATI ambulance eta 4 hours. Pt sitting at nursing station being monitored closely, pt shows no s/s of respiratory distress, bleeding subsided, no discharge or drainage noted from nose or ears, neuro checks in progress will cont. to monitor. 167/91-20-75-98%-97.8. R2's hospital record documents R2 was transferred to another hospital for trauma evaluation and management. R2's hospital records presented dated 10/28/23 timed 23:59 (11:59pm) and electronically signed by V29 (Medical Doctor) showed CT head without contrast, CT cervical Spine without contrast and	S9999		

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S9999	Continued From page 3	S9999		

Continued From page 3

Maxillofacial CT without contrast was done and the impression under Cervical documented in part that there may be a nondisplaced avulsion, fracture at the medial aspect of the left occipital condyles. Additionally, there may be nondisplaced avulsion fractures arising from the lateral masses of C1. These are age indeterminant. MRI may be helpful in determining acuity. Head impression showed there is no intracranial hemorrhage, midline shift, or calvaria fracture. Parenchymal volume loss and chronic microvascular ischemic changes of cerebral hemispheres are present. Mild chronic Crooner infarctions are seen within the right basal ganglia.Maxillofacial impression showed there is a mildly displaced right nasal bone fracture.

On 12/04/23 at 1:25pm, V2 DON (Director of Nurse's) stated, "V7 CNA (Certified Nurse's Aide) worked directly with R2 on the day of the incident and is no longer working at the facility".

On 12/04/23 at 12:35pm, V13 LPN (Licensed Practical Nurse) and 2nd floor unit manager stated, R2 needs staff supervision constantly. V13 stated, "Staff are supposed to monitor the areas where residents are gathered like the dining room, but whose to say R2 did not go back there after everyone had left. I'm just saying".

On 12/04/23 at 12:56pm, V16 (Activity Director) identified as the 2nd floor activity director stated, all the staff are responsible for monitoring the resident but the schedule for monitoring is activities staff monitors from 7:30am to 1:00pm and after that nursing staff monitors from 1:00pm to 2:00pm and this is worked into the nursing staff schedule daily.

On 12/04/23 at 1:01pm, surveyor observed nine

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S9999	Continued From page 4	S9999		

residents sitting in the first-floor dining room area without any staff monitoring or supervision. Surveyor observed R13 crying and appeared confused. Surveyor asked V11 (Unit Manager) and V20 (Case Manager) to come to dining room to identify the residents in the dining room. V11 and V20 identified the resident as: R9, R10, R11, R12, R13, R14, R15, R16, and R17. V20 stated, "There should be staff with the residents supervising/monitoring." V11 further stated there was a call off from a nurse today so she (V11) had to work the cart (referring to passing medication). V11 identified V9 as the CNA (Certified Nurse's Aide) who should have been supervising and monitoring the residents according to the daily dining room monitoring assignment sheet.

On 12/04/23 at 1:06pm V17 (Activity Director) for the first floor stated, there should be staff monitoring the dining room when the residents are present. V17 stated, the CNA's (Certified Nurse aides) monitors every thirty minutes whether there is an activity or not. V17 stated, the residents are to be supervised and not to be left alone. V17 stated, the daily schedule is for activity to monitor from 10am to 11am and from 2:00pm to 3:30pm.

On 12/04/23 at 1:08pm, V9 (CNA) stated, she was busy assisting another resident. V9 stated, it has being chaotic changing the residents and assisting in changing bandages. V9 stated, the previous staff supervising should not have left the residents without her (V9).

On 12/04/23 at 1:25pm, V2 DON (Director of Nurse's) stated, V7 CNA (Certified Nurse's Aide) worked directly with R2 on the day of the incident and no longer is working at the facility. V2 stated,

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S9999	Continued From page 5	S9999		

rounds are to be made frequently at least every hour.

On 12/18/23 at 3:09pm, V26 NP (Nurse Practitioner) stated, she is aware of R2's fall. V26 stated, R3 was found on the floor and was sent to the hospital and after R2 came back she saw (referring to assessment of R2) R2. V26 stated, she cannot say R2's nasal fracture was due to the fall of 10/26/23 because R2 is very impulsive, and it can be due to another incident. V26 stated, the hospital record she reviewed showed that R2 had a nose fracture.

As of 12/18/23 at 3:45pm, the facility was unable to provide the policy for hazard and supervision after several request.

During the course of the survey, V7 was unable to be contacted.

2. On 12/04/23 at10:04am, on the 3rd floor in the hallway surveyor observed emergency red and white cart unlocked and unattended and a green oxygen tank unsecured and being stored on the bare floor. V12 LPN (Licensed Practical Nurse) identified as the unit manager stated, they (referring to oxygen tank) should be hooked up to the emergency cart and the cart should be locked with the breakaway plastic tag lock. V12 stated the cart lock is broken and cannot be locked with the breakaway tag lock. V12 stated storing the oxygen tank on the floor unsecured is a fire hazard. V12 opened the cart with the surveyor and stated, there were needles (referring to IV needles), scissors, lancets, IV solutions that were stored in the cart. V12 tried to fix the black belt attached to the cart for holding the cart and the belt was broken.

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S9999	Continued From page 6 On 10/04/23 at 10:40am, V2 DON (Director of Nurse's) stated, the crash cart on each floor should be locked after use with the oxygen tank attached. On 12/05/23 at 2:01pm, V2 stated, the emergency cart should be locked with the plastic tag (referring to the breakaway tag lock) and oxygen tank attached to the emergency cart. Facility policy on Crash Cart and AED dated 1/2023 presented documented in part that in general the policy is to provide the staff with guidance on the crash cart contents and monitoring. Responsible party listed includes the DON (Director of Nurse's, RN (Registered Nurses), LPN (Licensed Practical Nurses), and maintenance. Listed items in the crash cart includes but not limited to sharp IV (Intravenous) needles, suture removal kit, lancet, and scissors. Facility protocol includes but not limited to making sure that the drawer to the crash cart is always locked to ensure contents remain intact. Securing that the cart is locked using breakaway tag lock. (B)	S9999		