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 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 2495028/IL174859 2494254/IL173776 Facility Reported Incidents: of 7.2.24/IL175117 of 6.14.24/IL174792	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 300.1010h) 300.1210b) 300.1210d)2) 300.1210d)3) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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	S9999		

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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:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to follow physician orders by not obtaining a urinalysis and culture for one resident who was identified as being incontinent of urine with a new onset of lethargy. This affected one of three residents (R4) reviewed for physician orders. This failure resulted in R4 being sent to the hospital with a diagnosis of urinary tract infection and sepsis.

Findings include:

R4 was admitted to the facility on 5/31/24 with a diagnosis of hemiplegia, abnormalities of gait,

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weakness, depression, hypertension, functional quadriplegia, and compression of the brain.

R4'as physician order dated 6/4/24 at 8:05PM documents: STAT chest x-ray, STAT CBC, CMP and Urinalysis with culture and sensitivity.

On 7/26/24 at 12:26pm, V14(Lab Tech) said they did not receive any notification from the facility for any urine collection pick ups and did not receive any urine specimens from the facility for R4.

On 7/31/24 at 11:32AM, V19(Nurse Consultant) said the facility practice on obtaining a urinalysis from an incontinent patient, would be to get an order for urine straight cath from the doctor and family consent. Staff should let the doctor know if unable to obtain urine specimen. The staff will usually get the sample during night shift or earlier because the lab will pick up specimens in the morning. V19 said the lab comes every morning to the facility.

On 7/31/24 at 9:17AM, V36(Nurse Practitioner) said if R4 had an order for urinalysis, she would expect staff to have collected specimen prior to hospitalization. Staff should have called to obtain order for straight cath if no urine was able to be obtained especially in an incontinent resident within first day. V36 denies receiving any calls related to R4 needing a straight cath order. V36 said she does not recall receiving any calls related to a change in mental status for R4 and said if she did, she would have sent R4 to the hospital immediately because she was a new admit and a change in her condition.

R4's hospital record dated 6/6/24 documents: R4 presents from facility with altered mental status. R4 opens eyes to name but unable to answer

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questions or follow commands. R4's white blood count was 12.6 high (normal range 4.2-11.0). Clinical impression documents sepsis, tachycardia and acute urinary tract infection. R4s urinalysis dated 6/6/24 documents urine color orange; appearance turbid; occult blood large (normal is negative); leukocytes large (normal result negative), bacteria moderate (normal result none); Mucous present. Urine culture collected 6/6/24 and completed 6/9/24 documents greater than 100,000 Escherichia coli. Blood culture collected 6/6/24 and completed 6/9/24 documents Escherichia coli.

R4's minimum data set dated 6/6/24 documents under section H bowel and bladder under urinary continence documents always incontinent.

(B)

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300.1010h)
300.1210b)
300.1210d)3)
300.1210d)6)

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time

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of notification.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 conduct a comprehensive body assessment on a resident observed with his left leg/knee contorted

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under his wheelchair, facial grimacing and yelling out with movement. This affected one of three residents (R3) reviewed for quality of nursing and assessment. This failure resulted in R3 waiting twenty hours for an x-ray order which resulted in a diagnosis of a new acute transcervical left femoral neck fracture with marked impaction and varus angulation.

On 7/25/24 at 3:13PM V10 (Nurse) said, R3 was wheelchair bound, very weak and could not articulate well. V10 said, V13 (CNA) updated her that R3 was yelling when she touched his left leg. R3 had a history of left knee pain. V10 said, R3 allowed her to move his left leg. R3 was in pain. V10 said, R3 had a facial grimace when she attempted to reposition R3's leg while he was in the wheelchair. V10 said, she lifted R3's leg up and down while R3 sat in his wheelchair. V10 demonstrated lifting her leg by gathering both hands underneath her posterior thigh just behind her bent knee and lifted her leg up, with her foot coming off the floor a few inches while she sat in the chair. V10 did this motion once as an example of how she assessed R3 while he was sitting in his wheelchair. V10 said, she administered, R3's scheduled muscle rub to the knee and gave an acetaminophen. V10 said, she was not sure what happen after that because she ended her shift earlier than scheduled. V10 said, R3 was sent to the hospital the following day. R3 was diagnosis with a fracture. V10 said, she thought R3 was having knee pain.

On 7/25/24 at 3:30PM, V13 (CNA) said, she was passing dinner trays, R3 was in his room sitting by the closet which was odd. Normally, R3 was in the hallway, self-propelling in his wheelchair using his feet and the handrail to go back and forth in the hallway. R3 normally ate in the dining room.

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V13 said, she placed R3's dinner tray on his bedside table. V13 said, she noticed R3's left leg was bent completely back up under his wheelchair. V13 demonstrated how R3 was sitting in his wheelchair by scooting towards the edge of her seat and placing her leg, with a bent knee behind her completely under her chair. V13 said, she tried to move R3's leg. R3 was in so much pain. R3 was unable to report what happen. V13 said, she informed V10.

On 7/26/24 at 1:33PM, V18 (PAN Nurse) said, R3 was observed in the bed moaning and groaning in pain. The nurse should have assessed R3's pain by completing a comprehensive head to toe assessment which includes vitals, range of motion to limbs, extending and flexing extremities, asking the resident if something happen, notified MD/family and followed given orders. R3 required staff assistance for transfers. R3 was able to self- propel with feet once in wheelchair.

On 7/30/24 at 3:55pm, V32 (Nurse) said, R3's words and actions contradicted each other. R3 will say he is not in pain while guarding or holding on to a body part.

On 7/31/24 at 12:58pm, V33 (Medical Doctor) said, she was not notified of R3's change of condition on 6/13/24. Severe osteoporosis/osteopenia can contribute to a fracture but whatever trauma happen to R3's leg that caused his leg to be bent completely under his wheelchair was the cause of his hip fracture. V33 said, she was notified about R3's fracture after he returned from the hospital. V33 said, she would expect the nurse to lay R3 down on his bed and complete a full body exam to include range of motion of the extremities after R3 was groaning

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with facial grimacing and yelling out in pain. R3 would have had severe pain with a hip fracture. V33 said, she would have ordered a stat x-ray had she been informed of R3's change of condition. Most hip fractures are caused by a traumatic event. V33 said, she does not know exactly how R3 fractured his hip. R3 has a diagnosis of prostate cancer but there was no documentation that R3's cancer metastasized to his bones in R3's medical record therefore it cannot be considered as a factor.

Nursing note dated 6/13/24 written by V10 at 18:36 (6:36pm) documents: Prior to dinner CNA (V13) attempted to reposition resident's (R3) left foot to bring side table towards him. Resident (R3) voiced vulgar language and told the V13 to get away from him and also grimaced. Nurse observed R3, R3 grimaced, when moving left leg but not right leg. R3 voiced he was not in pain but did mumble something incoherent. R3 was sitting in wheelchair at time of assessment and refused to go in bed. Resident was observed in room, ambulating in wheelchair but resident did not leave the room during the evening. PRN acetaminophen administered and pain ointment was administered. Left hip was touched, no abnormal reaction to touching site. Knee was assessed as resident refused care, no signs of dislocation fracture or bruising to site. Medication appeared effective. No signs of pain assessed prior to leaving.

Witness stated written by V10 documents at approximately 18:15 (6:15pm) on 6/13/24: C.N.A (V13) requested she observe R3. While sitting in his wheelchair R3 was observed with resistance to moving his left lower extremity (LLE) and would not move his left foot. R3 exhibited grimacing and stated "leave me alone" when the C.N.A (V13)

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attempted to assist with mobility. V10 assessed R3's left ankle and LLE for any signs of injury. NO sign or symptoms of injury were observed.

Witness stated written by V25 dated 6/14/24 documents: during the shift change, second shift CNA stated, she noticed something with his (R3) leg when shew was putting him to bed the night before, V25 then squeezed his (R3) knee again, got no reaction but when I tried to move his leg, he reacted in pain.

Telehealth evaluation dated 6/14/24 documents: R3 started to have left leg pain, therefore he had x-ray left hip, knee and left ankle. Left hip revealed impacted fracture of left femoral neck. R3 complained of pain with movement of hip and leg. This is an acute new problem. R3 condition is worsening pain. Transfer to emergency department.

Diagnostic Order dated 6/14/24 at 15:29 (3:29pm) documents: left knee, three view, left hip, unilateral with pelvis.

Facility radiology result report dated 6/14/24 at 20:55 (8:55pm) documents: impression pelvis: impacted transcervical fracture of the left lower neck with varus deformity.

Hospital paperwork dated 6/14/24 documents: He (R3) has been complaining of severe left hip pain which prompted them (facility) to get an x-ray. R3 was able to answer yes and no to questions. Musculoskeletal: Left lower extremity is shortened. Cat scan (CT) pelvis without contrast dated 6/15/24 document: New acute transcervical left femoral neck fracture with marked impaction and varus angulation demonstrated. No dislocation. Diagnosis: Closed hip fracture.

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S9999	Continued From page 9 (A) 3 of 3 300.610a) 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 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	S9999		

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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 observation, interview and record review, the facility failed to implement effective individualized fall interventions to include supervision/monitoring and reduce the risk of multiple falls. This affected two of three residents (R2, R8) reviewed for falls prevention interventions. This failure resulted in R2, who had a diagnosis of Dementia and Alzheimer's disease and identified as high fall risk sustaining a second unwitnessed fall from bed requiring hospitalization for an acute comminuted displaced fracture of the bilateral nasal bones and one centimeter lip laceration. In addition, the facility left R8 unsupervised on the floor for 13 minutes following an unwitnessed fall.

Findings include:

R2 was admitted to the facility on 6/21/24 with a diagnosis of Alzheimer's Disease, weakness, and dementia. Resident's brief interview for mental status score dated 6/28/24 documents a score of 3/15 which indicates severe cognitive impairment.

R2's fall risk assessment dated 6/21/24 documents a score of 21 which indicates a high fall risk.

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R2's incident report dated 6/21/24 documents: Certified nursing aide reported to nurse that R2 was on the floor. Observed patient lying on her back on the floor at the base of the bed. Resident stated that she fell. The patient was unable to say why she got up but did say that she hit her head when she fell. Under mental status documents oriented to person. Under predisposing physiological factors: confused, hypotensive, gait imbalance and impaired memory. R2's fall management meeting form documents under root cause observed in a prone position on the floor in her room apparent roll from bed. Intervention placed floor mats while in bed.

R2's incident report dated 6/24/24 documents: Nurse informed by staff patient is on the floor. Nurse entered room and observed patient lying on the floor on the right side with blood noted on the left side of the face and on the floor. Bed observed in low position with floor mats on both sides of the bed. Resident said I was looking for friends. Under injury, skin tear to left knee and face. Under mental status documents oriented to person. Under predisposing physiological factors: confused, hypotensive, gait imbalance and impaired memory. Under predisposing situation factors ambulating without assist. R2's fall management meeting form documents under root cause observed on the floor mat in her room Resident said she was looking for friends; confusion contribute to attempt to self transfer and get up. Intervention placed room change closer to nursing station.

R2's facility state report dated 6/24/24 documents: R2 fall resulted from confusion related to dementia leading to either roll from bed or R2 attempting to get up without assistance per

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staff resulting in mechanical fall.

On 7/31/24 at 2:58PM V13 (Restorative Nurse) said R2 was admitted with standard fall precautions in place: Document signs and symptoms of adverse effects of medication on resident; Encourage resident to keep room free of obstacles/ clutter; Keep bed in lowest position; Keep frequently used items within reach; Monitor labs/ notify MD of abnormal findings; Notify MD and family of any new fall; Skilled therapy as ordered; Staff to assist as needed. After the fall on 6/21/24 the interventions added were Floor mats while in bed and rounding for prompt assist for change in position, toileting, offer fluids, and ensure resident is warm and dry. V13 was asked was there individualized preventive fall interventions implemented for R2 after the first fall and V13 said No. V13 said floor mats are not a preventive fall intervention. Floor mats are utilized to minimize injury to the resident. V13 was asked were floor mats an effective intervention if R2 sustained a nasal fracture for the fall on 6/24/24. V13 said the floor mats do not prevent someone from falling. V13 was asked about the intervention (rounding for prompt assist for change in position, toileting, offer fluids, and ensure resident is warm and dry) and asked how often rounding would occur. V13 said rounding would be done every 2 hours unless otherwise specified. V13 said all residents are rounded on every two hours and that is in place for all residents.

R2's care plan Date Initiated: 06/21/2024 Created on: 06/21/2024 documents the following interventions: Document signs and symptoms of adverse effects of medication on resident; Encourage resident to keep room free of obstacles/ clutter; Keep bed in lowest position;

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Keep frequently used items within reach; Monitor labs/ notify MD of abnormal findings; Notify MD and family of any new fall; Skilled therapy as ordered; Staff to assist as needed. Floor mats while in bed Date Initiated: 06/22/2024 Created on: 06/22/2024. Rounding for prompt assist for change in position, toileting, offer fluids, and ensure resident is warm and dry Date Initiated: 06/23/2024 Created on: 06/23/2024. Falling Star Program Date; Move resident to room with optimal visual access from the nurse's station; Orient resident to surroundings frequently, including location of bathroom, dining room, bedroom and activity locations; Provide proper, well maintained footwear; wing mattress Initiated: 06/24/2024.

On 7/26/24 at 1:00pm, V16(Therapy Director) said R2 was seen by occupational therapy on 6/23/24. At that time R2 required moderate assistance which means 50% help by one person to complete transfers and bed mobility. R2 required frequent cueing during therapy due to cognition.

R2's therapy evaluation dated 6/23/24 documents under fall risk does patient feel unsteady when standing documents an answer of yes; does patient feel unsteady when walking documents an answer of yes; Under balance patient stands without upper extremity support with assistive device as needed x ten seconds? Documents no. Under reason for therapy: Patient presents with impairments in balance, dexterity, fine motor coordination, gross motor coordination, mobility, strength, attention, follow through, planning problem solving, self modification, self monitoring, interpersonal routines/behavior, and use of coping strategies resulting in limitations and /or participation restrictions in the areas of

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	IL6012611	A. BUILDING: _____ B. WING _____	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF HOMEWOOD	940 MAPLE AVENUE HOMEWOOD, IL 60430

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self care, mobility, and general tasks and demand which requires skilled OT services.

R2'a hospital record dated 6/24/24 documents under physical exam: Small laceration to bridge of nose approximately one centimeter. Additional small laceration upper lip, approximately 1.5 cm in length and small interior upper lip laceration. Under laceration upper exterior lip 1 cm length and 0.5cm depth, repair method tissue adhesive. Under CT facial bones impression documents: mildly comminuted displaced acute fractures of the bilateral nasal bones.

Facility fall prevention and management policy reviewed 1/2024 documents: The facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies and facilitate as safe an environment as possible. All resident falls shall be reviewed, and resident existing plan of care shall be evaluated and modified as needed. Resident at risk for falls will have fall risk identified on interim plan of care with interventions implemented to minimize fall risk. A fall risk evaluation Is completed by the nurse, a score of ten or greater indicates the resident is high risk for falls. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence.
R8 admitted in the facility on 4/18/24 under hospice care and expired in the facility on 5/29/24.

R8 has diagnoses of Metabolic Encephalopathy, Malignant Neoplasm, Anemia, Type 2 Diabetes, Pain in Right Hip, and Convulsion.

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R8 has a BIMS of 3 (Severe Cognitive Impairment).

R8 had 2 fall incidents in the facility. Fall incidents dated 5/26/24 and 5/28/24.

R8 has care plan for high risk for fall with an initial date of 4/18/24.

R8 has care plan for high risk for falls related to impaired mobility and history of seizure with a created date of 4/21/24 and revised date of 5/30/24.

R8's 5/26/24 fall incident reads in part: R8 was observed on the floor, during final rounds laying on the right side, using right arm to support his head. When R8 was asked what happened. R8 was unable to explain what happened, but when asked if he was trying to turn, R8 said "yes".

R8 fall care plan updated after the first fall on 5/26/24 and intervention added was provide perimeter pillows dated 5/26/24.

R8's 5/28/24 fall incident reads in part: Nurse was called and notified by R8's family member who was visiting R8 that R8 was on the floor mat. Upon entering the room, writer observed R8 on the floor mat. R8 was rounded on 10 minutes before the incident. R8 was in bed sleeping and bed in low position. No injury. Assisted back to bed with 2 staff.

R8 fall care plan updated after the second fall on 5/28/24 and interventions added were bed bolsters for perimeter awareness and rounding for prompt assist for change in position, toileting, offer fluids, and ensure resident is warm and dry dated 5/28/24.

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On 7/26/24 at 2PM, V31 (Complainant) stated that another family member came in before her and saw R8 on the floor next to his bed. V31 stated that this family member recorded the time that the nurse was made aware of the fall. V31 stated her family member stopped recording when V31 arrived on the scene. V31 observed R8 on the floor, no staff with the resident just the other family member. V31 reported that 2 female staff members entered the room and assisted in placing back R8 into his bed. They waited 13 minutes with no staff watching R8 and R8 was left on the floor.

Review of family's attached video with this complaint. Video shows V28 (Nurse) walking in the room. R8 on the floor, laying on floor mat with pillow on his head. Nurse left the room. Video ended.

On 7/26/24 at 2:40PM, V7 (IP Nurse, covering DON) stated that for any fall incident, the team will meet and discuss the root cause analysis. Based on the fall, they will add interventions appropriate for the resident. For R8's fall incident on 5/26/24, the team doesn't know how R8 really fell, might be due to R8 was restless and maybe repositioning himself in bed. We added perimeter pillows after the first fall. Floor mats were in place the morning of 5/28/24, before his 2nd fall. Due to the fall of 5/26/24, pillows were used to tuck on his side that will give awareness to R8 that he is close to the edge of the bed. Somedays R8 was more alert than other days, the intervention added would be helpful on the days R8 was more alert. V7 stated that after R8's second fall the team added interventions of monitoring and bolster small foam, which is a little more solid than a pillow. During R8's health decline, that was when

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the falls happened. In general, CNAs or staff that found the patient on the floor, has to call or yell out for help or push the call light; but stay in the room because we don't want the resident to move until they are assessed by a nurse.They need to assess the resident before moving and placing the resident back to bed. The nurse has to give an okay in order for them to move the resident. Our expectation is for the staff to keep an eye on the patient to prevent anything else that could happen with the patient. Expectation to call for assistance immediately, we have plenty of people around to help.

Fall Prevention and Management Policy with a revised date of 1/2024, reads in part: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as [possible. All resident falls shall be reviewed, and the resident existing plan of care shall be evaluated and modified as needed.

A fall risk evaluation will be completed on admission, readmission, and quarterly, significant change and after each fall.

Care plan to be updated with new interventions based on the root cause analysis after each fall occurrence.

(B)