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	IL6003628	A. BUILDING: _____ B. WING _____	C 10/04/2024

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ALIYA OF GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

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S 000	Initial Comments Facility Reported Incident of 9/1/24/ IL177997	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999		

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and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

These requirements were not met as evidenced by:

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Based on interview and record review, the facility failed to supervise one resident (R2) who was diagnosed with Dementia, cognitively impaired with a history of falls and identified as high fall risk from sustaining three falls within forty-five days. This affected one of three residents (R2) reviewed for falls. This failure resulted in R2 sustaining an unwitnessed fall with a laceration to the back of the head injury requiring suture and staple repair and sustaining another fall with a laceration to the back of the head requiring staples.

Findings include:

R2 was admitted to the facility on 6/15/24with a diagnosis of type II diabetes, dementia, psychosis, Alzheimer's disease, anemia, encephalopathy, and history of falling. R2's minimum data set dated 8/26/24 documents brief interview for mental status score a 3/15 which indicate severe cognitive impairment.

R2's fall risk dated 8/26/24 documents R2 at risk for falls.

R2's psycho therapy progress note dated 8/15/24 documents: chief complaint: follow up on restlessness and dementia. Info gathered from staff: staff report patient is less anxious, less restless, confused, tries to get up at times with no assistance, requires close monitoring. Patient seen sitting on wheelchair by the nurses' station, appears comfortable, pleasantly confused. Denies anxiety or depression. denies sleep and appetite concerns. Patient is being continuously monitored by staff for safety due to unsteady gait and trying to get up with no help.

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R2's incident report dated 8/17/24 documents: Resident noted face down on the side of her bed. Resident was assessed head to toe. No injury noted. R2 assisted back to wheelchair. Under mental status: disoriented but within normal limits for this resident, oriented to person. Under predisposing physiological factor: impaired memory; Under predisposing situation factors- ambulating without assistance.

On 10/3/24 at 12:32PM, V11 (Restorative nurse) R2 is confused due to diagnosis of dementia and she can be restless. V11 said R2's fall on 8/17/24 was due to R2 unaware of safety needs. V11 said R2 has dementia and may do things that are unsafe. Interventions placed were x-rays, toileting before and after meals, and floormats were added. R2 is in the busy bee program during the day and should be monitored by staff. R2 needs to be in a high visual area when out of bed. R2 will sometimes be at the nursing station after activities so staff are present. R2 has a behavior of standing up from her wheelchair.

R2's incident report dated 9/1/24 documents: Writer was informed by another staff that resident was on the floor. Writer observed laceration to the back of head and resident was bleeding. Under mental status: disoriented but within normal limits for this resident, oriented to person. Under predisposing situation factors documents restless.

Facility reportable dated 9/1/24 documents: R2 had an unwitnessed fall on 9/1/24 around 6:26PM at the nurse's station. Resident was unable to state what occurred. Full body assessment noted bleeding from the head. Md notified and order to the hospital for evaluation. Resident retuned with a diagnosis of laceration to the head and four

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staples to the area. Under Final: Based off the facility investigation, it can be determined that the resident had a fall event due to standing from her wheelchair, causing it to tilt backwards. As a precaution, antitippers were added to R2' wheelchair while remaining in visible sight of staff during wake hours. Under summary of investigation: V5 (laundry aide) was interviewed. V5 said he was pulling linen on C/D wing when R2 suddenly stood up form her wheelchair and fell backwards. V21 (nurse) said she was administrating medication on her assigned wing when she heard V5 call for help.V9 (Nurse) said she was administrating medication on her assigned wing when she was notified by peer that resident had fallen.

On 10/1/24 at 2:52PM, V5 (laundry aide) said he was going to pull the soiled linen near nursing station and observed R2 sitting behind the nursing station at the desk. V5 said there were no other staff present. The nurses were in the hallways passing medication. V5 said he saw R2 start to stand up and heard another resident telling for R2 to sit down. V5 said he heard a noise and when he looked he did not see R2 anymore. V5 said he went closer and observed R2 on the floor next to her wheelchair. V5 said the wheelchair was flipped back. R2 hit her head on the floor.

On 10/3/24 at 3:23PM, V10 (CNA)said he was familiar with R2's care. R2 likes to stand up from her wheelchair and try to walk. R2 requires frequent checks and staff will take turns sitting with her because of her impulsive behaviors. R2 will usually sit by the nursing station so someone is with her because she is a high fall risk. On 9/1/24, V10 said he was R2's assigned aide. V10 said R2 was sitting behind the nursing desk with

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staff. V10 said he told staff he was going on break and when he returned he received report that R2 had fallen and was sent to the hospital.

On 10/3/24 at 3:48PM, V9 (Nurse) said she was familiar with R2 care needs. V9 said R2 is agitated and restless and staff will keep her at the nurses station for close monitoring. R2 is always trying to stand up from her wheelchair to go to the store or home. V9 was one of nurses working on 9/1/24 when R2' fall occurred. V9 said she was not at nursing station when R2 fell and unsure what staff was there. R2's fall was unwitnessed and she was found behind the nursing desk on the floor with head injury. V9 said someone should have been at the nursing station watching the residents.

On 10/3/24 at 12:32PM, V11 (Restorative nurse) said the fall on 9/1/24 root cause was impulse, and anti-tippers added to wheelchair and therapy screen.

On 10/4/24 at 10:31AM, V20 (ADON) said they do not currently have any residents on one to one monitoring. Some residents maybe on close monitoring which indicates staff are making frequent rounds and watching the residents closely. Some at risk residents are placed near the nursing station when activities are not being done for close monitoring. The nurse's station is not left unattended, and staff are always near the area. The nurses or aides are responsible for monitoring the residents.

R2's fall IDT note dated 9/2/24 documents: Summary of incident: The writer was notified by the other nurse that the resident is on the floor. The writer assesses the resident and observes that the resident is bleeding from her head, the

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writer stabilizes the resident until the ambulance arrives at about 6:31pm. Root cause of fall determined by IDT: nothing documented. New interventions and/or changes suggested by the IDT at this time: Bed mat in place , call light within reach and bed in lowest position.

R2's hospital record dated 9/1/24 documents under notes: R2 is alert and oriented x1 which is her baseline. R2 states she does not recall how the fall happened as it occurred very quickly. Per nurse who spoke to nursing home staff, fall was unwitnessed, but they suspect R2 fell out of her wheelchair. Under physical exam: 2 centimeters by 3 centimeter laceration in the shape of a cross with central gaping revealing skull. Under laceration repair for occipital scalp length 3 centimeters x 4 milmeters depth. Sutures and staples used. Two sutures used for gaping center and 4 staples applied to the edges.

R2's therapy notes dated 9/5/24 documents under precautions: fall risk, confusion with decreased safety awareness, 1:1 supervision for safety.

R2's facility state reportable dated 9/28/24 documents: R2 had witnessed fall on 9/28/24 around 11:30PM at the nurse's station. Full body assessment noted bleeding from the head. MD notified and order to send the hospital for evaluation. R2 returned with diagnosis of laceration and four staples to the area.

R2's incident report dated 9/29/24 documents: Resident was observed sitting in wheelchair across from the nurses station, she stood up and tried to sit back down and missed the chair and fell on her buttocks, hit her head against the wall, a small laceration with blood was noticed from the

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back of her head pressures was applied, 911 called.

On 10/3/24 at 1:13PM, V12 (Nurse) said he was working the night R2 fell on 9/28/24. V12 said R2 has behaviors of trying to get out of bed and standing up from wheelchair. R2 has always had these behaviors and staff will take turns sitting with her during the shift to prevent her from falling. V12 said R2 was sitting across from the nursing station. V12 said R2 was attempting to get out of bed prior and that's why she was at the nursing station. V12 said they were doing change of shift report and V15(CNA) was assisting another resident with his shoes near R2. R2 stood up from her wheelchair and was instructed to sit back down but she must have moved and missed the wheelchair and fell to the ground. R2 hit her head on the floor or wall and did have an injury. R2 was sent out to the hospital.

On 10/3/24 at 3:48PM, V9 (Nurse) said R2's fall on 9/29/24 was during change of shift. R2 was sitting in her wheelchair in front of the nursing station. R2 stood up from her wheelchair and staff instructed her to sit back down but she must have stepped to the side because when she sat back down she missed the wheelchair and fell hitting her head on the wall or other chair near her. There was an aide sitting near R2 who was helping another residents with his shoes but she could not see R2. Nurses were all busy doing change of shift and could not reach R2 in time.

On 10/3/24 at 2:08PM, V15 (CNA) said she was familiar with R2's care needs and was present at time of fall on 9/28/24. V15 (CNA) said she was working on the unit and was near the station when another resident approached her to assist with his shoes. V15 said she took a chair that was

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near R2 and sat down with her back turned to R2. V15 said she assisted the resident with his shoes and during that time, R2 stood up and nursing staff was verbally instructing R2 to sit down. V15 said R2 will usually sit down when told and she was sitting but she moved and fell down to the floor by missing her wheelchair and hit her head possibly on the wall. V15 said she was not assigned to watch R2 at time of the fall.

On 10/3/24 at 2:40PM, V11 (Restorative nurse) said The root cause of fall on 9/29/24 was impulse. V11 was asked where and what interventions were in place for R2's impulsive behaviors. V11 presented careplan for behavior problem manifested by attention seeking behaviors that include sitting or laying on the ground, making statements that are false. Interventions documented: administrate medications as ordered and anticipate the needs of the residents.

R2's hospital record dated 9/29/24 documents under diagnosis fall, blunt head injury and scalp laceration. Under procedures laceration repair: occipital scalp 2 centimeter wound. Repaired with four staples.

R2 plan of care documents: R2 is at risk for High risk falls related to impaired mobility, weakness, Diabetes, high risk medication use, impaired cognition, agitation, history of falling prior to admission Date Initiated: 06/17/2024 Revision on: 06/27/2024.
Interventions:
Anticipate and meet The resident's needs. Date Initiated: 06/17/2024.
Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to

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all requests for assistance. Date Initiated: 06/17/2024
Dycem to bed added to wheelchair Date Initiated: 06/23/2024 Revision on: 07/05/2024
Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 06/17/2024
Ensure that the resident is wearing appropriate footwear shoes, non-skid socks when mobile on unit Date Initiated: 06/17/2024 Revision on: 06/25/2024
Follow facility fall protocol. Date Initiated: 06/17/2024
Medication review Date Initiated: 09/30/2024 Revision on: 09/30/2024
Placed in busy bee Activities during the day Date Initiated: 06/17/2024
Pt evaluate and treat as ordered or PRN. Date Initiated: 06/17/2024
PT screen Date Initiated: 09/01/2024
Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers as to causes. Date Initiated: 06/17/2024
Tippers to wheel chair Date Initiated: 09/01/2024 Revision on: 09/09/2024
Toilet before meals after meals, and at bed time. Date Initiated: 08/17/2024
Xray to left hand and Left knee Date Initiated: 06/25/2024

Facility policy titled Fall prevention and management reviewed 1/24 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 as an environment as possible.

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S9999	Continued From page 10 All residents fall shall be reviewed, and the residents existing plan of care shall be evaluated and modified as needed. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence. (B)	S9999		