| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145684 | A. Building<br>B. Wing | 07/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aliya of Homewood | 940 Maple Avenue<br>Homewood, IL 60430 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Based on interviews and record review, the facility failed to prevent an injury of unknown origin which occurred for one resident. This affected one of three residents (R1) reviewed for injury of unknown origin. This failure resulted in R1 sustaining an undetermined injury of an acute left humeral neck with displaced transverse fracture.Findings Include:R1's referral package dated 8/17/22 documents: past medical history of falls, osteoporosis and closed hip fracture. R1 was admitted with the diagnosis of Age-Related Osteoporosis without current pathological fracture. Minimal data set section C (Brief interview for mental status) dated 6/3/25 document a score of four (4) which indicates severe cognitive impairment. Section GG (functional abilities) documents: R1 required substantial/maximal assistance with upper body dressing, the ability to dress and undress above the waist: including fasteners, if applicable. Event report dated 6/29/25 documents: At approximately 4:00pm on 6/29/25, the assigned V6 (CNA) reported to V8 (nurse) that following taking R1's blood pressure with the vital machine there was a discoloration to her left arm. V8 and another nurse went to assess and noted a mild discoloration to R1 left arm where the cuff was applied. Action taken: range of motion within normal limits, R1 denied pain, MD notified of temporary discoloration that appears to have resolved. R1's X-ray requisition dated 7/1/25 documents reason: unable to move left arm. Radiology report dated 7/1/25 document: Impression: Left humerus (long bone in the upper arm neck extending from the shoulder to the elbow) with complete transverse fracture with displacement. V8's witness statement dated 7/2/25 documents: continues to monitor R1 with no worsening and it seemed to resolve.On 7/15/25 at 9:35am, V9 (nurse) said on Sunday June 29th at the end of her day shift, and the beginning of V8's (nurse) shift which was the evening shift (3pm-11pm), V8 asked V9 to look at R1. V9 said, R1 was observed with bruised area to the left upper arm. V6 reported taking R1's vitals, V9 said V8 was asking R1 questions about her left arm. V9 said, R1 was unable to report how she got the bruise or an incident. V9 denies knowledge of incident/abuse involving R1. On 7/15/25 at 10:07am, V6 (CNA) said, when he did his rounds and passed water to R1 around 2:30pm -3:00pm, R1 was relaxing perfectly fine in bed. V6 said, about an hour later he took R1's vitals. V6 said, R1 made a face when he took off the blood pressure cuff off her arm. V6 said, he informed the nurse who instructed V6 to update him if R1's bruise got worst. V6 said, R1's bruise was a little red. V6 said, R1's bruise did not get worst. V6 said, he asked R1 what happened, R1 denied fall or abuse. Vital report dated 6/28/25 and 6/29/25 taken by V6 (CNA) documents lying/r/arm. On 7/18/25 at 2:15pm, V2 said, r indicates Right arm.On 7/15/25 at 12:08pm, V1 (administrator) said R1's bruise was not an injury of unknown origin R1's left arm fracture was. V1 said, she does not know when R1's fracture occurred. V1 said, staff saw the discoloration to R1's arm after V6 (CNA) removed the blood pressure cuff. Then an x-ray was ordered which resulted in a fracture. V1 said, R1 did not have a traumatic event. V13 (nurse practitioner) said, R1's fracture was pathological. R1 had a diagnosis of osteoporosis and osteopenia. On 7/15/25 at 1:11pm, V16 (orthopedic specialist) said, R1's fracture was due to either a fall on the ground landing on her left arm or someone moved R1 attempting the wrong way, lifting by R1's arm instead of R1's core. Pathological fractures are due to underlying conditions associated with cancers/tumor. V16 said, a blood pressure cuff did not cause R1's fracture. R1 is not a healthy person but none of her current diagnosis would be associated with her fracture. V16 said, bruising/blood takes three to five days to come out of the bone, travel through the muscle and appear on the skin. On 7/15/25 at 1:29pm, V13 said, staff called him to report R1's bruise. Staff reported R1 had a routine blood pressure and when the cuff was removed, she had a bruised area where the cuff had been placed. V13 said he asked what happened, staff denied pain initially, fall or trauma. R1 had osteoporosis. R1's bruising increased. R1 complained of mild pain. R1 had swelling noted to her left upper arm. V13 said, he ordered an x-ray which resulted in a transverse fracture. V13 said, R1 was discharged to the hospital for further evaluation. No surgery was indicated. R1's fracture could be from osteoporosis or from normal activities of living (ADL) i.e. R1 could have been moving and the bone just snapped or with ADL care when staff was helping resident. R1 was on prednisone which can demineralized the bones. V13 said, he did not review the x-ray result, speak with any of the hospital doctors or the orthopedic doctor in order to determine the root cause of R1's fracture. V13 said, he cannot differentiate the cause of R1's fracture. V13 said, he relied on staff's information. V13's practitioner note dated 7/7/25 documents: Member (R1) with significant past medical history of osteoporosis, hypothyroidism, severe calories malnutrition and based on review of hospital note, her (R1) acute displaced fracture to left humerus is mostly due to pathological fracture. Per staff, on 6/30/25 evening, R1's blood pressure taken and they |