

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER Aliya of Glenwood		STREET ADDRESS, CITY, STATE, ZIP CODE 19330 South Cottage Grove Glenwood, IL 60425	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340</p> <p>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.</p> <p>Findings include:</p> <p>R2 was admitted to the facility on [DATE]with a diagnosis of type II diabetes, dementia, psychosis, Alzheimer's disease, anemia, encephalopathy, and history of falling. R2's Minimum Data Set, dated dated [DATE] documents brief interview for mental status score a 3/15 which indicate severe cognitive impairment.</p> <p>R2's fall risk dated 8/26/24 documents R2 at risk for falls.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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 returned with a diagnosis of laceration to the head and four 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 from her wheelchair and fell backwards. V21 (nurse) said she was administering medication on her assigned wing when she heard V5 call for help. V9 (Nurse) said she was administering medication on her assigned wing when she was notified by peer that resident had fallen.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>R2's fall IDT (interdisciplinary team) 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 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.</p> <p>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 milimeters depth. Sutures and staples used. Two sutures used for gaping center and 4 staples applied to the edges.</p> <p>R2's therapy notes dated 9/5/24 documents under precautions: fall risk, confusion with decreased safety awareness, 1:1 supervision for safety.</p> <p>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.</p> <p>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 back of her head pressures was applied, 911 called.</p> <p>On 10/3/24 at 1:13PM, V12 (Nurse) said he was working the night R2 fell on [DATE]. 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.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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 admitted Initiated: 06/17/2024 Revision on: 06/27/2024.</p> <p>Interventions:</p> <p>Anticipate and meet The resident's needs. Date Initiated: 06/17/2024.</p> <p>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 all requests for assistance. Date Initiated: 06/17/2024</p> <p>Dycem to bed added to wheelchair Date Initiated: 06/23/2024 Revision on: 07/05/2024</p> <p>Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 06/17/2024</p> <p>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</p> <p>Follow facility fall protocol. Date Initiated: 06/17/2024</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Medication review Date Initiated: 09/30/2024 Revision on: 09/30/2024</p> <p>Placed in busy bee Activities during the day Date Initiated: 06/17/2024</p> <p>Pt evaluate and treat as ordered or PRN. Date Initiated: 06/17/2024</p> <p>PT screen Date Initiated: 09/01/2024</p> <p>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</p> <p>Tipplers to wheel chair Date Initiated: 09/01/2024 Revision on: 09/09/2024</p> <p>Toilet before meals after meals, and at bed time. Date Initiated: 08/17/2024</p> <p>Xray to left hand and Left knee Date Initiated: 06/25/2024</p> <p>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. 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.</p>