STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145866	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Vlg Nrsg & Rhb	9246 South Roberts Road Hickory Hills, IL 60457

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to follow their notification of change guidelines by not immediately reporting one resident's (R1) fall to the physician and resident representative for one of three residents reviewed for notification. Findings include: R1 was admitted to the facility on [DATE] with a diagnosis of rheumatoid arthritis, depressive disorder, bilateral osteoarthritis of knees, restless leg syndrome, and fibromyalgia. R's1 Brief Interview for Mental Status score dated 11/20/24 documents a score of 14/15 which indicates cognitively intact. Facility reportable dated 12/27/24 documents: On 12/25/24 R1 had witnessed fall while staff was providing care. Family and physician notified on 12/27/24. Facility witness statement by V5 (Nurse) dated 12/27/24 documents: I did not notify anyone. On 1/9/25 at 5:07PM, V5(Nurse) said she received report from R1's aide that she rolled out of bed on Christmas day. V5 said she went to the room and saw R1 on the floor next to low bed. V5 said she forgot to complete an incident report or notify the family, physician, and management. V5 said if a resident has a fall, they are supposed to notify the family, physician, and management but she just forgot. V5 said she did not tell anyone else about the fall. On 1/10/25 11:10AM, V2 (Director of Nursing, DON) said for any resident fall the nurse should notify the family, Medical Doctor or representative, and Director of Nursing on the day event occurs. Fall and notification should be documented in medical record. V5 failed to follow this procedure and was terminated because of this failure. On 1/14/25 at 10:30AM, V13 (Medical Doctor, MD) said he expects staff to notify him or his staff of any falls on the day of the incident. Facility event report for R1 dated 12/31/24 documents: event date 12/25/24 fall in resident room. Under notifications to physician and resident representative it documents no. R1's progress notes do not document any notification to the family or medical doctor on 12/25/24. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility notification of change guideline dated 10/1/21 documents: It is the practice of the facility that changes in a resident condition or treatment are immediately shared with the resident and/or representative and are reported to and consulted with the attending physician. Facility employee report dated 12/27/24 documents: V5(Nurse) failed to report a fall incident to the Director of Nursing on 12/25/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to supervise one resident who was identified as a high fall risk as well as dependent on staff for bed mobility and toileting, by leaving the resident on their side unattended on an elevated bed (approximately 3 feet). This affected one of three (R1) residents reviewed for falls. This failure resulted in R1 having an unwitnessed fall, being transferred to the hospital, and sustaining a pelvis fracture. Findings include: R1 was admitted to the facility on [DATE] with a diagnosis of rheumatoid arthritis, depressive disorder, bilateral osteoarthritis of knees, restless leg syndrome, and fibromyalgia. R1's Brief Interview for Mental Status score dated 11/20/24 documents a score of 14/15 which indicates cognitively intact. R1's restorative program observation dated 11/20/24: toileting hygiene documents dependent on staff. Dependent helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity. Mobility roll left and right documents: dependent on staff. Dependent helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity. R1's fall risk observation dated 11/20/24 documents: high risk for falls. Facility reportable dated 12/27/24 documents: On 12/25/24 R1 had witnessed fall while staff was providing care. Staff was providing incontinence care when resident rolled out of bed. R1 reported pain on 12/27/24, MD notified and orders to send to hospital. Xray positive for pelvic fracture. Under occurrence resolution: Staff was in-service on bed mobility and incontinence care. Staff will provide care to R1 with two staff members. On 1/9/25 at 3:47pm V3 (Certified Nursing Assistant, CNA) said around 7:00pm V3 provided incontinence care to R1. V3 said she raised the bed to waist level (V3 self-reported she was 5 feet 9 inches) and when she turned R1 to her side she observed the linen was wet. V3 said she left R1 on her left side and went to get linen from the dresser. V3 said when she was at the dresser her back was to the resident and then she heard R1 fall from the bed. R1's hospital record dated 12/27/24 documents: pelvis xray acute fracture noted in the left pubic bone, extending to the left superior pubic ramus. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility accident management meeting form documents under root cause: Certified Nursing Aide, CNA was providing care in patient's bed. CNA rolled patient on her side and stepped away from the patient and she rolled onto the floor. New interventions: When providing care in bed CNA should always roll patient towards them and not away from them. CNA should position resident in the middle of bed before rolling patient to their side. Witness statement for V3 (CNA) documents: V3 went to provide care to R1. V3 raised the bed to waist level and turned R1 to the window. I stepped away to the dresser to grab a sheet because when V3 turned R1 she saw the bed was wet too. V3 said when she turned back around, she saw that R1 had fell . On 1/10/25 11:10AM, V2 (Director of Nursing, DON) said staff should not leave a resident unattended during care. Staff should never turn their back to a patient due to safety and fall risk. Facility in-service record sheets documents under information provided: CNAs in serviced on bed mobility. Residents should be in the middle of the bed. When rolling a resident to their side you should pull the resident to you and then roll them on their side. Always have another CNA with you when providing bed mobility. CNAs were in serviced on incontinence care. All supplies should be at the bedside when providing care. Never walk away from a patient when providing care in the bed to retrieve supplies. Always have another CNA with you when providing care.