STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146078	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahva Care of Stickney	3900 South Oak Park Avenue Stickney, IL 60402

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 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** 38796 Based on interviews and record reviews, the facility failed to follow the plan of care intervention to ensure that the resident's environment was free of clutter, which is necessary to promote a safe environment. This deficiency affected one of three residents (R4). As a result, R4 rolled from the bed and struck her head on the garbage can, causing facial lacerations that required 8 sutures. Findings include: R4 face sheet shows R4 has diagnoses of unspecified dementia, muscle wasting and atrophy, other abnormalities of gait and mobility, lack of coordination, insomnia. Facility final investigation to the department dated 1/9/25 denotes in-part, fall, R4, alert x/times one. [AGE] year-old, BIMS/Brief Interview for Mental Status) of zero. On 1/5/25 the doctor gave orders to send R4 to the hospital to be examined for a fall. The physician and family were informed. During the final investigation process and medical records review the following facts were determined: On 1/5/25 R4 returned from the hospital with eight stiches to her left eyebrow. During the investigation process R4 roommate informed staff that R4 rolled out of bed onto the floor mat by her bed and somehow hit her head on the trash can by her bed. Facility incident report dated 1/5/25 denotes in-part V2 (Registered Nurse) stated nurse responded to a noise of what sound like a garbage can and upon entry into resident's room the resident was noted lying on the floor mattress with head closest to the head of bed. (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 Level of Harm - Actual harm Residents Affected - Few	On 1/15/25 at 1:58pm V3 (CNA- certified Nursing aide) stated R4 was observed on the floor mattress (floor mat) at around 11:00pm or so. V3 stated V3 and V2 (RN) put R4 back in bed. V3 stated R4 brief was dry. V3 stated around 12:30am, R4 was observed on the floor mattress again. V3 stated R4 body was on the floor mattress and R4 head was off the floor mattress on the floor. V3 stated R4 was bleeding from the head/face. V3 stated the garbage can was flipped over by R4's head. V3 stated R4 could have hit her face on the wall socket also. V3 stated the Nurse did not give her any new directives after they picked R4 up from the floor the first time that night. V3 expressed that R4 was not a good fit for that room. V3 stated R4 roommate liked the television loud and the room cold. V3 stated R4 didn't sleep well at night in that room. V3 stated she has mentioned this to the Nurse. V3 stated she (V3) has mentioned that R4 was not a good fit several times. V3 stated she does rounds every two hours maybe every hour usually. V3 stated she has observed R4 on the floor mattress prior to that night. V3 stated R4 is at risk for falls. On 1/15/25 at 4:01pm V2 (RN) stated R4 was removed from the floor mattress prior to being observed on the floor mattress bleeding from the head. V2 stated the first time they (V2 and V3) put R4 back in the bed, the interventions were to check to see if R4 was wet and R4 was dry. V2 stated then put R4 back in bed. V2 stated R4 is rounded on every 1 to 2 hours. V2 stated she did not give V3 any further directives for R4 at that time of the first fall. V2 stated she did not recognize R4 first incident as a fall as R4 was having behaviors. V2 stated she did not contact anyone for directives when R4 was having behaviors. V2 stated the second incident is when she heard noise of a garbage can, as she went to investigate, R4 roommate put the call light on and stated R4 was doing something with the garbage can. V2 stated R4 was observed on the floor mattress bleeding from the head/face. V2 stated she rendered first aid; she V2 observed a laceration above R4 left eyebrow and a laceration under the left eye. V2 stated the garbage can was by R4s head. V2 stated she was not in the room so she can't say what happened. V2 denied knowing about R4 roommate keeping the room too cold and the television too loud for R4 to sleep. V2 stated R4 roommate does like to keep her fan on in the room. V2 stated she can't discern what is considered a loud TV. V2 stated R4 didn't sleep well at night but she administered melatonin to R4. V2 stated the melatonin only worked a few hours for R4. V2 stated she endorsed in the past for the nurse to inform the provider that the melatonin only worked for a few hours for R4. V2 stated she doesn't know if the Nurse reported to the Physician/Nurse practitioner. R4 progress notes dated 1/5/25 denotes in-part unwitnessed fall event. Writer observed resident lying on her left side on floor mattress at bedside. Left side of face bleeding with open areas x2. Resident noted awake and alert, at baseline. Pressure applied, sites cleaned, and dry dressings applied. Resident was assisted back into bed with staff assist x2. Head to toe assessment performed. No other visual injuries noted. Neuro (neurological) check performed. ROM (range of motion) to all extremities at baseline. Resident has Dx (diagnosis): Dementia, unable to state how fall occurred. Vitals: T(temperature) 97.6, R (respirations) 20. Unable to obtain B/P (blood pressure, pulse, and SPO2 because resident did not remain still long enough for an accurate reading. On call DON (Director of Nursing) made aware. V4 (Physician) made aware, awaiting MD (medical doctor) response. Attempt to make son aware, no answer. Left message to contact facility. Call to 911 to send resident to (hospital name) Hospital per facility protocol. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/15/24 at 3:00pm V5 (Director of Nursing) stated the first incident of R4 observed on the floor mat (full size mattress) was a fall. V5 stated the nurse failed to recognize that R4 had a fall. V5 stated V2 did not inform her that R4 had a fall or that R4 was experiencing behaviors prior to being observed bleeding from head. V5 stated V2 informed her that the garbage can was by R4 head, and that's why she implemented to remove the garbage can from R4's room. V5 stated V2 should have implemented a new intervention for R4 after the first fall that night. V5 stated the nurse should have used nursing judgement to determine an intervention based on what was observed at the time of the fall. V5 stated the Nurse does not have to wait for her directives to implement an intervention, she educated her staff on that. V5 stated she was aware that R4 didn't sleep well at night that's why she got the order for the melatonin. V5 stated she was not aware that the melatonin was only effective for a few hours and that R4 continued to be awake at night. V5 stated she was not aware that R4 roommate was not a good fit for R4 because the room was cold, and the television is loud at night. V5 stated the aide did not make her aware of this allegation/observation. V5 stated R4 floor mat was not the same height as the bed as mentioned by V2. V5 stated R4 did have a fall, it was a change in plane for both incidents. V5 stated she has to educate V2 and V3. V5 stated the nurse informed her that the garbage can was near R4 head and that's she implemented the intervention of removing the garbage can from R4 room. V5 stated she concluded that R4 hit her face/head on the garbage can. R4 plan of care with initiated date of 7/19/2024 denotes in-part the resident has a potential for falls due to current medical condition and confusion, deconditioning, gait/balance problems, poor communication/comprehensive, unaware of safety needs. Actual fall (12/12/24 and 1/5/25). The resident will not sustain serious injury through next review date, target date 1/15/25. Reduce the risk of injury by next review. The resident falls will be minimized. Interventions: anticipate the resident needs, encourage the resident to wait for the staff for assistance before performing any activities of daily living such as transfer, toileting etc. Ensure the resident is wearing appropriate footwear and floor mattress next to the resident bed. Keep bed at the lowest position and keep the floor dry to prevent the resident from slipping. Keep the pathway and resident's environment free from clutter. Keep the resident call light within reach and encourage the resident to use it for assistance as needed. May wear helmet to head PRN (as needed) when restless or agitated, to protect against head injuries as tolerated. Move resident room closer to nurse station. Orient the resident to the environment. Therapy to evaluate and treat as ordered by the physician and no garbage can at the bed side. 1/16/25 at 2:49pm V6 (Administrator) stated R4 fall with injury was an accident. V6 stated he (V6) does not understand how R4 hit her face/head on the garbage can. V6 state he only interviewed the resident during this investigation and that the Director of Nursing interviewed the nurse (V2) and CNA (V3). Upon exit of this survey V6 failed to present further information of how R4 suffered the two lacerations to her face after the fall/accident. Facility falls- (clinical protocol) policy with revised date of March 2020 denotes in-part the staff will evaluate, and document falls that occur while the individual is in the facility, the staff and physician will monitor the resident's response to interventions intended to reduce falling or consequences of falling. If the individual continues to fall, the staff and physician/NP will reevaluate the situation and consider other possible reasons for the residents falling and will reevaluate the continued relevance of current interventions.