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 _____	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHVA CARE OF STICKNEY	**3900 SOUTH OAK PARK AVENUE STICKNEY, IL 60402**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation: 2196806/IL138245- F689G, F777D cited	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have a plan in place with safety interventions to include monitoring a resident assessed to be at risk for fall and poor safety judgement. This affected 1 of 3 residents (R1) reviewed for safety. This failure resulted in R1 having an unwitnessed fall that resulted in a left hip fracture. Findings include: On 9-21-21 at 11:46 AM, V2 (DON) said V1 (LPN) notified nursing office about R1's unwitnessed fall. R1 is capable of activating call light, however R1 has poor safety awareness and is impulsive due to dementia. On 9-21-21 at 11:01 AM, V4 (LPN) said R1 is alert and oriented x 2-3 with periods of confusion and forgetfulness. V4 said R1 was known to get up by herself. R1 was a fall risk because of poor	F 689	Plan of Correction F689 Submission of this Plan of Correction by the facility is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the survey agency. Please accept the following as the facility□s credible allegation of compliance: 1. R2 is currently in the hospital. Upon R2□s return, the facility shall assess this resident for safety needs. R2□s plan of care shall also be updated based upon	9/29/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/29/2021

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F 689	Continued From page 1 safety judgement and unsteady gait. On 9-21-21 at 11:32 AM, V5 (CNA) said she was coming from break and noted R1 was sitting upright in the other bed in her room. V5 asked why she was in the other bed and how she got to the other bed. R1 said she was throwing something in the garbage closer to the other bed. R1 said she tripped over the oxygen cord which is hooked up to her concentrator. V5 said R1 admitted to falling. On 9-21-21 at 11:46 AM, V2 (DON) said 2nd shift nurse (who received R1's radiology report) attempted to notify MD/NP of R1's Radiology report but was unsuccessful in reaching either on 9-9-21. V2 was able to update MD/NP 3 days later and received orders to send to hospital for further evaluation on 9-12-21. R1 was admitted to hospital and initial hospital x-ray was inconclusive. Hospital then did a CT (9-13-21) which documented comminuted fracture of left greater trochanter extending to base of lateral neck. On 9-21-21 at 1:13 PM, V6 (MD) said he is not sure he received R1's inconclusive radiology results on 9-9-21. V6 said NP informed him of results when R1 was sent to hospital. On 9-21-21 at 1:13 PM, V6 (MD) said R1 has history of multiple falls, ataxia, and gait issues. V6 is unable to determine if this fall caused a fracture. The Facilities Falls Prevention Program (revised 10-16) documents, the staff, with physician guidance, will follow up on any fall with an associated injury until the resident is stable and	F 689	these assessed needs to ensure that adequate supervision and assistive devices are provided as warranted. 2. All residents assessed as at risk for falls are identified as having the potential to be at risk for this alleged deficient practice: 3. Measures and systematic changes the facility has taken to correct this alleged deficient practice and ensure it does not recur include: A. Nursing staff and the Inter-disciplinary Team has been inserviced regarding the importance of: " Ensuring the facility environment is free from hazards including, but not limited to, precenting tripping hazards such as O2 hoses on the floor, keeping call lights within resident reach, and prevention of other fall hazards; " Identifying resident fall risk/potential and ensuring that all approaches and interventions are in place to prevent a fall. The importance of accurately documenting these interventions and approaches in the resident□s plan of care was also emphasized; " Carefully monitoring residents identified as at risk for all falls; and " Contacting the resident□s physician in a timely fashion after an accident/incident and to call the facility DON, Medical Director, and/or Administrator if physicians are not responding in a timely manner for further	

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F 689	Continued From page 2 any complications such as fracture or subdural hematoma have been ruled out or resolved. Fall Risk Assessment (dated 9/3/2021) documents R1's score is 16 (at risk). Minimum Data Set (ARD 9-9-21) documents BIMS (Brief Interview for Mental Status) score= 8. Transfer: Self performance= 3 extensive assistance, Support = one person physical assistance. Moving from seated to standing position= not steady, only able to stabilize with staff assistance. Walking= not steady, only able to stabilize with staff assistance. Post Fall Investigation dated (9-9-21), documents R1 stood up due to poor safety awareness, but fell because of bilateral lower extremity weakness. Witnesses: No witnesses found. Radiology Report dated (9-9-21), documents Pelvis x-ray 1-view, Impression: mild suspicion of impacted fracture of the lateral aspect of the left femoral neck, versus positional artifact. Clinical correlation recommended. I recommend dedicated AP and frog leg oblique views of left hip for further assessment. Hospital x-ray Report (dated 9-13-21), documents x-ray hip left 2 or 3 views Findings: slight cortical irregularity involving the greater trochanter may be normal for this patient or could be due to old trauma, but a subtle nondisplaced fracture cannot be excluded. CT left hip Findings: The bones are demineralized. There is a comminuted fracture of the left greater trochanter extending to its base of the lateral neck. Hospital x-ray Report (dated 9-13-21), documents x-ray hip left 2 or 3 views, Findings: slight cortical irregularity involving the greater trochanter may	F 689	directives. 4. The facility has implemented the following Quality Assurance Plan to monitor on-going facility performance and compliance with this requirement: A. The DON and appointed designee(s) will audit all accidents and incidents weekly to ensure that: " Risk assessments were completed in a timely manner; " The plan of care identified interventions and approaches to address identified risk potential; and " Staff had implemented planned interventions and approaches and was appropriately monitoring and supervising the affected resident. Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be reported to the Quality Assurance Committee for further action(s) as necessary. 5. Completion Date: _____09/29/2021_____ _____ _____	

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F 689	Continued From page 3 be normal for this patient or could be due to old trauma but a subtle nondisplaced fracture cannot be excluded. CT left hip, Findings: The bones are demineralized. There is a comminuted fracture of the left greater trochanter extending to its base of the lateral neck. HPI: Patient lives at a nursing home and had an unwitnessed fall 4 days ago. X-rays were initially obtained but were not followed up on, they were found to have possible greater trochanter fracture.	F 689		
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow Policy "Falls Prevention Program" by not promptly notifying MD/NP of inconclusive radiology report of left hip fracture which resulted in resident being transferred to hospital 3 days later for CT which then diagnosed fracture. This failure affected 1 of 3 residents reviewed for falls. Findings include: On 9-21-21 at 11:46 AM, V2 (DON) said 2nd shift	F 777	Plan of Correction F777 Submission of this Plan of Correction by the facility is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by	9/29/21

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F 777	Continued From page 4	F 777		

nurse (who received R1's radiology report) attempted to notify MD/NP of R1's Radiology report but was unsuccessful in reaching either on 9-9-21. V2 was able to update MD/NP 3 days later and received orders to send to hospital for further evaluation on 9-12-21. R1 was admitted to hospital and initial hospital x-ray was inconclusive. Hospital then did a CT (9-13-21) which documented comminuted fracture of left greater trochanter extending to base of lateral neck.

On 9-21-21 at 1:13 PM, V6 (MD) said he is not sure he received R1's inconclusive radiology results on 9-9-21. V6 said NP informed him of results when R1 was sent to hospital.

The Facilities Falls Prevention Program (revised 10-16) documents, the staff, with physician guidance, will follow up on any fall with an associated injury until the resident is stable and any complications such as fracture or subdural hematoma have been ruled out or resolved.

Radiology Report (dated 9-9-21), documents Pelvis X-ray 1 view, Impression: mild suspicion of impacted fracture of the lateral aspect of the left femoral neck, versus positional artifact. Clinical correlation recommended. I recommend dedicated AP (anterior posterior) and frog leg oblique views of left hip for further assessment.

Hospital x-ray Report (dated 9-13-21), documents x-ray hip left 2 or 3 views, Findings: slight cortical irregularity involving the greater trochanter may be normal for this patient or could be due to old trauma, but a subtle nondisplaced fracture cannot be excluded. CT left hip, Findings: The bones are demineralized. There is a comminuted fracture of

the facility of the truth of any facts set forth in this allegation by the survey agency. Please accept the following as the facility□s credible allegation of compliance:

1. R2 is currently in the hospital. Upon R2□s return, the facility shall assess this resident for safety needs. R2□s plan of care shall also be updated based upon these assessed needs to ensure that adequate supervision and assistive devices are provided as warranted. Staff shall maintain timely communications with R2□s attending physician regarding any accidents, incidents, and/or changes of condition.

2. All residents who have had an incident or accident are identified as having the potential to be at risk for this alleged deficient practice:

3. Measures and systematic changes the facility has taken to correct this alleged deficient practice and ensure it does not recur include:

A. Nursing staff and nursing management has been inserviced regarding the importance of:

" Contacting the resident□s physician in a timely fashion after an accident, incident, and/or change of condition. Training was provided that if the attending the physician is not responding back in a timely fashion, they are to contact the facility DON, Medical Director, and/or

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F 777	Continued From page 5 the left greater trochanter extending to its base of the lateral neck. HPI: Patient lives at a nursing home and had an unwitnessed fall 4 days ago. X-rays were initially obtained but were not followed up on, they were found to have possible greater trochanter fracture. Nurses Note (dated 9-12-21) documents Resident alert and oriented x 2-3. Pelvis x-ray findings relay to NP. New orders receive to send resident out for possible impacted left femoral neck fracture. Resident sent to local hospital for further evaluation. Management made aware. Emergency contact (daughter) notified. Resident denies any pain or discomfort at this time. All due medication received. Will continue to monitor closely. Fall precautions maintained. Surveyor and V2 reviewed progress notes together and could not find any nursing note documenting MD/NP follow up until 9-12-21.	F 777	Administrator for further directives. 4. The facility has implemented the following Quality Assurance Plan to monitor on-going facility performance and compliance with this requirement: A. The DON and appointed designee(s) will audit all accidents and incidents weekly to ensure that staff have contacted the attending physician and that the physician has responded in a timely manner. Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be reported to the Quality Assurance Committee for further action(s) as necessary. Please see attached 5. Completion Date: _____09/29/2021_____ _____ _____	