DEPARTMENT OF HEALTH	I AND HUMAN SERVICES				APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	CON	E SURVEY IPLETED
	146078	B. WING			C / 23/2021
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
AHVA CARE OF STICKNEY			3900 SOUTH OAK PARK AVENUE STICKNEY, IL 60402		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000 INITIAL COMMEN	TS	F 0	00		
Complaint Investig	pation:				
	- F689G, F777D cited azards/Supervision/Devices 1)(2)	F 6	89		9/29/21
supervision and as accidents.	resident receives adequate sistance devices to prevent NT is not met as evidenced				
Based on interview failed to have a pla interventions to inc	v and record review, the facility n in place with safety lude monitoring a resident		Plan of Correction F689		
judgement. This af reviewed for safety	risk for fall and poor safety fected 1 of 3 residents (R1) y. This failure resulted in R1 ased fall that resulted in a left		Submission of this Plan of Correct the facility is not a legal admission deficiency exists or that this Stater	that a	
hip fracture.			Deficiencies was correctly cited. In addition, preparation and submiss this POC does not constitute an	า	
On 9-21-21 at 11:4 (LPN) notified nurs unwitnessed fall. R	6 AM, V2 (DON) said V1 ing office about R1's 1 is capable of activating call has poor safety awareness and dementia.		admission or agreement of any kir the facility of the truth of any facts forth in this allegation by the surve agency. Please accept the followir the facility s credible allegation of compliance:	set y ig as	
alert and oriented > and forgetfulness.	1 AM, V4 (LPN) said R1 is < 2-3 with periods of confusion V4 said R1 was known to get vas a fall risk because of poor		1. R2 is currently in the hospital. R2□s return, the facility shall asse resident for safety needs. R2□s pl care shall also be updated based of	ss this an of	
LABORATORY DIRECTOR'S OR PROVID Electronically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 09/29/2021

Electronically Signed

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.

PRINTED: 09/30/2021

		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM	09/30/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION			(3) DATE	SURVEY		
		146078	B. WING				
NAME OF PROVIDER OR SUPPLIER				ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
AHVA CARE OF STICKNEY				000 SOUTH OAK PARK AVENUE TICKNEY, IL 60402			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	coming from break upright in the other why she was in the the other bed. R1 s something in the ga R1 said she tripped hooked up to her co admitted to falling. On 9-21-21 at 11:46 nurse (who received attempted to notify report but was unsu 9-9-21. V2 was able later and received of further evaluation o hospital and initial h inconclusive. Hospi which documented greater trochanter en neck. On 9-21-21 at 1:13 sure he received R7 results on 9-9-21. V results when R1 wa On 9-21-21 at 1:13	AM, V5 (CNA) said she was and noted R1 was sitting bed in her room. V5 asked other bed and how she got to aid she was throwing orbage closer to the other bed. over the oxygen cord which is oncentrator. V5 said R1 6 AM, V2 (DON) said 2nd shift d R1's radiology report) MD/NP of R1's Radiology uccessful in reaching either on a to update MD/NP 3 days orders to send to hospital for n 9-12-21. R1 was admitted to nospital x-ray was tal then did a CT (9-13-21) comminuted fracture of left extending to base of lateral PM, V6 (MD) said he is not 1's inconclusive radiology '6 said NP informed him of	F 6	89	 these assessed needs to ensure that adequate supervision and assistive devices are provided as warranted. 2. All residents assessed as at risk falls are identified as having the poter to be at risk for this alleged deficient practice: 3. Measures and systematic change the facility has taken to correct this alleged deficient practice and ensure does not recur include: A. Nursing staff and the Inter-discipl Team has been inserviced regarding importance of: " Ensuring the facility environment free from hazards including, but not limited to, precenting tripping hazards such as O2 hoses on the floor, keepir call lights within resident reach, and prevention of other fall hazards; " Identifying resident fall risk/potent and ensuring that all approaches and interventions are in place to prevent a The importance of accurately documenting these interventions and approaches in the resident s plan of was also emphasized; 	for ntial es it linary the is s ing itial d a fall.	
	is unable to determ fracture. The Facilities Falls 10-16) documents, guidance, will follow	Prevention Program (revised the staff, with physician up on any fall with an till the resident is stable and			identified as at risk for all falls; and Contacting the resident⊡s physic in a timely fashion after an accident/incident and to call the facilit DON, Medical Director, and/or Administrator if physicians are not responding in a timely manner for furt	ty	

Facility ID: IL6007355

If continuation sheet Page 2 of 6

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 146078 B. WING 09/23/2021 NAME OF PROVIDER OR SUPPLIER AHVA CARE OF STICKNEY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 146078 B. WING 09/23/2021 NAME OF PROVIDER OR SUPPLIER AHVA CARE OF STICKNEY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1		0	<u>MB NO.</u>	0938-0391
146078 B. WING 09/23/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3900 SOUTH OAK PARK AVENUE AHVA CARE OF STICKNEY STICKNEY, IL 60402 STICKNEY, IL 60402 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)				` ´				
AHVA CARE OF STICKNEY 3900 SOUTH OAK PARK AVENUE STICKNEY, IL 60402 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			146078	B. WING_				-
AHVA CARE OF STICKNEY STICKNEY, IL 60402 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
STICKNEY, IL 60402 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		ARE OF STICKNEY						
	/				S	TICKNEY, IL 60402		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DATE	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
F 689 Continued From page 2 any complications such as fracture or subdural hematoma have been ruled out or resolved. F 689 directives. Fail 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. Moving from seated to standing versition= not steady, only able to stabilize with staff assistance. Post Fail 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. A. The DON and appointed designee(s) will audit all accidents and incidents weekly to ensure that: Radiology Report dated (9-9-21), documents Pelvis x-ray /nip left 2 or 3 views Findings: slight cortical irregularity involving the greater trochanter may be normal for this patient or could be due to dol trauma, but a subtle nondisplaced fracture cannot be excluded. C1 left hip Findings: slight cortical irregularity involving the greater trochanter may be normal for this patient or could be due to dol trauma, but a subtle nondisplaced fracture cannot be excluded. C1 left hip Findings: slight cortical irregularity involving the greater trochanter may be normal for this patient or could be due to dol trauma, but a subtle nondisplaced fracture cannot be excluded. C1 left hip Findings: slight cortical irregularity involving the greater trochanter may be normal for the spatient or call be abse of the lateral neck. 5. Completion Date: 09/29/2021 Mospital 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 cordia be ab to dol trauma, but a subtle nondisplaced fracture cannot		any complications is hematoma have be Fall Risk Assessme documents R1's sc Data Set (ARD 9-9- Interview for Menta Self performance= Support = one pers Moving from seated steady, only able to Walking= not stead staff assistance. Po (9-9-21), document safety awareness, I lower extremity wea witnesses found. Radiology Report d Pelvis x-ray 1-view, impacted fracture of femoral neck, versu correlation recommended dedicated AP and ff for further assessme Hospital x-ray Report x-ray hip left 2 or 3 irregularity involving be normal for this p trauma, but a subto be excluded. CT left demineralized. The the left greater troc the lateral neck. Hospital x-ray Report x-ray hip left 2 or 3 irregularity involving	such as fracture or subdural een ruled out or resolved. ent (dated 9/3/2021) ore is 16 (at risk). Minimum -21) documents BIMS (Brief al Status) score= 8. Transfer: 3 extensive assistance, on physical assistance. d to standing position= not o stabilize with staff assistance. by, only able to stabilize with ost Fall Investigation dated ts R1 stood up due to poor but fell because of bilateral akness. Witnesses: No dated (9-9-21), documents , Impression: mild suspicion of of the lateral aspect of the left us positional artifact. Clinical hended. I recommend rog leg oblique views of left hip nent. ort (dated 9-13-21), documents views Findings: slight cortical g the greater trochanter may patient or could be due to old e nondisplaced fracture cannot ft hip Findings: The bones are are is a comminuted fracture of hanter extending to its base of ort (dated 9-13-21), documents views, Findings: slight cortical g the greater trochanter may patient or could be due to old e nondisplaced fracture cannot ft hip Findings: The bones are are is a comminuted fracture of hanter extending to its base of			 4. The facility has implemented the following Quality Assurance Plan to monitor on-going facility performant compliance with this requirement: A. The DON and appointed design will audit all accidents and incidents weekly to ensure that: "Risk assessments were compliant timely manner; "The plan of care identified interventions and approaches to accidentified risk potential; and "Staff had implemented planned interventions and approaches and appropriately monitoring and super the affected resident. Noted problems shall be addressed immediately and identified patterns of non-compliance shall be reported Quality Assurance Committee for faction(s) as necessary. 5. Completion Date:09/29/2021	o nee(s) s eted in ddress d was vising d s/trends d to the urther	

PRINTED: 09/30/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/30/2021 APPROVED 0938-0391	
		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
146078		B. WING			C 09/23/2021			
NAME OF PROVIDER OR SUPPLIER				ST	REET 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689 F 777 SS=D	trauma but a subtle be excluded. CT lef demineralized. They the left greater trock the lateral neck. HP home and had an u X-rays were initially followed up on, they greater trochanter ff Radiology/Diag Srvy CFR(s): 483.50(b)(2) §483.50(b)(2) The f (i) Provide or obtain diagnostic services physician; physiciar or clinical nurse spe State law, including (ii) Promptly notify tl physician assistant, nurse specialist of r clinical reference ra facility policies and practitioner or per th This REQUIREMEN by: Based on interview failed to follow Polic by not promptly notif radiology report of la in resident being tra later for CT which th failure affected 1 of Findings include:	atient or could be due to old nondisplaced fracture cannot t hip, Findings: The bones are re is a comminuted fracture of nanter extending to its base of 1: Patient lives at a nursing nwitnessed fall 4 days ago. obtained but were not / were found to have possible racture. cs Ordered/Notify Results 2)(i)(ii)		589	Plan of Correction F777 Submission of this Plan of Correction the facility is not a legal admission to deficiency exists or that this Statem Deficiencies was correctly cited. In addition, preparation and submission this POC does not constitute an admission or agreement of any kind	that a nent of on of	9/29/21	

Facility ID: IL6007355

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
and plan C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COMPLETED
		146078	B. WING		C
	PROVIDER OR SUPPLIER	140070		STREET ADDRESS, CITY, STATE, ZIP CO	09/23/2021
				3900 SOUTH OAK PARK AVENUE	
AHVA CA	RE OF STICKNEY			STICKNEY, IL 60402	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
F 777	Continued From pa	ide 4	F 77	77	
		d R1's radiology report)	1 / /	the facility of the truth of any	facts set
		MD/NP of R1's Radiology		forth in this allegation by the	
		uccessful in reaching either on		agency. Please accept the fo	
	9-9-21. V2 was able	e to update MD/NP 3 days		the facility⊡s credible allegati	
		orders to send to hospital for		compliance:	
	further evaluation on 9-12-21. R1 was admitted to				
	hospital and initial h			1. R2 is currently in the hos	
		ital then did a CT (9-13-21) comminuted fracture of left		R2 s return, the facility shall	
		extending to base of lateral		resident for safety needs. R2 care shall also be updated ba	
	neck.	extending to base of lateral		these assessed needs to ens	
	nook.			adequate supervision and as	
	On 9-21-21 at 1:13	PM, V6 (MD) said he is not		devices are provided as warr	
	sure he received R1's inconclusive radiology			shall maintain timely commu	
		/6 said NP informed him of		R2 s attending physician reg	
	results when R1 wa	as sent to hospital.		accidents, incidents, and/or c condition.	hanges of
	The Eacilities Falls	Prevention Program (revised		condition.	
		the staff, with physician		2. All residents who have ha	ad an
		v up on any fall with an		incident or accident are ident	
		ntil the resident is stable and		having the potential to be at r	
		such as fracture or subdural		alleged deficient practice:	
	hematoma have be	en ruled out or resolved.			
				3. Measures and systematic	
		dated 9-9-21), documents		the facility has taken to corre alleged deficient practice and	
		, Impression: mild suspicion of of the lateral aspect of the left		does not recur include:	
		us positional artifact. Clinical			
		ended. I recommend		A. Nursing staff and nursing	
		rior posterior) and frog leg		management has been inser	
	oblique views of lef	t hip for further assessment.		regarding the importance of:	
	Hospital x-ray Repo	ort (dated 9-13-21), documents		" Contacting the resident□	s physician
	x-ray hip left 2 or 3	views, Findings: slight cortical		in a timely fashion after an ac	cident,
		g the greater trochanter may		incident, and/or change of co	
		batient or could be due to old		Training was provided that if	
		e nondisplaced fracture cannot		the physician is not responding	
	be excluded. CT left hip, Findings: The bones are demineralized. There is a comminuted fracture of			timely fashion, they are to co facility DON, Medical Directo	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/30/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		146078	B. WING	i			C 2 3/2021
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AHVA CARE OF STICKNEY			-	900 SOUTH OAK PARK AVENUE STICKNEY, IL 60402			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 777	the left greater trock the lateral neck. HF home and had an u X-rays were initially followed up on, they greater trochanter f Nurses Note (dated Resident alert and o findings relay to NP resident out for pos neck fracture. Resid further evaluation. N Emergency contact denies any pain or o medication received closely. Fall precau Surveyor and V2 re together and could	hanter extending to its base of PI: Patient lives at a nursing inwitnessed fall 4 days ago. obtained but were not y were found to have possible racture. I 9-12-21) documents priented x 2-3. Pelvis x-ray Y. New orders receive to send sible impacted left femoral dent sent to local hospital for Management made aware. (daughter) notified. Resident discomfort at this time. All due d. Will continue to monitor	F 7	777	Administrator for further directives. 4. The facility has implemented the following Quality Assurance Plan to monitor on-going facility performance compliance with this requirement: A. The DON and appointed design will audit all accidents and incidents weekly to ensure that staff have con- the attending physician and that the physician has responded in a timely manner. Noted problems shall be addressed immediately and identified patterns, of non-compliance shall be reported Quality Assurance Committee for fu- action(s) as necessary. Please see attached 5. Completion Date: 09/29/2021	ce and nee(s) ntacted y //trends d to the urther	

Facility ID: IL6007355

If continuation sheet Page 6 of 6