

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014831	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/13/2023
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NAME OF PROVIDER OR SUPPLIER ALIYA ON 87TH	STREET ADDRESS, CITY, STATE, ZIP CODE 2940 WEST 87TH STREET CHICAGO, IL 60652
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S 000	Initial Comments First onsite revisit to Annual Health & Complaint# 2387969/IL164766 survey of 10/31/2023	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b)4 300.1210d)5 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Requirments were not met as evidenced by: Based on observation, interview and record review the facility failed to provide timely ADL (Activities of Daily Living) care to four of five dependent residents (R3, R4, R5, R6) reviewed	S9999		

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S9999	<p>Continued From page 2</p> <p>for incontinence care. This failure resulted in R3 and R6 sustaining MASD (Moisture Associated Skin Damage).</p> <p>Findings include:</p> <p>The facility was cited for incontinence care concerns on (10/31/23) survey.</p> <p>The (11/1/23) facility POC (Plan of Correction) includes measures the facility will take to ensure that the problem will be corrected and will not recur; a.) Nursing staff were in-serviced on 10/27 and 11/1 to ensure that residents who need incontinence care were provided care timely. b.) An observation audit was created to ensure that residents were receiving timely incontinence care.</p> <p>During (11/13/23) follow-up investigation, skin integrity impairments (related to delayed incontinence care) were identified.</p> <p>R3's diagnoses include multiple sclerosis.</p> <p>The (10/13/23) functional assessment affirms R3 is dependent on staff for toileting hygiene.</p> <p>R3's care plan includes (7/18/23) resident is incontinent of bowel/bladder, toilet resident in a timely manner. (8/1/23) Resident requires assist with daily care needs related to multiple sclerosis, monitor skin integrity during routine care and report abnormal findings.</p> <p>R3's (10/13/23) BIMS (Brief Interview Mental Status) determined a score of 14 (cognitively intact).</p> <p>On (11/9/23) at 10:28am, surveyor inquired when R3's incontinence brief was last checked and/or</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>changed. R3 stated "I believe last night, I think the other lady (referring to night shift CNA/Certified Nursing Assistant) changed me before she left. I do have a rash I think, I asked my daughter to bring me some cream." Surveyor inquired where R3's "rash" was located. R3 responded, "It's on the left side by my leg." R3 was noted to be lying atop of a sheet (folded multiple times) and a pad. R3's incontinence brief was moderately saturated with urine. A (round) open ulcerated area was noted to R3's left thigh (below the buttock) with serosanguinous drainage. Surveyor subsequently requested that R3 be assessed today by the wound care nurse.</p> <p>R3's (11/9/23) wound assessment documented at 3:18pm (roughly 5 hours after surveyor assessment), states reported by staff alteration in skin noted to the right thigh back. Type: MASD. Classification: Incontinence. Size: 0.5 x 0.5 x 0.1cm (centimeters). Tissue type: Pink or red non granulating 100%.</p> <p>On 11/9/23 at 3:31pm, surveyor inquired about R3's skin integrity impairment. V13 (Wound Care Coordinator) stated, "I was notified today, she (R3) has MASD and this is actually on her thigh." Surveyor inquired what causes MASD. V13 responded "Moisture, urine, or sweat."</p> <p>R6's diagnoses include altered mental status, hemiplegia, and hemiparesis.</p> <p>R6's (9/11/23) functional assessment affirms (1 person) physical assist is required for toilet use.</p> <p>R6's (9/8/23) care plan states resident has hemiplegia, monitor/resident's abilities for ADL's and assist resident as needed. [Bowel/bladder incontinence is excluded].</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>R6's (9/11/23) BIMS determined a score of 7 (severe impairment).</p> <p>On 11/9/23 at 11:11am, surveyor inquired when R6's incontinence brief was last checked and/or changed. R6 stated, "It's been a while" and affirmed it was changed on the prior shift. V11 (Ward Clerk/CNA) removed R6's incontinence brief which was heavily saturated with urine and liquid stool. Upon further inspection a red (linear) open skin integrity impairment (roughly 2.5 inches long) was noted on R6's sacrum. Surveyor inquired about R6's skin integrity impairment. V11 responded, "I see a little bit of opening." Surveyor subsequently requested that R6 be assessed today by the wound care nurse.</p> <p>R6's (11/9/23) wound assessment documented at 3:14pm (roughly 4 hours after surveyor observation) states reported by staff alteration in skin noted to sacrum. Type: MASD. Classification: Intertriginous (where 2 skin areas may touch or rub together). Tissue Type: pink or red non-granulating 100%. Size: 0.0 x 0.0 x 0.2cm.</p> <p>On 11/9/23 at approximately 3:34pm, surveyor inquired about R6's skin integrity impairment. V13 (Wound Care Coordinator) stated, she (R6) has MASD right down the butt crack, which is related to moisture, its intertriginous that means linear. Surveyor inquired when R6 developed the linear skin integrity impairment. V13 responded, "Today, I was notified today."</p> <p>R6's diagnoses include diabetes mellitus and chronic kidney disease.</p> <p>R5's (9/25/23) functional assessment affirms (2</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>persons) physical assist is required for toilet use.</p> <p>R5's care plan includes (4/27/23) resident has self-care deficit related to generalized weakness, assist patient with transfers promptly as needed to bedside commode or toilet to ensure continence. (4/19/23) Resident has potential for skin integrity impairment related to self-care deficits, impaired mobility, and comorbidities provide peri-care and barrier after incontinent episode.</p> <p>R5's (9/25/23) BIMS determined a score of 11 (moderate impairment).</p> <p>On 11/9/23 at 11:04am, R5's hair appeared long, greasy, and unkempt. R5 was also unshaven. Surveyor inquired when R5's incontinence brief was last checked and/or changed. R5 stated, "In the middle of the night." Surveyor inquired when R5's hair was last washed. R5 responded, "5 weeks ago." Surveyor inquired about R5's beard. R5 affirmed, the razor is dull and doesn't remove hair properly. V10 (CNA) removed R5's incontinence brief. Surveyor observed R5's incontinence brief to be completely saturated with urine. The bath blanket folded twice (4 layers) beneath R5 was also visibly wet with urine. V10 stated, "He's kind of a heavy wetter." R5 responded, "I'm not a heavy wetter."</p> <p>R4's diagnoses include hemiplegia and hemiparesis.</p> <p>R4's (9/3/23) functional assessment affirms (2 persons) physical assist is required for toilet use.</p> <p>R4's (8/28/23) care plan states resident is at risk for alteration in skin integrity related to impaired mobility and diagnosis of hemiplegia, provide</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>peri-care after each incontinent episode, and apply barrier cream. [R4's care plan excludes ADL care and bladder incontinence].</p> <p>R4's (9/3/23) BIMS determined a score of 7 (severe impairment).</p> <p>On 11/9/23 at 10:55am, surveyor inquired when R4's incontinence brief was last checked and/or changed. R4 stated, "Before breakfast." V9 (CNA) subsequently removed R4's incontinence brief which was saturated with urine all the way up the back.</p> <p>On 11/13/23 at 12:07, surveyor inquired about potential harm to a resident that does not receive timely incontinence care (every 2 hours). V14 (Medical Director) stated, "It can cause a lot of skin irritation and a lot of problems with skin infections too."</p> <p>The (2/2023) Activities of Daily Living policy states a program of assistance and instructions in ADL skills is care planned and implemented. Elimination: assistance and instruction are given as required.</p> <p>The (1/2023) skin care prevention policy states all residents will receive appropriate care to decrease the risk of skin breakdown. Clean skin at time of soiling and at routine intervals.</p> <p>(B)</p>	S9999		