STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000640	A. BUILDING: _____ B. WING _____	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZAHAV OF DES PLAINES	9300 BALLARD ROAD DES PLAINES, IL 60016

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S 000	Initial Comments Annual Licensure Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1210c) 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. 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 resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 requirements were not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to implement intervention in preventing the development and worsening of pressure ulcers on a resident with physical and cognitive impairment. This failure applied to one (R36) of three residents reviewed for skin breakdown and resulted in R36's intact skin developing an unstageable pressure ulcer on the right buttock and right ischium; and Stage 3 pressure ulcer on the left ischium worsened into Unstageable. Findings include:	S9999		

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S9999	Continued From page 2 R36 is a 59-year-old, male, initially admitted in the facility on 12/31/21 with diagnoses of Acute and Chronic Respiratory Failure with Hypercapnia; Human Immunodeficiency Virus (HIV) Disease; Nontraumatic Intracerebral Hemorrhage, Unspecified; Metabolic Encephalopathy; Schizoaffective Disorder, Depressive Type; Anxiety Disorder, Unspecified; Contracture of Muscle, Right Upper Arm and Contracture of Muscle, Left Upper Arm. Per MDS (Minimum Data Set) dated 08/16/23, under Section C, R36 has long and short-term memory impairment. R36's cognitive skills for daily decision making are severely impaired. On 11/06/23 at 10:20 AM, R36 was observed in bed, asleep. He was using a low air loss mattress. R36 is nonverbal, does not respond to verbal stimuli but wakes up when repositioned. Facility's pressure ulcer list indicated that R36 has facility acquired pressure ulcers on the left ischium, right ischium, and right buttock/trochanter. On 11/07/23 at 11:30 AM, R36 was observed for wound care. The left ischium pressure ulcer had 95% (percent) granulation tissue with 2-5% slough present. The right ischium and right trochanter pressure ulcers' wound beds appeared beefy red; on negative pressure wound therapy at -125 mm Hg (millimeters mercury). R36 Physician Wound notes recorded the following, with corresponding measurements: 04/03/23: Stage 3 pressure wound of the left ischium was identified, duration of more than 1 day - 0.8cm (centimeters) x 0.5cm x 0.3cm 04/17/23: Unstageable (due to necrosis) of the left ischium - 2cm x 2cm x 0.1cm 04/24/23: Stage 3 pressure wound of the left	S9999		

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S9999	Continued From page 3 ischium - 2.6cm x 2.5cm x 1cm 05/15/23: Stage 4 pressure wound of the left ischium - 4cm x 3.5cm x 3.5cm 05/22/23: Stage 4 pressure wound of the left ischium - 4cm x 3.3cm x 3.5cm; Unstageable DTI (deep tissue injury) of the right ischium was identified - 1cm x 1cm x not measurable cm 06/01/23: Stage 4 pressure wound of the left ischium - 4.4cm x 3.3cm x 3.5cm; Unstageable DTI of the right ischium - 1cm x 0.4cm x not measurable cm 06/05/23: Stage 4 pressure wound of the left ischium - 4.8cm x 3.9cm x 3.5cm; Stage 3 right ischium - 1cm x 1cm x 0.1cm 06/19/23: Stage 4 pressure wound pressure wound of the left ischium - 5.5cm x 4.2cm x 3.5cm; Unstageable (due to necrosis) of the right ischium - 3cm x 2.7cm x 0.1cm; Unstageable (due to necrosis) of the right buttock - 5.1cm x 4cm x 0.1cm 06/26/23: Stage 4 pressure wound of the left ischium - 5.5cm x 4.1cm x 3.5cm; Unstageable (due to necrosis) of the right ischium - 4cm x 3.8cm x 0.1cm; Unstageable (due to necrosis) of the right buttock - 5cm x 4.2cm x 0.1cm 11/03/23: Plan of Care - Preventive Measures in place, general: Avoid bony prominence under direct pressure; repositioning in the bed and wheelchair as needed, or per facility protocol, if patient cannot do it. R36's census reports indicated that there were no hospitalizations occurred from 04/14/23 to 09/01/23. On 11/07/23 at 12:35 PM, V16 (Wound Care Nurse) was asked regarding R36's pressure ulcers. V16 replied, "His left ischium, right ischium and right trochanter or buttock are facility acquired pressure ulcers. He developed the	S9999		

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wounds because of moisture and not repositioning. He has HIV and wound is compromised."

On 11/08/23, random observation from 9:55 AM to 12:10 PM was conducted regarding R36's repositioning. The following were observed: From 9:55 AM to 11:31 AM, R36 was observed asleep in bed, lying on his back. The head of his bed was slightly elevated. From 11:55 AM to 12:10 PM, R36 was again observed in bed, asleep, head of bed slightly elevated, and was lying on his back. V27 (Wound Care Tech) was asked regarding repositioning. V27 stated, "He (R36) needs to be repositioned every two hours. We have to position him to one side and stay in that position for two hours. Then we put pillow between his knees." It was also observed that a signage was posted on R36's bedside stating, "Rock and Roll. Please turn and reposition every two hours."

On 11/08/23 at 11:45 AM, V22 (Licensed Practical Nurse) and V23 (Agency Certified Nurse Assistant, CNA) both stated residents with pressure ulcers need to be turned and repositioned every one to two hours.

V17 (Wound Care Coordinator) was interviewed on 11/08/23 at 12:15 PM regarding R36. V17 stated, "Unfortunately, in my opinion, he is immunocompromised. He has low air loss mattress; heel protectors and he needs repositioning every two hours."

V19 (Wound Physician) was also interviewed on 11/08/23 at 1:56 PM regarding R36's pressure ulcers. V19 verbalized, "He has severe contractures on both legs. In preventing the development of pressure ulcers, incontinence

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S9999	Continued From page 5 care; use of low air loss mattress and turning and repositioning every two hours." Facility's policy titled "Wound Prevention and Healing" dated 06/01/2022 documented in part but not limited to the following: Policy Statement: To provide wound care treatment/services (using a multidisciplinary approach) based on evidence-based standards of care under the direction of a physician. (A) Statement of Licensure Violations (2 of 2): 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. 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	S9999		

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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 resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on observation interview and record review, the facility failed to provide an individualized program for supervision to prevent recurring falls for a resident and prevent a resident who is NPO from eating and drinking by mouth (R12), failed to ensure a proper system was in place for safe and secure transfers and failed to safely transport one resident (R124) while riding on the facility bus. This failure affected two residents (R12 and R124) of seven residents reviewed for accidents. R12 have had four falls since admission, was sent to the

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hospital after the last fall and returned to the facility with four staples to the right top forehead. R12 has been drinking his G-tube feeding, stealing, and eating food and is currently receiving antibiotic treatment for possible aspiration on food. R124 sustained two fractures to two of the right ribs during transfer.

Findings include:

1. R12 is a 60-year-old male admitted to the facility on 9/12/2023, with past medical history of acute respiratory failure unspecified whether with hypoxia or hypercapnia, chronic obstructive pulmonary disease with acute exacerbation, bipolar disorder, muscle weakness, dysphagia oropharyngeal phase, schizophrenia, difficulty walking, shortness of breath etc.

11/5/2023 at 10:40AM during random observation in the unit, R12 was observed in his bed sleeping. R12 was on an air loss mattress, trach noted to the neck but was capped and not connected to the oxygen tank. R12's bed was not low to the ground.

Review of progress noted showed a fall incident on 11/7/2023 documented as follows: Sent patient to hospital for witnessed fall with superficial scrape on top of right side of head. Staff, CNA was in room 10 to 15 min ago for diaper change. RT reportedly in the room 10 min ago, changing the dressing on trach due to patient removing and throwing it on the floor. Patient is awake, alert, responsive, AXO 2-3. Resident returned to the facility with 4 staples for laceration to right forehead. Review of facility fall log showed resident had a fall on 9/17/2023 (found on the floor in his room), 9/21/2023 (found on the floor at the nursing station),10/31/2023

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S9999	Continued From page 8 and 11/8/2023 as documented in progress notes. Fall risk assessment dated 9/12/2023 scored resident as 12, indicating high risk for falls. Minimum data set (MDS) assessment dated 9/29/2023, showed section G (functional) coded R12 as requiring extensive assistance with two-person physical assist for transfer and bed mobility and extensive assistance to total dependence with one-to-two-person physical assist for all other ADLs. Care plan initiated 9/14/2023 indicated resident is at risk for falls, interventions include educate resident to use call light, frequently remind resident to use wheelchair for locomotion/long distance transfer, instruct resident to use his wheelchair for long distance transfer, etc. 11/8/2023 at 11:38AM, V4 (RN) said R12 was non-compliant with his diet, R12 is supposed to get nothing by mouth (NPO) and R12 was eating by mouth at one time. V4 stated, R12 fell at the nursing station on the third floor while carrying some ramen noodle cups. V4 asked R12 what happened but R12 could not explain. V4 said the incident happened in the evening, close to 6PM. V4 said V4 could not recall if R12 was NPO before the incident but that R12 needed assistance with ADLs including ambulation. Progress note dated 9/11/2023, documented R12 was admitted from the hospital and was supposed to have nothing by mouth (NPO). R12 has a G-tube and on Jevity 1.2, trac stoma with oxygen 2 liters via nasal canula. Review of medical record showed several documentations of resident wanting to eat food by mouth, stealing food from trays and drinking his tube feeding	S9999		

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S9999	Continued From page 9 formula. At 2:28PM, V28 (Dietary Manager) said R12 came to the facility on NPO status. R12 expressed wanting to eat. V28 spoke to R12 and explained to R12 what could happen if R12 ate by mouth. V28 said a mechanical soft diet was initiated, R12 was not tolerating diet so ENT was consulted. R12 was placed back on NPO status. On 11/8/2023 at 2:45PM V26 (ADON) said R12 came with an open stoma, R12 was supposed to be NPO but was insisting on eating. V26 said nursing staff spoke to the attending physician and he recommended to try giving resident something by mouth. However. speech therapy recommended NPO because resident could not tolerate PO feeding and was put back on NPO. V28 added resident was changed to bolus feeding to avoid R12 from drinking his tube feeding. V26 said R12's feeding should not be left in his room to avoid R12 from drinking it and possibly aspirating on it. On 9/29/2023, V33 (LPN) documented R12 was given a scheduled bolus feeding. A box of feeding was left in the room and when staff returned for the tube feeding it was gone. R12 stated he drank it. On11/9/2023 at 10:39AM, V33 (LPN) said R12 is supposed to be NPO. V33 was told R12 eats and drinks. V33 flushed the R12's tube and gave him scheduled bolus feeding. V33 said V33 left one box in a closed drawer for the next dose. Next morning V33 came to the room to give the bolus feeding and could not find it. V33 asked R12 who stated he drank the feeding. V33 said she placed the feeding in a drawer on the other side of the room. V33 said the feeding was supposed to be	S9999		

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S9999	Continued From page 10 in the nursing station or nursing cart but she left it in the room because she was going to give it soon. V33 stated R12 could choke or get an infection from drinking his feeding. On 10/29/2023, V34 documented R12 was observed putting back G-tube feeding bottle on the pole after drinking from it. R12 was sent out to the hospital and was treated with antibiotics for possible aspiration on food. On 11/9/2023 at 10:26AM, V34 (LPN) said she did not see R12 drinking the feeding but saw R12 hanging the bottle back on the pole. R12 was on continuous feeding. R12 returned to the facility with an antibiotic prophylactic order. V34 added R12 pulls off his trach and oxygen tubing. V34 said R12 is supposed to be monitored frequently, between the nurse and the C.N.A, R12 should be monitored every 15 to 30 minutes. On 11/9/2023 at 9:55AM, V32 (Therapy Director) said she is familiar with R12. Therapy worked with R12 initially when he was first admitted. Physical therapy evaluated him on 9/13/2023 and speech evaluated him on 9/12/2023. Speech therapy declared resident not appropriate for eating by mouth due to resident having an open stoma. Diet order was NPO and recommended for R12 to follow up with ENT. R12 went to the ENT appointment and was put back on trach due to paralysis of the vocal cord. Therapy department never cleared resident to have something by mouth. V32 said she is aware R12 was eating something by mouth at one time but was a decision made by the nursing department and the attending physician that R12 did not tolerate the PO diet and was placed back on NPO. V32 said she doesn't believe R12 had a video swallow study. R12 failed the ones he had	S9999		

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S9999	Continued From page 11 at the hospital according to the hospital record. R12 had not had another swallow study because the scheduler stated was trying to schedule in the R12, but R12 was going in and out of the hospital. Speech would not have upgraded R12 to an oral diet for risk of aspiration. 11/9/2023 at 2:11PM, V36 (Registered Dietician) said R12 was NPO and R12 failed speech therapy evaluation for diet upgrade. R12 was always hungry and always wanting to eat by mouth which was not appropriate for him. V36 said she was made aware R12 is always trying to steal food and was drinking his G-tube feeding. V36 recommended bolus feeding on 9/25/2023 but was not sure if and when R12 was changed back to continuous feeding. V36 said they increased R12's feeding and made sure he does not have any feeding or food in his room. V36 was not aware R12 was still drinking his feeding formula after he was changed to bolus. V36 added if this behavior is being documented all staff should have been aware and made sure R12 is being monitored. Fall policy revised 10/30/2023 states, facility is committed to its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting in harm and ensuring a safe patient environment is maintained. Under procedure, the policy states in part, high risks residents and patients for falls will receive individualized interventions as appropriate to risk factors. Interventions b. High risks residents and patients for falls will receive individualized interventions as appropriate to risk factors, interventions may include meaningful and or scheduled rounds. ---	S9999		

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S9999	Continued From page 12 2. R124 is a 65-year-old male who originally was admitted to the facility on 2/7/23 and continues to reside in the facility. Facility reported incident dated 9/27/23 states in part but not limited to the following: R124 was utilizing the facility bus to tour another facility as part of their discharge planning. While on the way back to the facility, one of the strap harnesses securing R124's wheelchair loosened and caused R124's wheelchair to tilt when the bus was making a turn. R124 called for help and V12 (Transportation Scheduler) pulled the bus over to assist. V12 observed R124 to be tilted at a 45-degree angle while still secured in the harness straps. R124 said he felt some pain by his rib cage on the side where he fell into the armrest when the wheelchair was tilted. R124 arrived back to the facility and was assessed by nursing staff. X-ray was ordered. X-ray impression result dated 10/1/23 shows acute fractures of the seventh and eighth right rib. On 11/7/23 at 10:29AM, R124 was interviewed regarding incident on 9/27/23. R124 said. "(V12) was transporting me back to the facility after touring another facility to potentially transfer to. On our way back to the facility, I was in a manual wheelchair and (V12) had made a left turn which caused me to fall on my right side. Either the strap that was strapping me in was not secure or my wheelchair brakes were not locked. I had hit my ribs on the armrest of the wheelchair and hit my head off something. They did an x-ray of my ribs where they said I fractured two of my ribs. I was in pain for about two weeks after the incident". On 11/8/23 at 10:03AM, V12 was interviewed	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000640	A. BUILDING: _____ B. WING _____	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZAHAV OF DES PLAINES	9300 BALLARD ROAD DES PLAINES, IL 60016

(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) COMPLETE DATE
S9999	Continued From page 13	S9999		

regarding the incident on 9/27/23. V12 said, "I had transported (R124) to another facility to tour. On our way back that day, I made a left turn and I heard (R124) yell for help. I immediately pulled over and assessed the situation. (R124) was strapped into the seatbelt and the floor straps but was leaning at a 45-degree angle. I adjusted his chair upright and asked him if I should call 911 which he refused. He wanted to go back to the facility however he was saying he was in pain in his rib area. At the time of the incident, it had looked as if one of the harnesses on the floor had come loose. I was able to tighten it and transport him back to the facility where he was evaluated by his nurse".

V12 said, "We are now required to complete a vehicle check off list before and after operating the vehicle. Prior to this we did not have this checklist in place". V12 said the floor straps on the bus were replaced due to normal use and wear and tear of the straps.

It is to be noted that this surveyor requested a transportation policy involving the use of the facility bus. V1 (Administrator) did provide this surveyor a policy titled Appointments and Transportation with reviewed date of 5/19/23. At 12:37PM, V1 said this policy does not have any details regarding our facility bus or the safety checklist that was implemented after the incident. V1 said this policy needs to be reviewed in our next quality assurance meeting. (A)