STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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
S 000	Initial Comments Complaint Investigation: 2496369/IL176628	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)3)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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 1	S9999		

includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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 2	S9999		

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 interviews and record reviews, the facility failed to follow its skin care prevention policy and implement effective interventions and monitoring to prevent one resident developing three facility acquired non-pressure wounds to the right foot and ankle. The facility also facility failed to implement effective pressure relieving interventions to prevent one resident, who's lower extremities are severely contracted, at very high risk for skin breakdown, and dependent on staff for all ADLs (activities of daily living), from developing a facility acquired pressure ulcer on the left posterior distal thigh due to pressure from posterior mold splint on the left lower leg. This affected one of three R1 residents reviewed for non-pressure wounds in a sample of 11. This failure resulted in R1 presenting to the hospital emergency room on 9/1/24 with sepsis secondary to a right heel wound that was infected and with acute osteomyelitis (bone infection) and with a pressure wound to the left posterior distal thigh with hamstring tendon exposed.

Findings include:

On 9/5/24 at 1:40 PM, V11 (wound care nurse)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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 3	S9999		

stated that the staff nurses are responsible for monitoring residents' skin for any breakdown. V11 stated that V11 noted R1 with right heel bruising on 8/19/24 and obtained order for wound cleaning and the application of skin prep. V11 stated that the blister opened on 8/24/24 and V11 obtained an order for xeroform and dry dressing daily. V11 stated that the wound on the top of R1's foot was still a blister so V11 continued applying skin prep to this wound. V11 stated that V11 placed a pillow between R1's legs, because V11 was concerned that R1's left lower leg cast was putting pressure on R1's right leg and foot. V11 stated that R1 is unable to move self in bed, dependent on staff. V11 stated that R1's legs were contracted, crossed at knees, and V11 was concerned for pressure on right leg. V11 stated that R1's right foot wounds were trauma related because nothing was wrong with R1 prior to left foot fracture on 8/7/24. V11 stated that V11 performed wound care treatments six days a week and repositioned R1 during treatments. V11 stated that V11 checked to ensure she was able to insert two fingers under R1's rim of cast at toes and positive capillary refill.

On 9/6/24 at 1:20 PM, V10 NP (nurse practitioner) stated that R1's legs were very contracted. V10 stated that R1 returned from the emergency room with a post mold to left tibia/fibula fractures on 8/8/24. V10 stated that V10 visited R1 on 8/12/24 and observed bruising to R1's right foot and left knee area. V10 stated that V10 would have V11 (wound care nurse) manage residents with bruising as well as open wounds. V10 stated that fractures, contractures, and poor nutrition puts R1 at risk for skin breakdown. V10 is unable to articulate how the bruising to R1's right foot and left knee could be from trauma on 8/7/24. V10 stated that if due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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 4	S9999		

trauma would have been present at the time of injury on 8/7. V10 was able to review R1's current hospital record which notes right heel wound infection with osteomyelitis. V10 stated that once a wound is present, it can deteriorate very quickly to an infection. V10 stated that the mottling and increased respirations observed by nursing on 9/1 could be due to R1's body responding to the infection.

On 9/6/24 at 4:26 PM, V14 (family member) stated that when she was visiting with R1 on 8/31/24, V14 noted R1's right foot wounds with a foul odor. V14 stated that V14 informed the nurse on duty of the foul odor.

R1's weekly skin observation, dated 8/8/24, notes R1's skin warm, dry, within normal limits. Skin turgor is fair. Swelling observed to left foot. No skin concerns noted. R1's left ankle down to the foot dark purple bruise, swollen and painful. Left elbow with dark purple bruising.

There were no further weekly skin observations documented between 8/9/24 and when 9/1/24 when R1 was hospitalized.

The CNAs (certified nurse aides) documentation, dated 8/8/24 -9/1/24, notes 8/8, 8/9, 8/14, and 8/21, the CNAs noted discoloration. On 8/11 and 8/18, the CNAs noted redness. On 8/21, the CNA charted skin tear.

There is no documentation found in R1's medical record noting the nurse assessed R1 for these skin abnormalities.

V10's NP progress note, dated 8/8/24 - 9/1/24, notes on three occasions, 8/27 at 1:18 AM, 8/28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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 5	S9999		

at 00:17 AM, and 8/29 at 1:49 AM, documentation of positive capillary refill and two fingers can fit under the rim of the soft cast. Progress note dated 8/12/24, notes R1 with a soft cast on left leg. There are surrounding bruising and discoloration to R1's left knee and right foot.

R1's wound assessment, dated 8/27/24, notes R1 was identified with a facility- acquired right dorsal foot hematoma (bruise) due to trauma on 8/27/24. It is a full thickness wound with 100% intact skin. Maceration (softening and breaking down of skin resulting from prolonged exposure to moisture) noted to periwound. Wound measured 11.10cm (centimeters) x 9.6cm. On 8/29/24, V11 initiated skin prep and gauze dressing treatment.

R1's wound assessment, dated 8/27/24, notes R1 with a facility acquired right heel bruise due to trauma, identified on 8/20/24. It is a full thickness wound with 100% bright pink or red tissue. Wound measured 5.5cm x 4.5cm with serous (clear) drainage. On 8/26/24, V11 initiated xeroform and gauze dressing treatment.

R1's wound assessment, dated 8/27/24, notes R1 with a facility-acquired right lower leg front bruise due to trauma, identified on 8/27/24. Wound with 100% pink or red non-granulating tissue. Wound measured 18.3cm x 3.1cm. On 8/27/24, V11 initiated application of skin prep treatment.

R1's POS (physician order sheet), dated 8/11/2024, notes an order to monitor left lower extremity cast and surrounding areas for circulation, motion, and sensation, signs/symptoms of skin breakdown every shift, notify physician of abnormalities.
R1's POS (physician order sheet), dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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 6	S9999		

8/20/2024, notes an order for right foot wound apply skin prep every day shift to prevent skin breakdown. There is an order, dated 8/24/24, for right ankle wound clean with wound cleaner pat dry, apply xeroform and rolled gauze every day shift for wound care.

R1's TAR (treatment administration record), dated August 2024, notes R1 did not receive treatment to right ankle wound on 8/25 or 8/31. R1 also did not receive treatment to right foot blister on 8/25 or 8/31.

R1's hospital record, dated 9/1/24, notes R1 presented to the emergency room at 11:07 AM. Condition is serious. R1's primary admitting diagnosis is osteomyelitis right foot. R1 with necrotic (dead tissue) right heel ulceration with foul-smelling drainage and right foot blister. R1's white blood cell count was 19.2 (normal range 4-11). X-ray of R1's right foot noted heel with soft tissue gas tracking superiorly along the achilles tendon. Impression: heel ulcer with evidence of infection by a gas-forming organism. R1 with sepsis secondary to necrotic infected right heel wound. Infectious disease physician consulted and noted severe sepsis, necrotic right heel ulcer with wet gangrene, and osteomyelitis. Along the medial ankle there appears to be tissue necrosis also. It is unlikely that the limb will be salvageable given the extensive necrosis of the heel. Antibiotics alone will not take care of the infection given the tissue damage. Very foul-smelling odor noted from the right foot. Wound dressings with small bugs noted. Podiatrist consulted and noted R1's right heel ulcer with achilles tendon exposed, limb not salvageable. Right heel wound measured 14.3cm x 12.2cm x 0.4cm. Podiatrist consulted and noted R1's left distal thigh wound with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF GLENWOOD	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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 7 hamstring tendon exposed related to pressure on leg from post mold splint on left lower leg. This facility's skin care prevention policy, reviewed 01/2024, notes dependent residents will be assessed during care for any changes in skin condition including redness and this will be reported to the nurse. The nurse is responsible for notifying the health care provider. (A)	S9999		