Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _

IL6014617

C B. WING 02/23/2024

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

4815 SOUTH WESTERN AVE

(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	S 000		
	Complaint Investigation: 2480699/ IL00169132			'h. '' '-
S9999	Final Observations	S9999		
	Statement of Licensure Violations			
	300.1210b) 300.1210d)2) 300.1220b)3)			
	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.			
	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.			
	Section 300.1220 Supervision of Nursing Services			
	b) The DON shall supervise and oversee the nursing services of the facility, including:			

Illinois Department of Public Health

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

Electronically Signed

TITLE

(X6) DATE

03/11/24

Illinois Department of Public Health

The state of the s	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION		E SURVEY IPLETED
		IL6014617	B. WING			C / 23/2024
	PROVIDER OR SUPPLIER	ONAL 4815 SOU	DDRESS, CITY, ST JTH WESTER D, IL 60609	TATE, ZIP CODE		
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S9999	3) Developing plan for each reside comprehensive ass and goals to be acc and personal care a Personnel, represe nursing, activities, of modalities as are of be involved in the plan. The plan shareviewed and modineeded as indicated. The plan shall be remonths. These requirement by: Based on interview failed to provide diathree residents who This failure resulted emergency department extremity edema, metabolic acidosis. Findings include: According to R3's fao1/05/2024, R3's dio1/05/2024, consist congestive heart failure ath, type 2 diabed disease, dependent cardiomegaly hyperfailure, and benign R3's progress note in part: R3 admitted	g an up-to-date resident care ent based on the resident's sessment, individual needs complished, physician's orders, and nursing needs. enting other services such as dietary, and such other ordered by the physician, shall preparation of the resident care all be in writing and shall be iffied in keeping with the care ed by the resident's condition. eviewed at least every three the ware not met as evidence and record review, facility alysis services to 1 (R3) out of the way and experiencing lower mild hypervolemia, and	\$9999			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
		IL6014617	B. WING		1	C 23/2024
	PROVIDER OR SUPPLIER	4815 SOU	DRESS, CITY, STATE WESTER D, IL 60609	TATE, ZIP CODE N AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$9999	admitting Dx; Cong Depression, Chest fibrillation, anemia, Hypertension, Diab Renal Cancer, Left receiving In-house Friday. On 02/13/2024, at on his bed. R3 is a he has no concern facility. On 02/22/2024 at Registered Nurse) the facility took pla R3 has not receive resident misses dia implications. If a recould have high bla and chemical imba more than three wisevere shortness of symptoms from chisses more than automatically send. On 02/22/2024 at stated that we messupposed to receive some reason. We we have put in place attention to our addoesn't happen ag. R3's Nursing Programveyor by V11 do 01/31/2024, R3 tol R3 was provided in R4 in R	gestive Heart Failure. SOB, Pain. R3 has a history of atrial, Acute Kidney Injury, betes Mellitus, Cardiomegaly, t nephrectomy. Resident will be dialysis Monday, Wednesday, 10:00 AM, R3 was seen laying lert oriented x4. R3 stated that s with receiving dialysis at the 1:30 PM, V11 (Dialysis stated that R3's first dialysis at ce on 01/31/2024. Prior to that, d any dialysis. V11 stated if a alysis, they could have serious esident misses dialysis they cod pressure, high potassium alance. If a resident misses eeks of dialysis they could have of breath and other physical emical imbalances. If anyone three treatments, we them out. 1:00 PM, V1 (Administrator) seed up with R3. R3 was we dialysis but then missed for have no excuse. But since then ce interventions and paid close missions to make sure this				

Illinois Department of Public Health

The second second	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED
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	PROVIDER OR SUPPLIER	4815 SOL	DRESS, CITY, S JTH WESTER D, IL 60609	TATE, ZIP CODE		
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S9999	consents, dialysis R3's initial Dialysis documents in part- 90.2. Post weight 8 1.5L (liters). R3's care plan docreceives Hemodial (central venous cahas potential for consential for con	communication report date: 1/31/2024. Pre-weight 39.2. Total fluids removed was suments in part (1/30/2024): R3 lysis treatment via Left CVC theter), 3 times per week. R3 amplications related to ment. No documentation of his date. er report (1/29/2024): In house dialysis on Tuesday, urday every day shift. e (1/23/2024) documents in ed orders to send R3 out to be dialyzed. rtable (1/23/2024) documents 2024 R3's chart reviewed with discovering R3 had missing doctor, R3 to be transferred to uation. R3 exited building on anied via x2 EMTs (emergency				

Illinois Department of Public Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ B. WING _ 02/23/2024 IL6014617 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4815 SOUTH WESTERN AVE**

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S9999	Continued From page 4			
	significant residual GFR (glomerular filtration rate) . Missed dialysis resulted in lower extremity edema, mild hypervolemia, and metabolic acidosis.			
	(A)			