

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Zahav of Berwyn		STREET ADDRESS, CITY, STATE, ZIP CODE 3601 South Harlem Avenue Berwyn, IL 60402	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>35541</p> <p>Based on interview and record review the facility failed to provide the necessary transportation for a resident to attend a doctor's appointment outside of the facility for 1 of 3 residents (R1) reviewed for necessary care and services in the sample 5.</p> <p>The findings include:</p> <p>R1's appointment note dated 6/28/24 showed R1 had a scheduled appointment to see a dermatologist, on 8/27/24, at a local outpatient clinic.</p> <p>On 9/13/24 at 9:28 AM, R1 stated, I missed my derm (dermatologist) appointment on August 27, 2024. I was supposed to go by the facility van but that van was broken so they couldn't take me. (V12 Facility Van Driver) told me it was because there was something broken in the van.</p> <p>On 9/13/24 at 9:42 AM, V13 Facility Scheduler stated, I was aware of (R1's) appointment on 8/27/24. I wrote it down in the appointment book. I arranged to have our van take her to it. I don't know exactly why she didn't go to the appointment. I think it had something to do with the van.</p> <p>On 9/13/24 at 9:50 AM, V12 Facility Van Driver stated on 8/27/24, There was an issue with the van so I couldn't take (R1) to her to her appointment. I can't exactly remember what was wrong with it.</p> <p>On 9/13/24 at 10:27 AM, V2 Assistant Administrator stated R1 missed her dermatology appointment on 8/27/24 because the wheelchair lift in the facility's van was broken and could not transport her.</p> <p>On 9/13/24 at 10:59 AM, V3 Executive Director stated, We screwed up on this one with (R1). We could have done a better job. I don't know why we didn't arrange alternative transportation for (R1) on August 27th.</p> <p>The facility's Appointments and Transportation policy dated 4/16/24 showed, When a resident has an appointment outside of the facility, the staff will make the transportation arrangements, unless the responsible party chooses to make the arrangements themselves . If the family is not making transportation arrangements, the staff nurse or designee will call the transportation company to set up date and time of pick up .</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>40085</p> <p>Based on interview and record review the facility failed to obtain medication from the pharmacy for 1 of 3 residents (R2) reviewed for pharmacy services in the sample of 5.</p> <p>The findings include:</p> <p>R2's face sheet shows he has diagnoses including: anxiety disorder, major depressive disorder recurrent, bipolar disorder, and mood disorder.</p> <p>R2's active Physician Order Summary (POS) shows he has an active order for Alprazolam 1 MG (milligram). One time a day for anxiety.</p> <p>R2's 8/1-8/31/24 Medication Administration Record (MAR) shows he should receive Alprazolam (xanax) tablet 1 MG. at 5:00 AM for anxiety. This dose of medication is documented in the MAR using a code 9 which indicates (see notes).</p> <p>A eMAR- Medication Administration Note completed on 8/21/24 at 5:10 AM by V6 (Licensed Practical Nurse/LPN) states, out of stock, f/up with pharmacy. insurance order for tomorrow.</p> <p>A Nurse Practitioner progress note completed on 8/21/24 at 9:35 AM states, {R2} was seen today at the request of the nursing staff for a medication refill. He takes xanax 1 mg and 2 mg for anxiety and needs refill.</p> <p>On 9/13/24 at 10:20 AM, V5 (Director of Nursing) said pharmacy delivers medications to the facility every day. There is a cubex (medication dispensing system) on the 2nd floor of the facility if there is a medication that is not at the facility. If a medication is not in the cubex then the nurses should call stat and obtain the medication from the pharmacy. V5 said if a narcotic or controlled medication needs a signature for a refill they call the Nurse Practitioner who is here Monday thru Friday, and obtain a code from the pharmacy to obtain the medication from the cubex to be able to obtain the medication. V5 said she was not aware of the missed xanax dose for R2.</p> <p>On 9/13/24 at 11:20 AM, V4 (Nurse Practitioner) said he did reorder R2's xanax on 8/21/24 but he was not aware that the morning dose was not given as scheduled at 5:00 AM. V4 said the nursing staff could have obtained the medication from the cubex and given it.</p> <p>On 9/13/24 at 11:30 AM, V6 (LPN) said he could not administer R2's 5:00 AM dose of xanax because it was not available from pharmacy. V6 said someone had forgotten to re-order the medication.</p> <p>The facility provided Pharmacy Services policy last reviewed on 4/14/24 shows the facility will provide pharmaceutical services to assure the accurate acquiring and dispensing of medications.</p>		