STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145070	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zahav of Berwyn	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to implement measures to prevent resident from acquiring pressure ulcer in the facility and updated wound care plan intervention. This deficiency affects one (R108) of three residents in the sample of 25 reviewed for Wound/Pressure Ulcer Prevention and management. Findings include: On 2/25/25 at 9:39AM, V18 Family member said that R108 has stroke and one side of the body is partially functioning. He cannot walk, talk nor eat on his own. He has been bed bound since July 2024. V18 said that R108 developed pressure ulcer on sacral area since last year and still not healing. V18 said that every time he comes to visit R108 he has to advocate for his needs. On 2/25/25 at 10:14AM, Observed R108 with V15 CNA (Certified Nurse Assistant) and V14 WCN (Wound Care Nurse) lying in bed. V15 and V14 preparing R108 for wound care treatment. V15 CNA then opened disposable brief of R108 soaked with feces. V15 turned him to his left side, observed disposable brief saturated with fecal matters and leak into the bottom sheet. The sacral wound dressing is contaminated with fecal matters. On 2/26/25 at 1:23PM, V3 ADON (Assistant Director of Nursing) said that he is also the wound care Director. He oversees the wound care management for the residents. He said that R108's Braden scale/skin assessment upon admission and most recent assessment indicated that he is at high risk for skin impairment. He has acquired pressure ulcer on sacral area on 10/29/24 full thickness, measures 7cm x 13cm x 0.10cm, 60% deep maroon and 40% bright beefy red tissue, scant amount of serosanguinous drainage, maceration, and bogginess on peri wound area. Reviewed R108's comprehensive wound care plan. Informed V3 that wound care plan intervention was not updated when there was an acquired new pressure. V3 said that he did the wound assessment on 10/29/24 and did not update the intervention because he has already intervention in placed. Informed V3 that their policy indicated that each new wound identified, after assessment and informing physicians for new treatment orders, care plan intervention has to be updated. V3 said R108's most recent wound assessment dated [DATE] indicated Stage 4 pressure ulcer on sacral area, full thickness, and tissue loss, in- house acquired, measures 5cm x 2.9cm x 0.3cm, 30% epithelial tissue, 20% granulation, 50% slough formation, moderate serosanguinous drainage, attached edges. Informed V3 of above observation made before wound care that R108 was soaked with feces. V3 said that prolong exposure of wetness, urine or fecal matters are factors in impaired wound healing or worsening of wound. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R108 is admitted on [DATE] with diagnosis listed in part but not limited to Acute and chronic respiratory failure, Acute kidney failure, Tracheostomy status, Stage 4 Pressure ulcer of sacral region, Gastrotomy status, Cerebral infarction, Intracranial hemorrhage. Comprehensive care plan indicates he has actual and potential for skin impairment. Intervention: Keep skin and dry. Prompt incontinence care. He has an ADL self-care performance deficit and impaired mobility. Intervention: total assistance. MDS /Resident assessment dated [DATE] indicated Section GG0130 Self-care functional abilities: Toileting hygiene and Personal hygiene- 01 (Dependent). Facility's policy on Skin management: Pressure injury treatment /general wound treatment reviewed date 4/2024 indicates: General: The following treatment guidelines have been developed to serve as a general protocol for selecting the type of treatment or dressing to be used. However, the facility recognizes that the selection of the treatment protocols is individualized based on the resident condition and health care provider practice patterns. Therefore, these are only guidelines and not all inclusive. An order is required for all treatment orders. General guidelines: * Implement prevention protocol according to resident needs *Moisture: avoid prolonged periods of wetness General treatment guidelines: 11. When the wound care team assess the resident, they will take a picture, measure the wound, review the orders, and update any notes and care plans as appropriate.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview, and record review the facility failed to ensure adequate supervision is rendered to dependent resident who is at high risk and had several unwitnessed falls in his room. This deficiency affects one (R108) of three residents in the sample of 25 reviewed for Fall prevention program. Findings include: On 2/25/25 at 9:39AM, V18 Family member said that R108 has stroke and one side of the body is partially functioning. He cannot walk, talk nor eat on his own. He has been bed bound since July 2024. Facility reported unwitnessed fall out from bed twice. He was placed in the far end of the facility as if being ignored away from the nursing station in case an emergency was to occur. V18 said that every time he comes to visit R108 he has to advocate for his needs. On 2/25/25 at 9:58AM, Observed R108 lying in low air loss mattress. He has tracheostomy tube connected to oxygen at 8LPM (liters per minute). He is awake and nonverbal; he needs total care with ADLs (Activity of Daily Living) and transfers. He has floormat on the left side of the bed. On 2/25/25 at 10:30AM, V16 LPN said R108 jerks and moves to the left side of the bed when he coughs. He worked with him on 2/1/25 when he was found on the floor. He was coughing too much that is why his body moved to the left side of the bed and fell to the floor. R108 is admitted on [DATE] with diagnosis listed in part but not limited to Acute and chronic respiratory failure, Acute kidney failure, Tracheostomy status, Stage 4 Pressure ulcer of sacral region, Gastrotomy status, Cerebral infarction, Intracranial hemorrhage. Fall assessment upon admission (8/28/24) and most recent fall assessment (2/18/25) indicated that he is at high risk for falls. Comprehensive care plan indicates he is at risk for falls related to current conditions. He has an ADL self-care performance deficit and impaired mobility. Fall admission assessment indicated he is at high risk for falls. Fall incident history indicated: 12/29/24 at 4:09AM, Unwitnessed fall in his room. R108 noted hanging off the bed, upper torso on the floor, bilateral legs on the bed. R108 unable to give description. He was sent to hospital for evaluation. Hospital record dated 12/29/24 indicated Chief complaint: Fall. Patient brought in by emergency medical services (EMS) for unwitnessed fall occurred at 4:09AM. Patient nonverbal, non-ambulatory, on trach collar suctioned by EMS, on heparin. 2/1/25 at 3:30PM, Unwitnessed fall in his room. R108 noted on the floor next to bed. Head, neck and shoulder on feeding pole and feet on the bed. R108 unable to give description. He went to hospital for evaluation. Hospital record dated 2/1/24 indicated Patient arrives via EMS due to unwitnessed fall. Per EMS, patient still on the floor upon their arrival. Patient nonverbal, bed bound, trach per baseline. Per EMS, copious amount of secretions suctioned on route. Patient tachypneic upon arrival. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 11:26AM, V3 DON (Director of Nursing) said that she started working in the facility [DATE]. Aside from DON, she is the fall coordinator. She oversees the fall prevention management program. She said that after each fall, fall investigation/ root cause analysis is conducted and developed individualized care plan intervention to prevent fall reoccurrence. Reviewed R108's medical records including fall incident reports with V3. Informed V3 of family concerns that R108 was placed at the far end of the nursing station, and they only moved resident closer to the nursing station as 2 weeks after he fell . Concern also presented to V3 of providing adequate supervision to prevent re-occurrence of 2nd fall. Informed V3 that R108, a totally dependent resident with trach, GT, and stage 4 pressure ulcer, had 2 unwitnessed falls in his room and had visited hospital emergency room for evaluation and undergone with different procedures and X-rays to check for injury. V3 said that they cannot prevent the resident from falling. They provide frequent rounding but did not document it. She added that they cannot document frequent rounding done to all resident at high risk for fall or resident with multiple falls. Facility's policy on fall prevention management reviewed dated 8/2024 indicates: General: This facility is committed to maximizing each resident's physical mental and psychosocial well-being. The facility will identify and evaluate those residents at risk for falls, plan for preventive strategies and facilities as safe an environment as possible. All resident falls shall be reviewed, and resident's existing plan of care shall be evaluated and modified as needed. Facility's policy on Patient monitoring and Safety reviewed 9/2024 indicates: Purpose: To ensure the safety and well-being of patients/residents through effective monitoring and response protocols.Definitions: Patient monitoring: The continuous or period observation of a patient's physical and emotional status, including vital signs and overall condition.Safety protocols: Specific guidelines are designed to monitor patients through various preventive measures.Purposeful rounding: A structured approach where staff routinely check on patients with a specific focus on addressing their needs, reducing fall risk, preventing discomfort and improving.