STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145087	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Oak Lawn	6300 West 95th Street Oak Lawn, IL 60453

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34516 Based on interview and record review, the facility failed to protect a resident from being physically abused by another resident. This failure applied to two of two (R1, R2) residents reviewed for abuse. Findings include: R1 is a [AGE] year-old female with diagnoses listed in part with atrial fibrillation, chronic obstructive pulmonary disease, protein calorie malnutrition, heart failure and osteoarthritis. R2 is a [AGE] year-old male with diagnoses listed in part with bipolar disorder, major depressive disorder, vascular dementia, and history of violent behavior. V1 administrator and abuse prohibition coordinator was unable to be interviewed due to the administrator no longer being employed by the facility during the start of this investigation. Facility records show that on 9/21/24 at 12 PM, R2 hit R1 in the back of her head while in a group activity. On 10/16/24 at 12:30 PM, R1 stated, I was passing by and got hit in the back of the head. There were two other men (patients) that saw this. I ain't seen no nurses around, no. I saw this guy (R2) in a wheelchair and as I was passing by, he hit me from behind the back of my head. It startled me but it didn't hurt. It was just shocking that someone would do that, but I figured out he must've been crazy, but he shouldn't be doing that to people. Surveyor asked if any nurse examined her to ensure she was not hurt, R1 stated, No, no nurse checked me out after this happened. Asked again, R1 stated, Yes I'm sure nobody checked me out. Surveyor asked if there were any staff that saw this incident, R1 stated, No there were no staff around, there was a nurse all the way at the end of the hall, but no staff were around. Surveyor asked if she felt abused by R2, R1 indicated that she did not and that she attributed the resident's behavior to him having mental issues beyond his control. On 9/26/24 at 1:30 PM, V17 (Social Worker) wrote in progress notes, 1:1- Social worker met with patient to discuss any concerns. Patient was resting comfortably in her bed. Patient was in a pleasant mood and had no concerns. Patient thanked the Social Worker for checking in on her and for the conversation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 10:45 AM, V38 (RN) stated, I was sitting right at the nursing station about 10 feet away from where the incident happened. I heard a slap and I got up and saw R2 passing by R1. That's when I discovered R2 slapped R1 in the back of the head for no reason. I assessed R1 right away and she said she was fine and that she was just startled by R2. I then called the doctor and informed the Assistant Administrator (V2) and family, and we sent R2 out to the hospital. On 11/4/24 at 12:20 PM, V20 (Director of Social Services) indicated that she checked in on R1 to ensure she was okay after her encounter with R1, and the resident was fine and had no concerns about the encounter whatsoever. On 9/22/24 at 9:00 AM V21 (Nurse Practitioner), wrote in progress notes, [AGE] year-old female seen today for admission due to recent hospitalization for lower back and bilateral lower extremity pain. The patient has a past medical history of Bladder cancer, coronary artery disease, COPD, diabetes, gout, and hypertension. Per chart the pain was lasting a total of five days. The patient also noted to have foul smelling urine. The patient's urine was tested and was found to have yeast and was treated. She was also treated for pain management and hypertension in the emergency room and sent for rehab. Patient seen in bed and stated that that she was not in any pain. Patient appears in no apparent distress. Today this patient continues with increase lower extremity muscle weakness and associated fatigue requiring assistance with ADLs. She currently participates in physical therapy utilizing a wheelchair and requires maximum assistance with bed transfers. She is weakest in the mornings but improves throughout the day. Lab and chart reviewed. On 11/4/24 at V21 (Nurse Practitioner) indicated upon interview that she recalled the visit with R1 and that she was not aware of the encounter with R1 and that the purpose of her visit was just for a follow-up to ensure R1 was transitioning well to the facility after hospitalization for lower extremity pain and that the patient had a history of bladder cancer. V21 added that there was no mention of any encounter with another resident.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066 Based on observation, interview, and record review, the facility failed to obtain orders for urinary catheter and urinary catheter care; the facility also failed to implement care plan interventions related to urinary catheter care and monitoring, including monitoring for signs of urinary tract infection symptoms. This failure applied to one of three (R11) residents reviewed for catheter care and resulted in R11's emergent hospitalization and subsequent diagnosis of septic shock requiring intensive care unit admission. Findings include: R11 is a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including but not limited to Schizophrenia; Atherosclerotic; Heart Disease of Native Coronary Artery without Angina Pectoris; Chronic Kidney Disease; and Obstructive and Reflux Uropathy. According to R11's admission MDS (Minimum Data Set) assessment dated [DATE], under section H, R11 had indwelling urinary catheter present upon admission. Absent are any physician orders to show R11 had urinary catheter or required urinary catheter care. On 11/04/2024 at 11:46 AM Surveyor interviewed V22 (Registered Nurse) who stated in the summary, I started my shift on 10/16/2024 at 6:30 AM. I received a hand off report indicating that R11 had a fever and received fever medication overnight. V24 (Registered Nurse) who worked overnight, received an order to collect urinalysis and urine culture sensitivity test. R11's urine sample was collected and sent by the time I arrived. V24 (RN) stated that the last time she checked R11's temperature, it was 98.9 (degrees Fahrenheit). During my morning assessment, R11 was alert and oriented x(times) 3 and very talkative, as always. I asked if R11 needed pain medication, he denied pain and asked for cold water. I rechecked R11's temperature before giving morning medications and it was 100.1 (degree Fahrenheit), so I gave another dose of fever medication. When I rechecked R11's temperature an hour later, it was 104.1 (degree Fahrenheit). R11 kept asking for more water. The only abnormal vital sign was his temperature. I notified V27 (Nurse Practitioner) who gave orders for stat blood work. I told V27 (NP) that it will take up to 4 hours and I don't feel comfortable waiting, so V27 (NP) ordered to send R11 to the hospital. I decided to give a little more time before I send R11 out, because I wanted to see if the temperature will go down. I checked the temperature again; it was still 104 (degrees Fahrenheit) and that time R11 became confused. I called V27 (NP) again and she confirmed the second time that it is appropriate to send to R11 to the hospital. I didn't look at R11's urinary catheter, I hadn't fully assessed R11 that morning. R11's urinary catheter was special, and nurses were not supposed to touch it. Certified Nurse Assistants provide perineal care with every brief change, that's when they're supposed to provide urinary catheter care. Nurses are supposed to do urinary catheter assessments once a shift. It should be documented only if there are abnormalities related to the catheter. Nurses document urine output, but it's usually done if there is an order. I base my documentation on abnormalities, there is not enough time to document everything. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Sequence of R11's documented temperatures and fever medication administration, per record review shows: - 10/16/2024 01:10 AM - 100.5 degrees Fahrenheit - fever medication administration documented at 00:45 AM - 10/16/2024 08:26 AM - 98.2 degrees Fahrenheit - 10/16/2024 10:06 AM - 99.2 degrees Fahrenheit - 10/16/2024 11:30 AM - 104.5 degrees Fahrenheit - - fever medication administration documented at 11:09 AM On 11/04/2024 at 12:01 PM Surveyor interviewed V23 (Wound Care Nurse/Licensed Practical Nurse) who stated in the summary, I went in after breakfast to change R11's dressings. R11 complained about pain to his penis. I opened his brief to conduct an assessment and observed a brown discharge from his penis. R11 was very cold and shaking but his body was warm to the touch. R11 generally complained of penis pain when we repositioned him. R11 had a penile implant that he was admitted with. R11 stated the implant placement procedure went wrong, hospital doctors suggested that it should have been removed, but R11 declined. Once I noticed the brown discharge, I notify V22 (RN). When I told V22 (RN), she came in to do her assessment, and I exited the room. I document in real time; therefore, the progress note shows the time when I saw R11, which was (10/16/2024) 11:47 AM. Last time I saw R11, before 10/16/2024 was on Monday 10/14/2024 and he appeared fine. On 11/04/2024 at 1:37 PM Surveyor interviewed V19 (Director of Nursing) who stated in the summary, R11 does not have urinary catheter order nor urinary catheter care order. Urinary care is part of ADL (Activities of Daily Living) and incontinence care, and it should be done every 2 hours and as needed, which is related to Certified Nurse Assistant duties. Nurses should assess urinary catheter and document every shift. Nurses were not supposed to change R11's urinary catheter due to penile implant, it had to be changed in the urologist office. Upon request from V19 (/Director of Nursing/DON) absent is any urinary catheter assessment to show R11 urinary catheter was assessed during R11's stay in the facility (08/21/2024 - 10/16/2024). On 11/04/2024 at 1:57 PM Surveyor interviewed V26 (Certified Nurse Assistant) who stated in the summary, as a CNA, I provide urinary catheter care with ADLs, every two hours or as needed. I document it in the task area in resident's electronic medical record under Bladder Continence tab. That should be documented every two hours. If there is blood in the tubing or bag, cloudiness, or change in urine appearance, it needs to be reported to the nurse on duty. R11's urinary continence sheet for October 2024 shows that urinary catheter care was provided 12 times in the entire month. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 11/04/2024 at 3:14 PM Surveyor interviewed V27 (Nurse Practitioner) who stated in the summary, I was on-site (in the facility) on 10/15/2024, when I saw R11 during my rounds, between 9:30a-10:00a. R11 complained about penile pain. I completed my assessment and ordered urinalysis and urine culture sensitivity test. I order R11's test verbally with nurse on duty (V29 Licensed Practical Nurse). There was no blood, and urine was flowing without obstruction; however, based on the labs, I was going to decide whether I should move R11's urology appointment sooner (originally scheduled for 11/4/2024). The following day, V22 (RN) called me and told me that the R11 has a fever. I told her that we have to send R11 out to the hospital if his temperature reaches 104 (degrees Fahrenheit). I talked to V22 (RN) later that day, and she told me that she sent R11 out. Surveyor asked V27 (NP) to clarify how R11 suffered from septic shock, V27 (NP) said, R11 had a chronic urinary catheter, which body recognized as a foreign object. In the process of trying to fight it, the body can go into a septic shock. Antibiotic treatment is detrimental in preventing septic shock. I specifically ordered R11's urine analysis on 10/15/2024 to monitor for UTI (Urinary Tract Infection) and order antibiotic if needed. Urinary assessment and care play also a big role in preventing infection and should not be undermined. On 11/04/2024 at 3:45 PM Surveyor interviewed V24 (Registered Nurse) who stated in the summary, On 10/16/2024 around midnight, I checked R11's temperature and it showed that he had some fever, I don't remember what it was, but it is in my progress note. I called the third-party provider and received orders for urinalysis and urine culture sensitivity test. I collected urine and left it for the lab to pick it up in the morning. I think the third-party provider ordered antibiotic to be started after the urine lab results come back. On 11/04/2024 at 3:57 PM Surveyor interviewed V29 (Licensed Practical Nurse) who stated in the summary, I took care of R11 on 10/15/2024 on day shift. R11 was his usual self that day. As a matter of fact, V27 (Nurse Practitioner) was there, and she looked at R11 as well. V27 (NP) told me that R11's urinary catheter is a special kind and was inquiring about R11's urology appointment. I think she ordered some labs that day, but I don't remember, there was so much going on. Normally, medical provider relay lab orders to me, I transcribe it into the resident's electronic medical record, print it and put it into the lab binder. If there are stat lab, I call the lab. I am not sure if V27 (NP) ordered any labs R11 that day (10/15/2024). Upon request from V19 (DON), absent are any R11's urine related labs ordered on 10/15/2024. R11's laboratory order dated 10/16/2024 3:13 AM reads in part, URINALYSIS, W/REFLEX CandS ** SENT Uncollected 10/16/24 3:14 AM CT ** one time only. R11's laboratory results showed: Collection Date: 10/16/2024 00:00 (AM); Received date: 10/16/2024 12:54 (PM); Reported Date: 10/22/2024 08:01(AM). Detected abnormalities include but are not limited to: BLOOD, SEMI-[NAME]. Large (presence). Escherichia coli ESBL GREATER THAN 100,000 COLONIES/ML. Enterobacter aerogenes GREATER THAN 100,000 COLONIES/ML. Progress note dated 10/15/2024 written by V27 (NP) reads in part, (R11) was seen and examined on this day for the above CC (chief complaint). (R11) was sitting on his bed when he reported to be doing well. (R11) reported pain in his penis, (R11) has a special foley and has an upcoming Urology appt, his (urinary catheter) has not been changed since admission. New verbal orders for UA/CS given to nursing. New order - UA&CS, Upcoming Urology services appt November 4th. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Progress note dated 10/16/2024 1:10 AM written by V24 (RN) reads in part, (R11) c/o intermittent hot and cold, noted to be shaking. Temperature elevated at 100.5, (Urinary) catheter in situ. (R11) also hypertensive at 179mmHg systolic and hypoxic at 89% before supplemental O2 applied. Given (fever medication), (R11) now states he feels marginally better, but his feet are cold. Denies any dyspnea, states he has an infection in my penis. Progress note dated 10/16/2024 10:06 AM written by V22 (RN) reads in part, A & o X 2-3 febrile 99.2 prn (fever medication) given. noted (urinary) cath patent & intact output 240 ml cloudy & dark yellow. Ate 97% of his breakfast, AM meds well tolerated, drank 700 ml of cold water within 3 hrs. temp recheck @ 11:30 temp 104.5 & agitated. Informed NP likewise called 911.VS:BP 111/64 HR 95 RR 20 TEMP 104.5 SPO2 95% RA. Progress note dated 10/16/2024 11:37 AM written by V23 (Wound Care Nurse/LPN) reads in part, While performing wound care, (R11) complained of pain to penis, rated at 6/10. Upon assessment, (R11) noted with brown discharge from penis around (urinary) catheter site. Nurse in duty made aware. R11's hospital record dated 10/16/2024, (R11) is a [AGE] year-old male with (past medical history) significant for chronic (urinary catheter), HFrEF s/p AICD s/p cardiac arrest, CAD, HTN, HLD, asthma, presenting to the (local hospital) emergency department via EMS transfer from (the facility) for fever 104 (degrees Fahrenheit), penile pain, cloudy urine. (R11) arrived to the ED on 4L NC and is AOx4. Admission vitals febrile 103 (degrees Fahrenheit), tachypneic 24, hypotensive 84/54 satting 94%. (R11) reported ED physicians that he has had penile pain for the past 1 year approximately and has a chronic (urinary) catheter. Reports 2 days of weakness, fatigue, (R11) denies cough, shortness of breath, chest pain, abdominal pain, vomiting, diarrhea and only endorses some rhinorrhea. (R11) also endorsed chronic left leg wound but denies any pain. Urine from (urinary) catheter discolored and (R11) report condensed milk urine consistency in (urinary catheter) bag. Assessment and plan: [AGE] year-old male with PMH (past medical history) significant for chronic (urinary catheter), HFrEF s/p AICD s/p cardiac arrest, CAD, HTN, HLD, asthma admitted to MICU (medical intensive care unit) for urosepsis requiring pressors. R11's urinary catheter care plan dated 08/22/2024 reads in part, (R11) requires use of an indwelling catheter r/t (Obstructive uropathy) is at risk for of infection. (R11) Will remain free of complications and infection of foley catheter placement throughout next review. Interventions: Assess for continued need of indwelling catheter; Empty Foley bag every shift and as needed; Monitor for s/s UTI: flank pain, strong odor, increased temp, decreased output, hematuria. The facility Indwelling catheter care policy dated 01/2024 reads in part, Daily and PRN catheter care will be done to promote comfort and cleanliness. Responsible party: RN, LPN, CNA. Catheter bag to be emptied at the end of every shift, and PRN. Record output and catheter care in POC. Absent is laboratory related policy per V19 (Director of Nursing) statement. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The facility Registered Nurse/Licensed Practical Nurse job description reads in part, Implement total nursing care plan through assessment, planning, and evaluation; Administer prescribed medications and treatments according to policy and procedures; evaluate treatment effectiveness on continuing basis; Recognize significant changes in the condition of residents and take necessary action; Document nursing care rendered, resident response , and all other pertinent and necessary data as outlined in facility's policies and procedures.