

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Zahav of Des Plaines		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Ballard Road Des Plaines, IL 60016	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45395</p> <p>Based on interviews and record reviews, the facility failed to follow their abuse policy by not protecting a resident from abuse and/or preventing a physical assault in 2 separate incidents on the same day for 2 (R5, R6) of 4 residents reviewed for abuse.</p> <p>Findings include:</p> <p>Facility reported incident final investigation report with send date of 02/09/2024 indicated that at about 2:52 PM on 02/07/2024, V1 (Administrator) received notification indicating there was a resident to resident altercation on the first floor, involving R5 and R6. While in the activity room on the first floor, R6 was watching television when R5 came over. Both residents had an argument about the television show and they each snatched the remote control. R6 then threw an object (Wii console) towards R5. Both residents were immediately separated and redirected. R5 resides on first floor and R6 resides on the third floor. During smoke time, R6 went down to the first floor and heard R5 threatening to press charges. R6 grabbed the wet floor sign used by housekeeping and started to be physically aggressive with R5. R6 allegedly hit R5 with the wet floor sign. Staff intervened and both residents were then immediately separated and educated. R5 was assessed, no visible injuries noted, head to toe assessment by wound care team, pain assessment and vital signs checked. Medical Doctor (MD) and family notified. R5 denied pain or discomfort related to the incident. Laboratory and radiology tests completed in-house with negative results. R6 was redirected, assessed by staff. Nurse Practitioner (NP) notified with order to transfer him for psychiatric evaluation due to physical and verbal aggression. R6 returned to facility a few hours later with clinical impression of anger reaction and no new orders. Interviews conducted and medical records reviewed. Both residents were seen by psychiatric NP in-house. Investigation completed with no evidence of abuse or neglect. Incident happened as a result of spontaneous response to unpleasant words that were exchanged between residents. Both residents felt offended and threatened by each other's words resulting to sudden agitation. There was no content to cause harm or injury. Both residents, family and guardian are informed of the outcome of the investigation with no concerns.</p> <p>R5:</p> <p>R5's medical records indicate he last admitted to the facility on [DATE] and has a past medical history not limited to: generalized anxiety disorder, muscle weakness, hypertension, encephalopathy, heart failure, gait and mobility abnormalities, and personal history of cocaine abuse.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Zahav of Des Plaines		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Ballard Road Des Plaines, IL 60016	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R5's recent Brief Interview for Mental Status (BIMS) dated 02/07/2024, indicated he is cognitively intact.</p> <p>R5's care plan with last completion date of 03/15/2024 reads in part: history reveals a previous allegation of suspected abuse, prior to admission pre-morbid functioning was impacted by resident's poor/declining health, smoking, ventilator, Chronic Obstructive Pulmonary Disorder, Congestive Heart Failure, Hypertension, Hyperlipidemia, anxiety, and cocaine abuse; potential for Abuse (Physical, Mental, Sexual, Verbal, Financial, Involuntary Seclusion, Neglect, Exploitation, and Misappropriation of Property) with date initiated of 02/27/2024.</p> <p>R5's Potential for Abuse and Neglect assessment dated [DATE] (post 2/7/24 incident) showed R5 is at minimal risk for abuse and does indicate any previous verbal and/or physical abuse under question 1.</p> <p>R5's active order summary report as of 05/01/2024 showed an order for x-ray facial bones with order date of 02/07/2024.</p> <p>On 04/29/2024 at 2:00 PM, R5 said he had gotten into some verbal altercations with R6 about 2 months ago that turned into an assault. R5 said the first incident was over a television program that ended with R6 throwing a game console at him that grazed my head. R5 stated staff came in the room after the incident, and he left the room. R5 stated that less than an hour later, he was in another resident's room that is a few doors down from his room, and they were talking about what happened earlier when R6 passed by this room and started talking trash to him (R5). R5 said he went into the hallway and started heading down the hall to smoke when R6 came up to him and began swinging a wet floor sign at him that he blocked with his arms. R5 said he wasn't injured during the incident just frustrated by it all.</p> <p>On 04/30/2024 at 1:04 PM, R5 said he was very upset about the incidents but didn't want to let those 2 negative issues ruin the rest of his day. R5 stated R6 should not have hit him with the game console or the floor sign. R5 said he felt that he was assaulted by R6, but added what can you do about it, it's better than prison. R5 said facility staff have been informed about issues in the past, but nothing was done about it. When asked to elaborate on the issues, R5 declined to speak about any previously reported issues.</p> <p>R6:</p> <p>R6's medical records indicate he last admitted to the facility on [DATE] and has a past medical history not limited to: encephalopathy, hypertension, opioid use with withdrawal, depression, and psychoactive substance abuse.</p> <p>R6's care plan with last completed date of 03/06/2024 reads in part: has displayed verbally aggressive behaviors towards staff before. Staff recognize that adjustment here has been difficult, and R6 might be fighting; has displayed conflictual and/or verbal/physical aggressive behavior towards others, has a difficult time controlling his temper towards others, and a general intolerance and limited ability to deal with his frustrations, presents with unprovoked expressions of anger towards his peers and becomes verbally/physically aggressive, is aware of his behaviors and becomes apologetic, however he struggles with maintaining control over his temper. Reviewed R6's current physician orders with no order for the management of his anger or aggression.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Zahav of Des Plaines		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Ballard Road Des Plaines, IL 60016	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R6's recent Brief Interview for Mental Status (BIMS) dated 04/10/2024 indicated he is cognitively intact.</p> <p>R6's conduct and behavior contract dated 04/10/2024 (2 months post incident) indicated R6 will be compliant with treatment and plan of care, and will behave in a safe manner, refraining from all acts that might be constructed as aggressive, intimidating, and/or harmful that may result in discharge if non-compliant. No previous contract found on file.</p> <p>On 04/29/2024 at 12:04 PM, R6 said he entered the dayroom/dining room on the first floor on day of incident (02/07/2024) to watch television. R6 stated that the television was turned off, so he checked with the other residents who were present, if they wanted to watch television prior to turning it on. R6 said he began watching television then minutes later, R5 entered the room and started to complain about the television program R6 was watching. R6 said he was sitting in his wheelchair near the television holding the remote when R5 approached him and continued complaining about what was on the television. R6 said R5 then grabbed his hand that was holding the remote control and began pulling R6's arm towards him (R5). R6 said the two began tugging each other's arms back and forth for several minutes when R6 told R5 to let go of the remote because R6 said he feared falling out of his wheelchair due to R5 pulling on his arms. R6 said he felt threatened by R5, so he picked up a game console that was nearby and threw it at R5. R6 said the game console bounced off R5's upper body and/or head, he could not recall because everything happened so quickly. R63 said staff came after this and broke it up. R6 said about 30 minutes after this incident, he was on the first floor heading towards the patio area at end of hall to smoke when he saw R5 in another resident's room and heard R5 talking trash and about calling the police because he was assaulted by R6. R6 said he and R5 got into a verbal altercation when he again felt threatened by R5 who was approaching him (R6) with balled up fists so R6 grabbed a wet floor sign that was near a room door and began striking R5 to his upper body in self-defense because he felt threatened by R5. R6 said R5 had blocked the strikes with the wet floor sign with both of his arms but was unsure if he was injured. R6 said he was sent to the hospital where staff talked with him. R6 returned to the facility approximately 2 hours with no problems or changes to his plan of care.</p> <p>Reviewed R6's hospital paperwork with admitted [DATE], indicated R6 presented to the emergency room for aggressive behavior after threatening another resident. R6 stated he punched this resident and was going to kill him. R6 was not administered any medications while at hospital and was discharged back to facility with clinical impression of anger reaction and with no new orders.</p> <p>On 04/30/2024 at 2:45 PM, V1 (Administrator) said R5 and R6 were involved in a verbal altercation about a television program in the first floor dining room on 02/07/2024 that led to R5 grabbing the remote control from R6. R6 threw a game console towards R5's direction. V1 said when R6 threw the object at R5, it was a concern to V1 because it was done out of anger and could have potentially injured R5. V1 said she was unsure whether R6's physician was notified after R6 initially threw the console. V1 had learned about the first incident involving the thrown console after the second incident that involved a wet floor sign.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Zahav of Des Plaines		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Ballard Road Des Plaines, IL 60016	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/30/2024 at 3:15 PM, V20 (Activity Aide) said at about 2:00 pm on day of incident (02/07/2024), R5 and R6 started speaking loudly about a television program and were pushing at each other with the remote control. V20 said R6 picked up the game console and through it towards R5 but V20 could not see whether it hit R5. V20 said she tried to separate the residents, but they did not listen to her, so she called her boss (V21). V20 said V21 (Activity Director) came into the room while R5 was leaving the room.</p> <p>On 05/01/2024 at 9:45 AM, V1 (Administrator) said neither she nor the nursing staff knew about the first incident until after the second incident had occurred and she was surprised that it even had occurred because there should have been supervision in the activity room.</p> <p>On 05/01/2024 at 10:31 AM, V21 (Activity Director) said she wasn't in the first floor activity room at the time of incident because she was in her office that is down the hall. V21 said V20 (Activity Aide) called her into the room after the incident occurred, and upon entering, R5 was walking out of the room and R6 was still present. V21 said R6 told her that R5 approached him, and they got into a verbal altercation because R5 approached R6 and tried to take the television remote. R6 grabbed a game console, and said he threw at R5 because R5 had come at him (R6) first. V21 (Activity Director) added that V20 (Activity Aide) had separated the residents after the console was thrown.</p> <p>On 05/01/2024 at 10:50 AM, V23 (Licensed Practical Nurse) said around 230-245 PM on day of incident (02/07/2024), she was at the nurse's station on the first floor when she heard a noise coming from the east dining room. V23 said as she headed down the hallway, she saw R5 and R6 were in the hallway and could see R6 holding a wet floor sign and he was also saying that he was going to stab R5. She added that R5 was screaming that R6 hit him with the sign. She separated the residents and took R5 back to his room for assessment. V23 (LPN) said that R5 was refusing to be sent out to the emergency room because he was going to call 911 and the police to press charges against R6 for assaulting him.</p> <p>On 05/01/2024 at 11:00 AM, V24 (Registered Nurse) said she was R6's nurse but did not find out about the incident until after 3pm because she was on break during the time of incident with wet floor sign. V24 said she received the order from the psych nurse practitioner to send R6 to the hospital for evaluation of his mental state and aggressive behavior.</p> <p>On 05/01/2024 at 11:30 AM, V1 (Administrator) said the initial incident between R5 and R6 began as a verbal altercation that turned into a physical altercation over a television program. V1 said it was not reported to her by V21 (Activity Director) but should have been report immediately. At 11:48 AM, V1 (Administrator) said her expectations are for staff to report any incidents of abuse in a timely manner. V1 said R6's physician should have been notified after he threw the game console and would most likely had ordered to send R6 out for a psych evaluation.</p> <p>On 05/01/2024 at 11:46 AM, V25 (Nurse Consultant) said the facility has system in place to train staff on abuse reporting and prevention that will be reviewed to include education scenarios so that staff can better recognize abuse and understand the importance of immediately reporting any incidents of abuse. At 11:53 AM, V25 (Nurse Consultant) acknowledged R6 throwing the gaming console was a willful intent in a physical way against R5 and there should have been more supervision during smoke break times for R5 and R6.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Zahav of Des Plaines		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Ballard Road Des Plaines, IL 60016	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/01/2024 at 12:06 PM, V1 (Administrator) said she was not convinced of willful intent on the part of R6 during her initial investigation of the incident between R5 and R6, but now after further review and thought, she understands R6 had a willful intent to throw the console at R5. At 2:48 PM, V1 said a request was made on 02/07/2024 for R6 to be seen the next day by psych NP but R6 had refused. No documentation of this request was previously noted. V1 said she spoke to psych NP on 04/30/2024 and advised her to create a document indicating the refusal. V1 provided refusal document dated and signed on 04/30/2024 along with ongoing abuse education that was initiated on 04/30/2024. Attempted to contact V34 (R6's Physician) on 05/02/2024; detailed message and call-back number both left with no return call.</p> <p>Abuse Prevention Program Policy with effective date of 11/22/2017 reads in part:</p> <p>Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment.</p> <p>Purpose: to describe the process for identification, assessment, and protection of residents from abuse, neglect, misappropriation of property, and exploitation. This will be accomplished by:</p> <p>Orientating and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse, neglect, exploitation, misappropriation of property or mistreatment.</p> <p>Establishing an environment that promotes resident's sensitivity, resident security, and prevention of mistreatment.</p> <p>Identifying occurrences and patterns of potential mistreatment</p> <p>Immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property.</p> <p>Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences.</p> <p>Filing accurate and timely investigation reports.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Zahav of Des Plaines		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Ballard Road Des Plaines, IL 60016	
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066</p> <p>Based on observation, interview and record review, the facility failed to provide adequate nutrition by not following dietary order for 2 of 3 residents (R7, R13) reviewed for nutrition in the sample of 13. This failure has a potential to affect all 28 residents on NAS (No Salt Packet on Tray) diet.</p> <p>Findings include:</p> <p>1. R7 is a [AGE] year old male admitted to the facility on [DATE] with diagnosis including but not limited to Major Depressive Disorder; Bilateral Primary Osteoarthritis of Hip; Alcohol Dependence; Adjustment Disorder with e Depressed Mood; Chronic Kidney Disease, Stage 3; and Type 2 Diabetes Mellitus.</p> <p>According to R7's MDS (Minimum Data Set) assessment dated [DATE] under section C, R7 has BIMS (Brief Interview of Mental Status) score of 15 indicating intact cognition.</p> <p>R7's dietary order dated 10/27/2023 reads in part, NAS = No Salt Packet on Tray diet. Regular Texture, Thin Consistency, for requests double portions.</p> <p>2. R13 is a [AGE] year old female admitted to the facility on [DATE] with diagnosis including but not limited to Cerebral Infarction; Type 2 Diabetes Mellitus with Unspecified Diabetic Retinopathy without Macular Edema; Unspecified Dementia; Cognitive Communication Deficit; Major Depressive Disorder; and Schizoaffective Disorder, Bipolar Type.</p> <p>According to R13's MDS (Minimum Data Set) assessment dated [DATE] under section C, R13 has BIMS (Brief Interview of Mental Status) score of 5 indicating severely impaired cognition.</p> <p>R13's dietary order dated 05/18/2021 reads in part, LCS (Low Concentrated Sweets) diet. Regular texture, Thin consistency, NAS diet.</p> <p>3. On 04/29/2024 at 12:03 PM Surveyor interviewed R7 who stated in summary: I'm on NAS (No Salt Packet on Tray) diet. I also don't eat pork due to religious beliefs and I dislike fish, so then, I get hamburgers as a substitution and it's just a burger patty and a bun, no condiments whatsoever. I eat hamburgers seven days a week and that can't be good for me.</p> <p>On 04/30/2024 at 11:11 AM Surveyor observed dietary staff plate R13's lunch plate. Surveyor observed dietary staff serving: Hamburger patty on a bun, lettuce, onion, mustard, and broccoli.</p> <p>R13's Lunch Meal Ticket dated 04/30/2024 reads in part, Diet: CCHO (LCS)/Regular/NAS/Thin; Menu: Baked Turkey Crunch, Rice Pilaf, Vegetable Medley, Unsweetened Fruit, and Diet Beverage. Likes: fresh fruit every meal if available.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Zahav of Des Plaines		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Ballard Road Des Plaines, IL 60016	

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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/30/2024 at 11:15 AM Surveyor interviewed V15 (Dietary Director) who stated in summary: NAS (No Salt Packet on Tray) diet is the same as a regular diet, but it doesn't come with any additional salt packets. Residents should get the same meal but no salt packet. Hamburgers should be served only if resident asks for a substitution. V15 denied any instances, such as food delivery problems, food quality issues, planned special events, or disaster situation, that would prevent R13 from getting planned lunch meal.</p> <p>V15 (Dietary Director) clarified with dietary staff if R13 requested substitution for today's lunch, staff denied. V15 educated dietary staff that meals should be served according to residents' meal ticket not based on staff judgment.</p> <p>On 04/30/2024 at 11:18 AM Surveyor interviewed V16 (Cook) who stated in summary: Residents on NAS diet doesn't get today's baked turkey crunch because gravy is very salty, so they get hamburger instead.</p> <p>On 04/30/2024 at 11:28 AM Surveyor attempted to interview R13. R13 non-interviewable due to severe cognitive deficit.</p> <p>The facility policy Sodium Precautions (no date) read sin part, The diet follows the Regular Diet and guides residents away from excessively high sodium foods. Salt is not used at the table and salt packets are not added to the meal tray.</p> <p>The facility policy Menu Substitution or Changes and Approval (no date) read sin part, One time menu changes are made for instances such as food delivery problems, food quality issues, planned special events, in disaster situations, etc.</p>