

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 11/15/2024
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** 39781</p> <p>Based on interview and record review the facility failed to protect the resident from unwelcome physical touch of another resident to her shoulder. This deficiency affects one (R3) of three residents reviewed for Abuse prevention Program.</p> <p>Findings include:</p> <p>On 11/12/24 at 12:20PM, Observed R2 sitting on bed in his room. He is alert and oriented, able to express himself. He denied complaint allegation of R3. He refused to talk about the allegation.</p> <p>On 11/12/24 at 12:32PM, Observed R3 receiving dialysis treatment monitored by V12 Dialysis Nurse in the dialysis room. R3 was sleepy and refused to be interviewed.</p> <p>On 11/12/24 at 1:38PM, V1 Administrator denied complaint allegation of R3 that R2 touched R3's left breast in the elevator. V1 said, their final investigation of facility reported incident revealed that on 10/25/24 after lunch time, both R2 and R3 were together in the elevator. Both are able to use and operate the elevator for transport, no other person was in the elevator when the incident happened. Both were facing the elevator door. When the elevator opened on the first floor. R3 did not moved. R2 tapped both R3's shoulder and signaling to R3 that he wanted to get out the elevator. R3 got out of the elevator first then R2 got out the elevator next. Later during therapy, R3 mentioned that she was touched by R2 inappropriately in the elevator. R3 denied any pain or physical discomfort. Skin assessment was done with no skin alteration. R3 verbalized feeling safe at the facility. Staff and resident were interviewed. Both residents were sent to the hospital for evaluation and returned to the facility a few hours later with no new orders. R2 is in 2nd floor and R3 is in 3rd floor. Both residents are monitored for safety. Police report completed and filed. It was determined that R2 and R3 were together in the elevator. Misdemeanor complaint was filed by [NAME] County Sheriff's police against R2 under case No. SH-24-00396164 for Battery/Physical contact with the court date on [DATE].</p> <p>Review R3's initial and final incident report -unwelcome touch to IDPH dated 10/25/24 and 10/30/24. Review [NAME] County Sheriff's police report dated 10/25/24 against R2 for Misdemeanor complaint of Battery/Physical contact.</p> <p>On 11/13/24 at 9:30AM, V3 Infection Coordinator said R3 was sent to the hospital for evaluation due to change of clinical condition.</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/13/24 at 10:00AM, Informed V1 Administrator of concern identified of failure to protect R3 from R2's unwelcome touched to her shoulder in the elevator.</p> <p>On 11/14/24 at 9:28AM, V3 Infection Coordinator said that R3 was admitted with diagnosis of Hypoglycemia and Pneumonia.</p> <p>R3 is admitted to the facility on [DATE] with diagnosis listed in part but not limited to Toxic encephalopathy, Chronic respiratory failure with hypoxia, End stage renal disease, Generalized anxiety disorder. Active physician order indicates she is on Buspirone HCL 5mg 1 tablet by mouth two time a day for anxiety related to adjustment disorder with mixed emotion and depressed mood. Mirtazapine 15mg 1 tablet by mouth at bedtime for depression. Olanzapine 5mg 1 tablet by mouth at bedtime for bipolar disorder. Comprehensive care plan indicates that she is at risk for abuse (physical, mental, sexual, verbal, financial involuntary seclusion, neglect, exploitation, and misappropriation of property). She has impaired cognitive function or impaired thought processes related to disease processes of anoxic brain injury, cognitive communication disorder, adjustment disorder, depression and dysphagia, impaired decision making, neurological symptoms. She has a behavior problem related to younger age and being at nursing home. She was caught involved with another resident. She disclosed allegations of inappropriate physical contact by another resident.</p> <p>R2 is readmitted on [DATE] with diagnosis listed in part but not limited to Metabolic encephalopathy, Acute and chronic respiratory failure with hypercapnia, Type 2 Diabetes Mellitus, Bipolar disorder, Cognitive communication deficit, Schizophrenia, Opioid dependence with withdrawal. Comprehensive care indicates that he is an identified offender, He has history of criminal behavior. He has demonstrated stability during the admission screening process, does not appear to present an unusual risk and is therefore considered appropriate for admission. According to the available history he was convicted of possession of illegal substances and multiple thefts. Behavior care plan indicates that he is sexually preoccupied and focused on female staff. He is exposing himself while sitting in wheelchair by the entrance to his room. He has potential to demonstrate physical behaviors related to poor impulse control as evidenced by grabbing by hand of female staff. He has mood problem related to disease process of schizophrenia and bipolar disorder. He uses psychotropic medications. He is at risk for abuse (physical, mental, sexual, verbal, financial, involuntary seclusion, neglect, exploitation, and misappropriation of property).</p> <p>Facility's policy on Abuse prevention indicates:</p> <p>Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. The facility prohibits abuse, neglect, misappropriation of property and exploitation of its residents, including verbal, mental, sexual, or physical abuse, corporal punishment, and involuntary seclusion. The facility has a no tolerance philosophy, persons found to have engaged in such conduct will be terminated.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to follow physician order in providing wound treatment. The facility failed to implement wound prevention management. The facility also failed to follow manufacturer recommendation in using low air loss mattress for resident with multiple stage 4 pressure ulcers. This deficiency affects all five (R1, R4, R5, R6 and R7) residents reviewed for Wound care management.</p> <p>Findings include:</p> <p>On 11/12/24 at 11:28AM, Observed R1 lying in bed with tracheostomy connected to oxygen. He has gastrostomy feeding and indwelling catheter. He has low air loss mattress (LAL). V5 WCN (Wound care nurse) was preparing wound care to R1 assisted by V7 Wound Tech and V8 CNA (Certified Nurse Assistant). Observed folded bath blanket in quarters and flat sheet over the LAL mattress. R1 wearing disposable brief. V5 said, R1 should only have flat sheet over the mattress. V8 CNA said, she did not put it, it was from the night shift. V6 LPN said, he did not notice the multilayers of linen when he administered R1's medication this morning. Observed R1 does not have bilateral heel protectors. V5 said, R1 should have bilateral heel while on bed as preventive measures. V8 said, she did not put the bilateral heel protectors because the BP cuff is placed on R1's right ankle and the pulse oximeter is placed on right great toe. V5 WCN provided wound care to R1. V5 cleansed all wound (left hip, left ischium, Sacrum, and right ischium) with Dakins solution and applied wet to dry Dakins dressing. V5 said, R1 has multiple stage 4 pressure ulcers namely: Left hip with 60% non-granulating tissue and 40% slough; Left ischium with 80% granulating tissue and 20% non-granulating; Sacrum with 70% non-granulating and 30% slough; Right ischium with 60% slough and 40% non-granulating. At 11:52AM, V5 WCN removed dressing on back of the head. V5 said, R1 has stage 3 pressure ulcer at the back of his head with 40% non-granulating and 60% slough. V5 cleansed with Dakins solution, applied calcium alginate, and covered with bordered gauze dressing.</p> <p>R1 was readmitted on [DATE] with diagnosis listed in part but not limited to Spastic quadriplegic Cerebral palsy, Acute and chronic respiratory failure, Type 2 diabetes Mellitus with other skin ulcer, Stage 4 pressure ulcer on sacral region, left hip, right buttock, left buttock and stage 3 back of head, Tracheostomy, Gastrostomy. Admission and most recent Braden scale skin assessment indicated that he is at very high risk for developing skin impairment. Active physician order indicates Stage 3 Posterior back of head cleanse with normal saline pat dry, apply skin prep then Adaptic and calcium alginate and cover with a foam or bordered gauze dressing every day and as needed. Stage 4 left ischium cleanse with 1/4 strength Dakins solution, apply moist saline gauze cover with bordered gauze every day shift and as needed. May apply Metrocream for contamination from feces. Stage 4 right ischium cleanse with 1/4 strength Dakins solution, apply moist saline gauze cover with bordered gauze every day shift and as needed. Stage 4 sacrum cleanse with 1/4 strength Dakins solution, apply moist saline gauze cover with bordered gauze every day shift and as needed. May apply Metrocream for contamination from feces. Comprehensive care plan indicates that he has alteration in skin integrity and is at risk for additional skin breakdown related to comorbidities, decreased mobility, decreased nutrition, decreased sensory perception, incontinent bladder and bowel, unavoidability due to condition. Interventions: Off load heels with heel protectors or pillow and per physician orders. Provide low air loss mattress. He requires dependent assist of 1-2 staff members in regard to his functional and cognitive impairments.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/13/24 at 10:38AM, V14 Wound Care Nurse Practitioner said he expects that facility will follow physician's order in performing wound care, will implements the wound care prevention and treatment management such as using of LAL mattress and heel protectors. V14 said, LAL mattress manufacturer recommendation of using 1 flat sheet over the mattress.</p> <p>On 11/14/24 at 10:50AM, Informed V2 ADON and V3 Infection Coordinator of the above concerns identified: 1. failed to follow manufacturer recommendation in using low air loss mattress for all 5 residents (R1, R4, R5, R6 and R7) with multiple stage 4 pressure ulcers. 2.V5 WCN failed to follow physician order in providing wound treatment for R1. V5 used Dakins solution for cleansing and applying wet to dry dressing to R1's left hip, left ischium, sacrum, and right ischium. However, physician order was to apply moist saline gauze after cleansing with Dakins solution. 3. Failed to apply bilateral heel protectors as indicated in care plan for pressure ulcer prevention. Both V2 and V3 said, they should follow physician's order in performing wound care, they should implement the wound care prevention and treatment management such as using of LAL mattress and heel protectors. Both said, LAL mattress manufacturer recommendation of using 1 flat sheet over the mattress.</p> <p>R4</p> <p>On 11/12/24 at 11:57AM, Observed R4 lying in bed with LAL mattress. V5 WCN checked LAL mattress covering and observed folded bath blanket in quarters and flat sheet over the mattress. R4 is wearing disposable brief. V5 said, R4 should only have 1 flat sheet over the LAL mattress.</p> <p>R4 was readmitted on [DATE] with diagnosis listed in part but not limited to Metabolic encephalopathy, Chronic respiratory failure, Type 2 Diabetes Mellitus, Cerebrovascular disease, Limitation of activities due to disability, Dependence on respiratory (ventilator) status, Severe protein calorie malnutrition. Admission and most recent Braden scale skin assessment indicates that she is at high risk for skin impairment. Active physician order indicates Metrocream external cream 0.75% (metronidazole topical) apply to sacrum topically every day shift and as needed for Stage 4 pressure injury cleanse with 1/2 strength Dakins solution, apply Metrocream, Adaptic cover with border gauze or foam dressing. Left anterior lower leg, left foot 5th toe, left heel, left lateral ankle, left lateral lower leg, right 2nd toe, right 5th toe, right ankle lateral/outer, right distal lateral foot, right lateral foot, right great toe hallux, right heel, right medial ankle, right medial foot cleanse with normal saline (NS), pat dry, paint with betadine and cover with 4x4 or ABD pad wrap with kerlix and secure with tape every day shift every Mon, Wed, Fri and as needed. Left ischial tuberosity cleanse with 1/2 strength Dakins solution, pat dry, apply Metrocream, Adaptic cover with bordered gauze dressing every day shift and as needed for stage 4 pressure injury. Right ischial tuberosity cleanse with 1/2 strength Dakins solution, pat dry, apply calcium alginate cover with bordered gauze dressing every day shift and as needed for stage 4 pressure injury. Comprehensive care plan indicates she has alteration in skin integrity and at risk for additional skin breakdown related to comorbidities, decreased mobility, decreased nutrition, decreased sensory perception, diabetes, incontinent bladder, and bowel. Intervention: Low air loss mattress. She requires dependent assist of 1-2 staff members in regard to her functional mobility and ADLs related to physical and cognitive impairments.</p> <p>R6</p> <p>On 11/12/24 at 12:00PM, Observed R6 lying in bed with LAL mattress. V5 WCN checked LAL mattress covering and observed folded linen in quarters and 2 disposable bed pads over the mattress. R6 is wearing disposable brief. V5 said, R6 should only have 1 flat sheet over the LAL mattress.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R6 was admitted on [DATE] with diagnosis listed in part but not limited to Hydrocephalus, Acute and chronic respiratory failure with hypercapnia, Human immunodeficiency virus disease, intracerebral hemorrhage, Stage 4 pressure ulcer of sacral region, contracture of muscle right and left upper arm. Admission and most recent Braden scale skin assessment indicates that she is at high risk for skin impairment. Active physician order indicates Left elbow cleanse with NS, apply Medihoney cover with a bordered gauze or foam dressing every day shift and as needed for cellulitis. Left and right ischium, right trochanter, and sacrum cleanse with NS, apply collagen sheet /powder or Adaptic and calcium alginate cover with a bordered gauze or foam dressing every day shift and as needed for stage 4 pressure injury. Low air loss mattress. Comprehensive care plan indicates he has alteration in skin integrity and is at risk for additional skin breakdown related to disease process, impaired mobility, and incontinence. He requires dependent assist 1-2 staff members in regard to his functional mobility and ADLs related to physical and cognitive impairments.</p> <p>R5</p> <p>11/12/24 at 12:04PM, Observed R5 lying in bed with LAL mattress. V5 WCN checked LAL mattress covering and observed folded linen in quarters and cloth bed pads over the mattress. R6 is wearing disposable brief. V5 said, R5 should only have 1 flat sheet over the LAL mattress.</p> <p>R5 was admitted on [DATE] with diagnosis listed in part but not limited to Chronic respiratory failure with hypoxia and hypercapnia, Type 2 Diabetes Mellitus, Persistent vegetable state, Stage 4 pressure ulcer of sacral region, tracheostomy, gastrostomy. Admission and most recent Braden scale skin assessment indicates that she is at high risk for skin impairment. Stage 4 pressure injury on Sacrum cleanse with NS, pat dry, apply Medihoney, Adaptic, calcium alginate cover with foam dressing or similar every day shift and as needed. May apply Metrocream external .75% (Metronidazole)topically as needed for contamination from feces. Comprehensive care plan indicates he has alteration in skin integrity upon admission to sacrum stage 4 and is at risk for additional skin breakdown related to chronic disease process, impaired mobility, and bowel movement. Intervention: Provide pressure reducing/relieving mattress. He requires dependent assist 1-2 staff members in regard to his functional mobility and ADLs related to physical and cognitive impairments.</p> <p>R7</p> <p>On 11/12/24 at 12:07PM, Observed R7 lying in bed with LAL mattress. V5 WCN checked LAL mattress covering and observed folded linen in quarters and cloth bed pad over the mattress. R6 is wearing disposable brief. V5 said, R6 should only have 1 flat sheet over the LAL mattress.</p> <p>R7 was admitted on [DATE] with diagnosis listed in part but not limited to Anoxic brain damage, Acute respiratory failure with hypoxia, Type 2 Diabetes mellitus, Cerebral infarction, End stage renal disease, Tracheostomy. Admission and most recent Braden scale skin assessment indicates that she is at high risk for skin impairment. Active physician order indicates Metrocream external 0.75% (Metronidazole) apply to sacrum to both buttocks topical every day shift and as needed for stage 3 pressure injury cleanse with NS, apply Metrocream and calcium alginate cover with bordered gauze or foam dressing. Comprehensive care plan indicates she has alteration in skin integrity and at risk for additional skin breakdown related to comorbidities, decreased mobility, decreased nutrition, decreased sensory perception, incontinent bladder, and bowel, unavoidable due to condition. Intervention: Low air loss mattress. She requires dependent assist of 1-2 staff members related to physical and cognitive impairments.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Facility's policy on Wound care reviewed 8/1/2024 indicates:</p> <p>Policy statement: To provide wound care treatments/services based on standards of care under the direction of a physician.</p> <p>1. Risk assessment and prevention</p> <p>a. implement interventions to prevent development of pressure injuries</p> <p>2. Wound assessment and documentation tool</p> <p>d. Re-assess need for interdisciplinary services and appropriate DME (Durable medical equipment) -air mattress, heel protectors, positioning devices/wedges, etc.</p> <p>Facility's policy on Skin management: Specialty mattress review date 5/2023 indicates:</p> <p>Guidelines for the use of specialty mattresses:</p> <p>The following are guidelines for the use of specialty mattress, however, the facility wound care nurses, DON, and physician will continue to use their professional judgement to determine the type of mattresses most appropriate for the individual resident.</p> <p>Low Air Loss:</p> <p>Stage 3, stage 4, unstageable, DTI to the buttocks, multiple stage 2, very high risk with multiple co-morbidities or residents who need this type of mattress for comfort.</p> <p>Procedure:</p> <p>1. As per manufacturer guideline, no more than 1 piece of linen will be placed between the mattress and the resident</p> <p>Facility's policy on Physician orders reviewed 2/28/24 indicates:</p> <p>Guidelines:</p> <p>4. The RN/LPN will follow physician/practitioner's order as written per the resident's POS (Physician order sheet).</p>		