

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145684	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/15/2024
NAME OF PROVIDER OR SUPPLIER  Aliya of Homewood		STREET ADDRESS, CITY, STATE, ZIP CODE  940 Maple Avenue Homewood, IL 60430	

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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>49871</p> <p>Based on observation, interview, and record review the facility failed to ensure the antibiotic prescribed include duration, care plan, and documentation of long term used. This deficiency has the potential to affect 1 of 2 residents (R103) reviewed for antibiotic use in a sample of 23.</p> <p>Findings Include:</p> <p>On 11/12/2024 at 12:31PM, R103 on Enhanced Barrier Precaution (EBP). R103 said he takes medication for infection. On 11/14/2024 at 01:02PM, R103 said he knows he is on antibiotic medication for infection but does not know the name and has been taking it since he came to facility in September 2024.</p> <p>On 11/14/2024 at 10:35AM, V4 (Infection Control Nurse) said R103 is prescribed antibiotic, Metronidazole, should include a start and stop date along with indication for use. V4 said as part of Antibiotic Stewardship program, V4 review all antibiotic prescribed within a day or two of admission and communicate to the doctor if the duration is not indicated and document on resident medical records. V4 said the antibiotic prescribed for R103 on September admission should have a stop date.</p> <p>On 11/14/2024 at 10:58AM, V2 (Director of Nursing/DON) said all antibiotic should have a start and stop date along with indication for use. Doctor should be informed if duration is not indicated. R103 Metronidazole antibiotic should have a stop date and not indicated for long term used.</p> <p>On 11/14/2024 at 01:05PM, V14 (Licensed Practical Nurse/LPN) said she is a regular on the unit where R103 resides but do not give antibiotic to R103 on her shift. V14 reviewed physician order with Surveyor which include the Metronidazole antibiotic. V14 said there should have been a stop date for the antibiotic.</p> <p>Admission Record: Diagnosis Information: Sepsis, Unspecified Organism</p> <p>Order Summary Report: Metronidazole Oral Tablet 500 MG (Metronidazole) Give 1 tablet by mouth every 12 hours for Bacterial Infection, Order date - 9/25/2024, Start date - 9/26/2024, no End date.</p> <p>Care Plan (Created on 11/14/2024) Focus: R103 is on Antibiotic Therapy r/t bacterial infection.</p> <p>Policy:</p> <p>Guideline: Antibiotic Stewardship</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:  145684	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/15/2024
NAME OF PROVIDER OR SUPPLIER  Aliya of Homewood		STREET ADDRESS, CITY, STATE, ZIP CODE  940 Maple Avenue Homewood, IL 60430	
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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review Date: 2/2024</p> <p>Policy: It is the policy of . to maintain an Antibiotic Stewardship Program with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use. Components of the policy were developed by using evidence-based practice guidelines and are aligned with the Core Elements of Antibiotic Stewardship for Nursing homes, published by Centers for Disease Control and Prevention (CDC)(1), and State Operations Manual (Appendix PP): Guidance to Surveyor of Long Term Care Facilities, published by CMS (2).</p> <p>Prescribing record keeping:</p> <p>Dose, duration, route, and indication of every antibiotic prescription MUST be documented in the medical record for every resident.</p> <p>Records will be reviewed monthly to assess compliance with this requirement, as well as prescription appropriateness for the individual resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145684	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/15/2024
NAME OF PROVIDER OR SUPPLIER  Aliya of Homewood		STREET ADDRESS, CITY, STATE, ZIP CODE  940 Maple Avenue Homewood, IL 60430	
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50469</p> <p>Based on observation, interview, and record review the facility failed to implement ongoing monitoring of antibiotics. This deficiency affects one (R103) of three residents in the sample of 23 reviewed for Antibiotic Stewardship Program.</p> <p>Findings include:</p> <p>On 11/14/2024 at 10:36AM, V4 (Infection Preventionist) said that she reviews the antibiotic medications prescribed weekly and an infection assessment evaluation is done prior to the start of antibiotic use for the purpose of monitoring for the antibiotic stewardship program. V4 said that R103 is currently on Metronidazole 500mg every 12hours for bacterial infection with no stop date. V4 said she is unable to locate R103's infection assessment evaluation record upon start of antibiotic.</p> <p>On 11/14/24 at 1:58PM, V2 (Director of Nursing) said that her expectations for the antibiotic stewardship program should be an ongoing monitoring of antibiotics.</p> <p>R013 admitted on [DATE] with diagnosis listed in part but not limited to sepsis unspecified organism, periprosthetic fracture around internal prosthetic left knee joint, subsequent encounter. Active physician order sheet indicates: Metronidazole tablet 500 MG every 12 hours for bacterial infection started on 9/26/24.</p> <p>Facility's policy on Antibiotic Stewardship Program indicates: Reviewed 2/2024.</p> <p>It is the policy of . to maintain an Antibiotic Stewardship Program with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use. Components of the policy were developed by using evidence-based practice guidelines and are aligned with the Core Elements of Antibiotic Stewardship for Nursing Homes, published by Centers for Disease Control and Prevention (CDC) (1), and the State Operations Manual (Appendix PP): Guidance to Surveyors of Long-Term Care Facilities, published by CMS (2).</p> <p>Actions</p> <p>Prescribing and record keeping.</p> <p>-Dose, duration, route, and indication of every antibiotic prescription MUST be documented in the medical record for every resident, regardless of prior prescriptions or documentation elsewhere (e.g., in medical record of a discharging facility). Notation of this information should be made on the day that an in-house prescription is written or on the day that a resident returns to the facility on an antibiotic prescribed elsewhere.</p> <p>-When a new antibiotic is prescribed, the receiving nurse will open a new case in the PCC Infection Control module and an Antibiotic therapy form in PCC.</p> <p>-Records will be reviewed monthly to assess compliance with this requirement, as well as prescription appropriateness for the individual resident, site, and type of infection.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145684	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/15/2024
NAME OF PROVIDER OR SUPPLIER  Aliya of Homewood		STREET ADDRESS, CITY, STATE, ZIP CODE  940 Maple Avenue Homewood, IL 60430	
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Assessment of residents suspected of having an infection. Providers will utilize the McGeer's Criteria or the Loeb Criteria for initiating Antibiotic usage.</p>		