STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145758	A. Building B. Wing	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Glenwood	19330 South Cottage Grove Glenwood, IL 60425

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 0690 Level of Harm - Minimal harm or potential for 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** 44570 Based on observation, interview, and record review, the facility did not provide timely incontinence care for one resident who is dependent on staff for activities of daily living including incontinence care. This failure affected one of one resident (R1) reviewed for incontinence care who developed moisture associated skin dermatitis. Findings include: R1 is [AGE] years old, admitted to the facility 2/7/24 and has diagnoses that include but are not limited to Peripheral Vascular Disease, Chronic atrial fibrillation, and Diabetes Mellitus with Diabetic Neuropathy. According to the Minimum Data Assessment, R1 was assessed as unable to ambulate (walk), is frequently incontinent of bowel and bladder function and requires physical assistance from nursing staff to perform hygiene related to incontinence care. On 11/19/24 at 11:35am R1 was observed alert and coherent in bed. R1 expressed a tone of frustration regarding the lack of responsiveness from nursing staff when R1 uses the call light in order to receive care. R1 said, that even though R1 can feel the need to urinate or have a bowel movement, staff insist on using disposable briefs because it's understood, that they may not arrive to assist R1 in time. R1 also explained that in R1's current condition, R1 finds it difficult to change position or sit up enough to use a urinal. R1 verbalized within the past week, R1 began to feel burning and itching whenever the brief was soiled. R1 mentioned just earlier that day at about 1:00am, R1 waited for over an hour sitting in discomfort before using the cell phone to call the main nurse's station and showed the call log. R1 said that although the call light was used, staff came into the room to deactivate the call light but did not render care nor return until using the cell phone. R1 denied having a history of skin breakdown or receiving skin treatments to the groin or buttock. R1's electronic health record was reviewed. R1 was assessed to have moderate risk of developing skin issues due to a scale that evaluates history of wounds, bedfast activity and nutrition. R1's records did not indicate a history of skin breakdown to the perineal, groin or sacral area. The facility did not provide any skin assessment results for R1 in the week of 11/15/24. (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 12:12pm, a skin integrity observation was conducted with V10 Wound Care Coordinator and the Wound Care Technician. R1 was noted with reddened skin with some small, scattered openings to the posterior scrotum and anterior genital area. At the time of this observation, V10 said the nursing staff had not made V10 aware of this skin condition, although they should have as it was considered a new concern. V10 verbally categorized the concerns as Moisture Associated Dermatitis, red in color, with skin tears. V10 said new orders would be placed for zinc ointment as well as providing education and reminders to nursing staff regarding notification of new skin concerns. Wound assessment dated [DATE] was viewed and included the following: Wound site: groin; Date identified: 11/20/24; Type MASD (Moisture Associated Dermatitis); Classification: incontinence. After the observation was conducted, V10 said that timely incontinence care and application of moisture barrier cream are measures used to prevent MASD for residents who demonstrate incontinence. V4 said timely care reduces time the resident the exposure of urine or stool. Physician's Order Sheet dated 11/20/24 included the following order: Groin: Clean with soap and water, pat dry apply zinc. On 12/02/24 at 11:03am V10 said after applying the zinc ointment daily, R1 was healed of the skin issue on 11/29/24. Photos were uploaded and viewed in the wound care application associated with the electronic health record. On 11/20/24, the facility presented an in-service record for one CNA (Certified nursing Assistant) who proved care for R1 in the early morning. Topic Title: Informing nurse and wound care immediately where new wound found. Description: Inservice to fill out shower sheets and report to nurse and wound care immediately with any concern. CNA verbalized understanding. Inservice's dated 11/20/24 also included Shower sheets to be done, Skin Assessments 2x (times) weekly for Nurses and CNA's; and When New Wound found, fill out shower sheet, inform nurse and wound care immediately! Skin Care Prevention Policy (no revision date) states in part: General- All residents will receive appropriate care to decrease the risk of skin breakdown. Guideline: 1. The Nursing Department will review all new admissions/readmissions to put a plan I place for prevention based on the resident's activity level, comorbidities, mental status, risk assessment and other pertinent information. 2. Dependent resident will be assessed during care for any changes in skin condition including redness (non-blanching erythema), and this will be reported to the nurse. The nurse is responsible for alerting the Health Care Provider. 3. All residents will be evaluated for changes in their skin condition. 9. Clean skin at time of soiling and at routine intervals. 10. If incontinent, use a topical agent as a moisture barrier.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570 Based on interview and record review, the facility failed to have physician ordered pain medication available for administration for a resident experiencing pain. This failure applies to one (R1) of four residents reviewed for pain management. Findings include: R1 is [AGE] years old, admitted to the facility 2/7/24 with diagnoses that are not limited to peripheral vascular disease, Type II Diabetes Mellitus, Diabetic Neuropathy, Opioid Dependence and Hypertension. According to Minimum Data Set (9/13/24) R1 is cognitively intact, frequently experiences pain with a score of eight out of ten on the pain scale and pain occasionally affects R1's sleep. R1's Physician's Order Sheet reviewed includes an active order since admission for Oxycodone 10-325mg (milligrams) give one tablet by mouth every eight hours as needed for Pain. R1's care plan initiated on 3/5/24 documents, Focus: I have pain/potential for pain related to multiple wounds, status post toe amputation, PVD (peripheral vascular disease). Intervention: initiated 3/5/24, revision on 11/13/24 Administer analgesics Oxycodone/Acetaminophen 10/325 as per orders. Give 1/2 hour before treatments of cares. On 11/19/24 at 11:30am, R1 was observed siting up in bed, alert and coherent. R1 said that recently the facility underwent a change in ownership which affected ordering of the medications. R1 said the nurses explained due to the change of ownership, the pharmacy provider also changed, and they were unable to get the oxycodone ordered. R1 said R1 usually asks nurses daily for Oxycodone for pain, and without it, the nurses were only administering acetaminophen because it was the only thing available on hand. R1 said this went on for more than five days, and the pain affected R1's ability to sleep or get rest. R1 said the Oxycodone was finally delivered by the new pharmacy and R1 had been getting the medication since for about a week since it was unavailable. V3 Assistant Director of Nursing (ADON) was interviewed 11/21/24 at 2:20pm and explained that the facility has recently undergone a change in ownership during in the first week of November which included changing pharmacy providers. During the interview, the ADON said that although the pharmacy changed, there was no interruption of pharmacy services and medications were available as usual. V3 personally communicated with the new pharmacy and was directly involved in the transition of pharmacy services. V3 said they were not aware of R1's concerns regarding Oxycodone not being available and if they knew about the concern, the facility's in-house nurse practitioners would be able to help address any needs for prescriptions or refills. The drug control sheet for Oxycodone 10-325mg were requested for review for the month of November 2024. The facility presented the record from 11/13/24, however was unable to locate the control sheet prior in order to show the medication was available to be administered. R1's November Medication Administration Record was also reviewed, and it was noted that Oxycodone was not signed out as given from 11/4/24 to 11/13/24. R1's MAR's only document Aceteminophen 650 milligrams administered one time on 11/10/24 at 1:13PM. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy Pain (no revision date) states in part; General- To facilitate and provide guidance on pain observations and management. To facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. Guideline: The pain management program is based on a facility-wide commitment to resident comfort. Pain is defined as whatever the experiencing person says it is and exists whenever he or she says it does. Pain Management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Pain management is a multidisciplinary care process that includes the following: Observing for the potential for pain. Effectively recognizing the presence of pain. Identifying the characteristics of pain Addressing the underlying causes of the resident's pain. Developing and implementing approaches to pain management. Identifying and using specific strategies for different levels and sources of pain. Monitoring for the effectiveness of interventions; and modifying approaches as necessary.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44570 Based on interview and record review, the facility failed to take and record food temperatures prior to serving in order to ensure meals were provided at an appetizing temperature. This failure affected five (R1, R2, R3, R4 and R7) of five residents who were reviewed for dietary services. Findings include: On 11/19/24 at 10:35am R2 and R3 were observed in their room, alert and coherent and expressed concerns about dinner being served cold on several occasions within the past week. R2 and R3 both clarified that the issue was on-going and specific to dinner. At 11:00am R4 Resident Council President said the food is often served cold when it should be warm, but people (other residents) get tired of complaining about it. At 11:30am R1 and R7 was observed alert and coherent in their bedroom. R1 and R7 expressed sometimes getting dinner that is ice cold by the time it is served in their rooms. On 11/20/24 at 12:24pm the temperature logs for Breakfast, Lunch and Dinner were reviewed with V4 Dietary Manager. During this observation, it was noted that temperatures for Dinner Service were not recorded for dates from 11/9/24 to 11/14/24 and 11/19/24. Copies of these logs were requested at the time of viewing. V4 said that during these dates, V4 had time off from the facility and a new cook (V14) was on duty during these dates. V4 said after returning to the facility, V4 was informed by resident's and staff that there were complaints of residents receiving cold dinner which was intended to be warm. V4 said that without the documented temperatures, it would be hard to determine if the food was at the proper temperature prior to being served. On 11/20/24 at 1:59pm V14 [NAME] said, V14 was new to the facility- about a few weeks and V14 said I haven't been doing the temperature logs or writing the temperatures down. V14 said V14 has only been cooking dinner and knows that the temperatures should be documented before serving but has been forgetting. V4 provided an in-service sheet dated 11/20/24 signed by V14 which states: Topic- Temperature log sheet. Temperature control is one of the most critical factors in preventing foodborne illness. Pathogens that cause foodborne illness can grow rapidly if food is not kept at the correct temperatures, either too hot or too cold. By logging temperatures regularly, we are able to ensure that food is stored, prepared, and served safely. Temperatures must be logged for each meal daily. Monitored by Food Service Director. Food temperature logs were not given as requested on 11/20/24. On 12/2/24, V4 presented temperature logs that were edited to include temperatures that were missing at the time of observation. These temperatures were confirmed not to be documented per the cook on duty (V14). (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Food Safety Policy (no revision date) states in part; Purpose: [Facility] maintain proper food safety to ensure resident well being. This policy includes a general overview of food safety best practices followed: Keep hot foods at 135 degrees and cold foods at 41 degrees Fahrenheit. Take food temperatures during and after cooking and keep temperature logs; food safety monitoring software can help ensure compliance.