

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/10/2025
NAME OF PROVIDER OR SUPPLIER Aliya of Glenwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 50469</p> <p>Based on interview and record review the facility failed to implement measures for unstageable wound. This facility also failed to implement wound care treatment orders and develop a wound care plan. This deficiency affects one (R4) of three residents reviewed for Wound/Pressure Ulcer Prevention and management.</p> <p>Findings include:</p> <p>On 5/10/25 at 10:25AM, V5 (Wound Care Nurse) said that R4 sacral wound was identified on 4/28/25. V5 said that R4 had multiple co morbidities and was declining rapidly.</p> <p>On 05/10/25 at 1:20PM V3 (Director of Nursing) said that R4 develop a wound in facility and based on documentation it was observed on 4/26/25 by staff V6 (Certified Nurse Aide) and V7 (Licensed Practical Nurse). V3 said that residents with new skin concerns or wounds should have been notified to Nurse Practitioner or MD for treatment orders, and care plan should be updated with interventions. Treatment orders should reflect on the resident treatment administration record for wound care management. V3 said that there is no treatment administration record for the month of April 2025 for R4, no treatment orders were put in place on the physician orders to reflect wound care. The nurse who identified the sacral wound should have called MD or Nurse Practitioner to obtain treatment orders.</p> <p>On 5/10/25 at 1:35PM, V7 (Licensed Practical Nurse) said that V6 (Certified Nurse Aide) notified her about R4 sacral wound, V7 cleansed area and applied dry border gauze dressing. V7 said she did not notify Nurse Practitioner or MD to obtain any treatment orders. V7 said she knows she is supposed to notify Nurse Practitioner and MD of any new open skin areas, obtain treatment orders and update care plan but did not do it.</p> <p>On 5/10/25 at 1:45PM, V6 (Certified Nurse Aide) said that she noticed the sacral area completely opened and notified V7 (Licensed Practical Nurse). V6 said she documented on R4 shower sheet and gave it to V7.</p> <p>On 5/10/25 at 2:30PM, V5 said that there should have been a wound care order on 4/26/25 when the wound was identified, and care plan should have been updated as well. V5 said she is unsure of what happened.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145758	If continuation sheet Page 1 of 2

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/10/25 at 3:03PM, V1 (Administrator) made aware of above findings, and said that her expectations for wound care management are to have the staff notify the physician or Nurse Practitioner for orders, make sure that there is a treatment administration record in place, and care plans updated.</p> <p>R4 readmitted on [DATE] with diagnosis listed in part but not limited to other encephalopathy, Dysphagia, other lack of coordination, acute respiratory failure, iron deficiency, unspecified dementia, atrial fibrillation. R4 is at moderate risk for skin impairment. Physician orders for 4/1/2025 through 4/30/25 did not indicate any wound care treatment orders. No available Treatment administration record for 4/1/24 through 4/30/25. Wound care plan updated on 4/30/25 indicated the resident has potential/actual impairment to skin integrity of the buttocks. interventions include Monitor /document location, size, and treatment of skin injury, Report abnormalities, failure to heal, symptoms of infection, maceration, etc. to MD. Review of physician order for 5/1/2025 through 5/7/25 indicated wound care order dated 5/5/25 Sacrum: clean with wound cleaner pat dry apply Santyl and alginate and bordered gauze. every day shift for wound care. Progress note dated 5/5/25 skin/wound note, with treatment orders received. Treatment administration record indicated 5/5/25 order Sacrum: clean with wound cleaner pat dry apply Santyl and alginate and bordered gauze. every day shift for wound care. record indicated documentation wound care treatment completed on 5/6/25 and 5/7/25.</p> <p>Facility unable to provide policy on Prevention of Pressure/Wound Management</p> <p>Facility's policy on Skin Care Prevention revised 1/2024</p> <p>General: All residents will receive appropriate care to decrease the risk of skin breakdown.</p> <p>Responsibility: All nursing Staff</p> <p>Guideline:</p> <ol style="list-style-type: none"> The nursing department will review all new admissions/readmissions to put a plan in place for prevention based on the residents activity level, comorbidities, mental status, risk assessment and other pertinent information. Dependent residents 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. All residents will be evaluated for changes in their skin condition. <p>Facility's policy on Change in Resident Condition revised 1/1/24.</p> <p>General: It is the policy of the facility, except in a medical emergency to alert the resident, resident physician and residents responsible party of a change in condition.</p> <p>Policy:</p> <ol style="list-style-type: none"> Nursing will notify the residents physician or nurse practitioner when: <ul style="list-style-type: none"> There is a significant change in the residents physical, mental, or emotional status. 		