

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 04/10/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46334</p> <p>Based on observation, interviews and record review, the facility failed to follow the infection control policy related to placement of isolation precaution signs and wearing of personal protective equipment before entering room and during provision of care for four (R51, R87, R99 and R107) of five residents in the sample of 41 reviewed for infection control.</p> <p>Findings include:</p> <p>1. R87 is a [AGE] year-old, male, admitted in the facility on 01/07/25 with diagnoses of Malignant Neoplasm of Rectum; Colostomy Status; and Metabolic Encephalopathy. POS (Physician Order Sheet) dated 03/26/25 documented R87 is on contact precautions for E. coli (Escherichia coli) of sacral wound.</p> <p>R87's care plan dated 03/27/25 recorded: Resident has active infection of the wound - Interventions: Isolation as per physician's orders.</p> <p>On 04/07/25 at 10:52 AM, it was observed that a sign stating R87 is on contact isolation was posted by the door. An isolation bin containing yellow gowns, gloves and masks were stored. R87 is alert, oriented, has colostomy bag and indwelling urinary catheter intact and in placed.</p> <p>On 04/07/25 at 12:35 PM, V17 (Hospice Account Executive) was observed inside R87's room conducting interviews not wearing any PPE (personal protective equipment) such as gown and gloves. V17 was asked regarding R87, stated that she was just explaining about hospice and hospice care.</p> <p>Signage posted on R87's door stated:</p> <p>Contact Precautions</p> <p>Providers and Staff must also:</p> <p>Put on gloves before room entry</p> <p>Put on gown before room entry. Discard gown before room exit.</p> <p>2. R99 is a [AGE] year-old male, admitted in the facility on 11/17/24 with diagnoses of Unspecified Injury at Unspecified Level of Cervical Spinal Cord, Subsequent Encounter; Paraplegia, Unspecified; Neuromuscular Dysfunction of Bladder, Unspecified.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R99's care plan dated 08/09/24 documented: Enhanced barrier precautions will be maintained.</p> <p>Interventions:</p> <p>Educate staff/resident/family on enhanced barrier precautions as needed.</p> <p>Gown and glove during high contact resident care activities (such as dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care/use, wound care (any chronic skin opening))</p> <p>Maintain enhanced barrier precautions for the duration of their stay OR until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.</p> <p>On 04/07/25 at 10:58 AM, R99 was in bed, alert, oriented. R99 has an indwelling urinary catheter in placed, connected to a urinary bag, draining well. A sign at his door stating that he is on enhanced barrier precaution (EBP).</p> <p>On 04/08/25 at 11:42 AM, CNAs V19 and V20 were observed in R99's room providing care without wearing isolation gowns. V19 was assisting R99 in putting on his shirt. V20 was emptying his (R99) urinary bag. Subsequently, V19 and V20 used a mechanical lift device and transferred R99 to his motorized wheelchair. V19 was asked regarding EBP on R99. V19 stated, I'm not sure if he is on EBP, because I don't work here every day. On EBP, we are supposed to wear gloves, gown, and goggles. We have to wash our hands before and after.</p> <p>Signage posted on R99's door:</p> <p>Providers and staff must also:</p> <p>Wear gloves and a gown for the following High-Contact resident care activities.</p> <p>Dressing</p> <p>Transferring</p> <p>Device care or use: central line, urinary catheter, feeding tube, tracheostomy.</p> <p>3. R51 is a [AGE] year-old, female, admitted in the facility on 09/11/18 with diagnoses of Malignant Neoplasm of Colon, Unspecified; Colostomy Status and Alzheimer's disease, Unspecified. R51 has colostomy bag, intact and in placed.</p> <p>There was no sign at R51's door stating she is on any type of precautions, as observed on 04/06/25, 04/07/25 and 04/08/25.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/08/25 at 9:46 AM, V3 (Infection Preventionist) was asked regarding R51. V3 replied, She has colostomy. She should be on enhanced barrier precautions for that. They must have flipped the sign around backwards by accident. Every room does not need a supply bin. I have binders at the nurses' station as well. If the signs get knocked down, staff is supposed to go to the nurse and ask or go to the nurses' station and look at the binder. And there is supposed to be an orange dot to know who is on enhanced precaution. V3 flipped the sign to show that resident is on enhanced barrier precautions.</p> <p>On 04/08/25 at 1:37 PM, V3 was interviewed regarding transmission based and enhanced barrier precautions. V3 verbalized, For transmission-based precautions (TBP) such as contact/droplet precautions, there should be a signage at the door upon entrance; orders need to be placed; isolation bins placed outside the room. Staff needs to wash their hands before and after entering and exiting the rooms; staff and visitors need to wear PPE - gown; gloves and if its droplet - gown, gloves, face shields; N95. For contact isolation - anybody entering the room should wear gown and gloves. So, infection is contained. For enhanced barrier precautions, anybody that is on high contact with resident needs to wear gown and gloves. High contact such as bathing, transferring, feeding, changing linens; administering IV (intravenous); indwelling urinary catheter care; gastrostomy tube care or ADL (activities of daily living) care.</p> <p>On 04/09/25 at 12:46 PM, V2 (Director of Nursing) was also asked regarding infection control in the facility. V2 stated, Staff has to follow all infection control policies and procedures, which includes isolation precautions; TBP; EBP and standard universal precautions. I am a part of providing education on staff regarding infection control. We constantly asking questions on staff regarding what to do for isolation, handwashing, hand hygiene, donning and doffing PPE. We do random audits on staff for hand hygiene, hand washing and PPE. Staff has to make sure outside vendors, visitors that PPE should be worn for isolation rooms.</p> <p>4. R107 is [AGE] years of age. Current diagnoses include but are not limited to Cerebral Infarction affecting the left side, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Urinary Tract Infection, Obstructive and Reflux Uropathy, and Resistance to Vancomycin.</p> <p>R107's comprehensive assessment section C cognitive patterns dated 2/7/2025 documents a brief interview for mental status score of 15 out of 15 indicating he is cognitively intact.</p> <p>On 04/07/25 at 11:00 AM, this surveyor observed the 400 hallway during screening of residents. There are multiple residents with EBP (Enhanced Barrier Precaution) and TBP (Transmission Based Precaution) signs and PPE Personal Protection Equipment bins in place at the room entrance.</p> <p>On 04/07/25 at 11:32 AM, this surveyor entered R107's room for interview. Upon entrance to the room, there is no signage at the door for R107 indicating contact isolation precautions. There is no hand sanitizer solution in the dispenser at the entrance to R107's room.</p> <p>On 04/07/25 at 11:34 AM, while this surveyor is conducting an interview with R107 in his room, V3 arrived in the room with a contact isolation sign and PPE bin. V3 was inquired of the sign and PPE bin placement. V3 said, R107 is on contact isolation for VRE (Vancomycin Resistant Enterococcus) in his urine, he has a urinary catheter. We just moved his room. The only supplies he needs are gowns, gloves, and hand sanitizer. Little said, It' important for the staff and visitors to know R107 is on contact isolation so the infection isn't spread.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Policy: Set up - contact: sign on door; hand hygiene is required; gloves are required upon entry to room, must be removed before exiting, followed by hand hygiene; gown is required.</p> <p>Facility's policy titled IC - Enhanced Barrier Precautions (EBP) dated 1/2024 stated in part but not limited to the following:</p> <p>General: EBP expand the use of PPE and refer to the use of gown and gloves during high - contact resident care activities that provide opportunities for transfer of MDROs (multidrug resistant organisms) to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/ or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.</p> <p>Policy: EBP requires the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Use of eye protection may be necessary when splash or spray may occur but is not necessary in other situations.</p> <p>High contact resident care activities requiring gown and glove use among residents that trigger EBP use include: dressing; transferring; providing hygiene; device care or use: urinary catheter.</p> <p>Citation written by Surveyor: Ma Melodia [NAME] with supporting documentation based on observations from April [NAME], [NAME] and [NAME].</p>