

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145936	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Aliya of Highwood		STREET ADDRESS, CITY, STATE, ZIP CODE 50 Pleasant Avenue Highwood, IL 60040	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>35541</p> <p>Based on observation, interview, and record review the facility failed to provide the necessary care and treatment to residents with nonpressure wounds for 2 of 3 residents (R2, R3) reviewed for nonpressure wounds in the sample of 4.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. R2's admission skin and nursing assessments dated 7/14/24 showed R2 was admitted to the facility, from a local hospital, with diagnoses of infectious wounds to her right and left buttock related to a diagnosis of necrotizing fasciitis (flesh eating bacterial infection) to both areas. Clusters of wounds were also noted to R2's right and left posterior lower legs. These assessments showed R2 was cognitively intact. <p>R2's wound care notes dated 7/21/24 showed R2's wounds as the following:</p> <ol style="list-style-type: none"> 1. A left buttock infectious wound measuring 6.5 cm (centimeters) x 16 cm x 0.3 cm. 2. A right buttock infectious wound measuring 10 cm x 28 cm x unknown. 3. A cluster of vascular wounds to R2's left lower leg measuring 15 cm x 17 cm x 0.3 cm. 4. A cluster of venous wounds to R2's right lower leg measuring 22 cm x 20 cm x 0.3 cm. <p>R2's left and right buttock physician treatment orders dated 7/17/24 showed, Cleanse with 1/2 Dakins (wound cleanser), pat dry, pack wound with moist Kerlix (gauze dressing) every day.</p> <p>R2's left and right lower leg physician treatment orders dated 7/14/24 showed, Cleanse with 1/2 Dakins, pat dry, apply Neosporin (antibacterial ointment), Xeroform (petroleum gauze dressing), and wrap wound with gauze, secure with tape, every day.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/23/24 at 8:49 AM, R2 was in bed, lying flat on her stomach. A large, linear, open, weeping wound was noted to R2's right buttock. No dressing was noted to the wound. A large amount of serous drainage was noted to the bed sheet lying on top of R2's right buttock wound. A smaller linear wound was noted to R2's left buttock. No drainage was noted from the wound. No dressing was noted to the wound. Gauze dressings, dated 7/21/24, were noted around both of R2's ankles, leaving the wounds to R2's posterior right and left lower legs exposed. Large reddened, clusters of open wounds were noted to both of R2's posterior lower legs. When R2 was asked when her wound dressing were last changed, R2 stated, A couple of days ago.</p> <p>On 7/23/24 at 10:45 AM, V3 Wound Nurse stated, (R2) should have wound care done every day. She should have dressings to her right and left buttocks and lower legs. If I am not here to do wound treatments, the floor nurse can do wound care also.</p> <p>2. R3's wound care notes dated 7/19/24 showed R3 had open wounds to his left axila, right axila, and left groin areas related to his diagnosis of Hradenitis Suppurativa (chronic skin condition causing lumps and blistering to the skin).</p> <p>R3's left and right axila physician treatment orders dated 4/28/24 showed, Cleanse with 1/2 Dakins solution and apply Medihoney (wound cream) and leave open to air every day shift.</p> <p>R3's left groin physician treatment order dated 4/17/24 showed, Cleanse with NS (normal saline), pat dry, apply Bacitracin (antibacterial ointment), leave open to air daily.</p> <p>R3's July 2024 Treatment Administration record showed R3 received no wound care to his axila wounds or groin wound on 7/6/24, 7/9/24, 7/11/24, 7/16/24, 7/18/24, and 7/20/24.</p> <p>On 7/23/24, V1 Administrator was asked for a facility policy on the care and treatment of nonpressure resident wounds. No policy was provided by the facility.</p>		