

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  09/25/2024
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 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>40798</p> <p>Based on observation, interview, and record review, the facility failed to ensure wound treatment was provided as ordered for 1 of 3 residents (R3) reviewed for wounds in the sample of 9.</p> <p>The findings include:</p> <p>On 9/24/24 at 11:41 AM, V3, (Wound Care Nurse/Assistant Director of Nursing-ADON), said R3 should have had wound care/dressing change to her coccyx wound on Sunday (9/22/24), as her treatments are ordered every other day. V3 and V4, Certified Nursing Assistant (CNA) positioned R3 on her side to allow V3 to provide her wound care. R3 had a dressing in place on her backside which was dated 9/18.</p> <p>On 9/25/24 at 12:57 PM, V7, (Licensed Practical Nurse), said wound care/dressing changes are done according to the doctor's orders.</p> <p>The facility's Pressure Wounds as of 9/24/24 shows R3 has an active pressure ulcer of her sacrum first identified on 8/8/2023.</p> <p>R3's Order Summary Report dated 9/25/24 shows active treatment orders for cleansing, medication, and a dressing to be completed every other day and as needed to R3's sacral wound. R3's current care plan provided by the facility shows R3 has a stage 4 pressure ulcer of her sacrum and wound treatment is to be applied as ordered by the physician.</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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