STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145936	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Highwood	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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 39537 Based on observation, interview, and record review the facility failed to ensure a resident with a reasonable suspicion of mental illness was referred for a Level II PASARR screening for 1 of 1 residents (R2) reviewed for PASARR screening in the sample of 20. The findings include: On 11/13/24 at 10:46 AM, R2 was lying in his bed, watching TV. The surveyor asked R2 how it was going at the facility. R2 replied, Not great, but there's nothing you can do about it. R2 had a flat affect and continued to make negative statements. R2 was alert and oriented and able to express himself. The surveyor asked R2 if he had any specific complaints. R2 looked at the ground and stated, It is what it is. R2 didn't want to speak any further. R2's Facesheet dated 11/14/24 showed diagnoses to include, but not limited to: epilepsy, heart failure; bipolar disorder; and suicidal ideations. This document showed R2 was admitted to the facility 6/21/19. R2's Care Plan initiated 10/26/19 showed R2 is on antipsychotic medications due to bipolar diagnosis. R2's Care Plan initiated 5/20/20 showed he was on antidepressant medications. R2's Care Plan initiated 6/21/19 showed he had a mood problem related to bipolar disorder and had depression and passive death wishes. R2's Interagency Certification Screening Results dated 12/6/19 showed R2 had a reasonable basis for suspicion mental illness and had been formally diagnosed with bipolar disorder. This form showed that if yes was marked in Part II or III of the form (both boxes contained a yes answer), then the facility should refer R2 to the appropriate agent to complete Part IV (PASARR Level II screening). The facility was unable to provide R2's PASARR Level II screening or any documentation to show that the referral had been made to the appropriate agency. (R2 had resided at the facility for 5 years. The surveyor requested R2's PASARR Level II screening on 11/12, 11/13, and 11/14/24. The facility was unable to provide it.) On 11/14/24 at 10:41 AM, V7 (RN - Registered Nurse) said R2 has behaviors sometimes due to his bipolar disorder. V7 said R2 gets irritated with other residents and argues with other residents. V7 stated, We just try to keep him calm and redirect. V7 said R2 is alert and oriented and is able to make his needs known. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 11:04 AM, V6 (Social Services Director) said she had been in the role for 2-3 years, but was working in Admissions when R2 admitted to the facility (2019). V6 said the residents initial screening is completed at the hospital, prior to admission. V6 said if the Level I screening showed there is a reasonable suspicion of mental illness, then she will reach out to the referral agency for further evaluation. V6 said the purpose of the PASARR Level II was to further evaluate mental illness and ensure the resident is in the appropriate care setting and determines any additional services that are needed. V6 said she was unable to find a PASARR Level II screening for R2. V6 said she didn't know why it wasn't completed. V6 said there should have been a referral to the proper agency and she would see if she could locate any documentation (V6 was unable to provide documentation that R2's referral had been made.). V6 said once the referral is made, then the agency usually comes to complete the assessment within a week. V6 said if they did not show up to complete the assessment, then she would call to follow-up. V6 said she was not the Social Service Director when R2 was admitted and was unsure what happened. V6 said R2 should have had a PASARR Level II screening completed. On 11/14/24 at 11:19 AM, V2 (DON - Director of Nursing) said R2 was alert and oriented. V2 said R2 does have mood changes due to his bipolar disorder. V2 said she wasn't involved in the PASARR Level I or II screenings for residents. V2 stated, I think that's more Admissions or Social Services. The facility's PAS Screening Policy reviewed 1/2024 showed, In accordance with Illinois regulatory standards and recommended practices, this organization requests Level I (one) and Level 2 (two, where applicable) Pre-Admission Screening documents prior to the individual's arrival at the facility . Responsible Party: Admissions, Social Services. Policy: It is the policy of this facility to: 1. Comply with Illinois standards addressing the PAS assessment/screening process. 2. Request full and complete PAS materials (Level 1 and 2) from each referral source prior to admission. 3. Review the PAS documents to help assess/ascertain what type of problems, needs and issues need to be addressed to help the resident function at his/her maximum level of well-being. 4. Provide a copy of OBRA -1 and PAS-MR 1 (as applicable) to an identified clinician (in most cases this will be the Director of Social Service). 5. Place the PAS paperwork in the resident's business file . Procedure: 1. Facility representative shall request the complete screening packet from appropriate screening agency/referral source. 2. A copy of all materials received will be placed in the resident's business file and a copy may be placed in the chart at the discretion of administration. 3. The screening agency/referral source may be contracted, as indicated via phone/fax/email and asked to provide any missing or incomplete documents. Facility documentation should include information addressing the date, time, and person contacted. 4. As indicated, the screening material should be reviewed as a component of the assessment process and treatment suggestions/recommendations should be identified and appropriately addressed .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to assess a new wound and failed to document treatment orders for 1 of 2 residents (R51) reviewed for non-pressure wounds in the sample of 20. The findings include: R51's face sheet printed on 11/14/24 showed diagnoses including but not limited to cellulitis of the left lower limb, lymphedema, morbid obesity, and heart failure. R51's facility assessment dated [DATE] showed moderate cognitive impairment. R51's wound summary report printed on 11/14/24 showed a history of venous stasis wounds to the left lateral and left posterior leg. The same report showed a history of lymphedema to the right leg. On 11/12/24 at 11:38 AM, R51 was seated on the edge of his bed and was wearing shorts. Both lower extremities were wrapped with bandages from just below the knees to the toes. R51 stated he has poor circulation to his lower legs and trouble with fluid build-up. R51 said the staff found a new sore on his right leg yesterday. R51 said he was unsure what was being done for the new wound. R51's electronic wound round reports were reviewed on 11/12/24 and did not show any open or active wounds. On 11/13/24 at 9:39 AM, R51 was seated on the edge of his bed and wearing shorts. Both lower extremities were still wrapped from the knee to the toes. R51 stated he was due for a shower in the afternoon and was very concerned about the new sore getting wet. On 11/13/24 at 1:26 PM, V8 (Registered Nurse) stated R51 has a history of open wounds but all have been healed. V8 stated there are no current skin issues and no orders for any wound treatments. V8 stated the wound care nurse wraps his legs a few times per week to treat his lymphedema but there are no active wounds. On 11/13/24 at 1:32 PM, V3 (WCN-Wound Care Nurse) stated R51 has his leg wraps changed three times per week. V3 said R51 has a history of venous ulcers and was being followed by the wound doctor in the past. V3 said since he is healed, the doctor no longer sees him at the weekly visits. V3 said R51 has no current skin issues and nothing has been reported to her. V3 said any new skin changes should be reported to her immediately and the wound doctor needs to be notified. V3 said R51 is cognitively alert and only has slight short term memory problems. On 11/13/24 at 1:42 PM, R51 was lying on his bed and V3 (WCN) unwrapped both bandages on his lower legs. R51 had a 4 inch by 4 inch dressing on his right lateral calf area. V3 said it was the first time she was aware of any skin issues and removed the dressing. An oblong, egg size fluid filled blister was under the it. V3 said the blister should have been reported to her the day it was found. V3 said she did not know how it was being treated or when it was discovered. V3 said the wound looked to be venous related. V3 said the wound doctor should have been notified and a treatment order should have been received. V3 stated there are no wound orders or wound assessments in R51's medical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 2:48 PM, V2 (Director of Nursing) and V7 (Registered Nurse) stated they both were aware of R51's blister on his right leg on 11/11/24 (two days ago). The nurses said it was discovered when the leg wraps were being changed. The nurses said the nurse practitioner was notified and an order to cover it was obtained. The nurses stated they failed to document the new order or perform any assessment of the new skin issue. On 11/14/24 at 11:20 AM, V3 (WCN) stated the wound doctor just looked at R51's leg yesterday and a new treatment order was obtained. V3 stated yesterday was the first time the wound was assessed. V3 said the wound should have been assessed the day it was found, and treatment orders placed directly in the medical record. V3 stated R51 had open sores on his lower legs in the past and is already a high risk for more to develop. V3 said the assessment is important to have an ongoing comparison of any improvement or decline. Clearly documented orders ensure the next shift's nurse can follow through and do the treatment properly. R51's wound evaluation dated 11/13/24 (two days after identified) showed a lymphademic wound to the right lateral leg measuring 1.5 x 4.5 centimeters with a duration of greater than two days. The report showed an order for xerofoam gauze three times per week and as needed for 30 days. The facility's Skin Management policy review dated 1/2024 states: It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed to safely transport a resident in a wheelchair for 1 of 4 residents (R83) in the sample of 20. The findings include: On 11/12/24 at 10:08 AM, R83 was sitting in his wheelchair, at the nurses' station, drawing in a sketch book. V6 (SSD - Social Service Director) asked R83 if he wanted to go participate in activities. V6 stood and pushed R83's wheelchair down the length of the hall to the elevator. R83 did not have foot pedals on his wheelchair. R83 was wearing running shoes. Initially, R83 crossed his ankles and attempted to lift his feet under the wheelchair, with his toes pointing toward the ground. R83's toes hit the ground multiple times, slowing the transport. V6 reminded R83 to lift his feet and stopped. R83 then moved his feet forward, easily lifting the left foot 2 inches off the floor, but was unable to consistently hold his right foot off the ground. R83 put his right foot down multiple times from the middle of the hallway to the elevator. R83's Facesheet dated 11/14/24 showed diagnoses to include, but not limited to: Alzheimer's; restlessness and agitation; epilepsy; and cerebral amyloid angiopathy. This document showed R83 was admitted on [DATE]. R83's facility assessment dated [DATE] showed he had severe cognitive impairment and required substantial/maximal assistance from staff for personal hygiene, sit to stand and transfers. R83's Admission Evaluation dated 10/14/24 showed he was at High Fall Risk. R83's Progress notes showed he had a fall on 10/20/24 and 11/8/24. On 11/14/24 at 10:41 AM, V7 (RN - Registered Nurse) said R83 had dementia was very confused. V7 said R83 was at high risk for falls and required frequent monitoring. V7 said R83 can self-propel his wheelchair, but if staff are pushing him in the wheelchair, then he needs to have foot pedals on the wheelchair. V7 said R83 had a tendency to put his feet down. V7 said using foot pedals on R83's wheelchair, during transport, will prevent him from putting his feet down and possible getting injured or falling from the chair. V7 stated, It's a safety thing. On 11/14/24 at 11:19 AM, V2 (DON - Director of Nursing) said if a resident is being pushed in a wheelchair by staff, then the wheelchair should have food rests in place for safety. V2 said the purpose of foot rests is to prevent any injury to the resident's leg or reduce the risk of falls. A policy for Safely Transporting a Resident in a Wheelchair was requested and not provided.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to check placement of a gastrostomy tube (G-tube) prior to performing water flushes for 1 of 1 resident (R35) reviewed for feeding tubes in the sample of 20. The findings include: R35's face sheet printed on 11/14/24 showed diagnoses including but not limited to chronic respiratory failure, cerebral infarction, dysphagia (difficulty swallowing), use of a tracheostomy tube (tube through neck and trachea for breathing) and gastrostomy tube (tube through abdomen to supply liquid nutrition to stomach). R35's facility assessment dated [DATE] showed severe cognitive impairment and staff assistance for all activities of daily living. R35's November 2024 physician orders showed an order start dated 8/21/24 for: Enteral feed order every 4 hours rec (receive) 200 milliliters flush every 4 hours. On 11/13/24 at 2:08 PM, V8 (Registered Nurse) stated R35 receives water flushes through the G-tube every shift and medications via the G-tube. V8 gathered supplies for the flush and went to the bedside. V8 connected a piston syringe onto the G-tube and poured the water flush directly into the tube. V8 did not check for tube placement prior to performing the flush. On 11/14/24 at 10:36 AM, V2 (Director of Nurses) stated staff should be checking for the proper placement of the tube before inserting any medications or water flushes into it. It is important to ensure it is open and in the proper position. The resident is at a high risk of aspiration if it is not in the stomach. Nurses should be checking gastric residual levels or listening for an air swoosh. V2 said our policy does not directly state how to check placement, but it is necessary. It is important and is a standard of safe nursing care. The facility's Enteral Tube Medication policy dated 1/2023 states: The facility assures safe and effective administration of enteral formulas, route and methods of administration .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39543 Based on observation, interview, and record review the facility failed to follow manufacturer instructions regarding the use of an insulin pen. This applies to one resident (R21) reviewed for insulin administration outside the sample of 20. The findings include: R21's Admission Record showed he had type II diabetes. R21's Order Summary Report (Physician Order Sheet) showed an active order for 5 units of rapid-acting insulin to be given at meals. In addition to the 5 units of rapid-acting insulin, R21 order sheet showed an order for blood sugar dependent (Sliding Scale) insulin. The order showed 8 units of the same rapid-acting insulin should be given for a blood sugar between 301 and 350. On 11/12/24 at 12:41 PM, V5 Registered Nurse (RN) began preparing R21's rapid acting insulin pen. V5 removed the pen cap, dialed in 2 units of insulin, held the pen horizontally and depressed the injection button. V5 then selected 2 more units, held the pen horizontally, and depressed the injection button. (During this priming process, the needle was not attached.) V5 then attached the needle and selected 13 units of insulin for a blood sugar reading of 311. The manufacturer instructions for the rapid-acting insulin pen (Dated July 2023) showed, Step 4: Push the capped needle straight onto the pen and twist the needle on until it is tight. The instructions continue with steps 5 and 6 which were removing the outer caps of the needle. The instructions continued, Step 7: Turn the dose selector to select 2 units. Step 8: Hold the pen with the needle point up. Tap the top of the pen gently a few times to let any air bubbles rise to the top. Step 9: Hold the pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0. A drop of insulin should be seen at the needle tip. If you do not see a drop of insulin repeat steps 7 to 9. If you still do not see a drop of insulin change the needle and repeat steps 7 to 9 . On 11/13/24 at 1:39 PM, V2 Director of Nursing stated the purpose of priming the insulin pen is to ensure the resident receives the full dose of insulin. V2 said the needle should be attached prior to priming the insulin pen. V2 said the purpose of holding the pen vertically is to expel any bubbles so the resident receives the full dose of insulin.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39543 Based on observation, interview, and record review the facility failed to double lock the controlled substance box in a medication cart. This applies to 5 of 5 residents (R56, R85, R46, R65, R2) reviewed for medication storage in the sample of 20 and 5 residents (R86, R58, R19, R43, R3) outside the sample. The findings include: The facility provided list of residents with controlled substances in the long term medication cart showed; R56 had morphine (narcotic pain medication); R86 had hydrocodone/acetaminophen (combination narcotic and over-the-counter pain medication); R85 had oxycodone (narcotic pain medication); R46 had zolpidem (prescription sleep medication); R58 had hydrocodone/acetaminophen, methadone (narcotic pain medication), and alprazolam (anti-anxiety medication); R65 had tramadol (narcotic pain medication); R19 had clonazepam (anti-anxiety medication), codeine/acetaminophen (narcotic pain reliever), and methylphenidate (stimulant medication); R43 had tramadol; and R3 had tramadol. Beginning on 11/12/24 at 11:03 AM through 11/12/24 at 11:31 AM, a continuous observation of V5's morning medication administration was conducted while he administered R16, R56, and R17's medications. At 11:08 AM, V5 prepared R16's medications he then entered R16's room without locking the medication cart. During his time in R16's room, V5 was not able to see his medication cart. At 11:14 AM, V5 prepared R56's medications and then entered her room without locking the medication cart. While V5 was in R56's room, he was unable to maintain visual contact with his medication cart. At 11:24 AM, V5 prepared R17's medications and then entered her room without locking the medication cart. V5 was not able to see his medication cart while he was in R17's room. At 11:31 AM, when V5 exited R17's room, the medication drawer, which housed the controlled substanc lockbox, was pulled out. The controlled substance lockbox was not locked and was able to be opened without the key. The lockbox housed numerous controlled substances. V5 stated this was the long-term medication cart. (During the time the cart was out of view, the controlled substances were not single or double locked.) At 11/13/24 at 1:39 PM, V2 Director of Nursing stated the medications in the controlled substances box are the residents' medications that are prone to abuse and therefore, most likely to be stolen. V2 said the purpose of double locking is to prevent theft of the residents' medications. The facility's Medication Administration policy (1/2023) showed, .never leave the medication cart open and unattended .

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed to provide water for 1 of 1 residents (R56) reviewed for hydration in the sample of 20. On 11/12/24 at 10:57 AM, R56 was lying in her bed. R56's lips were dry. There was no water cup, water pitcher, or beverages in R56's room. R56 mouth, tongue, and lips were dry. It was difficult to understand what R56 was saying due to her dry mouth. R56 stated, I'm really thirsty. I need water. The surveyor asked R56 if she had something to drink in her room. R56 replied, No, I don't know why they don't leave water in my room. I'm just so thirsty. The surveyor left the room and notified V5 (RN - Registered Nurse) that R56 was thirsty and needed water. At 11:14 AM, V5 (RN) took water to R56's room for medication administration. R56 drank the entire cup of water and stated, I was so thirsty. On 11/13/24 at 10:26 AM, R56 was lying in bed with her eyes closed. There was no water cup, water pitcher, or beverages in R56's room. R56's lips and mouth were dry and she said she was thirsty. On 11/14/24 at 10:35 Am, R56 was lying in bed. There was a pitcher of water on R56's overbed table, but the table was pushed away from the bed, near the window. The water was not in R56's reach. R56's Facesheet dated 11/14/24 showed resident had diagnoses to include, but not limited to: stroke, severe protein-calorie malnutrition, Alzheimer's Disease, dysphagia, weakness, anxiety, lack of coordination, and major depressive disorder. R56's Physician Order Sheet dated 11/14/24 was reviewed. R56 was not on a fluid restriction, did not have orders for swallowing precautions, and showed she could receive thin liquids. R56's facility assessment dated [DATE] showed she had severe cognitive impairment; required partial/moderate assistance with eating and oral hygiene; was dependent for transfers and personal hygiene; and had no documented swallowing disorder. R56's Dietary Evaluation dated 8/20/24 showed she was on hospice care. This note showed on 8/8/24, R56 received intravenous therapy for hydration/nutrition needs due to labs showed probable dehydration. This document showed R56 needed 1400-1800 ml of fluids a day. Care Plan initiated 5/20/24 showed resident is at risk for alteration in fluid volume. Encourage fluid intake. Keep fresh water in reach of resident. Monitor resident for early signs and symptoms of dehydration: thirst, loss of appetite, dry skin, dark colored urine, fatigue. On 11/14/24 at 10:41 AM, V7 (RN) stated, R56 is alert and oriented to person, but is able to make her needs known. V7 said R56 is on hospice now, but it is important that the staff emphasize the importance of nutrition and hydration for her. V7 said R56 isn't on a fluid restriction and he's not aware of her having any swallowing issues. V7 stated, There's no reason why she shouldn't have water (at her bedside). V7 said an early sign of dehydration could be dry lips and mouth. V7 said hydration is important for over health and could also be a comfort measure. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 11:19 AM, V2 (DON - Director of Nursing) said the residents have water pitchers in their rooms. V2 said in the morning, the CNAs are expected to refresh the water for the residents. V2 said the nurses provide water in the clear cups, during medication passes. V2 said the water should be within the resident's reach. V2 said R56 was able to verbalize her needs and doesn't have any swallowing concerns. V2 said R56 was safe to have water at her bedside because she's not on any restrictions. V2 said water is important to keep the residents hydrated, decrease the risk of UTI (urinary tract infection), and overall health. V2 said if a resident becomes dehydrated, their skin and lips may become dry. The facility's Hydration Policy reviewed 1/2024 showed, The policy allows for each resident to be provided with sufficient fluid intake to maintain proper hydration and health. This is done through an evaluation to identify risk factors that may lead to dehydration, and, if present, a preventative care plan is developed . Guideline: 1. Nursing will routinely monitor each resident for signs of dehydration such as cracked lips, dry oral mucosa, poor skin turgor and dark urine color. If present, they will be recorded in the medical record and the Health Care Provider will be notified. 2. Nursing will routinely observe the resident's consumption of fluids to determine if individual residents have reduced fluid intake. Pertinent observations will be recorded in the resident's medical record. The Intake Record may be used for this purpose . 5. Unless restricted by diet or food preference, residents will receive appropriate fluids at each meal. Water will be made available to residents unless otherwise restricted .