

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145983	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2025
NAME OF PROVIDER OR SUPPLIER  Aliya on 87th		STREET ADDRESS, CITY, STATE, ZIP CODE 2940 West 87th Street Chicago, IL 60652	

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 - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110</b></p> <p>Based on interviews, and record reviews the facility failed to follow their wound prevention policy to ensure one [R1] of two [R2, R3] residents did not develop pressure wounds. This failure resulted in R1 developing a facility acquired stage [3] pressure ulcer to the sacrum.</p> <p>Finding include,</p> <p>R1's clinical record indicates in part; R1 is a seventy-year-old admitted on [DATE], with the medical diagnosis include but not limited to osteoarthritis of left shoulder, atrial fibrillation, cardia pacemaker, acute respiratory failure, and difficult walking. Minimum data set [MDS] section [C] Brief Interview Mental Status Score Indicates R1 is cognitively impaired. MDS section [GG] indicates R1 is dependent for all ADL's, bed mobility, turning, repositioning, and transfers. MDS section [M] dated 12/9/24 indicates, R1 did not have a pressure ulcer.</p> <p>R1's Care plan document in part:</p> <p>R1 is at risk for alteration in skin integrity related to self-care deficits, impaired mobility and comorbidities, dated 12/4/24. Interventions: Check skin daily during routine care, dated 12/4/24. Provide peri-care after each incontinent episode and apple barrier cream dated 12/4/24.</p> <p>R1's emergency room document indicates in part:</p> <p>2/4/25 at 5:27 AM note:</p> <p>R1 has a large sacral wound that has likely causing acute sepsis possible tracking into R1's spine causing osteomyelitis.</p> <p>R1's skin assessment: R1 has Large sacral wound noted with purulent drainage, covered with foam dressing measured: 10cm x 10cm stage 4 decubitus ulcer filled with stool, is erythematous. (R1's wound was filled with stool when R1 arrived to the emergency room )</p> <p>R1's Hospital Admission document:</p> <p>2/5/25 R1's neurosurgical evaluation after CT scan done there showed extensive decubitus ulcer with osteomyelitis and extending into spinal canal, no spinal abscess noted.</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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>2/5/25, R1's medical plan; R1 remains alert and oriented x1, bedbound. There are at this point, no plans for surgical intervention. Wound recommend a discussion in regard to goals of care and continue intravenous antibiotics for now. The plan for intravenous antibiotics seven-day course, for skin and soft tissue infection, the risk of on-going antibiotics outweighs the benefits of R1's sacral osteomyelitis without surgical intervention. Would consider discussion in regard to palliative care.</p> <p>R1's Wound Care Assessment reports indicates in part:</p> <p>12/4/24, V8's wound assessment, sacrum pressure ulcer measures 5.5 x 7.0 x 0.20cm. V8 documented: Incorrect documentation, refer to current image. [The image of sacrum shows no open area]. Outcome: Maintenance.</p> <p>12/11/24, V8's wound assessment, sacrum area measures 0x0x0cm. No further treatment needed at this time. Outcome: healed.</p> <p>1/7/25, V13 [Former Wound Care Licensed Practical Nurse] assessment; Writer [V13] made aware of skin alteration on the buttocks. Assessment reveals: Facility acquired re-opening of stage #3 sacrum wound pressure ulcer, no slough. Sacrum wound measured: 7.0x 8.0x unknown cm. V10 [R1's Family Member #2] made aware of re-opening of stage #3, all questions answered. Outcome: Probable Decline.</p> <p>1/14/25- V5 [Wound Care Coordinator] assessment; R1 noted with 50% slough, primary medical doctor aware, orders received and carried out. Wound measures 7.0x 8.0x unknown cm. Preventative measures in place, heels off loaded, reposition as needed and skin checks, and skin barrier after each incontinent episode.</p> <p>[The wound declined, with 50% of slough noted].</p> <p>On 1/15/25 V3 [Wound Physician] R1 visit has been rescheduled. R1 at dialysis. (wound doctor did not see R1)</p> <p>1/21/25 V13 [Former Wound Care Licensed Practical Nurse] assessment; R1 noted with 50 % slough in sacrum wound. Assessment completed; no changes noted this week. Sacrum wound measures 7.0 x 8.0x unknown cm. Primary physician made aware.</p> <p>1/23/25 V3 [Wound Physician] assessment; R1's noted with 50% of slough in sacrum wound. Measures 7 x 8 x unknown cm, depth is unmeasurable due to presence of nonviable tissue and necrosis. No labs for this visit.</p> <p>1/28/25 V11 [Wound Care Nurse Licensed Practical Nurse] assessment; R1 noted with 90% slough in sacrum wound. Wound is stable, primary care made aware, no new orders at this time. Wound measures 7.0 x 8.0x unknown.</p> <p>[The wound declined with 90% of slough, no new orders noted.]</p> <p>1/29/25 V3 [Wound Physician] R1's noted with 50% of slough in sacrum wound.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Measures 6.5 x 8 x 0.4cm. Dressing plan Iodosorb gel. Apply once daily for 24 days. Gauze sponge sterile, apple once daily and as needed for 24 days. Gauze island with boarder apply daily and as needed for 24 days. Sharp selective debridement procedure to remove biofilm, remove devitalized tissue at margins of wound.</p> <p>[R1's wound was debrided]</p> <p>R1's progress notes:</p> <p>2/3/2025 22:27 Nursing</p> <p>Note: Writer called hospital to check on the status of R1. Writer was informed that they are searching for a hospice to relocate R1 where she will be treated for a spinal infection.</p> <p>Interviews:</p> <p>On 2/27/25 at 9:50 AM, V4 (R1's Family Member) stated, R1 is currently in the hospital due to bed sore that has went to the spine and set up infection. R1 had a stroke and is total dependent for assistance. R1 had a bed sore but healed before being admitted to the facility. The area re-opened back up due to the facility staff not turning and repositioning. I was made aware R1's butt sore had re-opened at the beginning of January, but I was not made aware R1's wound had worsened.</p> <p>On 2/27/25 at 12:56 PM, V8 [Licensed Practical Nurse/Wound Care Nurse] stated, On 12/4/24, I completed R1's skin assessment. R1 did not have any open wounds. The sacrum was noted an old scar from a previous pressure ulcer. I measured the scar surface area and placed in those measurements on R1's body assessment. I placed a note on R1's assessment stated I placed incorrect documentation, refer to current image. The image showed no open areas. There was an order placed for a protective dressing only, to apply to the old, healed area as a preventative measure. On 12/11/24 skin assessment, again R1 did not have any open areas on her sacrum. I entered on R1's assessment 'healed' due to the previous wrong documentation. Once R1 wound healed in December 2024, the wound care team does not monitor the resident's skin. The nursing staff, and certified nurse assistances monitor all the resident's skin during incontinence care and bathing. If noted any skin alteration or skin openings, the staff nurse will open a new skin assessment in the electronic chart, notify the physician and family of any changes. Then I was promoted and no longer assessed R1's wound, I was on longer on the wound care team.</p> <p>On 2/27/25, at 1:14 PM, V11 [Wound Care Nurse/License Practical Nurse] stated, I am familiar with R1 wounds. R1 is alert and oriented x1, not able to voice her needs, and is total dependent for assistance. On 1/28/25 I completed R1's skin assessment, no changes in the wound size and the wound were stable. I did document the wound was noted with 90% slough and the previous assessment on 1/28/25 there was 50% of slough noted, so yes there was a decline in R1's wound. When there is an increase in slough means the wound not healing properly. If R1 was sleeping or refused to be repositioned, then the nursing staff was not allowed to turn and reposition R1. I remember R1 not wanting to be repositioned at times, and she had that right.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 2/27/25 at 2:28 PM, V5 [Wound Care Coordinator] stated, I assessed R1's wound on 1/14/25, the sacrum wound was noted with 50% slough, and the measurements were the same as the previous assessment on 1/7/25. The slough was new, I notified the primary physician. The wound measurements were the same, and there was no change in the wound, the wound was stable. Yes, the wound developed slough, but there were no signs of infection. I think her wound declined due to dialysis, sitting in the chair. The facility has a dialysis unit here, where R1 received her treatment.</p> <p>On 2/28/25 at 11:08 AM, V12 [Director of Operations of Dialysis Unit] stated, The dialysis unit in the facility runs six days a week. If a resident needs their scheduled modified, chair time length, time or day of treatment, is always accommodated. The dialysis chair is a big recliner with specialize pressure reducing cushion. Also, if a resident has a cushion in their wheelchair, the dialysis staff places that cushion in the dialysis chair as well. According to R1's dialysis record she has received services with this company starting 8/14/24. Our company also treated her at another nursing facility prior to her coming here. I have not received any concerns regarding her dialysis chair time or concerns about wound healing. The dialysis unit would have been able to accommodate R1's needs.</p> <p>On 2/27/25 at 1:44 PM, V3 [Wound Physician] stated, I'm currently at the airport, and only can talk for a minute. I assessed R1's wound on 1/29/25, and my documentation should answer all your questions, my assessment speaks for itself. I missed assessing R1's wound due to her attending dialysis treatments. The wound care team are aware the dates and times I will be at the facility, it was their responsibility to ensure R1 was available for her wound care assessment. On 1/29/25, I completed a bed side debridement on R1's sacrum wound to remove the slough, I did not order any labs or wound cultures. I must end the interview and board my airplane. I feel the decline in her sacrum wound came from dialysis.</p> <p>Policy document in part:</p> <p>Skin Management dated 1/2024.</p> <p>It is important that the Facility have a system in place to assure that the protocols for daily monitoring, frequency of assessments, documentation are implemented consistently throughout the facility.</p> <p>The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection such as increase in redness, swelling around the wound, increase drainage from the wound or pain.</p> <p>If the wound shows no signs of healing after three weeks, a reevaluation of the treatment plan including determining whether to continue or modify the current interventions is done. If the decision is made to retain the current regimen, documentation of the rational for continuing the current plan will occur.</p>		