

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057893		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/21/2025	
NAME OF PROVIDER OR SUPPLIER ALIYA OF OAK LAWN				STREET ADDRESS, CITY, STATE, ZIP CODE 6300 WEST 95TH STREET , OAK LAWN, Illinois, 60453			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000			12/01/2025	
	Annual Licensure and Certification						
S9999	Final Observations		S9999			12/11/2025	
	Statement of Licensure Violations 1 of 2:						
	300.610a)						
	300.1010h)						
	300.1210b)						
	300.1210d)6)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1010 Medical Care Policies						
	h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.						
	Section 300.1210 General Requirements for Nursing and Personal Care						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations are not met as evidenced by: Based on interview and record review the facility failed to promptly notify the physician of abnormal X-ray results of right femur fracture and failed to transport a resident to emergency room after receiving orders. This affected one of three residents (R10) reviewed for standards of care. This failure resulted in a delay of notification to the physician for 3 hours, and a delay of transporting the resident to hospital for 2 hours. R10 face sheet shows diagnosis of adult failure to thrive, dementia, history of falling, type 2 diabetes, unsteadiness on feet, and disorders of muscle. R10 BIMS (Brief Interview for Mental Status) score for cognitive status is 5 denoting impairment, per MDS dated 11/3/25. R10 radiology results report for date of service 8/27/25, electronically signed 8/28/25, reported date 8/28/25 12:30am denotes in-part right femur, examination reveals right hip pinning with slightly oblique fracture of the distal shaft of the right femur with some overriding of the fracture fragments. Right hip pinning and fracture of the distal right femur. R10 emergency room records dated 8/28/25, emergency department arrival at 6:00a.m. denotes, chief complaint fall and leg injury. Paperwork from facility shows that patient had X-ray done at facility home yesterday showing distal femur fracture with mild displacement and some fragments noted. Right fracture and pain rated 10/10 following a fall, details which are unclear, severe pain rated 10/10. Exam denotes right leg			S9999			

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S9999	Continued from page 2 shortened and externally rotated. Patient able to wiggle toes. Pulse intact. Sensation to light touch intact plus pain/ tenderness to the right thigh to palpation plus moderate swelling to the right thigh. CT (Computed Tomography) femur without contrast; moderately comminuted fracture of distal femoral meta-diaphysis is displaced poster laterally one bone width with 2 cm (centimeters) of foreshortening. Moderately ill-defined hematoma/extravasated blood products in the vastus inter-medialis muscle. Additional ill-defined blood products posterior to the fracture. Morphine four milligrams given. R10 radiology results report date of service 8/27/25, electronically signed 8/28/25 denotes in-part right knee: fracture of distal femur. 11/22/25 at 12:00pm V26 (radiology representative) stated that the company was onsite and completed R10 X-ray on 8/27/25 at 11:10pm and the results was sent electronically to the facility at 12:30am on 8/28/25. V26 said the facility was verbally notified of the X-ray on 8/28/25 at 1:30am the company spoke to a female name (V33), that identified herself as the receptionist and spoke to V34 (Nurse). V26 said two people was notified. V26 said the X-ray results was uploaded to the electronic records at 12:30am for the facility to view. On 11/21/25 at 3:18pm V32 (Physician Assistant) V32 stated third eye is a group of providers that take calls for Aliya Oak Lawn residents from 7pm to 7am Monday through Friday and 24 hours a day on the weekend. V32 said the same staff may not take the calls and the staff rotate shifts. V32 said the third eye providers can see previous documentation from their peers. V32 reviewed her documentation for R10, V32 stated she documented at 3:54am, and she was notified 4 or 7 minutes prior to her documentation of R10 X-ray results. V32 said she called back right away. V32 said the Nursing staff sent the report for her to view. V32 said her expectation is that the facility notifies third eye providers or the physician of an abnormal X-ray report immediately. V32 said she gave orders for R10 to be sent to the hospital, V32 said R10 did not need to go via 911, R10 was not in distress. V32 said she was not aware that R10 did not arrive to the hospital until 6:00am. V32 said if transportation would be greater than 30 minutes the facility should notify third eye providers or the physician. V32 said she assessed R10 via a web call, R10 right leg was swollen, the nurse informed her that R10 leg was warm to touch, complaints of pain, limited range of motion to right knee. V32 said R10 was not in distress.		S9999				

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S9999	Continued from page 3 11/21/25 at 10:10am, survey finding reviewed with V20 (Medical Director), V20 said that it is unusual that the facility did not complete an X-ray for R10 for greater than a day. V20 said the facility is usually more aggressive with testing and X-rays after an unwitnessed fall. V20 said that could be considered a delay in care. V20 said he does recall that R10 had a fall with complaints of pain to the left leg, the complaints of pain to the right leg came later. V20 said a displaced fracture is cause by trauma. V20 said he can't explain why R10 had pain to the right leg later in comparison to initially after the fall. V20 said a displace fracture can cause a tear so it's not uncommon to have a hematoma surrounding the bone that's fractured. V20 said maybe R10 had another fall but that's not documented, and he can't explain the femur fracture. V20 said R10 could have sustained a fracture from anything. V20 was made aware that the V6 (restorative nurse) fall nurse and V2 (Director of Nursing) did not identify R10 having another fall after the fall on 8/26/25. Surveyor asked if that would be a good reason for diagnostic exam after an unwitnessed fall. V20 restated that R10 was not complaining of pain to the right leg initially, and he can't explain that femur fracture because there's no documentation of any other falls. 11/21/25 V2 (Director of Nursing) said she has no documentation that R10 sustain another fall after 8/26/25 and no other falls before being transferred on 8/28/25. On 11/20/25 at 3:34pm V6 (Restorative Nurse) said R10 was observed sitting on the floor on 8/26/25. V6 said the root cause of R10 fall is R10 was trying to reach for a curtain and rolled out of bed. V6 said R10 has a Reacher (something to grab objects with) and was educated to use the Reacher. V6 said R10 has cognitive deficits, and R10 may not remember to always use the Reacher. V6 said R10 has poor safety awareness and may not understand that reaching for a curtain could cause R10 to fall and sustain an injury. V6 said R10 has had multiple falls and it's seeming as R10 is always trying to do something when she falls. V6 said prior to the fall in August 2025, R10 was able to ambulate with a two-wheel walker, ambulate 10 feet with therapy, stand and pivot with one person assist. V6 said R10 had a functional decline after the fall, R10 is also noted with a decline in mental status. V6 said R10 is at high risk for falls. On 11/20/25 at 2:35pm V25 (LPN) said on 8/26/25, she was the nurse for R10, she heard R10 hollering and		S9999				

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S9999	Continued from page 4 observed R10 sitting on the floor in her room. V25 said R10 said she was reaching for her curtain when she slid out the bed. V25 said R10 did complain of pain to the left leg. V25 said she completed a pain assessment, and she can't recall why she said R10 denied pain when she documented in the progress note. V25 said R10 did not have complaints of pain prior to the fall, the pain to the leg was a new onset of pain. V25 explained that she needed to call surveyor back to finish review of R10's fall. V25 did not call surveyor back upon exiting on the survey. Surveyor wanted to inquire about the details of V25 physical assessment of R10 after the fall to determine how V25 completed her assessment of R10, to determine how V25 competed the range of motion, to determine what joints was the range of motion on, to determine how V25 assessed for internal and external rotation, to determine how V25 assessed for pain in all extremities, to determine how V25 assessed for shortening of lower extremities, to determine how staff picked R10 up from the floor after the fall, to determine what possible objects was near R10 when she was found on the floor, to determine where was R10's Reacher when R10 was observed on the floor. 11/21/25 V2 (Director of Nursing) said she has no documentation that R10 sustain another fall after 8/26/25 and 8/26 is the only documented fall. During a follow up interview 11/20/25 at 1:50pm V2 said her expectation is that the Nurse notify the physician of a change in condition follow the physician orders. R10 comprehensive pain evaluation dated 8/26/25 at 1:00am, are there reports of pain- yes, site left lower leg, do resident have any diagnosis which give you reason to believe he/she would be in pain- no. Vocal complaint- yes. Intensity of pain- hurts a bit. R10 progress note dated 8/26/25 at 1:33am denotes writer doing rounds and noted resident hollering help, writer entered room and noted the resident on the floor in sitting position. Resident stated she was trying to close the curtains when she rolled on the floor from the bed, resident denies hitting her head at this time. (ROM) Range of motion completed resident denies any pain at this time, resident picked up by staff and transferred to bed. Body the assessment completed, no injuries noted, NP (Nurse practitioner) was made aware son made aware fall nurse made aware DON (Director of Nursing) made aware new neuro checks initiated vital signs taken. R10 progress notes dated 8/26/25 at 1:12am acetaminophen 325mg (milligrams), complain of pain 4 out of 10 to left lower leg.		S9999				

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S9999	Continued from page 5 R10 provider progress note dated 8/26/25 at 2:42am denotes primary chief complaint fall with injury, 80-year-old female with past medical history of falls. Nursing reports the patient had an unwitnessed fall. Patient states she was trying to close the curtain and slid out of bed. The patient was observed sitting on the floor. The patient denies hitting her head. The patient complained of left leg pain range of motion within normal no obvious injury the patient is on aspirin. Physical exam findings per nurse notes no acute distress no visible injury had a traumatic no hematoma. No pain on palpitation of extremities and baseline range of motion intact no bruising or skin tears noted neuro at baseline. Diagnosis acute pain due to trauma. This is an acute new problem condition is worsening complain of acute left leg pain status post unwitnessed fall. No obvious injuries deny hitting head will order to monitor closely with neuro checks and profile protocol administer Tylenol as ordered monitor pain if pain persists notify a clinician for additional work up. R10 provider progress note dated 8/27/25 at 8:36pm 80-year-old female with a past medical history of a fall yesterday is having pain in the right knee/ thigh. Patient fell yesterday and reported that she is having pain in her thigh and knee. Patient does not have any bruising or redness noted per nursing. Nursing reports that it is warm to touch. Nursing reports that patient has not had any imaging of her leg since she fell. Patient does have significant edema of her upper thigh and knee noted by Ryder on evaluation. Decrease range of motion of right leg swelling of right thigh and knee diagnosis pain in right leg this is an acute new problem. Stat 2-view of right pelvis hip femur knee tibia/ fibula. Notify a clinician of any change in condition. Disposition stay at facility. R10 provider progress note dated 8/27/25 at 9:16pm denotes does the resident /care giver reports change in pain status-yes. Does the resident/ care giver reports change in ADL (activity of daily living) mobility status- yes. Order Stat X-ray 2 views of right pelvis, hip, femur, knee, tibia/fibula. R10 progress noted dated 8/27/25 at 9:24pm denotes while writer was administering medication to the resident, she complained of pain on her right leg writer assessed the leg and observed that the right knee and thigh is swollen. Vital signs taken. Third eye provider notified and made new orders and carried out endorsed a night nurse to continue to monitor.		S9999				

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S9999	Continued from page 6 R10 provider progress note dated 8/27/25 at 9:26pm acetaminophen 650 mg by mouth every six hours for pain. R10 progress note dated 8/27/25 at 8:36pm denotes primary chief complaint: MSK (musculoskeletal): Extremity Swelling, history present Illness (HPI): 80-year-old female with PMHX of a fall yesterday is having pain in her right knee/thigh. Patient fell yesterday and reported that she is having pain in her thigh and knee. Patient does not have any bruising or redness noted per nursing. Nursing reports that it is warm to touch. Nursing reports that patient has not had any imaging of her leg since she fell. Patient does have significant 2+ edema of her upper thigh and knee noted by writer on evaluation. VSS (vital signs). Review of Systems: as per HPI, all other systems reviewed and are negative PMH and SH (past medical history and social history): Reviewed PMH, SH and medications source of verification for all history: Per nurse and/or patient. R10 progress note dated 8/28/25 at 3:54am denotes in-part 4:27am R10, primary chief complaint: radiology review: abnormal results and/or requiring provider assessment. History present illness (HPI): Resident noted to have fallen on 8/27/25 am, patient with c/o (complaints of) pain to the right leg. Right knee and thigh swelling. Order for X-ray of right hip and femur/ knee, pelvis X-ray. X-ray: right pelvis, right hip- neg for acute fracture or dislocation, X-ray of right knee: fracture of the distal femur. Review of Systems: (ROS) as per HPI, all other systems reviewed and are negative PMH and SH (past medical history and social history): reviewed PMH, SH and medications source of verification for all history: Per nurse and/or patient. Physical exam: exam findings per nurse and video observation physical exam - Notes: GEN (general): alert, NAD (no acute distress), lungs: unlabored, msk (musculoskeletal): right leg swelling +2 to right upper thigh and knee, Dec (decline) ROM (range of motion) to right leg. Diagnostic results: reviewed radiology report by primary team: X-ray of right pelvis, right hip and knee, diagnosis, assessment/plan: Femur fracture right. Unspecified fracture of right femur, initial encounter for closed fracture (Primary), distal right femur fracture- new onset s/p fall right thigh and knee swelling, pain to the right leg with dec ROM- unable to flex at the knee, X-ray confirming right distal femur fracture, neg (negative) frx (fracture). to right hip, pelvis. This is an acute new problem Condition is guarded. R10 progress note dated 8/28/25 at 4:57am denotes		S9999				

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S9999	Continued from page 7 in-part, Pt (patient) X-ray reviewed by V32 (PA). Orders as follow: Transfer patient to emergency department for acute right distal femur fracture. R10 progress note dated 8/28/25 contacted (hospital name) ER(emergency room). Patient admitted due to closed femur fracture. Fall prevention and management dated 1/2023 denotes in-part this facility is committed to maximizing each resident physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for prevention strategies, and facilitate as safe as an environment as possible. All resident's falls shall be reviewed, and the resident existing plan of care shall be evaluated and modified as needed. A fall risk evaluation will be completed on admission, readmission and quarterly, significant change and after each fall. (A) Statement of Licensure Violations 2 of 2: 300.610a) 300.1210b) 300.1210d)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and		S9999				

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S9999	Continued from page 8 personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to follow their dialysis policy by not communicating to their IN –HOUSE Dialysis Company that a new resident who was diagnosed with acute kidney failure and dependent on renal dialysis was admitted into the facility. This affected one of three residents (R159) reviewed for hemodialysis. This resulted in R159 missing treatments, subsequently R159 central venous catheter clotted requiring two hours of anti-clog therapy and having to remain in the dialysis chair for a total of four hours and forty-six minutes which caused R159 to have extreme leg pain. Findings include: Hospital paperwork service date 10/1/25 documents: Impressions/Recommendation-planning daily hemodialysis times three with incrementing time- third hemodialysis today three hours then will keep on Monday, Wednesday and Friday for now. R159 was admitted to the facility on 10/10/25 with the diagnosis of heart failure, chronic kidney disease stage four (CKD4) and diabetes. Admission evaluation dated 10/10/25 documents: renal insufficiency, renal failure and end stage renal disease. Does resident receive dialysis: Yes. Type of dialysis: Hemodialysis. Dialysis access type and location of access site: Right subclavian port double lumen. Physician order dated 10/10/25 documents: Resident will receive dialysis IN-HOUSE on Monday, Wednesday, Friday. R159 care plan initiate on 10/22/25 documents: R159 needs dialysis (hemodialysis) related to CKD4. On 11/20/25 at 10:30am, V10 (dialysis nurse) said, he was not aware of R159 admission on 10/10/25. V10 said, R159 was in the facility for six days without dialysis. V10 said, he had email corresponding that read R159 was going to be admitted to the facility. V10 said, he was never informed by medical record or any facility staff prior to 10/16/25 that R159 was admitted. V10 said, he was not given electronic access to R159 medical record. V10 said, dialysis does not have a way of knowing if a	S9999					

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S9999	Continued from page 9 pending dialysis resident has been admitted to the facility unless dialysis is verbally informed or given electronic access to the resident chart by the facility. V10 said, dialysis is only granted access to dialysis residents by the facility. V10 said, dialysis cannot go in the facility electronic record to search for a resident. V10 said, he just happened to be in the hallway, taking another dialysis resident back to their room when V18 (nurse) asked him, when R159 was going to be dialyzed. V10 said, he replied, when was R159 admitted. V10 said, he returned to the dialysis unit, checked the computer and did not have access to R159's chart. V10 said, he went to R159's room, asked R159 if she receives dialysis, to which R159 replied, no. V10 said, he asked R159 if he could check for a dialysis catheter. V10 said, he unzipped R159 sweater and saw R159's dialysis catheter without a dressing located on her right chest wall. V10 said, R159 missed two scheduled days of dialysis due to the facility not notifying the dialysis unit that R159 arrived at the facility. V10 said, R159 was dialyzed without him having access to R159's electronic record. V10 said, V11 was called, updated about R159 missing two schedule treatments. V10 said, V11 ordered, R159 to run on low after having missed two treatments. V10 said, running low dialysis is done in order not to shift fluid to much fluid of the resident too fast. V10 said, due to R159 missing two scheduled days of dialysis, R159 had to have dialysis two days in roll and her catheter was clogged. Facility email to dialysis dated 10/7/25 documents: R159 is clinically and financially approved for HD (hemodialysis). Facility email 10/10/25 at 11:36am documents: Hey patient is ready to admit today ETA (estimated time of arrive) pick up 7:00pm. Dialysis email to facility dated 10/10/25 at 12:51pm documents: Fantastic!! Please keep us posted on the patient's arrival so our unit know when to place her (R159) on the schedule. On 11/20/25 at 12:35pm, V2 (Director of Nursing/ DON) said, admission is primary responsible for notifying dialysis that a resident needs dialysis. On 11/20/25 at 12:44pm, V12 (admission) said, the admission nurse is given a notice that a resident with hemodialysis, had been admitted. V12 said, she is responsible for notifying the dialysis unit via email that a dialysis resident was admitted into the facility. On 11/20/25 at 1:04pm, V12 was asked who makes dialysis aware of a dialysis resident that is scheduled to		S9999				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057893		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/21/2025	
NAME OF PROVIDER OR SUPPLIER ALIYA OF OAK LAWN				STREET ADDRESS, CITY, STATE, ZIP CODE 6300 WEST 95TH STREET , OAK LAWN, Illinois, 60453			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 10 arrive at 7:00pm. V12 said, she does not know who would make dialysis aware, she does not work at 7:00pm and she is not clinical. On 11/20/25 at 2:00pm, V11 (nephrologist) said, R159 was admitted to the facility but dialysis was not informed R159 was in the building. V11 said, the dialysis nurse is his contact to the facility. V11 said, dialysis is important to manage electrolytes. V11 said, dialysis treatments are done at a slow rate to prevent seizures and a quick drop in blood pressure related to complication associated with dialysis. On 11/20/25 at 2:17pm, R159 who was assessed to be alert and orient to person place and time, said she did not have dialysis when she first arrived to the facility. R159 said, a male staff member asked if had dialysis in the facility, to which she replied no, then that staff member asked if he could check for her dialysis catheter. R159 said, she was a new dialysis patient. R159 said, she did not know her dialysis days. R159 said, she was so confused when she was in the hospital. R159 said, the first day of dialysis was when a male staff member came into her room and asked to check her dialysis catheter. R159 said, she guess the facility realized that she had a dialysis catheter and took her to dialysis. R159 said, her legs were swollen with fluid filled blisters. R159 said, after dialysis her legs hurt so bad she cried all night. R159 said, she did not receive the care she needs. R159 said, she was treated poorly. On 11/20/25 at 4:30pm, V18 (nurse) said, when R159 returns from dialysis, she complained of pain to her legs from sitting in the dialysis chair so long. V18 said, R159 had weeping wounds on her legs. V18 said, R159 was provided pain management. Hemodialysis Treatment Flowsheet dated 10/16/25 documents: Patient arrived in wheelchair, alert and oriented times three, no apparent distress noted and denied complaints. CVC has no dressing intact, no sign or symptoms of infection or bleeding. Communication report dated 10/16/25 documents: Post treatment duration two hours and thirty minutes. Patient condition or events during/post dialysis: stable central venous catheter/CVC malfunctions required activase (used to dissolve blood clots in central venous access device (CVAD) for restoration of function to CVC. Hemodialysis Treatment Flowsheet dated 10/16/25 documents: Discharge to nursing home. Daily notes			S9999			

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NAME OF PROVIDER OR SUPPLIER ALIYA OF OAK LAWN				STREET ADDRESS, CITY, STATE, ZIP CODE 6300 WEST 95TH STREET , OAK LAWN, Illinois, 60453			
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S9999	Continued from page 11 (general): patient tolerated treatment well but CVC malfunction prolonged HD session considerably. Hemodialysis Treatment Flowsheet Notes documents: Treatment initiated at 1616 (4:16pm); Treatment started without complications; during treatment at 1652 (4:52pm); Pt alert, no distress noted during treatment at 1723 (5:23pm);Pt alert, watching TV no complaints voiced at 1725 (5:25pm); Treatment pause for Cathflo administration during treatment at 1747 (5:47pm); Patient off treatment cathflo dwelling 1833 (6:33pm); Patient remains off treatment while Cathflo dwells during treatment at 1942 (7:42pm); Patient alert no complaints. Treatment resumed during treatment 2013 (8:13pm); Patient alert, denies complaint, access and lines visible during treatment 2044 (8:40pm); Alert patient watching TV no distress noted treatment ended 2101 (9:01pm); Treatment completed, blood returned post blood pressure sitting 2110 (9:10pm) On 11/21/25 at 2:57pm, V30 (dialysis registered nurse) said, she was not notified of R159 admission until the 11/16/25. V30 said, she goes by her dialysis schedule for admission due to not having access to the resident's chart until the facility gives them access to the electronic record. R159 was a pending admission on their sheets Dialysis schedule dated 10/10/25 Friday, 10/13/25 Monday, 10/15/25 Wednesday documents: admit status: pending; patient: R159; date approved: 10/7/25; anticipated admission: 10/7/25 On 11/21/25 at 3:40pm, V2 (Director of Nursing/ DON) provide surveyor with a newly created Dialysis Acknowledgment Workflow which documents: Admission Director will notify Dialysis Intake of any/new dialysis Admission. Admission audit to be done by Unit Manager including Dialysis Orders. Unit Manager initiate and sign the Dialysis Acknowledgement Form. Once signed, Unit Manager hand the form to Dialysis Nurse to acknowledge and sign the form. Completed form will be submitted to the DON to verify and ensure that resident is added to the schedule. Dialysis Protocol dated 1/2023 documents: Dialysis in a facility. Receive home hemodialysis (HHD) or peritoneal dialysis (PD) treatment in nursing home, by trained and qualified staff who have received training and competency from dialysis facility. Shared communication between the facility and the dialysis facility. The care of the resident receiving dialysis service will reflect ongoing communication, coordination and		S9999				

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S9999	Continued from page 12 collaboration between the facility and the dialysis staff. The communication process includes how the communication will occur, who is responsible for communicating and where the communication and responses will be document. (A)			S9999			