STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000288	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF CRESTWOOD	13259 SOUTH CENTRAL AVENUE , CRESTWOOD, Illinois, 60418

(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 ANNUAL LICENSURE SURVEY	S0000		
S9999	Final Observations Statement of Licensure Violations: ONE of SIX 300.696 b) 3) 300.696 d) 1)5)7) 300.696 g) Section 300.696 Infection Prevention and Control b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. 3) Facility activities shall be monitored on an ongoing basis by the Infection Preventionist to ensure adherence to all infection prevention and control policies and procedures. d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340):	S9999		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000288	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2025

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S9999	Continued from page 1 1) Guideline for Prevention of Catheter-Associated Urinary Tract Infections 5) Guidelines for Preventing Healthcare-Associated Pneumonia 7) Infection Control in Healthcare Personnel: Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services g) Certified facilities shall comply with 42 CFR 483.80(h). These requirements were NOT MET as evidenced by: Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to contain respiratory equipment, and failed to date and/or document weekly respiratory equipment change. The facility also failed to obtain physician orders for indwelling urinary catheter, failed to document indwelling urinary catheter bag change, and failed to document daily catheter care for 4 of 25 residents (R1, R2, R4, and R5) reviewed for infection control. Findings include: 1. R4's (4/10/25) functional assessment affirms resident is dependent on staff for toileting hygiene. R4's (4/10/25) BIMS (Brief Interview Mental Status) determined a score of 13 (cognition intact). On 7/14/25 at 11:08am, a lot of sediment was observed in R4's indwelling urinary catheter tubing, the urine was notably cloudy, and the bag was undated. V9 (Family) stated "She's (R4) been back and forth to the hospital due to catheter infection." R4's Meropenem (Antibiotic) IVPB (Intravenous Piggyback) was dangling from the IV pole adjacent the bed. R4 affirmed the antibiotic was prescribed for recent urinary tract infection and completed last week. On 7/14/25 at 11:20am, V3 (LPN/Licensed Practical Nurse) affirmed that she's assigned to R4. Surveyor inquired about R4's Meropenem V3 stated "That's discontinued, they just haven't moved it out yet. It was for ESBL in the urine." V3 accessed R4's EMR and affirmed that prescribed Meropenem was completed 7/6/25 (8 days prior). Surveyor inquired about concerns with R4's urine V3 responded "Why does it look like there's something in the tubing, it's a little cloudy in the tubing." R4 replied "It's been like that for a couple of days." Surveyor inquired when R4's indwelling	S9999		

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S9999	Continued from page 2 urinary catheter was inserted R4 stated “About 30 days ago when I was in the hospital.” Surveyor inquired when R4’s catheter bag was last changed V3 stated “Your (facility) policy is every 7 days right?” V4 (Nurse Supervisor) replied “Yeah, every 7 days” however neither answered the question. On 7/16/25 at 9:18am, surveyor inquired about requirements for indwelling catheter care V8 (Infection Preventionist Nurse) stated “We should be making sure that you’re documenting the way that the urine is, if it’s cloudy or clear. You want to make sure there’s no sediment and no leakage. The bag change should be on the MAR (Medication Administration Record) or the TAR (Treatment Administration Record). Surveyor inquired who’s responsible for obtaining physician orders for indwelling urinary catheters V8 responded “It’s the Nurses responsibility when they (Residents) come in on admission that its orders in.” R4’s (July 2025) MAR & TAR exclude required indwelling urinary catheter care and/or bag change. R4’s active orders (as of 7/14/25) exclude indwelling urinary catheter insertion, catheter care and/or bag change. The (1/2023) equipment change schedule states (indwelling urinary catheter) bags are changed if they become cloudy, leak, or have an order. 2. R5’s diagnoses include COPD (Chronic Obstructive Pulmonary Disease) and acute/chronic respiratory failure. R5’s (5/5/25) BIMS determined a score of 14 (cognition intact). On 7/14/25 at 11:33am, R5’s nebulizer mouthpiece (at bedside) was undated. R5’s nasal cannula (in use) was also undated. On 7/14/25 at 11:47am, surveyor inquired if R5’s oxygen tubing was dated V5 (LPN) stated “Yes” and pointed to a red (illegible) smear near the end of the tubing. Surveyor advised that there was no date observed V5 responded “Sometimes tape isn’t available to date it.” Surveyor inquired if R5’s nebulizer mouthpiece was dated V5 replied “I don’t think this one was dated, this one was supposed to be dated.” R5’s (July 2025) MAR and TAR exclude weekly change of respiratory equipment (per facility policy).	S9999		

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S9999	Continued from page 3 The (2/2023) oxygen safety/use policy states oxygen tubing will be changed weekly and appropriately stored to prevent contamination when not in use. Chart as a nursing order on treatment administration record. The (2/2023) infection control policy states the facility is committed to ensuring that all appropriate infection and control measures are in place as determined by State and Federal Regulations as well as CDC (Centers for Disease Control) recommendations and guidance. This facility has established a policy to identify, record, investigate, control, test, and prevent infections in the facility. 3. On 7/14/2025 at 11:01am, R1 was observed lying on her back, with oxygen being administered at 3L NC (nasal cannula). R1 said, "I've (R1) been here a couple months. Not sure when they (nurses) change the tubing." R1's nebulizer mask was observed not contained, lying in R1's bedside dresser drawer, with the end of the tubing hanging out R1's dresser drawer touching the floor. R1's face sheet documents diagnoses that include but are not limited to pleural effusion, chronic obstructive pulmonary disease, and dyspnea. R1's Brief Interview of Mental Status (BIMS) score, dated 5/22/25, documents, in part, a BIMS score of 11 which indicates R1's cognition is moderately impaired. R1's "Order Summary Report," dated 7/16/25, documents, in part, "Apply 02 per nasal canula prn (as needed) and check 02 (oxygen) sat (saturation) Q (every) shift as needed for SOB (shortness of breath) notify PHYSICIAN if below 90%." R1's "Order Summary Report," dated 7/16/25, documents, in part, "Change nebulizer tubing and mask weekly and PRN (as needed). every night shift every Sun (Sunday) for COPD (chronic obstructive pulmonary disease)." R1's "Order Summary Report," dated 7/16/25, documents, in part, "Change O2 tubing and humidifier weekly every night shift every Sun for Infection Control." R1's care plan, revised date 5/20/25, documents, in part, "(R1) has dx. (diagnosis) of COPD (chronic obstructive pulmonary disease," with interventions that document, in part, "Give oxygen therapy as ordered by the physician." 4. On 7/14/25 at 11:06am, R2 was observed sitting in the chair with oxygen being administered at 3L NC	S9999		

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S9999	Continued from page 4 (nasal cannula.) R2's nebulizer mask was observed not contained lying in R2's bedside dresser drawer. R2 said, “I (R2) let the nurse’s do their thing with my oxygen. I (R2) don’t mess with it.” R2’s face sheet documents diagnoses that include but are not limited to chronic obstructive pulmonary disease, pleural effusion, and pneumonia. R2’s Brief Interview of Mental Status (BIMS) score, dated 5/26/25, documents, in part, a BIMS score of 8 which indicates R2’s cognition is moderately impaired. R2’s “Order Summary Report,” dated 7/16/25, documents, in part, “May start 02 at 2L/NC and titrate to 4L/NC to maintain 02 SATS above 90% PRN. Change O2 tubing and humidifier weekly every night shift every Sun for Infection Control. Change nebulizer tubing and mask weekly. every night shift every Sun." R2's care plan, dated 2/25/25, documents, in part, "RESPIRATORY: (R2) has potential for difficulty in breathing r/t COPD. His (R2) head is elevated to prevent SOB (shortness of breath) when lying flat. Administer oxygen as ordered." On 7/14/2025 at 1:30pm, V8 (Assistant Director of Nursing/ADON/Infection Preventionist/IP) said, “I (V8) started here in January as a floor nurse and became the IP and ADON at the end of May (May of 2025). Yes, I (V8) am both the ADON and Infection Preventionist. I (V8) do about 3 to 4 hours a day of Infection Preventionist work, and the rest of the hours is spent on ADON duties. No, I (V8) don't dedicate a full 40 hours a week to IP. Yes, we (facility) have IV (intravenous therapy) here too." On 7/17/25 at 9:11am, V8 (Assistant Director of Nursing/ADON/Infection Preventionist/IP) said, “Oxygen tubing and nebulizer masks, when not in use, should be kept in a plastic bag. Never lying on the dresser or in the dresser without being in a bag. Never on the floor. Oxygen equipment is kept in a plastic bag to prevent bacteria.” Facility policy titled, “Oxygen Safety/Use,” reviewed date 1/2025, documents, in part, “… 9. Oxygen tubing will be changed weekly and appropriately stored to	S9999		

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S9999	Continued from page 5 prevent contamination when not in use…" (B) TWO OF SIX 300.697d) 300.697e) Section 300.697 Infection Preventionists A facility shall designate a person or persons as Infection Preventionists (IP) to develop and implement policies governing control of infections and communicable diseases. The IPs shall be qualified through education, training, experience, or certification or a combination of such qualifications. The IP's qualifications shall be documented and shall be made available for inspection by the Department. (Section 2-213(d) of the Act). The facility ' s infection prevention and control program as required by Section 300.696(e) shall be under the management of an IP. d) Facilities with more than 100 licensed beds or facilities that offer high-acuity services, including but not limited to on-site dialysis, infusion therapy, or ventilator care shall have at least one IP on-site for a minimum of 40 hours per week to develop and implement policies governing control of infectious diseases. For the purposes of this subsection (d), "infusion therapy" refers to parenteral, infusion, or intravenous therapies that require ongoing monitoring and maintenance of the infusion site (e.g. central, percutaneously inserted central catheter, epidural, and venous access devices). e) A facility ' s IP shall coordinate with the facility group listed in Section 300.696(c) to ensure compliance with Section 300.696. (Source: Added at 46 Ill. Reg. 6033, effective April 1, 2022) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to have an infection preventionist on-site for a minimum of 40 hours per week developing and implementing policies governing control of infectious diseases. This failure has the potential to affect all 129 residents that reside within the facility.	S9999		

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S9999	Continued from page 6 Findings include: Record review of facility census, dated 7/14/2025, documents in part that 129 residents reside within the facility. On 7/14/2025 at 1:30pm, V8 (Assistant Director of Nursing/ADON/Infection Preventionist/IP) said, “I (V8) started here in January as a floor nurse and became the IP and ADON at the end of May (May of 2025). Yes, I (V8) am both the ADON and Infection Preventionist. I (V8) do about 3 to 4 hours a day of Infection Preventionist work, and the rest of the hours is spent on ADON duties. No, I (V8) don't dedicate a full 40 hours a week to IP. Yes, we (facility) have IV (intravenous therapy) here too." On 7/14/25 at 1:30pm, V2 (Director of Nursing/DON) said, "Yes, (V2) that's correct. She (V8/Infection Preventionist/ADON) only works like 3 to 4 hours a day as the IP nurse, not full time. You mean tube feeding? Yes, we have residents with parenteral infusion and IV (intravenous) therapy. No, I (V2) was not aware that if we have more than 100 certified beds or parenteral infusion or IV (intravenous) therapy that we (facility) need a full time Infection Preventionist." On 7/15/25 at 10:08am, V1 (Administrator) said, "Yes, the IP (Infection Preventionist) is also the ADON (Assistant Director of Nursing). We (facility) have a job posting up right now for a full time IP employee. Currently, The ADON has been monitoring infection prevention and control and is currently certified as an Infection Preventionist." Facility policy titled, “Infection Control Program-General,” reviewed date 2/2025, documents, in part, “General: (Name of Facility) is committed to ensuring all appropriate infection and control measures are in place as determined by State and Federal Regulations as well as CDC (Center for Disease Control) recommendations and guidance… All (Name of Facility) facilities will have a designated infection preventionist as required by State and Federal Regulations…” Pamphlet titled, “Illinois Long-Term Care Ombudsman Program Residents’ Rights for People in Long-Term Care Facilities,” revised date 11/18, documents, in part, “Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike…” (B)	S9999		

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S9999	Continued from page 7 THREE OF SIX 300.1060 b) 300.1060 d) 300.1060 f) Section 300.1060 Vaccinations b) A facility shall document in the resident's medical record that an annual vaccination against influenza was administered, arranged, refused, or medically contraindicated. (Section 2-213(a) of the Act) d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated. (Section 2-213(b) of the Act) f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act) These requirements were NOT MET as evidenced by: Based on interview and record review, the facility failed to document in medical record the screening for risk factors with hepatitis B, hepatitis C, and HIV and failed to document the status of influenza/ pneumonia vaccinations. These deficient practices affected 5 residents (R1, R2, R3, R4 and R5) reviewed for vaccinations in a total sample size of 25 residents. Findings include: Upon review of R3's, R4's, and R5's EMR (electronic medical record) from admission date to 7/14/25, there were no findings of documentation of the status (administered, refused, or medically contraindicated) of R3's, R4's, and R5's influenza and pneumococcal pneumonia annual vaccinations. Upon review of R1's, R2's, R3's, R4's, and R5's EMR from admission date to 7/14/25, there were no findings of documentation of screening for risk factors with hepatitis B, hepatitis C, and HIV for R1, R2, R3, R4,	S9999		

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S9999	Continued from page 8 and R5. On 7/17/25 at 9:11am, V8 (Assistant Director of Nursing/ADON/Infection Preventionist/IP) said, “We (facility staff) are currently working on a questionnaire to screen for those (hepatitis B, hepatitis C, and HIV). No, we (facility) are not currently screening, but will start doing that. No, I (V8) had to call to get (R3, R4, and R5) flu and pneumonia vaccine status because it wasn’t in the system. I (V8) just started as IP at the end of May (May 2025). I’m (V8) working on all of this. It takes a lot of time.” Facility policy titled, ““Infection Control Program-General,” reviewed date 2/2025, documents, in part, “General: (Name of Facility) is committed to ensuring all appropriate infection and control measures are in place as determined by State and Federal Regulations as well as CDC (Center for Disease Control) recommendations and guidance…All immunizations should have appropriate documentation including but not limited to, consents, refusals, historical, and administration of immunizations…” Facility policy titled, “Influenza (Flu) Vaccine,” review date 1/2024, documents, in part, “…4. The influenza vaccine will be obtained from the stock received from pharmacy, administered, and documented on the eMAR. 5. All refusals for the influenza vaccine will be documented in the Immunization Tab of the EHR (electronic health record) to include the reason for refusal. The consent will serve as the primary education piece with collateral education provided as necessary. 6. When a new resident is admitted, they will be asked about the Influenza vaccine and the above procedure will also occur. 7. If vaccine is received outside of the facility, the date and location of vaccination will be recorded in the Immunization Tab of the EHR.” Facility policy titled, “Pneumococcal Vaccinations,” review date 1/06/2025, documents, in part, “…2… If the resident has previously received any of the pneumonia vaccines previously, the date and location will be entered into the Immunization Tab of the EHR. 3…If the vaccine is contraindicated or the Resident or Responsible party refuses the specific reason for the refusal of either or both vaccines will be documented in the Immunization Tab of the EHR… 6. If the resident or responsible party declines the vaccine, this information will be documented in the Immunization Tab of the EHR.	S9999		

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S9999	Continued from page 9 Pamphlet titled, “Illinois Long-Term Care Ombudsman Program Residents’ Rights for People in Long-Term Care Facilities,” revised date 11/18, documents, in part, “Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike…” (B) FOUR OF SIX 300.1210a) 300.1210b)1)2)4) 300.1210c) 300.1210d)1)2)3)4)A)C)5) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. Restorative measures shall include, at a minimum, the following procedures: 1) The licensed nurse in charge of the restorative/rehabilitative nursing program shall have successfully completed a course or other training	S9999		

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S9999	Continued from page 10 program that includes at least 60 hours of classroom/lab training in restorative/rehabilitative nursing as evidenced by a transcript, certificate, diploma, or other written documentation from an accredited school or recognized accrediting agency such as a State or National organization of nurses or a State licensing authority. Such training shall address each of the measures outlined in subsections (b)(2) through (5) of this Section. This person may be the Director of Nursing, Assistant Director of Nursing or another nurse designated by the Director of Nursing to be in charge of the restorative/rehabilitative nursing program. 2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF CRESTWOOD	13259 SOUTH CENTRAL AVENUE , CRESTWOOD, Illinois, 60418

(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 11 means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. C) Each resident shall have clean, suitable clothing in order to be comfortable, sanitary, free of odors, and decent in appearance. Unless otherwise indicated by his/her physician, this should be street clothes and shoes. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. This requirement was NOT met as evidenced by: Based on observation, interview and record review, the facility failed to follow policies and procedures; failed to ensure restorative care was delivered to prevent range of motion decline; failed to ensure the licensed nurse had required training/coursework to manage the facility's restorative program; failed to provide timely ADL care; failed to implement care plan interventions; failed to ensure medications were administered within regulatory requirements; failed to conduct weekly skin assessments; failed to ensure low air loss mattress (LALM) settings were correct in accordance to manufacturer's guidelines. These failures affect 18 of 25 residents (R3, R4, R5, R8, R11, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25) reviewed for medication administration; all 68 residents within that receive restorative programming within the facility. These failures caused harm to R4, R5 and R8 as evidenced by R4 sustaining a sacrum skin integrity impairment on 7/14/25 (stage 4 pressure ulcer reopened), R5 sustained a stage 2 sacrum pressure ulcer (identified date is unknown) and R8 sustained ROM	S9999		

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S9999	Continued from page 12 decline to R8's bilateral hands. Findings include: 1. R4's diagnoses include generalized muscle weakness, acquired absence of left leg (below knee), acquired absence of right leg (above knee), and pressure ulcer sacral region (stage 4). R4's (4/10/25) functional assessment affirms resident is dependent on staff for shower/bathe and toileting hygiene. R4's (July 2025) care plan includes ADL (Activities of Daily Living), intervention: staff will provide total care related to bathing, toileting, and bed mobility. Risk for skin complications, interventions: use pressure redistribution surface. R4's (4/10/25) BIMS (Brief Interview Mental Status) determined a score of 13 (cognition intact). On 7/14/25 at 11:08am, surveyor inquired about concerns at the facility R4 stated "If it's not our shower day we have to ask to be cleaned up and when it's not my shower day they (staff) tell me there's not enough staff." V9 (Family) affirmed "My mom likes to be washed up every day." Surveyor inquired if R4 has any wounds R4 stated "I got one on my backside." On 7/14/25 at 11:20am, R4 was noted to be lying atop of a LALM however an incontinence brief, folded bath blanket (multiple layers), and fitted sheet were beneath her. Surveyor inquired about the requirements for LALM use V3 (LPN/Licensed Practical Nurse) stated "It should be only a fitted sheet we got too much on there." R4's brief was removed; a dressing was present on the left buttock wound however a (bleeding) open area was observed between R4's buttocks (sacrum area). Surveyor inquired why R4 was bleeding between the buttocks V3 responded "It looks like an open area right there" and affirmed there was blood on R4's brief. Surveyor inquired when R4's dressing was changed R4 stated "Around 6 or 7 am today." On 7/16/25 at 11:23am, surveyor inquired about R4's skin integrity impairment (identified 7/14/25 – by surveyor) V17 (Wound Care Nurse) stated "Her (R4) sacrum was healed 5/9, I took care of her that morning (7/14/25) around 6am. She (R4) has a stage 4 to the left gluteal fold and there was scar tissue to the sacrum, the sacrum reopened that day" and affirmed she (V17) was unaware of R4's sacrum skin integrity impairment until late afternoon.	S9999		

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S9999	Continued from page 13 2. R5's diagnoses include palliative care. R5's (5/5/25) functional assessment affirms R5 requires partial/moderate assistance with dressing and toileting hygiene. R5's (July 2025) care plan states resident has a stage 3 pressure ulcer to sacrum, intervention: notify medical doctor of any significant change in wound status. Treat as ordered per medical doctor. R5's (5/5/25) BIMS determined a score of 14 (cognition intact). On 7/14/25 at 11:33am, R5's call light was on therefore surveyor entered the room. Surveyor inquired about facility concerns R5 stated "I'm not getting my medicine on time. I have a wound and every time I ask for the dressing to be changed, they (staff) tell me they don't have any orders for that. I need to be changed right now because I'm wet. I had the call light on, and someone turned it off, so I turned it back on. They don't have enough staff, my CNA (Certified Nursing Assistant) was changing someone next door. I turned the light back on, so somebody doesn't forget me. I was changed sometime this morning before 6am (roughly 5.5 hours prior)." On 7/14/25 at 11:35am, a staff entered R5's room, R5 stated "I need to be changed, I've been waiting to be changed." The staff turned R5's call light off, left the room, and did not return. On 7/14/25 at 11:47am, surveyor located R5's assigned Nurse (14 minutes after initial observation) and advised that R5's incontinence brief needs changed due to staff failing to provide requested assistance. R5 was lying atop of a LALM, the settings were on #7 and static mode (firm setting). Surveyor inquired what "7" indicates on R5's LALM V5 (LPN) stated "That's how firm and soft is goes, right?" Surveyor inquired who's responsible for the LALM settings V5 responded "I'm not sure." Surveyor inquired about R5's wounds/treatments V5 stated "It's on her sacrum, its real small. She (R5) don't have a treatment with us (facility), there's no orders for us to treat her wound but she has a hospice nurses taking care of her." R5 affirmed that the hospice nurse visits "Monday and Friday." V5 removed R5's brief (as requested) which was soiled with bowel movement and a soiled (sacrum) foam dressing was present. R5 stated "I have not been changed since like 6 this morning, it might have been 5 this morning (roughly 6.75 hours prior)." Surveyor inquired when	S9999		

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S9999	Continued from page 14 incontinent residents should be checked and/or changed V5 responded “Every 2 hours.” R5’s (1/29/25) physician orders state complete weekly skin checks to ensure no new skin alterations are present. If new alteration is present, complete a new skin condition assessment. [Wound care orders are excluded]. On 7/14/25 at 3:33pm, surveyor requested R5’s recent wound/skin assessment V2 (Director of Nursing) stated “We don’t have anything for her.” R5’s (July 2025) TAR (Treatment Administration Record) excludes wound treatment administration. On 7/16/25 at 11:10am, surveyor inquired about LALM use V17 (Wound Care Nurse) responded “There should be only a flat sheet on it or a pad. The settings are according to the patient’s weight so it’s functioning properly. Should they (staff) know that it should NOT be set at static? Absolutely.” Surveyor inquired what the setting “7” indicates on R5’s LALM V17 responded “I would have to look at it, I’m not 100% sure because it was provided by hospice. If I had to guess it would be for the weight. She (R5) weighs 82.1 pounds as of 7/1/25 so she would not require a heavy weight setting” [the setting of 7 was notably high for R5’s weight]. Surveyor inquired about R5’s sacrum wound V17 responded “She admitted with an area to her sacrum which was healed. It’s a pink wound bed on her sacrum (stage 2). Her current treatment is medihoney and a dry dressing, the orders were entered 7/14/25 at 16:39 (4:39pm)” [After surveyor observation/inquiry]. On 7/15/25 at 10:04am, seven of V13’s (LPN) assigned residents (R8, R13, R14, R15, R16, R17, R18) were highlighted red on the EMAR (Electronic Medication Administration Record). Surveyor inquired why the residents were highlighted red on the EMAR V13 stated “I still have a couple people left (to give medication to), there’s seven that are red. It just means they were due at 9am and once it hits after 10:00 it’s overdue” and affirmed that (R8, R13, R14, R15, R16, R17, R18) did not receive their scheduled 9am medications. On 7/15/25 at 10:16am, nine of V3’s (LPN) assigned residents (R4, R11, R19, R20, R21, R22, R23, R24, R25) were highlighted red on the EMAR. Surveyor inquired what the red highlight indicates on the EMAR V3 stated “That I am late” and affirmed that (R4, R11, R19, R20, R21, R22, R23, R24, R25) did not receive their scheduled 9am medications.	S9999		

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S9999	Continued from page 15 The (2/2023) activities of daily living policy include Hygiene: showers and baths are scheduled, and assistance is provided when required. Elimination: assistance and instruction are given as required. The (2/2023) skin care prevention policy states all residents will be evaluated for changes in their skin condition. Dependent residents will be assessed during care for any changes in skin condition including redness, and this will be reported to the nurse. For residents who are bed or chair bound a pressure reducing mattress is needed. The LALM manufacturer guidelines state in static mode, the mattress provides a firm surface. Turn the pressure adjust knob to set a comfortable pressure level using the weight scale as a guide. The (1/2023) medication administration policy states check medication administration record prior to administering medication for the right medication, dose, route, resident, and time. Verify that the medication is being administered at the proper time. 3. On 7/14/2025 at 12:07 PM, R8 explained, “My hands are getting really difficult to move, they are so stiff and they hurt. I told the staff about it and have asked for therapy, but I am not getting any (therapy). I have asked for therapy many times, but I don’t understand why I am not getting it. I am afraid if they do not give me therapy, I won’t be able to move my hands anymore.” R8 stated that R8 was observed bending both of R8’s fingers/hands with approximately 50% range of motion and was unable to squeeze a baseball-sized foam ball (“stress ball”). R8 was unsure what restorative nursing was and denied that any staff complete range of motion exercises with R8. R8 stated, "They don't do any of that kind of stuff with me, all I have is my stress ball". R8's "POC Response History" (6/15/2025-Present) documents in part, "Active ROM* resident will perform AAROM to all extremities 6-7 days/week for a minimum of 15 minutes as tolerated throughnext review". No AAROM was provided on 6/21/25, 7/4/2025, 7/5/2025, 7/6/2025, 7/11/2025, and 7/13/2025. R8's care plan (7/13/2025) identifies that R8 "is at risk for developing an impairment in functional joint mobility. (R8) has impaired functional mobility to r/t: weakness", has a goal of "(R8) will maintain with current ROM/strength through next review" and interventions of "(R8) will perform AAROM to all	S9999		

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S9999	Continued from page 16 extremities 6-7 days/week for a minimum of 15 minutes as tolerated through next review" On 7/15/2025 at 10:52 AM, surveyor reviewed R8's restorative program documentation with V2 (Director of Nursing). V2 stated that there was documentation that restorative services were provided on 6/21/25, 7/4/2025, 7/5/2025, 7/6/2025, 7/11/2025, and 7/13/2025. V2 affirmed that the restorative department should be documenting the minutes and care provided within the medical record. On 7/15/2025 at 2:41 PM, V19 (Restorative Nurse, Licensed Practical Nurse) affirmed that V19 has noticed decreased mobility to R8's hands and described the decreased mobility as "stiffness" and "impairment". V19 estimated that R8 has approximately 65% range of motion to R8's bilateral hands. V19 affirmed that the documentation was incomplete and "was completed today". V19 affirmed that the documentation of restorative programming provided should be documented within the clinical record. R8's minimum data set 4/14/2025 documents in part that R8 has a brief interview of mental status summary score of 14 indicating R8 is cognitively impaired and that R8 has no impairment to R8's upper extremities, (indicating physical decline). Facility policy titled "Restorative Nursing Program" (1/2025) documents in part, "To promote each resident's ability to maintain or regain the highest degree of independence as safely as possible... Documentation of the interventions and the resident's response will be completed with each implementation..." On 7/15/2025 at 2:41 PM, V19 (Restorative Nurse, Licensed Practical Nurse) affirmed that V19 has not completed any courses/training program related to restorative nursing but that the facility is in the process of trying to enroll V19. On 7/16/2025 at 10:24 AM, V2 (Director of Nursing) affirmed that V19 (Restorative Nurse, Licensed Practical Nurse) and V2 had not completed any coursework/training program related to restorative nursing. On 7/17/2025 at 12:56 PM, V1 (Administrator) affirmed that 68 residents receive restorative nursing services. Facility policy titled "Restorative Nursing Program" (1/2025) documents in part, "...All nursing personnel	S9999		

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S9999	Continued from page 17 that carry out restorative programs will be trained on appropriate techniques for that particular program. Training will be repeated annually and as needed..." Facility restorative nursing job description does not identify/require that the restorative nurse shall have successfully completed a course or other training program as required by Section 300.1210. No other documentation of completion of a training program/coursework related to restorative nursing (that would meet this requirement) was provided for any facility staff prior to the exit of the survey. 4. On 7/15/25 at 11:18am, R3 was observed lying in bed, positioned on back, on a LAL (low air loss) mattress. The setting of R3's LAL mattress was observed at 350 pounds. Unable to interview resident due to altered mental status. R3's face sheet documents diagnoses that include but are not limited pressure ulcer of sacral region, muscle wasting and atrophy, and difficulty in walking. R3's Brief Interview of Mental Status (BIMS) score, dated 4/10/25, documents, in part, a BIMS score of 7 which indicates R3's cognition is severely impaired. R3's "Weight Summary Report," dated 7/16/25, documents, in part, that R3's most recent weight on 7/01/25 at 5:29pm was 140.9 pounds. R3's most recent Braden Scale, dated 7/01/2025, documents, in part, a Braden Score of 9 (Very High Risk for developing pressure ulcers); friction and sheer: problem. R3's most recent "Wound Rounds," dated 07/11/2025 7:38am, documents, in part, "Wound Assessment Details Report… Wound: Sacrum… Status: Active… Type: Pressure… Clinical Stage: Stage 4…" R3's Minimum Data Set (MDS), Section M, dated 6/10/25, documents, in part, "… Risk of Pressure Ulcers: Yes… Unhealed pressure ulcer: Yes… Number of stage 4 pressure ulcers: 1… Pressure reducing device for bed: Yes…" R3's care plan, revised date 4/03/25, documents, in part, "(R3) has a stage 4 to sacrum. Wound healing may be impeded related to impaired mobility, bowel incontinence, PAD (peripheral artery disease), CVA (cerebrovascular accident), dementia and COPD (chronic	S9999		

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S9999	Continued from page 18 obstructive pulmonary disease) with interventions that document, in part, “Apply specialty mattress when in bed.” On 7/16/25 at 11:07am, V17 (Wound Care Nurse) said that the low air loss mattress should only have either a flat sheet or a pad only. V17 stated that the low air loss mattress should be set at the resident’s weight. V17 said that if the low air loss mattress is set too high above the resident’s weight or too low below the resident’s weight “it defeats the purpose of the low air loss mattress.” V17 affirmed that “Absolutely,” if the setting of the low air loss mattress is not at the resident’s correct weight, it (weight setting) can make the pressure ulcer worse or cause a pressure ulcer to develop. In Center for Medicare and Medicaid Services article, dated 4/7/22 and titled "Pressure Reducing Support Surfaces - Group 2 - Policy Article," documents, in part, that styles of Group 2 "powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by all of the following: an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, and inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate beneficiary lift, reduce pressure and prevent bottoming out, and a surface designed to reduce friction and shear, and can be placed directly on a hospital bed frame." Pamphlet titled, “Illinois Long-Term Care Ombudsman Program Residents’ Rights for People in Long-Term Care Facilities,” revised date 11/18, documents, in part, “Your facility must provide services to keep your physical and mental health, at their highest practical levels…” (B) FIVE OF SIX 300.1420a) 300.1420b) Section 300.1420 Specialized Rehabilitation Services If physical therapy, occupational therapy, speech	S9999		

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S9999	Continued from page 19 therapy or any other specialized rehabilitative service is offered, it shall be provided by, or supervised by, a qualified professional in that specialty and upon the written order of the physician. a) In addition to the provision of direct services, any such qualified professional personnel shall be used as consultants to the total restorative program and shall assist with resident evaluation, resident care planning, and in-service education. b) Appropriate records shall be maintained by these personnel. Direct service to individual residents shall be documented on the individual clinical record as set forth in Section 300.1810(c). A summary of program consultation and recommendations as set forth in Section 300.1810(h) shall be documented. This requirement is NOT met as evidenced by: Based on interview and record review, the facility failed to provide physical and occupational therapy as ordered by the physician. This failure affects 1 resident (R8) reviewed for rehabilitation services. Findings include: On 7/14/2025 at 12:07 PM, R8 explained, “My hands are getting really difficult to move, they are so stiff and they hurt. I told the staff about it and have asked for therapy, but I am not getting any (therapy). I have asked for therapy many times, but I don’t understand why I am not getting it. I am afraid if they do not give me therapy, I won’t be able to move my hands anymore.” R8 was observed bending both of R8’s fingers/hands with approximately 50% range of motion and was unable to squeeze a baseball-sized foam ball (“stress ball”). R8’s physician orders documents in part that R8’s physician ordered physical therapy and occupational therapy to evaluate and treat on 6/27/25, 7/6/2025, and 7/9/2025. On 7/15/2025 at 10:52 AM, surveyor reviewed R8’s therapy orders with V2 (Director of Nursing). V2 was unsure if R8 was receiving therapy services as ordered by R8’s physician and would need to follow up with V16 (Regional Director of Rehab). On 7/15/2025 at 12:56 PM, V16 (Regional Director of Rehab) affirmed that V16 is managing the therapy services within the facility. V16 explained that V16 spoke with V2 and that R8’s 6/27/2025 therapy order was	S9999		

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S9999	Continued from page 20 communicated to the former director of rehab and they quit without notice so R8 was not evaluated. V16 stated that the 7/6/2025 and 7/9/2025 orders were not communicated to the therapy department from the nursing department. V16 stated, “They (the therapy orders) must have fallen through the cracks from nursing”. V16 stated that the facility standard is that a resident is treated within 48 hours of the physician order. V16 affirmed that no therapy screen or documentation was completed related to R8’s therapy needs. On 7/15/2025 at 2:41 PM, V19 (Restorative Nurse, Licensed Practical Nurse) affirmed that V19 has noticed decreased mobility to R8’s hands and described the decreased mobility as “stiffness” and “impairment”. V19 estimated that R8 has approximately 65% range of motion to R8’s bilateral hands. R8’s minimum data set 4/14/2025 documents in part that R8 has a brief interview of mental status summary score of 14 indicating R8 is cognitively impaired and that R8 has no impairment to R8’s upper extremities, (indicating physical decline). Facility policy titled, “Therapy Policy” (1/2025) documents in part, “Purpose: To provide guidelines for screening residents and providing therapy services by the therapy provider… 2. Therapy staff will conduct a screening to determine the appropriate discipline of therapy to complete an evaluation…” (B) SIX OF SIX 300.2210 b)6)7)8) Section 300.2210 Maintenance b) Each facility shall: 6) Maintain the grounds and other buildings on the grounds in a safe, sanitary, and presentable condition. 7) Maintain the grounds free from refuse, litter, insect, and rodent breeding areas. 8) The building and grounds shall be kept free of any possible infestations of insects and rodents by eliminating sites of breeding and harborage inside and outside the building; eliminating sites of entry into the building with screens of not less than 16 mesh screen to the inch and repair of any breaks in construction.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000288	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF CRESTWOOD	13259 SOUTH CENTRAL AVENUE , CRESTWOOD, Illinois, 60418

(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 21 These Requirements were NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the dumpster compactor was closed and failed to maintain the facility premises free of waste and garbage, creating potential conditions for insect and rodent infestations. These failures have the potential to affect all 129 residents residing at the facility. Findings include: Record review of facility census, dated 7/14/2025, documents in part that 129 residents reside within the facility. On 7/14/2025 at 10:04am, with V10 (Dietary Director), upon observation of the facilities dumpster, the following was observed: 1. Pasta noodles on ground near dumpster. 2. 4 open plastic bottles on ground. 3. 1 open trash bag on ground with food in it and multiple flies swarming around the bag. 4. Trash compactor uncovered (not closed shut) with visible garbage in it. On 7/14/2025 at 10:04am, V10 (Dietary Manager) said, “Oh man! This is not our (kitchen staff) fault. The housekeepers take the garbage out. There should not be food all over and the dumpster should be completely shut. We (facility) don’t want no mice up in here.” On 7/16/2025 at 10:59am, V21 (Housekeeping Manager) said, “Yes, we (housekeeping staff) take the trash out from the kitchen and throw it in the outside dumpster. We (facility staff) don’t want rodents in here, so we close the dumpster and make sure there’s no trash outside of the dumpster. The trash on the ground is from (Name of Garbage Company). When they (Name of Garbage Company) pick it up they drop the trash on the ground and have been told to clean it up. There shouldn’t be any trash outside of the dumpster. They (Name of Garbage Company) said they came Friday but	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000288	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2025

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S9999	Continued from page 22 were blocked in, so they came Monday (7/14/25). Food and garbage all over will attract rodents and raccoons. We (facility staff) don't want that." Facility policy titled, "Preventive Maintenance Plan," revised date 1/2025, documents, in part, "General: To provide the staff with guidance on preventative maintenance within the facility…" Facility policy titled, "Pest Control," review date 1/2025, documents, in part, "Purpose: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. Standards:.. 4. Facility will utilize a variety of methods in controlling certain seasonal pests, i.e. flies. These involve indoor and outdoor methods that are deemed appropriate by the outside pest service and state and federal regulations. 5. Facility will ensure that the outside pest service also treats the exterior perimeter of the facility and any outlying buildings or structures, i.e.. Dumpster area, etc." Facility policy titled, "Housekeeping Policy/Guidelines," review date 1/2025, documents, in part, "Purpose: To provide guidelines to maintain a safe and sanitary environment for residents, facility staff and visitors… 3. Waste handling and disposal will be in accordance with local and state regulations. 4. Pest control service will be monitored by housekeeping personnel…" Pamphlet titled, "Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities," revised date 11/18, documents, in part, "Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike…" (C)	S9999		