

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057885		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/20/2026	
NAME OF PROVIDER OR SUPPLIER ALIYA OF HOMEWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 940 MAPLE AVENUE , HOMEWOOD, Illinois, 60430			
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S0000	Initial Comments		S0000			02/23/2026	
	Annual Licensure and Certification Survey						
S9999	Final Observations		S9999			02/23/2026	
	Statement of Licensure Violations:						
	1 of 2						
	300.610a)						
	300.1010h)						
	300.1210b)						
	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. These Requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to notify the physician and registered dietitian of a resident's poor appetite and decreased oral intake, which resulted in significant weight loss, and failed to implement timely interventions to prevent further decline. This affected one of three residents (R9) reviewed for nutritional status in a sample of 44 residents. This failure resulted in R9 experiencing a significant unplanned weight loss of 13.3% over a three-month period. Findings include: On 2/17/26 at 12:47 PM, R9 received lunch meal tray. R9's head of bed was at 45 degrees. At 1:10 PM, R9 was observed eating one piece of canned fruit. R9 was observed coughing while eating. By 1:25 PM, R9 had consumed two pieces of canned fruit and drank 100 ml (milliliters) juice. V20 CNA (certified nurse aide) removed R9's tray from room. On 2/18/26 at 1:12 PM, R9's lunch tray was set up and head of bed 45 degrees. By 1:36 PM, R9 had not eaten anything. By 2:15 PM, R9 ate one bite of cornbread. R9 was observed coughing while eating. V20 CNA removed R9's tray from room. On 2/18/26 at 12:20 PM, V21 CNA stated that she lets the nurse know if resident does not eat or eats very little. On 2/18/26 at 3:50 PM, V28 (attending physician) stated that he was not made aware of R9's poor appetite or R9's weight loss. V28 stated that he just spoke with R9's nurse who informed him that R9 was fine, no concerns with eating. V28 stated that he expects the nurse to notify him when a resident has a weight change of +/- 5 pounds in a month. V28 stated that he expects the nurse to notify him if resident eats very little or refuses a meal. On 2/19/26 at 10:25 AM, R9's meal intake for the past		S9999				

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S9999	Continued from page 2 30 days was reviewed with V7 RD (registered dietitian). V7 stated that she was not made aware of the frequency that R9 was consuming 0-50% and refusing meals. V7 stated that she would have made recommendations for supplements if staff had notified her. R9's medical record notes the following weights: On 2/19/26, R9 weighed 130.5 pounds. On 2/6/26, R9 weighed 132 pounds. On 1/6/26, R9 weighed 130 pounds. On 12/3/25, R9 weighed 150 pounds. There is no weight documented for November 2025. On 10/7/25, R9 weighed 151.5 pounds. On 8/4/25 R9 weighed 153.5 pounds. On 2/19/26, This surveyor observed V26 (restorative aide) and V27 (restorative aide) weigh R9 using a mechanical lift device. R9 weighed 130.5 pounds. R9 had a 14.98% weight loss in six months and 13% weight loss since 12/3/25. On 2/20/26 at 1:45 PM, V25 ST (speech therapist) stated that she just completed an evaluation on R9. V25 stated that R9 did not exhibit any coughing while eating. When questioned if the coughing this surveyor observed while R9 was eating could be related to R9 lying in bed with head of bed raised only 45 degrees, V25 responded that there is a direct relationship of coughing when head of bed is not at 90 degrees. V25 stated that V25 is always informing the staff to make sure residents are sitting upright during the meal and for 30 minutes after. V25 stated that swallow strategies she recommends for R9 include 1:1 feeding assistance, alternating liquids and solids, upright posture during meals and for 30 minutes after meal, soft and bite sized food. On 2/20/26 at 3:35 PM, V31 (regional nurse consultant) stated that R9 had a lot of edema (swelling) documented in R9's medical record in December and January to account for R9's significant weight loss. R9's medical record, dated 12/2/25-1/6/26 notes the following documentation regarding R9's edema: On 12/2, the nurse practitioner noted R9's extremities normal, no edema.	S9999					

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S9999	Continued from page 3 On 12/3, pulmonary nurse practitioner noted R9's lungs clear to auscultation; trace edema resolving. On 12/4, the nurse practitioner noted no edema. On 12/9, the nurse practitioner noted R9's extremities normal, no edema. On 12/12, the nurse practitioner noted R9's extremities normal, no edema. On 12/23, nephrology nurse practitioner noted R9 euvolemic (normal healthy volume of blood and body fluids). On 12/30, the nurse practitioner noted R9's extremities normal, no edema. On 1/6/26, nephrology nurse practitioner noted R9 euvolemic. No edema noted. On 2/20/26 at 3:51 PM, V31 stated that R9's weight loss was due to R9 having Covid-19 in December. R9's medical record, dated 12/3/25 notes R9 tested positive for Covid-19. On 12/4, the nurse practitioner noted R9 being seen for follow-up on Covid-19. R9 had a routine Covid-19 test, which was positive. R9 is asymptomatic. R9's POC (point of care) charting, dated 12/1-12/31, notes documentation of R9's meal consumption for 88 out of 93 meal opportunities. R9 consumed 0-25% of meal served 13 times; 26-50% of meal served 23 times; and refused the meal 6 times. R9 was unavailable for one meal. R9's POC (point of care) charting, dated 1/1-1/30, notes documentation of R9's meal consumption for 92 out of 93 meal opportunities. R9 consumed 0-25% of meal served 21 times; 26-50% of meal served 22 times; and refused the meal 4 times. R9's POC (point of care) charting, dated 2/1-2/19, notes documentation of R9's meal consumption for 56 out of 57 meal opportunities. R9 consumed 0-25% of meal served 13 times; 26-50% of meal served 18 times; and refused the meal 5 times. There is no documentation found in R9's medical record noting V28 was notified each time R9 consumed 0-25% or refused the meal. There is no documentation found in R9's medical record			S9999			

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S9999	Continued from page 4 that R9's weight loss is medically unavoidable. The facility's weight change policy, dated 05/2025, notes this facility will monitor the nutritional status of all residents, including all significant or trending patterns of weight change. It also notes in part review weights for significant weight change. Notify dietitian, physician, and resident representative. Dietitian will review and provide recommendations. (B) 2 of 2 300.610a) 300.1210b) 300.1210d)3)4)A) 300.1220b)8) 300.2040c)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 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:			S9999			

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S9999	Continued from page 5 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out. Section 300.2040 Diet Orders c) Medical providers shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. A medical provider may delegate writing a diet order to the dietitian. 2) The diet shall be served as ordered. These Requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that residents who were at risk for malnutrition and dependent on enteral feedings received nutrition as ordered to maintain adequate nutritional status and prevent weight loss. The facility also failed to ensure staff demonstrated competency in the administration and management of enteral nutrition and care. This affected 2 of 3 residents (R82 and R89) reviewed for enteral nutrition in a sample of 44 residents. As a result, R82 experienced a significant weight loss of 14.1% between			S9999			

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S9999	Continued from page 6 July 2025 and February 2026, and R89 experienced a weight loss of 4.4% within eight weeks of admission. Findings include: On 2/17/26, intermittent observations were made from 12:20 PM until 4:00 PM, R82 was observed self-propelling wheelchair in halls and attending activities; R82 was not connected to enteral feeding pump. On 2/18/26 at 3:36 PM, R82's enteral feeding container shows R82 received 600ml since it was started on 2/17/26 at 10:09 PM. Continuous observations were made on R82's nursing unit from 11:55 AM until 4:00 PM; R82 was not observed receiving enteral feeding during this time. On 2/17/26 at 10:15 AM, R89 was observed lying in bed. R89's enteral feeding pump was turned off. Intermittent observations were made from 12:20 PM until 4:00 PM, R89 was in wheelchair at nurses' station not receiving enteral feeding. On 2/18/26 at 9:30 AM, R89 was observed in wheelchair at nurses' station, not receiving enteral feeding. At 2:00 PM, R89 was observed in room with family; R89 was not receiving enteral feeding. On 2/18/26 at 3:44 PM, R89 was observed sitting in wheelchair in room, not receiving enteral feeding. Enteral feeding container shows R89 received 150ml since it was started at 5:45 AM at 80 ml/hour. On 2/19/26 at 3:30 PM, V29 (activity director) stated that R82 is in wheelchair participating in activities or self-propelling in halls all day every day. On 2/19/26 at 10:32 AM, V24 (nurse) stated that R89's enteral feeding was started at 5:50 AM. When questioned how it is communicated to oncoming nurses the amount of feeding delivered and/or amount left, V24 did not respond. When questioned how does V24 know when the resident has received the total amount of feeding per 24 hours, V24 responded the pump will shut off. When questioned how to check pump settings and amount fed, V24 did not respond and left R89's room. On 2/19/26 at 10:35 AM, V7 RD (registered dietitian) stated that enteral feedings are ordered to deliver feeding over 20 hours daily to ensure the resident is receiving adequate nutrition. V7 stated that the total volume of feeding is based on the resident's caloric needs. V7 stated that residents should not lose weight		S9999				

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S9999	Continued from page 7 if receiving nutrition as prescribed. V7 stated that she reviews the total volume fed on the feeding pump. V7 stated that she has increased R89's feeding by 5ml/hour each month since December because he was not receiving the prescribed daily total volume. V7 stated that she did this hoping R89 would receive the nutrition he needs. V7 stated that R89 should receive 1680 ml (milliliters) total feeding and 1050 total water per 24 hours. V7 reviewed on R89's enteral feeding pump the amount of feeding R89 received in the past 24 hours and 48 hours. V7 stated that the pump shows R89 received 1080 ml of feeding and 715 ml of water flush in 24 hours and 2264 ml feeding and 1240 ml water flush in the past 48 hours. V7 stated that R89 is not receiving adequate nutrition. V7 stated that these residents are discussed at the NARS (nutrition at risk) meetings and she voices her concerns. On 2/19/26 at 10:50 AM, V7 RD stated that R82 should be receiving 1500 ml total feeding and 1800 ml water flush per 24 hours. V7 stated that R82's feeding pump shows R82 received 1021 ml of feeding and zero water flush in 24 hours and 1852 ml feeding and zero water flush in the past 48 hours. V7 stated that R82 is not receiving adequate nutrition. On 2/19/26 at 11:15 AM, V2 DON (director of nursing) stated that the nurses received an in-service on the enteral feeding pump one year ago. V2 stated that the nurses were not competencied on the feeding pump. V2 stated that the nurse is expected to ask V2 or the nurse manager for assistance if the nurse does not know how to use the enteral feeding pump or has any questions. V2 stated that nurses that started working at this facility after 1/27/25, received 1:1 training on the enteral feeding pump during orientation. The facility provided a list noting there are 47 current licensed nurses working at this facility. Of these 47 nurses, 21 started after 1/27/25. On 2/20/26 V2 DON presented the facility's enteral feeding pump in-service documentation dated 1/27/2025. Six of the 47 licensed nurses were in-serviced. The facility was unable to provide documentation that the 21 nurses that started after 1/27/25 received training during orientation. The facility was unable to provide any documentation that the 41 nurses that did not attend the in-service on 1/27/25 received any education on the feeding pump. The facility was unable to provide any documentation that all nurses are competent in using the feeding pump. R82's weight documentation:			S9999			

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S9999	Continued from page 8 On 7/2/25, R82 weighed 195.5 pounds. On 10/7/25, R82 weighed 168 pounds. On 1/6/26, R82 weighed 171.5 pounds. On 2/19/26, R82 weighed 167.8 pounds. R89's weight documentation: On 12/26/25, R89's admission weight was 147.5 pounds. On 1/23/26, R89 weighed 145.6 pounds. On 2/19/26, R89 weighed 141 pounds. The facility's tube feeding policy, dated 01/2024, notes in part, the health care provider should be notified if tube feeding amount not infused as ordered. Feeding pump: pump should be cleared at the end of each shift. Document tube feeding delivered. Alert health care provider of any issues or concerns. (B)			S9999			