STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145087	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Oak Lawn	6300 West 95th Street Oak Lawn, IL 60453

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to update R2's comprehensive wound care plan when new wounds were identified on May 13, 2026. This failure affected one resident (R2) in a sample of four residents reviewed. On 6/9/2026 at 10:43 AM, R3 stated that no complaints regarding staffing and reported that staff are consistently available to assist her with her care needs, including providing assistance with changing her dressing. R3 further stated that she previously had wounds on her left leg that have since healed. On 6/9/2026 at 10:48 AM, R4 stated that he has been residing at the facility for approximately one month and said that everything has been going well thus far. R4 stated that he was admitted with a wound on his right foot and reported that the wound care team provides treatment on a daily basis. R4's right foot wound was observed dressed appropriately.On 6/9/2026 at 11:21 AM, R6 stated that he has served as the resident council president for an extended period of time and reported that the council meets regularly once a month. R6 added that the facility has a strong wound care team, which he observes conducting daily rounds. R6 stated, They keep a list of residents they see on a regular basis. R6 further stated, I am very comfortable here, staff are respectful and I do the same. I have no complaints.On 6/10/2026 11:03 AM, V10 (Certified Nursing Assistant/CNA) said that she cared for R2 and was very familiar with her needs. V10 attested that the wound care team regularly came to assess and treat R2's wounds and address any other care needs she had. R2 had a bedside commode and liked to get up early, so she was usually one of the first or second residents she assisted in the morning. At times, R2 would be heavily incontinent of urine due to use of water pill. V10 said R2 was never neglected. On 6/10/2026 at 11:21 AM, V12 (Registered Nurse/RN), stated that R2 was stable during the times she provided care. V12 reported that the wound care team evaluated and treated R2's wounds on a daily basis and routinely monitored her skin condition. R2 was assisted on a regular basis and that staff attended to her care needs appropriately. Regarding concerns that medications were not administered as ordered, V12 stated that she did not recall any incidents involving missed medications. She explained that R2's blood pressure fluctuated at times and that blood pressure medications were administered in accordance with physician orders and established clinical parameters. V12 added that she routinely explained medications to R2 and answered questions regarding their purpose and administration.On 6/10/2026 at 12:00 PM, V13 (Wound Care Director), and V5 (Wound Care Nurse), were interviewed together regarding R2's lower-extremity skin condition and wound care treatment. The wound care team reported that the bilateral lower-extremity blisters were identified on 5/13/2026. According to the wound care team, the blisters were believed to be related to fluid retention and edema resulting in increased fluid accumulation in the lower extremities. R2 was subsequently transferred to the hospital on 5/17/2026. Wound care services were provided during the period between identification of the blisters and the hospital transfer. R2's daughter was present during the skin assessment and was made aware of the findings at that time. The wound care team added that education was provided to R2's family regarding the wound treatment plan, including that dressing changes were scheduled three times per week and additionally as needed. Staff explained that dressings would be changed (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	whenever clinically indicated, such as when dressings became soiled or compromised. According to the wound care team, the daughter requested dressing changes much more frequently; however, staff explained that hourly dressing changes were not clinically indicated or practical. Staff stated that dressings were changed whenever assessment findings warranted intervention.On 6/10/2026 at 1:31 PM V15 (Registered Nurse/RN) stated that the drainage from the resident's legs was not saturating the dressings and that there was nothing observed that suggested an acute emergency or significant deterioration in condition at the time of R2's send out. V15 added that R2 herself did not express complaints to the staff member. V15 denied that R2 was neglected. According to V15, R2 followed a normal daily routine that day. R2 was assisted with morning care, transferred to her chair, provided meals, and monitored throughout the day. The staff member recalled that shortly before the daughter's concerns arose, R2 appeared comfortable, was eating, and exhibited no signs that anything was seriously wrong.Record review revealed the following:eMAR (Electronic medication administration) and TAR (Treatment administration record) records indicated that medications and treatments were administered in accordance with provider orders.R2's wound was assessed and evaluated upon identification, and documentation reflects that the nurse practitioner and family were notified.R2 has a Brief Interview for Mental Status (BIMS) score of 12, dated 4/16/2026.Nursing documentation and resident education records indicate that R2 was provided with updates regarding her medications and treatments.Record review of physician and nurse practitioner (NP) visits showed that R2 was referred, seen, and evaluated on multiple occasions in the facility prior to transfer out to the hospital. Specialty providers and nurse practitioners involved in R2's care included Cardiology, Nephrology, Physiatry, Wound Care, Pulmonary, and Primary Care services.The nurse practitioner (NP) visited R2 on May 16, 2026. According to the NP's documentation, R2 presented with swelling and weeping of the right lower extremity, and staff charting noted the presence of blisters. A venous ultrasound was completed, which showed no evidence of deep vein thrombosis (DVT).Upon reviewing the wound assessment details report provided by the wound care team on 6/10/2026, R2 has other wounds: Blister on left lower leg and blisters on right lower leg. It also describes that R2's legs were noted swollen with fluid filled blisters.R2's Wound care plan was also reviewed. R2's wound care plan on wounds that was initiated on 4/10/2026 with a revision date of 5/6/2026 states that R2 has MASD/Moisture Associated Skin Damage to abdominal fold and right hip. The care plan was not addressing the newly identified wounds on both lower extremities. In a follow up interview to V13 (Wound Care Director) on 6/10/2026 at 1:12 PM, V13 acknowledged the presence of R2's wounds and confirmed that R2's care plan had not been updated. V13 stated that the resident's care plan should be updated immediately whenever there is a significant change in condition, including the development of acquired blisters or new skin integrity issues. V13 acknowledged that timely updates are necessary to ensure that appropriate interventions, monitoring, and treatment measures are identified and implemented. V13 added, I will re-educate them on updating care plan. According to [NAME] Health Care Policy on Baseline Care Plan, dated 1/2023 with a review date of 1/2026, state that Because the baseline care plan documents the interim approaches for meeting the residents immediate needs, it should also reflect changes to approaches, as necessary, resulting from significant changes condition or needs, occurring prior to the development of the comprehensive care plan.