STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145681	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Crestwood	13259 South Central Avenue Crestwood, IL 60418

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that staff ordered and administered medications to a newly admitted resident (R156); failed to document the administration of medications immediately following administration for 12 (R6, R25, R52, R61, R87, R106, R115, R120, R126, R131, R139, and R142) residents. These failures affected 13 residents reviewed in a sample of 76 residents. Findings include: 1) R6's Medication Admin Audit Report, dated 4/22/26, documents that on 4/08/26, R6's medications that were due for 9:00am: Docusate Sodium, Hydroxyzine HCl, Levetiracetam, Furosemide, Loratadine, Gabapentin, Aspirin, Calcium, Nabumetone, Polyethylene Glycol, Magnesium Oxide, and Vitamin C were administered at 11:33am (one hour and 33 minutes late). R25's Medication Admin Audit Report, dated 4/22/26, documents that on 4/08/26, R25's medication, Cetirizine, that was due for 8:00am was given at 2:15pm (5 hours and 15 minutes late) and R25's medication, Lexapro, that was due for 9:00am was given at 2:15pm (4 hours and 15 minutes late). R52's Medication Admin Audit Report, dated 4/22/26, documents that on 4/08/26, R52's medications that were due for 9:00am: Eliquis and Memantine HCl were given at 3:45pm (5 hours and 45 minutes). R61's Medication Admin Audit Report, dated 4/22/26, documents that on 4/08/26, R61's medication, Sucralfate, that was due for 7:00am was given at 2:01pm (6 hours and one minute late); R61's medications that were due for 9:00am: Aspirin, Amlodipine, Losartan were given at 3:51pm (5 hours and 51 minutes late); and R61's medications that were due for 9:00am: Carvedilol, Plavix, Docusate Sodium, Ferosul, Tizanidine, Polyethylene Glycol were given at 5:05pm (7 hours and 5 minutes late). R87's Medication Admin Audit Report, dated 4/22/26, documents that on 4/08/26, R87's medications that were due for 9:00am: Famotidine, Pyridoxine HCl, Thiamine HCl, Carvedilol, Losartan Potassium, Dapagliflozin Propanediol, and Folic Acid were given at 1:43pm (3 hours and 43 minutes late). R106's Medication Admin Audit Report, dated 4/22/26, documents that on 4/08/26, R106's medications that were due for 9:00am: Protonix, Lexapro, Hydralazine, Ferrous Sulfate, Folic Acid, Aspirin, Amlodipine Besylate, Potassium Chloride, And Metoprolol Tartrate were given at 2:54pm (4 hours and 54 minutes late). R115's Medication Admin Audit Report, dated 4/22/26, documents that on 4/08/26, R115's medications that were due for 9:00am: Metformin, Amlodipine Besylate, Metoprolol Tartrate, Baclofen, Vitamin C, and Gabapentin were given at 2:30pm (4 hours and 30 minutes late). R120's Medication Admin Audit Report, dated 4/22/26, documents that on 4/08/26, R120's (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication, Aspirin, that were due for 8:00am was given at 1:29pm (4 hours and 29 minutes late) and R120's medications that were due for 9:00am: Multivitamin, Cholecalciferol, Amlodipine Besylate, and Enalapril Maleate were given at 1:29pm (3 hours and 29 minutes late). R126's Medication Admin Audit Report, dated 4/22/26, documents that on 4/08/26, R126's medications that were due for 8:00am: Cholecalciferol and Coreg were given at 11:57am (2 hours and 57 minutes late); R126's medication, Metformin and Lasix, that was due for 8:00am was given at 5:11pm (8 hours and 11 minutes late); and R126's medications that were due for 9:00am: Gabapentin, Eliquis, and Farxiga were given at 5:12pm (7 hours and 12 minutes late). R131's Medication Admin Audit Report, dated 4/22/26, documents that on 4/08/26, R131's medications that were due for 9:00am: Aspirin, Calcium, Docusate Sodium, Ferrous Sulfate, Lasix, Cephalexin, and Acetaminophen were given at 12:00pm (2 hours late). R139's Medication Admin Audit Report, dated 4/22/26, documents that on 4/08/26, R139's medication, Depakote, that was due for 8:00am was given at 3:53pm (6 hours and 53 minutes late) and R139's medications: Polyethylene Glycol, Levetiracetam, and Loratadine, that were due for 9:00am were given at 3:53pm (5 hours and 53 minutes late). R142's Medication Admin Audit Report, dated 4/22/26, documents that on 4/08/26, R142's medications that were due for 9:00am: Gabapentin, Duloxetine HCl, and Centrum were given at 5:00pm (7 hours late). On 4/22/26 at 2:58pm, V28 (Registered Nurse/RN) affirmed that V28 was responsible for administering medication to R6, R25, R52, R61, R87, R106, R115, R120, R126, R131, R139, and R142 on 4/08/26 am shift (7:00am to 3:00pm). V28 said, I believe I gave the medications on time, and I just signed them out at a later time than when they (medications) were actually given. I gave them (medications) on time and signed them out later. It being my first day off orientation, I just wanted to make sure I got all the medications passed out on time. When I give the medication I am supposed to sign it off. Right away. Record review of facility document titled, Daily Assignment Sheet, dated 4/08/26, documenting that V28 (Registered Nurse/RN) was the nurse assigned to R6, R25, R52, R61, R87, R106, R115, R120, R126, R131, R139, and R142 on 4/08/26 am shift (7:00am to 3:00pm). On 4/22/26 at 4:08pm, V2 (Director of Nursing/DON) said, Sign off that the medication was given immediately, once they swallow the medication. I did speak with all the nurse's about that. Record review of facility policy titled, Medication Administration, dated 2/2026, documents, in part, General: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Check medication administration record prior to administering medication for the right medication, dose, route, patient/resident and time. Verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route. Document as each medication is prepared on the MAR (medication administration record). Explain procedure to resident and give the medication. Remain with the resident to ensure that the resident swallows the medication. If medication is not given as ordered, document the reason on the MAR and notify the Health Care Provider if required. If the physician's order cannot be followed for any reason, the physician should be notified in a timely manner (depending on the situation), and a note should reflect the situation in the resident's medical record. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must be safe, clean, comfortable, and homelike. 2) R156 is [AGE] years old admitted to the facility on [DATE], face sheet listed the following past medical history, chronic obstructive pulmonary disease, hypokalemia, alcohol abuse with withdrawal, rheumatoid arthritis, tobacco abuse counseling, hypothyroidism, noninfective gastroenteritis, chest pain, etc. admission evaluation dated 4/20/2026 documented that R156 is alert and oriented x3, can make needs known and communicate with a clear speech. Review of medical record showed after visit summary from the hospital, medication list and 5 medication scripts scanned on 4/20/2026 at 1600. On 04/21/2026 1:30 PM, R156 was observed in her room, awake and alert with the daughter and both were visibly upset. R156 said that she was admitted to the facility yesterday (4/20/2026) at 1:30PM, she did not receive any medication the whole day until this morning. R156 stated that she was upset and up all night, she did not get her anxiety medication or breathing treatments, she ended up calling her daughter in the middle of the night. The nurse on duty kept on telling her that she is working on her medications. Resident's daughter stated that she handed her medication list from the hospital to the social worker when they arrived, and she does not understand why facility could not get her medication on time. On 04/21/2026 12:00PM, V25 (LPN) said that R156 is very upset about not getting her medication yesterday, she came around 2:00PM, V25 said that she took the initial vitals and handed it over to the afternoon shift nurse. Resident's daughter brought her, and she did not come with any packet, her medication list was not available. On 4/21/2026 at 1:45PM V44 (Admissions Director) said that R156 arrived at the facility around 2PM with paperwork that included medication list and about 5 scripts, the documents were scanned into the system but the person at the front desk forgot to give it back to the person transporting the resident to the unit. V44 said that the documents were scanned two hours later, and it was given to the nursing staff when they asked for it. V44 is not sure how long it takes the nurses to get medications from pharmacy. Medication administration record (MAR) for R156 showed that the following medications were not signed out as given on 4/20/2026: Mirtazapine 15mg tablet scheduled at 2100, Ativan 1mg tablet every 8 hours for anxiety, Ipratropium-albuterol 0.5mg-3mg (25mg base) for wheezing, Lomotil oral tablet 2.5-0.25mg. 1 tablet by mouth every 6 hours for diarrhea, and Albuterol 90mcg/actuation inhaler, inhale 1 puff into lungs every 4 hours as needed for wheezing. On 4/22/2026 at 2:07PM, V2 (DON) said that when a new resident is admitted , the nurse is supposed to send the medication list to pharmacy after verifying the medication with the physician and clarify the expected time of arrival (ETA). If the medication does not arrive on time, the nurse is supposed to pull the medication from the emergency box if it takes time for the medication to arrive. All nurses have been in-serviced, and they all have access to the emergency box. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Emergency medication list provided by V2 showed that, Ativan 1mg tablet every 8 hours for anxiety, Ipratropium-albuterol 0.5mg-3mg (25mg base and Albuterol 90mcg/actuation inhaler were among the listed medications. Surveyor attempted several times to speak to the afternoon shift and night shift nurses assigned to R156 on 4/20/2026 but none of them answered their phone. Surveyor informed V2 (DON) of not being able to contact the 2 nurses and she said, I have tried to call them, and they did not answer, I cannot force them to answer their phone. Surveyor requested a facility policy on ordering medications for new admissions, but none was provided. Job description for registered nurses (RN) and practical licensed nurses (LPN) (undated) documents in part: Basic Function: Under the direction of the physician, is responsible for total nursing care to all residents on assigned unit during the assigned shift including responsibility for delegation of duties, resident nursing care, staff performance and adherence by staff members to facility policies and procedures. Essential Duties 1. Participate in the development and implementation of individualized patient care plan for the residents with allied health team members. 9. Recognize significant changes in the condition of residents and take necessary action. 10. Document nursing care rendered, resident response, and all other pertinent and necessary data as outlined in facility's policies and procedures. United RX STAT orders policy dated July 2024 stated in part: Emergency pharmaceutical services will be available at all times. An emergency need for medication will be met by using facility's approved contingency supply or by sending an emergency order to unitedRX pharmacy. Procedure: 1. When an emergency or STAT order is received, the nurse will determine if the medication is in the emergency dispensing kit by referring to the list of contents posted on it. 2. If the medication is not available, an emergency delivery can be requested by faxing a stat order to the pharmacy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that staff ordered and administered medications to a newly admitted resident (R156) and failed to ensure that a witnessed fall was documented in the resident's electronic health record (R8). R156 was admitted to the facility on [DATE] between 1:30 and 2:00PM and did not receive any medications till the morning of 4/21/2026. These failures affected two (R8 and R156) of two residents reviewed for quality of care. Findings include: 1.R156 is [AGE] years old admitted to the facility on [DATE], face sheet listed the following past medical history, chronic obstructive pulmonary disease, hypokalemia, alcohol abuse with withdrawal, rheumatoid arthritis, tobacco abuse counseling, hypothyroidism, noninfective gastroenteritis, chest pain, etc. admission evaluation dated 4/20/2026 documented that R156 is alert and oriented x3, can make needs known and communicate with a clear speech. After visit summary dated 4/20/2026, scanned in resident's medical record listed the following medications: Gabapentin 300mg capsule, take one capsule by mouth daily Ipratropium-albuterol 0.5mg-3mg (25mg base), take 3mls by nebulization every 6 hours as needed for wheezing, last time given (4/20/2026 at 6:44AM). Mirtazapine 15mg tablet, take one tablet by mouth daily, las time given (4/20/2026 at 8:05PM), Albuterol 90mcg/actuation inhaler, inhale 1 puff into lungs every 4 hours as needed for wheezing, Amlodipine-benazepril 5-20mg per capsule, take 1 capsule by mouth daily. Diphenoxylate-atropine 2.5-0.25mg per tablet. Take one tablet by mouth 4 times daily as needed. Levothyroxine 100mcg tablet, take one tablet by mouth daily, last time given (4/20/2026 at 9:09AM). Montelukast 10mg tablet, take 1 tablet by mouth daily (last time given 4/20/2026 at 9:06AM). Pantoprazole 40mg tablet, take one tablet by mouth daily (last time given (4/20/2026 at 9:04AM). Trelegy Ellipta 100-62.5-25mcg blister with device inhaler. Inhale 1 puff into lungs daily. There were also 5 scripts for nicotine 21 mg/24hr patch, Gabapentin 300mg capsule, Mirtazapine 15mg tablet, Ipratropium-albuterol 0.5mg-3mg (25mg base, and thiamine 100 mg tablet among the documents scanned by admissions at 4:00Pm. On 04/21/2026 1:30 PM, R156 was observed in her room, awake and alert with the daughter and both were visibly upset. R156 said that she was admitted to the facility yesterday at 1:30PM, she did not (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive any medication the whole day until this morning. R156 stated that she was upset and up all night, she did not get her anxiety medication or her breathing treatment and ended up calling her daughter in the middle of the night. The nurse on duty kept on telling her that she is working on her medications. Resident's daughter stated that she handed her medication list from the hospital to the social worker when they arrived, and she does not understand why facility could not get her medication on time. On 04/21/2026 12:00PM, V25 (LPN) said that R156 is very upset about not getting her medication yesterday, she came around 2:00PM, V25 said that she took the initial vitals and handed it over to the afternoon shift nurse. Resident's daughter brought her, and she did not come with any packet, her medication list was not available. V25 added that some of resident's medication was in the cart this morning, V25 is not sure why she did not get her 6:00Am medication but V25 gave them to resident because it was still within the hour. On 4/21/2026 at 1:45PM V44 (Admissions Director) said that R156 arrived at the facility around 2PM with paperwork that included medication list and about 5 scripts, the documents were scanned into the system but the person at the front desk forgot to give it back to the person transporting the resident to the unit. Surveyor asked V44 to pull up the scanned documents in his computer and noted that resident's documents were scanned at 4:00PM. V44 said that the documents were scanned two hours later, and it was given to the nursing staff when they asked for it. V44 is not sure how long it takes the nurses to get medications from pharmacy. Medication administration record (MAR) for R156 showed that the following medications were not signed out as given on 4/20/2026: Mirtazapine 15mg tablet scheduled at 2100, Ativan 1mg tablet every 8 hours for anxiety, Ipratropium-albuterol 0.5mg-3mg (25mg base) for wheezing, Lomotil oral tablet 2.5-0.25mg. 1 tablet by mouth every 6 hours for diarrhea, and Albuterol 90mcg/actuation inhaler, inhale 1 puff into lungs every 4 hours as needed for wheezing. On 4/22/2026 at 2:07PM, V2 (DON) said that when a new resident is admitted , the nurse is supposed to send the medication list to pharmacy after verifying the medication with the physician and clarify the expected time of arrival (ETA). If the medication does not arrive on time, the nurse is supposed to pull the medication from the emergency box if it takes time for the medication to arrive. All nurses have been in-serviced, and they all have access to the emergency box. Emergency medication list provided by V2 showed that, Ativan 1mg tablet every 8 hours for anxiety, Ipratropium-albuterol 0.5mg-3mg (25mg base and Albuterol 90mcg/actuation inhaler were among the listed medications. Surveyor attempted several times to speak to the afternoon shift and night shift nurses assigned to R156 but none of them answered their phone. Surveyor informed V2 (DON) of not being able to contact the 2 nurses and she said, I have tried to call them, and they did not answer, I cannot force them to answer their phone. 2.Surveyor requested for facility policy on ordering medications for new admissions but none was provided. On 04/20/2026 at 1:33pm, R8 stated the CNA (who was later identified as V40 – CNA) was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changing him and she put him on his side facing the window and she was pushing something on his side and the next thing he knew he was on the floor, naked. R8 stated (V40) left him for about 35minutes. She came back with other staff (who was later identified as V17 – CNA and V41 CNA) and they picked him up on the floor. R8 stated he informed (V16 – Licensed Practical Nurse) the next day that he fell; and she told him he needed to go the hospital. On 04/21/2026 at 12:37pm, V17 (Certified Nursing Assistant) stated he was bringing coffee to one of his residents and noticed (V40) ran out of (R8)'s room and she (V40) said she needed to inform the nurse that he (R8) just fell. V17 stated his (R8) nurse on that day was (V25 –Licensed Practical Nurse). V17 stated he went inside the room to assess the situation, and he saw him (R8) lying on his side between his (R8) bed and the window, facing the window. V17 stated he (R8) said he was not in pain. V17 stated (V25) came and assessed him on the floor, after the nurse assessed, he (V17) and (V41- CNA) put him back to bed. V17 stated he left his room after transferring him back to his bed. V17 stated she (V40) stayed in the room. V17 stated the incident happened between 8am - 9am. V17 stated she (V25) assessed him on the floor, she (V25) knew he (R8) fell. On 04/21/2026 at 12:51pm with V1 (Administrator) as a witness. V25 stated it was during the morning shift when she (V40) approached her that he (R8) was slipping out of the bed and she (V40) was able to put him (R8) back on the bed. V25 stated she (V25) asked her (V40) if he fell and she (V40) stated no. V25 stated she (V40) said he did not touch the floor. V25 stated she did not see (V17) and (V41); and she did not assess (R8) on the floor. V25 stated she asked (R8), and he said he did not fall. On 04/21/2026 at 1:30pm with V1 as witnessed. V17 repeated his statement that he was bringing coffee to one of his residents and noticed (V40) ran out of (R8)'s room and she (V40) said she needed to inform the nurse that he (R8) just fell. V17 stated he went inside the room to assess the situation, and he saw him (R8) lying on his side between his (R8) bed and the window, facing the window. V17 stated she (V25) came and assessed him on the floor, after she assessed him, he (V17) and (V41) put him back to bed. V17 stated he left his room after transferring him back to his bed. V17 stated she (V25) assessed him on the floor, she (V25) knew he fell. On 04/21/2026 at 1:33pm, V1 stated it was the first time he was hearing about the incident and they were telling different stories. On 04/22/2026 at 9:46am, V40 (Certified Nursing Assistant) stated she was working the 7a-3pm shift. She got the towels and linens to give him a bed bath and to change the linens on his bed. V40 stated she noticed his bed sheet was wet because his indwelling urinary catheter was leaking. V40 stated it was not the urinary bag because she checked inside the bag, and it was not wet, so she knew the leak was coming from the indwelling urinary catheter. V40 stated she put the head of bed up at about 75 degrees, made sure he had his gown on; she left the room and let (V25- Licensed Practical Nurse) know his indwelling urinary catheter was leaking; she (V25) said she'd be in the room to change the indwelling urinary catheter. V40 stated she went back to the room and gave him a bed bath. She stripped the bed sheet, turned him (R8) to the left side towards the window and tucked in the clean linen under, and he rolled over the side of the bed between the window and the bed. V40 stated she went to the other side of the bed and helped him down to the floor. V40 stated she made sure he did not hit anything, and he (R8) said he was fine and did not hit anything. As she was running to get (V25), she saw (V41), and she told (V41) to watch (R8). V40 stated (V25) was in the middle of passing meds to a resident in b-wing. She (V40) told her (V25) that (R8) fell and he was on the floor. She (V25) said okay and she (V25) went to the room. V40 stated he was still on the floor by the window and she (V25) assessed him and did vitals and asked him (R8) and he said he was fine and that he did not hurt (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anything. V40 stated she was present when she (V25) assessed him on the floor. V40 stated (V41) ended up getting (V17) to help them put him back to bed. On 04/22/2026 at 10:54am, V41 (Certified Nursing Assistant) stated he was doing his rounds on the hallway and she (V40) was waiting for his (R8) nurse to come out of the other resident's room. He (V41) asked her what was going on and she (V40) informed him (V41) that (R8) fell off the bed and she has to inform his nurse (V25). V41 stated he (V41) went to (R8) room and assessed the situation. V41 stated he saw (R8) was on the floor, on the left side of the bed by the window facing the ground kind of on the side. Shortly after, she (V25), (V40) and (V17) went in the room and (V25) assessed him (R8), to make sure he was not injured. V41 stated she (V25) assessed him (R8) on the floor. After assessing him, they lowered the bed and transferred (R8) back to bed. On 04/22/2026 at 12:11pm, V2 (Director of Nursing) stated all falls should be documented so proper notification can be given to physician and family especially if resident is taking anticoagulant; to get the treatment needed in case the resident has internal bleeding or any injury; the care plan should also be updated with new intervention to prevent further falls. V2 stated the expectation is to document falls incident immediately. V2 stated she investigated his (R8) falls. She interviewed the (03/17/2026) morning shift staff and the (03/16/2026) night shift staff and they all stated he did not fall. V2 stated (V16 – Licensed Practical Nurse) completed a fall risk management on 03/17/2026. Of note, V25 who was assigned to R8 when he fell on [DATE] during the morning shift did not complete a Fall Risk Management for R8's fall. R8's admission Record documented that R8 diagnoses include but are not limited to Type 2 Diabetes Mellitus, hypertension, and spastic quadriplegia. R8's (Active Order As Of: 04/20/2026) Order Summary Report documented, in part Change urinary catheter as needed, if displaced, clogged or no urine output to ensure catheter patency as needed for catheter patency. Active R8's (02/20/2026) Minimum Data Set documented, in part Section C. – Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 14. Indicating the resident's mental status as cognitively intact. R8's (03/17/2026) Fall documented, in part Incident Location: Resident's Room. Person Preparing Report: V16 (Licensed Practical Nurse). Incident Description. Nursing Description: Upon making rounds, Resident self-reported to NOD (nurse on duty) that he had a fall the night prior. Resident Description: Resident stated I had a fall last night, and my head is hurting. Was this incident witnessed: N (NO) Notes. 3/17/2026 (R8) is at risk for fall due to the dx of myopathies, Lack of coordination, unsteadiness on feet, DM2, Anemia, encephalopathy, spastic quadriplegic cerebral palsy, anxiety, HTN, and depression. Problem: Resident stated that he fell from the bed and hits his head yesterday Monday 3/16/2026 while being changed. After completion of investigation and meeting with IDT it was determined that no fall occurred as staff had no knowledge of incident and (R8) is not able to get up unassisted. Resident was extremely confused. Of note, per V17 (Certified Nursing Assistant), V40 (Certified Nursing Assistant), and V41 (Certified Nursing Assistant) statements, they all witnessed V25 (Licensed Practical Nurse) assessed R8 while on the floor during the morning shift of 03/16/2026. R8's (Effective Range: 03/10/2026 – 03/20/2026) Progress notes were reviewed with no notes written for R8's witnessed fall on 03/16/2026. (continued on next page)

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	145681	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Crestwood	13259 South Central Avenue Crestwood, IL 60418

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's (11/17/2025) care plan documented, in part is at risk for falls decline in mobility and recent hospitalization. will remain free from falls through. Intervention: Notify MD and family of any new fall. Of note, careplan was not updated with a new fall. The (undated) Residents' Right For People in Long Term Care Facilities documented, in part As a long-term care resident in the State, you are guaranteed certain rights, protection, and privileges according to state and federal laws. Your rights to dignity and respect. Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide services to keep your physical and mental health, at their highest practical levels. The (2/2026) Fall Prevention and Management documented, in part This facility is committed to maximizing each resident's 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 preventive strategies, and facilitate as safe and environment as possible. All resident falls shall be reviewed, and the residents existing plan of care share shall be evaluated and modified as needed. Facility guidelines following a fall incident: 1. Evaluate the resident for any injury and notify the physician and emergency contact.2. Complete a full incident report in the PCC risk management portal. 3. Our fall risk evaluation is completed by the nurse. 4. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence. Local pharmacy orders policy dated July 2024 stated in part: Emergency pharmaceutical services will be available at all times. An emergency need for medication will be met by using facility's approved contingency supply or by sending an emergency order to local RX pharmacy. Procedure: When an emergency or STAT order is received, the nurse will determine if the medication is in the emergency dispensing kit by referring to the list of contents posted on it. If the medication is not available, an emergency delivery can be requested by faxing a stat order to the pharmacy. The pharmacy will deliver the emergency or stat medications as soon as possible, usually within 2 to 4 hours. Job description for registered nurses (RN) and practical licensed nurses (LPN) (undated) documents in part: Basic Function: Under the direction of the physician, is responsible for total nursing care to all residents on assigned unit during the assigned shift including responsibility for delegation of duties, resident nursing care, staff performance and adherence by staff members to facility policies and procedures. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Essential Duties 1. Participate in the development and implementation of individualized patient care plan for the residents with allied health team members. 9. Recognize significant changes in the condition of residents and take necessary action. 10. Document nursing care rendered, resident response, and all other pertinent and necessary data as outlined in facility's policies and procedures.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to implement individualized fall prevention intervention for a resident identified at risk for falls, failed to prevent falls during provision of ADL (activities of daily living) care, and failed to ensure oxygen tanks were secured in the storage room. These failures affected two (R4 and R8) residents and have the potential to affect all 17 residents in Unit C Wing. Findings include: 1) On 04/20/2026 at 1:33pm, R8 stated the CNA (who was later identified as V40 – CNA) was changing him and she put him on his side facing the window and she was pushing something on his side and the next thing he knew he was on the floor, naked. R8 stated (V40) left him for about 35minutes. She came back with other staff (who was later identified as V17 – CNA, V25 (Licensed Practical Nurse), and V41 CNA) and they picked him up on the floor. R8 stated he informed (V16 – Licensed Practical Nurse) the next day that he fell; and she told him he needed to go the hospital. On 04/22/2026 at 9:46am, V40 (Certified Nursing Assistant) stated she was working the 7a-3pm shift. She got the towels and linens to give him a bed bath and to change the linens on his bed. V40 stated she noticed his bed sheet was wet because his indwelling urinary catheter was leaking. V40 stated it was not the urinary bag because she checked inside the bag, and it was not wet, so she knew the leak was coming from the indwelling urinary catheter. V40 stated she put the head of bed up at about 75 degrees, made sure he had his gown on; she left the room and let (V25- Licensed Practical Nurse) know his indwelling urinary catheter was leaking; she (V25) said she'd be in the room to change the indwelling urinary catheter. V40 stated she went back to the room and gave him a bed bath. She stripped the bed sheet, turned him (R8) to the left side towards the window and tucked in the clean linen under, and all of the sudden he fell over the side of the bed. He was between the bed and the window. V40 stated she went to the other side of the bed and helped him down to the floor. V40 stated she made sure he did not hit anything, and he (R8) said he was fine and did not hit anything. This surveyor inquired what contributed to the fall. V40 stated his mattress was wet because his indwelling urinary catheter was leaking and she was tucking fresh linen underneath him while he was on his side, the mattress was wet because of the urine and he slipped. V40 stated she should not have tucked the linen underneath him while he was on his side with a wet mattress. She should have dried the mattress first so he would not slipped and rolled over. V40 stated it is not expected of a resident to fall during ADL (Activities of Daily Living) care. On 04/22/2026 at 10:54am, V41 (Certified Nursing Assistant) stated he was doing his rounds on the hall and she (V40) was waiting for his (R8) nurse. He (V41) asked her what was going on and she (V40) informed him (V41) that (R8) fell off the bed. V41 stated he (V41) went to (R8) room and assessed the situation. V41 stated he saw (R8) was on the floor, on the left side of the bed by the window facing the ground kind of on the side. V41 stated he asked (V40) what happened and she stated she was doing a bed bath and he rolled out of the bed. V41 stated it was not expected of a resident to fall while performing adl care. V41 stated what contributed to the fall was, he (R8) was using a low air loss mattress, the mattress was wet and she rolled him on his side; there is a high tendency for a resident to fall and injure self because the mattress is slippery when wet. V41 stated best practice is to keep the mattress dry before turning the resident on their side to prevent them from slipping and rolling out of bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/22/2026 at 12:20pm, V2 (Director of Nursing) stated it is not expected of a resident to fall during ADL (Activities of Daily Living) care. The expectation is not to roll a resident on a wet mattress, especially a low air loss mattress, to prevent falls because if the mattress is wet, it becomes slippery, and the resident will slip. V2 stated the CNAs are not expected to put fresh linen if the mattress is wet with urine; the expectation is to make sure the mattress is clean and dry before putting fresh linen in. R8's admission Record documented that R8 diagnoses include but are not limited to Type 2 Diabetes Mellitus, hypertension, and spastic quadriplegia. R8's (Active Order As Of: 04/20/2026) Order Summary Report documented, in part Change urinary catheter as needed, if displaced, clogged or no urine output to ensure catheter patency as needed for catheter patency. Active R8's (02/20/2026) Minimum Data Set documented, in part Section C. – Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 14. Indicating the resident's mental status as cognitively intact. Section G. Functional Abilities. GG 0170. Mobility. A. rolling left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed. 01 - Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Section H – Bladder and Bowel. H0100. Appliances. A. Indwelling catheter. R8's (11/17/2025) care plan documented, in part is at risk for falls decline in mobility and recent hospitalization. will remain free from falls through. Intervention: Notify MD and family of any new fall. R8's (11/17/2025) careplan documented, in part requires use of an indwelling catheter r/t (related to) Dx (diagnosis) Neurogenic Bladder. R8's (11/17/2026) careplan documented, in part At risk for skin complications r/t comorbidities including but not limited to impaired mobility, incontinence of bowel, cerebral palsy, contractures. Intervention: Use pressure redistribution surface if bed-or chair-bound. R8's (11/18/2025) care plan documented, in part has Alteration in musculoskeletal status r/t DX GOUT , dx Scoliosis. Intervention: Monitor for risk of falls. Educate resident, family /caregivers on safety measures that need to be taken in order to reduce risk of falls. R8's (12/03/2025) careplan documented, in part Wound healing /may be delayed related to Diabetes Mellitus, Immobility, Incontinence. Intervention: Pressure redistribution mattress. Keep linen clean, dry and wrinkle free. 2) R4's face sheet documents in part the following diagnoses: cerebral infarction, hemiplegia, pneumonia, dependence on supplemental oxygen, disorder of kidney and ureter, type 2 diabetes mellitus, hyperlipidemia, and morbid (severe) obesity. R4 is a DNR and on hospice service since 2/10/26. On 04/20/2026 11:20AM, R4 is alert and oriented to person with a BIM's score of 4. Observed R4 laying in bed in high position. R4 stated he cannot lower or raise the bed. Observed there was no thick floor mat to the right side of R4's bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/20/2026 2:50 PM, observed R4 in bed with mid-level height and no thick floor mat next to resident's bed. Observed 2 thick mattresses folded and upright by the resident's door. On 4/21/26 10:46 AM, no thick floor mattress to right side of R4's bed. The care plan dated 12/12/25 indicates resident has mattress in room. On 4/21/26 3:04 PM, observed V10 (Unit 2 Supervisor) placing thin floor mat in R4's room. Noted the 2 thick mattresses were missing. V10 (Unit 2 Supervisor) stated 2 mattresses were delivered on 4/20/26 and one was for R4 but both were taken back by accident. On 04/20/2026 11:20AM, R4's face sheet documents in part the following diagnoses: cerebral infarction, hemiplegia, pneumonia, dependence on supplemental oxygen, disorder of kidney and ureter, type 2 diabetes mellitus, hyperlipidemia, and morbid (severe) obesity. R4 is a DNR and on hospice service since 2/10/26. R4 is on Enhanced Barrier Precautions (EBP). R4 is alert and oriented to person with a BIM's score of 4. R4 laying in bed in high position. R4 states he cannot lower or raise the bed. R4 is a hoyer lift with 2 person assistance. Surveyors observed there was no thick floor mat to the right side of R4's bed. On 04/20/2026 2:50 PM, R4 is in bed with mid-level height and no thick floor mat next to resident's bed. Observed 2 thick mattresses folded and upright by the resident's door. On 4/21/2026 10:46 AM, no thick floor mattress to right side of R4's bed. The care plan dated 12/12/25 indicates resident has mattress in room. On 4/21/2026 3:04 PM, observed V10 (Unit 2 Supervisor) placing thin floor mat in R4's room. Noted the 2 thick mattresses were missing. V10 (Unit 2 Supervisor) stated 2 mattresses were delivered on 4/20/26 and one was for R4 but both were taken back by accident. On 4/22/2026 10:50 AM, R4 had thin floor mat to the right side of R4's bed. On 4/22/2026 5:00 PM, reviewed facility's falls' logs from January 2026 to current. R4 had two falls. Fall occurred on 2/6/2026 22:30 (10:30 PM) and on 4/20/2026 04:45 (4:45 a.m.). R4's falls incident report dated 2/6/2026 22:30 (10:30 PM) noted R4 observed on the side of the bed on the floor. R4 stated he was trying to reach for the bed remote. R4 verbalized hitting his head and had pain to bilateral lower extremities (BLE). Physician notified and staff received order to send R4 to the hospital for further evaluation. R4's incident report dated 4/20/2026 04:45 (4:45 AM) noted nursing observed R4 sitting on the floor on the side of the bed on the right side. R4 denied hitting his head. Note indicates R4 is confused and unable to give description of events. 3) Facility census, dated 4/20/26, documents 17 residents residing on the C Wing Unit 2 hall. On 4/20/26 at 10:14am, upon observation of the C Wing Unit 2 storage room with V18 (Housekeeping Aide), 2 unsecured oxygen tanks (1-approximately 1/4 full; 1-approximately half full) were observed on the floor. Also observed were 7 other secured oxygen tanks. V18 said that V18 would notify the nurse about the 2 unsecured oxygen tanks because we (facility) don't need things exploding. On 4/20/26 at 10:54am, upon observation of the C Wing Unit 2 storage room with V19 (Licensed Practical Nurse/LPN), the same 2 unsecured oxygen tanks (1-approximately 1/4 full; 1-approximately half full) were observed on the floor. V19 said, These oxygen tanks need to be in rack with others (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(oxygen tanks). V19 preceded to pick up and place the 2 unsecured oxygen tanks in the oxygen racks and replied, They (oxygen tanks) should be in the racks, so they (oxygen tanks) don't tip over and explode. On 4/22/26 at 4:08pm, V2 (Director of Nursing/DON) said, The tanks (oxygen tanks) should be on a rack, so they (oxygen tanks) are secured. Oxygen tanks are combustible, so the rack secures the tank (oxygen) and prevents that (combustion). Record review of facility policy titled, Oxygen Cylinder, dated 1/2026, documents, in part, Standards for the safe handling of cylinder gases are set by the national fire protection association (NFPA) and regulated by the Compressed Gas Association (CGA). AdministrativeAuthorities shall ensure that these standards and any others that apply are met. Storage of Oxygen Cylinders: Store in designated oxygen storage area, Oxygen cylinders must be protected from mechanical shock, falling objects, etc. Record review of facility policy titled, Oxygen Therapy, dated 2/2026, documents, in part, Oxygen therapy may be provided through various types of supply and delivery systems. Equipment may include the provision of oxygen through nasal cannulas, trans-tracheal oxygen catheters, oxygen canisters, cylinders or concentrators. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must be safe, clean, comfortable, and homelike. The (undated) Residents' Right For People in Long Term Care Facilities documented, in part As a long-term care resident in the State, you are guaranteed certain rights, protection, and privileges according to state and federal laws. Your rights to dignity and respect. Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide services to keep your physical and mental health, at their highest practical levels. The (2/2026) Fall Prevention and Management documented, in part This facility is committed to maximizing each resident's 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 preventive strategies, and facilitate as safe and environment as possible.