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	06/02/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to respect the resident's right of confidentiality of their personal health information, failed to dispose of personal health information in a manner that renders the information unreadable, indecipherable and otherwise unreconstructable. This failure affected five (R14, R16, R17, R18, and R19) residents in a sample of five reviewed during medication administration and has the potential to affect all 34 residents that reside in the unit 2 assignment. Findings include: R14's face sheet documents R14 is a [AGE] year-old resident with diagnoses including: type 2 diabetes mellitus, morbid obesity, cardiomegaly, chronic obstructive pulmonary disease, atopic dermatitis, spinal stenosis, chronic diastolic heart failure, atrial fibrillation, hypothyroidism, fibromyalgia, major depressive disorder, and anxiety disorder. On 5/20/2026 at 9:30 AM, observed medication pass with V35 (Licensed Practical Nurse). V35 withdrew R14's medications from the cart. The medications were packed into individual plastic sleeves that contained R14's name, medication, and dosing. V35 opened the top of each sleeve and placed the medications into a plastic medication cup. V35 disposed of R14's into the garbage receptacle on the cart. Observed R14's name, medication and dosing information while in the trash can. The garbage receptacle was approximately 60% full of other discarded resident's plastic sleeves that contained personal health information. R18's face sheet documents R18 is a [AGE] year-old resident with diagnoses including: non-traumatic intracerebral hemorrhage, type 2 diabetes mellitus, morbid obesity, hemiplegia of unaffected side, basal cell carcinoma, atopic dermatitis, chronic pain syndrome, atrial fibrillation, and hypertension. On 5/20/2026 at 9:54 AM, V35 withdrew R18's medications from the cart. The medications were packed into individual plastic sleeves that contained R18's name, medication, and dosing. V35 opened the top of each sleeve and placed the medications into a plastic medication cup. V35 disposed of R18's into the garbage receptacle on the cart. Observed R18's name, medication and dosing information while in the trash can. R17's face sheet documents R17 is a [AGE] year-old resident with diagnoses including: Ogilvie syndrome, moderate protein calorie malnutrition, anemia, enterocolitis due to clostridium difficile, acute kidney failure, cachexia, hypoxemia, major depressive disorder, anxiety disorder, and unspecified psychosis. On 5/20/2026 at 9:58 AM, V35 withdrew R17's medications from the cart. The medications were packed into individual plastic sleeves that contained R17's name, medication, and dosing. V35 opened the top of each sleeve and placed the medications into a plastic medication cup. V35 disposed of R17's into the garbage receptacle on the cart. Observed R17's name, medication and dosing information while in the trash can. R19's face sheet documents R19 is a [AGE] year-old resident with diagnoses including: chronic obstructive pulmonary disease, muscle wasting and atrophy, multiple sclerosis, type 2 diabetes mellitus, quadriplegia, osteoarthritis, and metabolic encephalopathy. On 5/20/2026 at 10:07 AM, V35 withdrew R19's medications from the cart. The medications were packed into individual plastic sleeves that contained R19's name, medication, and dosing. V35 opened the top of each sleeve and placed the medications into a plastic medication cup. V35 disposed of R19's into the garbage receptacle on the cart. Observed R19's name, medication and dosing information while in the trash can. R16's face sheet documents R16 is a [AGE] year-old resident with prior diagnoses, including but not limited to: systemic lupus erythematosus, (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	osteomyelitis, type 2 diabetes mellitus, anemia in chronic kidney disease, obesity, sickle cell disease, chronic kidney disease, acquired absence of left and right legs, and osteoarthritis. On 5/20/2026 at 10:25 AM, V35 withdrew R16's medications from the cart. The medications were packed into individual plastic sleeves that contained R16's name, medication, and dosing. V35 opened the top of each sleeve and placed the medications into a plastic medication cup. V35 disposed of R16's into the garbage receptacle on the cart. Observed R16's name, medication and dosing information while in the trash can. On 5/20/2026 at 10:30 AM, V35 accessed R16's electronic health record. V35 affirmed V35 needed to obtain another medication from the refrigerator to administer to R16. V35 left the medication cart and left the electronic health record open and unlocked on the medication administration record, which would allow any passerby access to any resident's personal health information. Observation was confirmed with V35. V35 affirmed the record should be closed when not in use. On 5/20/2026 at 10:45 AM, observed the discarded medication sleeves that contained residents' name, medication and dosing with V35. Observation confirmed with V35. V35 affirmed the information on the sleeves contained protected health information. V35 explained the procedure for the disposal of the sleeves is to tie the sleeves and place them in the garbage can. V35 stated, That's what we (nurses) all do. Is there something different we are supposed to be doing?. V35 denied staff ever ensure the personal health information is unreadable, indecipherable or otherwise unreconstructable when disposing of the used medication sleeves. On 5/21/2026 at 1:23 PM, V2 (Director of Nursing) affirmed the sleeves of the medication have personal health information. V2 explained after a nurse dispenses medication from the sleeve, the expectation is the sleeve is disposed of in a shredder or other manner that would ensure the resident's health information could not be read or reproduced. V2 affirmed nurses should not be disposing the discarded sleeves in the trash can. Facility policy titled, HIPAA Privacy and Security Policy (1/1/2025) documents the purpose of the policy is to ensure compliance with the Health Insurance Portability and Accountability Act of 1996 as well as applicable federal and state privacy/security regulations. Definitions follow 45 C.F.R. S 160.103 and subsequent applicable federal rules,including: PHI includes all individually identifiable health information, whether oral, written, orelectronic . 5. SAFEGUARDS FOR PHI & EPHI Facility will implement administrative, physical, and technical safeguards, including Encrypted storage and transmission of PHI, Multi-factor authentication (MF A) for system access, Endpoint detection and response (EDR) solutions, Secure disposal of PHI per current [NAME] guidelines. There is no safeguards listed for safeguards of written PHI. 9. INDIVIDUAL RIGHTS Facility recognizes and supports patient rights to: Access their PHI in the format requested (electronic or hard copy), Request amendments, Request restrictions on disclosures, Obtain accounting of disclosures, Receive electronic PHI via email upon request. This policy does not identify the resident's rights to the resident's right to privacy and confidentiality of their personal medical records. Review of Illinois Long-Term Care Ombudsman Program's Residents' Rights for People in Long-Term Care Facilities (revised 11/2018) documents residents have the right to privacy and confidentiality of their personal and medical records.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 staff failed to administer subcutaneous injections in accordance with the facility's procedure for subcutaneous injections and in accordance with professional standards for subcutaneous injections. This failure affected one (R16) in a sample of five residents reviewed for medication administration. Findings include: R16's face sheet documents R16 is a [AGE] year-old resident with prior diagnoses, including but not limited to: systemic lupus erythematosus, osteomyelitis, type 2 diabetes mellitus, anemia in chronic kidney disease, obesity, sickle cell disease, chronic kidney disease, acquired absence of left and right legs, and osteoarthritis. R16's minimum data set (4/13/2026) documents in part a brief interview of mental status summary score of 13, indicating R16 is cognitively intact. R16's care plan (4/23/2025) identifies R16 has renal failure due to chronic kidney disease, has alterations in hematological status related to anemia and is at risk for complications. Both identified care needs have interventions including giving medications as ordered by R16's physician. R16's physician orders (3/13/2026) document an active order for Epoetin Alfa Injection Solution (Epoetin Alfa) Inject 3000 unit subcutaneously one time a day every Monday, Wednesday and Friday for anemia. On 5/20/2026 at 10:39 AM, observed V35 (Licensed Practical Nurse) draw up 3000 units of Epoetin into a syringe with a subcutaneous needle. V35 entered R16's room and cleansed the lower right quadrant of R16's abdomen with an alcohol pad. V35 grabbed R16's skin and held the syringe at an approximately 15-degree angle, flush to R16's skin. V35 injected the medication at the 15-degree angle into R16's skin. R16 stated, I didn't even feel anything. I like when (V35) does (injects) it because I never feel anything. On 5/20/2026 at 10:45 AM, V35 recalled administering R16's Epoetin at a 15-30-degree angle. V35 was not sure what angle subcutaneous injections are performed. V35 stated, I can't remember maybe 5-10 degrees?. On 5/21/2026 at 1:23 PM, V2 (Director of Nursing) explained subcutaneous injections need to be administered at a 90-degree angle as the nurse pinches the resident's skin. V2 explained the purpose of the injection being at a 90-degree angle is to ensure the medication is delivered to the right area of the skin (subcutaneous tissue) so it is properly absorbed. If the medication is not delivered to the right area, it may not be as effective.On 5/27/2026 at 12:53 PM, V24 (Medical Director) affirmed V24 is the medical director for the facility. V24 affirmed the purpose of Epoetin Alfa is to increase red blood cell production to treat patients that have anemia, or chronic kidney disease. V24 confirmed Epoetin Alfa is administered as a subcutaneous injection. V24 was unsure what would happen if the medication was not administered correctly into the subcutaneous tissue or wrongly injected into another area of the skin like the dermis. V24 assumed the medication would not be as effective. V24 was informed V35 injected the Epoetin Alfa at the 15-degree angle into R16's skin. V24 affirmed staff should be injecting medication in accordance with professional standards and stated, that (injecting at the wrong angle) scares me a little. Review of FDA label prescribing information for Epogen (epoetin alfa) (9/2017) documents Epogen is indicated for the treatment of anemia due to chronic kidney disease (CKD), including patients on dialysis and not on dialysis to decrease the need for red blood cell (RBC) transfusion and is an injection for subcutaneous or intravenous use. Record review of the National Library of Medicine's Medline Plus Medical Encyclopedia's (An official website of the United States Government) page titled Subcutaneous (SQ) injections documents, Subcutaneous (SQ or Sub-Q) injection means the injection is given in the fatty tissue, just under the skin . The following steps should be followed when injecting the medicine (subcutaneously): -With the hand that is not holding the syringe, pinch an inch (2.5 cm) of skin and fatty tissue (not the muscle) between your fingers. - Quickly insert the needle all the way into the pinched skin at a 90-degree angle (45-degree angle if there is not much fatty tissue). -Once the needle is all the way in, release the skin. -Inject all the medicine by pushing in the plunger. -Once the medicine is all in, pull out the needle quickly . Some soreness is expected at the injection site. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This article was peer reviewed by multiple board-certified physicians on 10/19/2025 and developed in accordance with several references to evidence-based standards of practice. (retrieved at https://medlineplus.gov/ency/patientinstructions/000430.htm)Facility procedure for subcutaneous medication administration (7/2024) documents the purpose of medications administered via subcutaneous injection is when a rapid, systemic effect is desired and to administer medications that cannot be given orally. The procedure indicates the staff member should complete hand hygiene, apply gloves, draw up the medication into a syringe using a 23-gauge needle (or smaller), cleanse the site with alcohol prep, grasp/pinch a cushion of flesh while inserting the needle quickly at a 45-degree angle, bevel side up. After, medication should be injected slowly, and the needle removed from the skin. This policy does not meet standards of practice as evidenced by current standards being injected at a 90-degree angle, unless the resident does not have sufficient fatty tissue.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure facility staff were trained properly on CPR; failed to ensure staff initiated appropriate emergency response for a resident; failed to promptly activate Emergency Medical Services (EMS)/911 upon discovering an unresponsive resident; failed to accurately assess for the presence or absence of a pulse; and failed to perform uninterrupted cardiopulmonary resuscitation (CPR) for one (R4) of seven residents reviewed for cardiopulmonary resuscitation. These facility failures resulted in R4 not receiving uninterrupted CPR and emergency care prior to EMS arrival and has the potential to affect all 91 full code residents residing in the facility.Findings include: Record review of facility document untitled, dated [DATE], documents 91 full code residents residing at the facility. R4's face sheet documents R4 was admitted to the facility on [DATE] and documents the following diagnoses: encephalopathy, generalized muscle weakness, muscle wasting/atrophy, cognitive communication deficit, chronic kidney disease, seizures, and repeated falls. R4's minimum data set ([DATE]) documents a brief interview of mental status summary score of 10, indicating R14 was cognitively impaired and required partial to moderate assistance with activities of daily living. R4's minimum data set ([DATE]) indicates R4 died within the facility. R4's admission Evaluation ([DATE]) documents R4 was at high risk for falls due to impaired memory/judgement, history of falls, predisposing conditions such as HTN, CVA, Parkinson, Hypotension, Seizure, Osteoporosis, Unsteady gait and/or use of ambulatory device (cane, walker, wheelchair), age greater than 75, and incontinence. R4's advanced directives in the assessment indicate R4 is a full code. R4's Change in Condition Evaluation ([DATE]) documents on [DATE] at 5:50 AM, R4 had a functional status change including a fall with suspected serious injury, was unresponsive, had a laceration to the left side of the forehead. R4's blood pressure and pulse were zero. EMS was initiated and R4 was sent to the emergency department for evaluation. R4's progress notes document on [DATE], R4 was having a change in condition including Bleeding (other than GI), Falls Unresponsiveness. Recommendations and interventions include activating EMS for transport to the hospital. There was no narrative description of the incident/fall within the progress or nurse's notes nor was there indication that CPR was initiated. Record review of R4's Ambulance Run Sheet, dated [DATE], documents, in part, Unit Notified: [DATE] 6:06am; At the scene [DATE] 6:14am. In summary crew of 2302 was dispatched to the above location for a fall. Crew noted a 2-inch laceration to the left side of pts (R4) forehead that was no longer actively bleeding. Crew noted the blood in pts (R4) hair had already coagulated. Staff stated they began CPR between 5-10 minutes ago. Staff said the event was unwitnessed and they had walked into pt (R4) room and found him (R4) on the floor pulseless. Staff stated pt (R4) was last seen in bed between 4:00am to 5:00am. Staff was unable to provide exact time pt (R4) was last seen alive. Crew was informed by pts (R4) roommate (R6) that he (R6) heard pt fall between 4:00am to 4:30am. Crew placed pt (R4) on cardiac monitor and crew interpreted rhythm as asystole. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's hospital records, dated [DATE], documents, in part, Pt. (patient/R4) found down and pulseless after unwitnessed fall at his (R4) nursing home. Last known well was several hours before. Per EMS (emergency medical services) patient (R4) LKN (last known normal) was 4:00am to 5:00am. (R4), with a history of dementia, was admitted following an unwitnessed fall at his (R4) nursing home and subsequent pulseless electrical activity cardiac arrest requiring prolonged CPR (cardiopulmonary resuscitation) and multiple rounds of epinephrine before return of spontaneous circulation was achieved. Family ultimately decided to go comfort focused care and the patient ultimately passed at 3:17 PM on [DATE]. DNR status confirmed. Time of Death: 3:17pm Date: [DATE]. R4's FRI (facility reported incident), dated [DATE], documents, in part, (R4) is incontinent of bowel and bladder; he (R4) has impaired mobility and requires assistance with ADL (activities of daily) care and transfers as W/C (wheelchair) is the primary source of transportation. (R4) was observed laying on the floor on his left side in front of the dresser, head towards the window, feet pointed towards the door, brief soiled with urine. He (R4) had non-skid footwear. After interviewing staff and meeting with IDT, it was determined that the cause of the fall was secondary to cardiac arrest. (R4) was last seen by the nurse at approximately 5:20am at which time he (R4) was lying asleep in bed. Sent to ER (emergency room). (R4) later expired at (hospital). On [DATE] at 10:14am, R6 (R4's roommate), BIMS of 13, said, Oh yeah, my roommate (R4) was an older man. He (R4) fell the first day I was here (facility). I heard a boom and seen R4 on the floor. I pushed the call light button and looked at the clock and it about 4ish. Yeah. 4 in the morning. Surveyor observed a clock hanging on the wall, across from R6's bed. Surveyor noted that the clock currently had the correct time. R6 stated, My roommate's (R4) head was near my bed and blood was coming from his (R4) head. No one (staff) was coming. I did try to yell for help, but I was in a lot of pain. They (staff) didn't come for like 2 hours. I looked at the clock, and it was almost 6:00am. R6 had tears in his eyes and said, I wish I could have helped him (R4). I know CPR. R6 further stated, The nurse (V9/RN) finally came in and screamed, What happened?! Finally, staff came and were trying to save him (R4). Then the paramedics showed up and took over. On [DATE] at 1:41pm, V9 (Registered Nurse/RN) said, The last time I physically saw him (R4) was around 5:20am. I just peaked my head in the room and saw him (R4) sleeping. At that time, I went to another room to complete medication pass and a dressing change. Later, I noticed his (R4) call light was on and observed him (R4) on the floor. I assessed him (R4) and found him (R4) unresponsive. I initiated CPR, and 911 arrived shortly afterward and took over care. When I saw R4 and began CPR, I yelled for someone to call 911 and initiate the emergency response/code call procedure. The supervisor (V13) called 911. I documented the previous day vital signs when I transferred him (R4) out because when we (staff) found him on the floor, we (staff) were unable to obtain current vital signs because we (staff) immediately initiated CPR and emergency interventions. I mean, yeah they (R4's vital signs charted on [DATE] at 5:50am) were not his (R4) vital signs when we (staff) coded him (R4) because he (R4) didn't have any vitals. R4's eINTERACT SBAR Summary for Providers, dated [DATE] at 5:50am, documents, in part, At the time of evaluation resident/patient vital signs were Blood Pressure:113/60 - [DATE] 10:04pm, Pulse: 70 - [DATE] 10:04pm, RR (respiratory rate):17.0 - [DATE] 10:04pm; and Temp: 97.8 - [DATE] 10:04pm. On [DATE] at 12:11pm, V9 (Registered Nurse/RN) said, When I left the room, I went to answer R4's call light because I noticed it was on. I stepped inside the room and seen R4 on the floor bleeding. I assessed R4, couldn't find a pulse, and screamed out the door for help. I called V34 (Licensed (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	affirmed respirations are assessed by counting the rise and fall of the chest. On [DATE] at 3:32pm, V32 (Licensed Practical Nurse/LPN) said, The last time I was trained on CPR was today ([DATE]). When asked the ratio of chest compressions to breathes for AHA BLS CPR, V32 replied 20:2 (30:2 is the correct ratio). On [DATE] at 1:19pm, V10 (Certified Nursing Assistant/CNA) said, The 2 high risk fall residents were being monitored at the nurse's station the whole night. I was told one of them (residents) had Xanax or something discontinued which was why she was up all night. Yes, the residents were being monitored at the nurse's station from 11:00pm to 7:00am, the whole shift. No, I can't answer call lights if I'm monitoring residents at the nurse's station. Someone (staff) else would have to get the light. Can't remember the names (resident being monitored at the nurse's station). We could use another CNA at night, because some of these residents should be 1:1, but they (facility management) are not allowing them to be 1:1. On [DATE] at 9:25am, V34 (Licensed Practical Nurse/LPN) said, Yes, she (V9/RN) called me on cellphone, and I answered right away and asked to call a code blue for R4, so I overhead paged code blue for R4. I did it (overhead page) twice. She (V9/RN) could have called her (V9) unit floor. We're not required to have a phone on us. She (V9) would have to come out of room and go to nurse's station to make a call. If she (V9) has to go out the room that would delay CPR. On [DATE] at 11:56am, V24 (Medical Director) said, I think a delay in assessing the resident (R4) is the problem and is a big issue. If it took that long, that's on the facility. That's bad. Code Blue status, I do the carotid pulse and jump on CPR on spot. A lot of benefits, mortality benefit, to start CPR immediately and not interrupted. Check blood sugar. The minute I get the pulse back; I take the blood pressure. If no pulse, don't stop CPR whatsoever. Delay in care can be a serious problem. Record review of American Heart Association BLS CPR Guidelines, dated 2025, documents in part, 1. Verify unresponsiveness: Check for responsiveness, Assess breathing and pulse simultaneously for no more than 10 seconds; 2. Activate emergency response: Call 911 or activate the emergency response system and obtain an AED immediately. Begin high-quality CPR : Compression rate: 100–120 compressions per minute, Compression depth: at least 2 inches (5 cm) in adults, Allow complete chest recoil, Minimize interruptions., Compression fraction should be greater than 80%; 3. Compression-to-ventilation ratio: Adults without an advanced airway, 30 compressions : 2 breaths (single or multiple rescuers)., Deliver enough air to produce visible chest rise and avoid excessive ventilation. 4; Use an AED as soon as available. AHA continues to stress that CPR should begin immediately and interruptions should be minimized. Healthcare providers are encouraged to perform both compressions and ventilations for adult cardiac arrest. Record review of facility policy titled, Call Light Response, dated 2/2026, documents, in part, Code Blue, dated 5/2025, documents, in part, A code is initiated for all residents requiring emergency medical attention. If a resident requires emergency medical attention then a Code Blue should be announced. Upon finding a person without respirations and/or a pulse, call for help and confirm presence/absence of ADVANCE DIRECTIVES/CODE STATUS. If the resident is not a DNR, then a CODE BLUE should be announced and start CPR. When announcing a code blue, state the unit, room number or place. The bring the closest crash cart to the area of the code. As staff arrive the DON or designee should assign staff to the following items: a. Someone to call 911 b. Someone to assist with CPR c. Someone to notify the physician and family d. Someone to start the transfer form, get the paperwork together and notify the hospital. e. Someone to hold the elevator on the first floor, if applicable. f. Someone to remove other residents from the area and ensure there is a clear path for (continued on next page)

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	145681	A. Building B. Wing	06/02/2026

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the paramedics. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, 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 equal access to quality care regardless of diagnosis. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.

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F 0684 Level of Harm - 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 follow their facility policies and protocols, failed to implement fall care plan interventions failed to follow basic life support/CPR protocol, failed to provide sufficient rounding/supervision to ensure resident's needs were met, and failed to provide care and services in accordance with professional standards of practice needed for one resident that required life sustaining services after experiencing a fall. The facility also failed to provide a working call light for one (R25) resident. These failures affected two (R4 and R25) of six residents reviewed for quality of care. These failures resulted in R4 experiencing an unwitnessed fall and sustaining life-threatening injuries and subsequence death due to left frontal scalp/periorbital hematoma, acute L1 anterior vertebral body fracture with mild retropulsion, acute fracture along anterior/superior end plate at C7 with widening of the anterior C7-T1 disk space and widening of C7-T1 facet joints. R4 remained unattended on the floor for a prolonged period following traumatic injuries. R4 expired on [DATE] as a result of these injuries. Findings include: R4's death certificate documents cause of death as fall and complications of spinal injuries. R4's face sheet documents R4 was admitted to the facility on [DATE] and documents the following diagnoses: encephalopathy, generalized muscle weakness, muscle wasting/atrophy, cognitive communication deficit, chronic kidney disease, seizures, and repeated falls. R4's minimum data set ([DATE]) documents a brief interview of mental status summary score of 10, indicating R4 was cognitively impaired and required partial to moderate assistance with activities of daily living. R4's minimum data set ([DATE]) indicates R4 died within the facility. R4's hospital records, dated [DATE], (prior to admission to the facility), documents, in part, (R4) brought to the ED (emergency department) by the EMS (emergency medical services) with complaint of fall and altered mental status concerning for new onset seizure with postictal encephalopathy. CT head on admission with no evidence of acute abnormalities. Chest x-ray with no evidence of focal infiltrates, consolidation or pleural effusion. R4's FRI (facility reported incident), dated [DATE], documents, in part, (R4) is incontinent of bowel and bladder; he (R4) has impaired mobility and requires assistance with ADL (activities of daily) care and transfers as W/C (wheelchair) is the primary source of transportation. (R4) was observed laying on the floor on his left side in front of the dresser, head towards the window, feet pointed towards the door, brief soiled with urine. He (R4) had non-skid footwear. After interviewing staff and meeting with IDT, it was determined that the cause of the fall was secondary to cardiac arrest. (R4) was last seen by the nurse at approximately 5:20am at which time he (R4) was lying asleep in bed. Sent to ER (emergency room). (R4) later expired at (hospital). R4's FRI (facility reported incident), date reported [DATE], documents, in part, (R4) is incontinent of bowel and bladder; he (R4) has impaired mobility and requires assistance with ADL (activities of daily) care and transfers as W/C (wheelchair) is the primary source of transportation. (R4) was observed laying on the floor on his left side in front of the dresser, head towards the window, feet pointed towards the door, He (R4) had non-skid footwear. R4 was taken to (Hospital) admitted to ICU with Cardiac Arrest, Laceration to Right side of forehead (eyebrow) with 3 staples and 3 sutures, there was no intracranial/subdural hemorrhages and Hypoxic Ischemic Encephalopathy. X0ray report revealed 1. Acute bilateral pulmonary emboli within the right hear strain. 2. Acute L1 anterior vertebral body fracture. 3. Acute non-displaced right anterior 3-6 rib fracture. 4 Acute fracture C7-T1. (R4) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	expired on [DATE] 3:17pm. It was determined that the cause of the fall was secondary to Acute Bilateral Pulmonary Embolisms, and Cardiogenic Shock, STEMI. R4 has a history of CVA and Bilateral PE's caused him to collapse; he (R4) became unresponsive and ultimately arrested; and hit his head on the dresser when he fell causing left side eyebrow laceration causing 3 staples and 3 sutures, rib fractures 3-6, and C7-T1 fractures are consistent with the initiation of chest compressions and use of the [NAME] Chest Compression device as well as multiple rounds of CPR performed in ED. R4's admission Evaluation ([DATE]) documents R4 was at high risk for falls due to impaired memory/judgement, history of falls, predisposing conditions such as HTN, CVA, Parkinson, Hypotension, Seizure, Osteoporosis, Unsteady gait and/or use of ambulatory device (cane, walker, wheelchair), age greater than 75, and incontinence. R4's advanced directives in the assessment indicate R4 is a full code. R4's progress note dated, [DATE], documents, in part, Patient (R4) was observed to have altered mental status, alert and oriented to self only, with limited response to questions. He (R4) is a Full code. The hospital conveyed that he has an unsteady gait. He (R4) has enough strength to stand and pivot but requires supervision for any transfer. He (R4) is known to be incontinent of urine and continent of bowel. R4's Functional Abilities and Goals, dated [DATE], documents in part, that R4 is dependent for toileting hygiene; requires substantial/maximal assistance for shower/bathe, lower body dressing; and sit to stand position; and requires partial/moderate assistance for personal hygiene, sit to lying position, lying to siting on side of bed. R4's progress note dated, [DATE], per V29 (Licensed Practical Nurse/LPN), documents, in part, CNA asked to get resident (R4) up and placed in day room due to confusion; major fall risk. R4's progress note dated, [DATE], per V38 (Nurse Practitioner), documents, in part, Full Code. Repeated falls. Staff to assist with activities of daily living (AD Ls) and mobility. Resident has increased risk for falls. Restorative rehabilitation should be provided as tolerated. Falls plan of care documented that includes balance, strength, and gait training OR referral to an exercise program. Patient HAS a history of falls. R4's Physical Rehabilitation Initial Evaluation, dated [DATE], documents, in, part, Impaired ADL and mobility dysfunction due to generalized weakness. (R4) is an [AGE] year-old with a past medical history of Repeated Falls. Patient was admitted to this facility on [DATE] from hospital with acute encephalopathy and new-onset seizure activity following a fall at home with witnessed seizure-like episodes. Post-admission, he (R4) remains lethargic, confused, and functionally impaired, requiring skilled nursing care for neurological monitoring and medication management. Once patient stabilized, was discharged to this NH (nursing home) for continuation of care/rehab. The patient (R4) was referred for skilled therapy related to a noted functional decline. Patient (R4) is demonstrating new onset decrease in strength, balance, transfers, ambulation, and ability to perform self-care ADLs. Current Level Of Function (CLOF): Bed Mobility Roll left and right= Partial/moderate assistance; Sit to lying = Partial/moderate assistance; Lying to silting on side of bed = Partial/moderate assistance; Transfers Sit to stand= Substantial/maximal assistance; Chair/bed-to-chair transfer = Not attempted due to medical conditions or safety concerns; Toilet transfer= Not attempted due to medical conditions or safety concerns; Car transfer = Not attempted due to environmental limitations; Ambulation Walk 10 feet = Patient refused. Patient is now on therapy services for decline in ADLs, function, mobility and sip hospitalization. Consultation was requested for management of decline in (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	function with impaired mobility and self-care. RLE (right lower extremity) Strength = Impaired; LLE (left lower extremity) Strength = Impaired; RLE Strength Hip = Impaired; Knee = Impaired; Ankle = Impaired. Patient noted to have the following diagnoses and/or comorbidities which are impacting functional status. 1. Muscle Weakness resulting in impaired strength, endurance, balance, and transfer ability. Risk: High; Continue AROM exercises independently; Patient (R$) will continue to work on transfers, mobility, and strengthening to improve safety and independence to the maximal level. Staff to encourage participation in ADLs. 2. Impaired Mobility and ADLs Following Hospitalization. Risk: Moderate; Continue skilled PT/OT for transfers, gait mechanics, balance, and ADL participation Emphasis on safety awareness and fall prevention; 3. Repeated falls-Risk: MODERATE; Risk for fall, fall precautions in place, will continue working with therapy; Monitor closely for any signs of unsteadiness or difficulty during therapy sessions. Adjust the environment to minimize fall hazards. R4's care plan ([DATE]) identifies R4 is at high risk for falls r/t repeated falls at home due to seizures, recent hospitalization. R4's goal for R4's high fall risk was to remain free of falls causing hospitalizations. Interventions to address the high fall risk include, Educate resident on the importance of complying with safety measures. Document residents understanding of education and instances of noncompliance ([DATE]), Provide proper, well-maintained footwear ([DATE]), Encourage appropriate use of wheelchair ([DATE]), Keep bed in lowest position ([DATE]), Move resident to room with optimal visual access from the nurses station ([DATE]), Promote placement of call light within reach and assess residents ability to use. ([DATE]), Rounding at a minimum of q2 hours and prompt or assist for change in position, toileting, offer fluids, and ensure resident is warm and dry ([DATE]), and Staff to assist as needed. R4's Change in Condition Evaluation ([DATE]) documents on [DATE] at 5:50 AM, R4 had a functional status change including a fall with suspected serious injury, was unresponsive, had a laceration to the left side of the forehead. R4's blood pressure and pulse were zero. EMS was initiated and R4 was sent to the emergency department for evaluation. R4's progress notes document on [DATE], R4 was having a change in condition including Bleeding (other than GI), Falls Unresponsiveness. Recommendations and interventions include activating EMS for transport to the hospital. There is no narrative description of the incident/fall within the progress or nurse's notes. There is no indication that CPR was initiated. On [DATE] at 8:30 AM, V2 (Director of Nursing) documented, Writer called (Hospital) for update on resident's status and spoke with nurse and resident admitted to Hospital with Cardiac Arrest. There is no documentation that R4 expired in the hospital within the progress notes. There is no documentation that R4 expired in the hospital within the progress notes. Record review of R4's Ambulance Run Sheet, dated [DATE], documents, in part, Unit Notified: [DATE] 6:06am; At the scene [DATE] 6:14am. In summary crew was dispatched to the above location for a fall. Crew noted a 2-inch laceration to the left side of pts (R4) forehead that was no longer actively bleeding. Crew noted the blood in pts (R4) hair had already coagulated. Staff sated they began CPR between 5-10 minutes ago. Staff said the event was unwitnessed and they had walked into pt (R4) room and found him (R4) on the floor pulseless. Staff stated pt (R4) was last seen in bed between 4:00am to 5:00am. Staff was unable to provide exact time pt (R4) was last seen alive. Crew was informed by pts (R4) roommate (R6) that he (R6) heard pt fall between 4:00am to 4:30am. Crew placed pt (R4) on cardiac monitor and crew interpreted rhythm as asystole. Crew had placed pt (R4) in cervical c-collar due to possible spinal injury. Crew noted pupils were non-reactive and blown. R4's hospital records, dated [DATE], documents, in part, Pt. (patient/R4) found down and pulseless (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	after unwitnessed fall at his (R4) nursing home. Last known well was several hours before. Per EMS (emergency medical services) patient (R4) LKN (last known normal) was 4:00am to 5:00am. (R4), with a history of dementia, was admitted following an unwitnessed fall at his (R4) nursing home and subsequent pulseless electrical activity cardiac arrest requiring prolonged CPR (cardiopulmonary resuscitation) and multiple rounds of epinephrine before return of spontaneous circulation was achieved. The principal problem was cardiac arrest, but subsequent evaluation including emergent transesophageal echocardiogram demonstrated no was motion abnormalities or overt cardiomyopathy. STEMI (ST-elevation myocardial infarction) alert was cancelled as ST changes were attributed to severe metabolic acidosis rather than acute myocardial infarction. Troponin and BNP (B-type natriuretic peptide) negative. Family ultimately decided to go comfort focused care and the patient ultimately passed at 3:17 PM on [DATE]. DNR status confirmed. Time of Death: 3:17pm Date: [DATE]. R4's CT (Computed Tomography) of the head, dated [DATE], documents, in part, Early changes of global hypoxic ischemic encephalopathy; Left frontal scalp/periorbital hematoma. R4's CTA (Computed Tomography Angiography) of the chest, abdomen, and pelvis, dated [DATE], documents, in part, Acute L1 (lumbar) anterior vertebral body fracture with mild retropulsion; Acute nondisplaced right anterior 3 through 6 rib fractures. R4's CT (Computed Tomography) of the cervical spine, dated [DATE], documents, in part, Acute fracture along the anterior/superior endplate at C7 (cervical) with widening of the anterior C7 through T1 (thoracic) disc space, highly concerning for associated ligamentous injury secondary to hyperextension fracture; Slight widening of the C7 trough T1 facet joints which may represent associated capsular injury. R6's face sheet documents diagnose that include but are not limited to pain in right leg, fusion of spine, muscle wasting and atrophy, and radiculopathy of lumbar region. R6's BIMS (brief interview for mental status) score, dated [DATE], is 13 which indicates R6 is cognitively intact. On [DATE] at 10:14am, R6 (R4's roommate), BIMS of 13, said, Oh yeah, my roommate (R4) was an older man. He (R4) fell the first day I was here (facility). I heard a boom and seen R4 on the floor. I pushed the call light button and looked at the clock and it about 4ish. Yeah. 4 in the morning. Surveyor observed a clock hanging on the wall, across from R6's bed. Surveyor noted that the clock currently had the correct time. R6 stated, My roommate's (R4) head was near my bed, and blood was coming from his (R4) head. No one (staff) was coming. I did try to yell for help, but I was in a lot of pain. They (staff) didn't come for like 2 hours. I looked at the clock, and it was almost 6:00am. Tear eyed, R6 said, I wish I could have helped him (R4). I was just in so much in pain. If it happened today, I could have helped him (R4). I know CPR. I can get up now. I just couldn't get up that day ([DATE]). It was my first day here (facility). The nurse (V9/RN) finally came in and screamed, What happened?! I don't know her (V9/RN) name. She (V9/RN) was in and out of the room. Finally, staff came and were trying to save him (R4). Then the paramedics showed up and took over. I hear there's not enough staff. I hear the staff complaining and I haven't even been here long. How can you let a man just lie there and die. I'm thankful I'm going home Saturday ([DATE]), because I don't want to be the next one dead. On [DATE] at 1:41pm, V9 (Registered Nurse/RN) said, Yes, I'm familiar with R4. Yes, I was working when he (R4) fell and went to the hospital. I had been doing rounds. The last time I physically saw him (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 2:02pm, V2 (Director of Nursing/DON) said, After R4 fell, R4 was found unresponsive with no vital signs. I didn't think I had to call you (IDPH-State Survey Agency) to report R4's death because he (R4) died in the hospital and was admitted with cardiac arrest. The day of fall, R4 was admitted with cardiac arrest. Yes, we (facility) knew R4 died that day. I did send in a reportable of the incident to you guys (IDPH-State Survey Agency). On [DATE] at 3:40pm, V10 (Certified Nursing Assistant/CNA) said, Yes, I was working when R4 fell on [DATE]. I was not present during the actual fall, so I cannot say exactly how it happened. V9 (Registered Nurse/RN) hollered for me to yell for V13 (Nursing Supervisor/LPN/Licensed Practical Nurse) because V13 had just left our area. Yeah, V13 was visible down the hall, and I yelled for him (V13). I was monitoring high fall risk residents at the nurse's station. V13 started coming and then V9 was running my way to get the crash cart. Yeah, V12 (Registered Nurse/RN) came later. I'm not sure how much later. I was told to call the code over the intercom, and I did (this contradicts a later statement that V34/LPN called the code over the intercom). No, I wasn't present when they (staff) were doing CPR on R4. I did see the resident (R4) afterward, when the paramedics were taken to the hospital. I noticed that he (R4) had some bleeding, and it appeared to be a laceration. I'm not sure if he (R4) was barefoot. As far as R4 himself, that was only about my second time working with him (R4). I last seen him (R4) at 4:30am when I changed (R4). Yes, he (R4) was incontinent. However, I do know R4 was considered a fall risk, and staff were rounding on him every two hours. R4 uses the wheelchair, and I was told R4 needs to be watched closely because R4 is a high fall risk. I'm not sure if he (R4) was really impulsive. The incident really affected me emotionally because my son previously suffered a traumatic brain injury, so seeing R4 in that condition caused me a lot of anxiety and concern. Record of R4's progress notes do not indicate V10 (Certified Nursing Assistant/CNA) saw R4 at 4:30am. Record review of R4's POC Response History for Incontinence Care documents the last time staff provided incontinent care for R4 was [DATE] at 5:25pm. On [DATE] at 11:01am, V9 (Registered Nurse/RN) said, The last time I seen him (R4) was 5:20am, in bed asleep, when I peeked my head in the room and seen him (R4) sleeping. I can't hear the call light, but I can see it (call light). I just came out of room and seen it (R4's room call light) was on. I'm a say not even a good 10 minutes I was in another resident's room. I gave a med and changed a dressing. About 5 to 7 minutes, it took me in the other room. On [DATE] at 11:06am, V12 (Registered Nurse/RN) said, I was working that day (R4's fall on [DATE]). When the code was called, I was giving treatment to one of my patients. I heard code called. Immediately ran down to assist with code. I got to the room, and they (V9 and V13) were performing CPR with Ambu bag, chest compressions. They is V9 and V13. Yes, the AED was on. I seen blood, I didn't see a laceration, but I wasn't paying attention or looking for a laceration. Occasionally I will work A and B, but I was working C and D. Yes, D is the locked with dementia residents. I wouldn't say the halls are close to each other. If I'm on A, I cannot see B side or hear the call light. Call lights sound like an AI (artificial intelligence) voice but disconnects cause of internet or something and most of the time there is no sound for the call lights. If that's (sound when the call light is activated) not working, you just gotta keep monitoring your lights. Honestly, the sound for the call lights doesn't work often. Honestly, I don't remember about protective measures for his (R4) feet. No, not enough staff. We (facility) need another nurse and another CNA for the second floor for night shift. Some residents need extra attention. Some are confused and fall risks. (continued on next page)

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	145681	A. Building B. Wing	06/02/2026

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 - Actual harm Residents Affected - Few	On [DATE] at 12:03pm, V19 (CNA/Certified Nursing Assistant) said, Yes, I was working (R4's fall on [DATE]). I did not have R4 assigned to me that night ([DATE]). Around 6:00am, I heard a code being called while I was assisting another patient and helping get her into the dining room. By the time I came out, the ambulance was already there, so I did not personally witness what happened or see the resident on the floor. I think V10 (Certified Nursing Assistant/CNA) was at the nurse's monitoring the resident. We (V19 and V10) took turns monitoring the residents at the nurse's station. I did not see R4 at all the night of the incident (R4's fall [DATE]) because he (R4) was not my assigned patient. I had cared for him (R4) before, though. He (R4) was often confused. When placed in his wheelchair, he would lean or sit forward a lot, so he (R4) required close monitoring. When he (R4) was in bed, he (R4) usually did fine. He (R4) had attempted in the past to get up from both the wheelchair and the bed without assistance, so at times he (R4) did require increased supervision. I do remember seeing the call light (R4's room) on earlier that night because his (R6) roommate frequently used it. I believe I noticed it (R4's room call light) around midnight, but I cannot say for certain exactly when it (R4's room call light) was turned on. No, I didn't answer it (R4's room call light). Later, around approximately 12:45 am, I remember looking back toward the room (R4) and noticing that the call light was off. I do not recall seeing the call light on after midnight after that point. I only spoke with the roommate (R6) briefly after the incident. It was R6's first night here (facility), and the roommate (R6) did not say anything to me about the incident. I do not recall there being any specific call light system or monitor in the back nurses' station that clearly indicated which call lights were on now or before. I do not recall any changes in R4's condition that night or anyone mentioning that he (R4) was acting differently. Earlier in the shift, when I walked past the room on my way to the soiled utility area to get something from the cart, he (R4) was in bed sleeping. Around 12:00 a.m. or shortly after, the call light was on, but other than that I did not notice anything unusual. Again, I wasn't assigned to R4's area so I didn't see much. On [DATE] at 2:27 PM, V25 (Restorative Nurse, Licensed Practical Nurse) affirmed V25 oversees the fall program in the facility, however, the entire interdisciplinary team (IDT) is involved in fall prevention efforts. V25 recalled R4's care needs; R4 had poor cognition/memory, required one staff assistance for activities of daily living (ADLs) and used a wheelchair for mobility. R4 had dementia, was able to speak but not always communicate needs clearly. V25 denied recalling any behaviors or impulsivity but did recall staff would often keep R4 at the nurse's station for increased supervision. Staff try their best to keep high fall risk residents in high visibility common areas. R4 was a high fall risk. V25 believed R4 was admitted to the facility from a hospitalization following a fall that was related to seizure activity. V25 affirmed V25 was involved with the fall investigation, but V1 (Administrator) and V2 (Director of Nursing) were primarily involved in completing the investigation. From what V25 could recall from the investigation, R4 got up from bed, ambulated and then fell because R4 went into cardiac arrest. Cardiac arrest was the root cause of the fall. V25 was not aware R4 sustained any fractures as a result of the fall. V25 believed R4 did sustain a head injury. V25 explained from the unit R4 was assigned to, you cannot see into any resident room from the nurse's station and R4's room was over halfway down the hall, not in optimal visual location from the nurse's station. V25 stated staff try to place the residents at risk as close as they can to the nurse's station as practicable given the facility's physical layout/construction. Surveyor inquired as to why R4's room was halfway and not closer as other rooms were closer to the nurse's station. V25 replied that it depends on what is available, there may be a priority for other residents with obvious fall risk behaviors. Surveyor inquired the rationale as R4 had impulsivity, poor cognition, significant history of falls, is a very high fall risk, why R4 was not a priority to have a closer room. V25 replied staff cannot say one resident's needs are more important than the other. (This statement directly contradicts V25's statement that some residents are a priority for high fall risk behaviors). V25 explained since V25 started at the facility over a month ago, V25 has educated staff repeatedly on getting residents (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	up from their rooms and out in high visibility areas to for increased supervision as well as rounding frequently, alternating nurses and CNAs. Even if the care plan doesn't state it, round often. V25 denied the facility had a system in place to ensure rounding was completed or completed timely. V25 explained in an ideal world, nursing assistants would document each time they provided care to a resident, but the facility expectation is once per shift. If the charting was not completed, it means it wasn't done. R4's ADL charting was reviewed with V25 and V25 confirmed there was no documentation R4 received ADL assistance or toileting assistance/incontinence care during the shift of the incident ([DATE]). The last documented shift that CNAs provided care was evening shift the day prior ([DATE]). Surveyor inquired if V25 felt the staffing levels were adequate or safe in the facility, and V25 replied, we staff according to CMS guidelines. I mean, if it were up to me, CNAs would only care for 2-3 residents. On [DATE] at 3:11 PM, V2 (Director of Nursing) affirmed V2 oversees the nursing services provided in the facility. V2 affirmed V2 was familiar with R4. V2 recalled seeing R4 one or two times as R4 had only been admitted to the facility for about a week before the incident occurred. When V2 saw R4, R4 was in the dining room in a wheelchair. V2 affirmed R4 had impaired cognition and was alert/oriented times 1-2 (oriented to person and sometimes place, not oriented to time or situation). V2 confirmed R4's room was not near the nurse's station and was over halfway down the hall. V2 affirmed staff would be able to see a call light illuminated from the nurse's station but would be unable to see into the room or hear noises from the room. V2 explained there is other areas on the hallway including sitting areas and a vending machine area that is before resident rooms between the hall and the nurse's station (which increases the distance further from the nurse's station). V2 affirmed there are no rooms that you can see into or that are fairly close to the nurse's station on that unit. V2 denied the intervention of moving the resident into a room for optimal visual supervision to the nurses' station was an appropriate intervention for R4 or any resident on those units. V2 confirmed V2 was the staff member that c

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to staff the facility with a sufficient number of licensed nurses and nursing assistants to meet residents' needs, failed to staff the facility in accordance with the staffing needs/plan identified within the facility assessment, and failed to ensure sufficient staff were available to answer call light when one resident (R6) used the call light device to obtain help for his roommate (R4). The lack of sufficient staffing resulted in R4 self-ambulating, falling and experiencing a delay in care resulting in R4 sustaining major injuries. These failures affected one (R4) of seven residents reviewed for staffing and have the potential to affect all 145 residents residing in the facility. Findings include: Facility census ([DATE]) document 145 residents reside in the facility. Record review for facility's Daily Assignment Sheet, date [DATE] night shift (R4's fall), documents that V9 (Registered Nurse/RN), V12 (Registered Nurse/RN), V10 (Certified Nursing Assistant/CNA) and V19 (Certified Nursing Assistant/CNA) worked floor 2; and V42 (Certified Nursing Assistant/CNA) worked the locked unit on floor2. V13 (Registered Nurse/RN), V34 (Registered Nurse/RN), V37 (Registered Nurse/RN), V43 (Certified Nursing Assistant/CNA), V44 (Certified Nursing Assistant/CNA), V45 (Certified Nursing Assistant/CNA), V46 (Certified Nursing Assistant/CNA), and V47 (Certified Nursing Assistant/CNA) worked floor 1. R4's face sheet documents R4 was admitted to the facility on [DATE] and documents the following diagnoses: encephalopathy, generalized muscle weakness, muscle wasting/atrophy, cognitive communication deficit, chronic kidney disease, seizures, and repeated falls. R4's minimum data set ([DATE]) documents a brief interview of mental status summary score of 10, indicating R14 was cognitively impaired and required partial to moderate assistance with activities of daily living. R4's minimum data set ([DATE]) indicates R4 died within the facility. R4's admission Evaluation ([DATE]) documents R4 was at high risk for falls due to impaired memory/judgement, history of falls, predisposing conditions such as HTN, CVA, Parkinson, Hypotension, Seizure, Osteoporosis, Unsteady gait and/or use of ambulatory device (cane, walker, wheelchair), age greater than 75, and incontinence. R4's advanced directives in the assessment indicate R4 is a full code. R4's Change in Condition Evaluation ([DATE]) documents on [DATE] at 5:50 AM, R4 had a functional status change including a fall with suspected serious injury, was unresponsive, had a laceration to the left side of the forehead. R4's blood pressure and pulse were zero. EMS was initiated and R4 was sent to the emergency department for evaluation. Record review of R4's Ambulance Run Sheet, dated [DATE], documents, in part, Unit Notified: [DATE] 6:06am; At the scene [DATE] 6:14am. In summary crew of 2302 was dispatched to the above location for a fall. Crew noted a 2-inch laceration to the left side of pts (R4) forehead that was no longer actively bleeding. Crew noted the blood in pts (R4) hair had already coagulated. Staff stated they began CPR between 5-10 minutes ago. Staff said the event was unwitnessed and they had (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	walked into pt (R4) room and found him (R4) on the floor pulseless. Staff stated pt (R4) was last seen in bed between 4:00am to 5:00am. Staff was unable to provide exact time pt (R4) was last seen alive. Crew was informed by pts (R4) roommate (R6) that he (R6) heard pt fall between 4:00am to 4:30am. Crew placed pt (R4) on cardiac monitor and crew interpreted rhythm as asystole. R4's hospital records, dated [DATE], documents, in part, Pt. (patient/R4) found down and pulseless after unwitnessed fall at his (R4) nursing home. Last known well was several hours before. Per EMS (emergency medical services) patient (R4) LKN (last known normal) was 4:00am to 5:00am. (R4), with a history of dementia, was admitted following an unwitnessed fall at his (R4) nursing home and subsequent pulseless electrical activity cardiac arrest requiring prolonged CPR (cardiopulmonary resuscitation) and multiple rounds of epinephrine before return of spontaneous circulation was achieved. Family ultimately decided to go comfort focused care and the patient ultimately passed at 3:17 PM on [DATE]. DNR status confirmed. Time of Death: 3:17pm Date: [DATE]. On [DATE] at 10:14am, R6 (R4's roommate), BIMS of 13, said, Oh yeah, my roommate (R4) was an older man. He (R4) fell the first day I was here (facility). I heard a boom and seen R4 on the floor. I pushed the call light button and looked at the clock and it about 4ish. Yeah. 4 in the morning. Surveyor observed a clock hanging on the wall, across from R6's bed. Surveyor noted that the clock currently had the correct time. R6 stated, My roommate's (R4) head was near my bed and blood was coming from his (R4) head. No one (staff) was coming. I did try to yell for help, but I was in a lot of pain. They (staff) didn't come for like 2 hours. I looked at the clock and it was almost 6:00am. Tear eyed, R6 said, I wish I could have helped him (R4). I know CPR. R6 further stated, The nurse (V9/RN) finally came in and screamed, What happened?! Finally, staff came and were trying to save him (R4). Then the paramedics showed up and took over. On [DATE] at 1:41pm, V9 (Registered Nurse/RN) said, The last time I physically saw him (R4) was around 5:20am. I just peaked my head in the room and saw him (R4) sleeping. At that time, I went to another room to complete medication pass and a dressing change. Later, I noticed his (R4) call light was on and observed him (R4) on the floor. I assessed him (R4) and found him (R4) unresponsive. I initiated CPR, and 911 arrived shortly afterward and took over care On [DATE] at 3:40pm, V10 (Certified Nursing Assistant/CNA) said, I was monitoring high fall risk residents at the nurse's station. V13 started coming and then V9 was running my way to get the crash cart. Yeah, V12 (Registered Nurse/RN) came later. I'm not sure how much later. I was told to call the code over the intercom. No, I wasn't present when they (staff) were doing CPR on R4. I noticed that he (R4) had some bleeding, and it appeared to be a laceration. I'm not sure if he (R4) was barefoot. As far as R4 himself, that was only about my second time working with him (R4). However, I do know R4 was considered a fall risk, and staff were rounding on him every two hours. R4 uses the wheelchair, and I was told R4 needs to be watched closely because R4 is a high fall risk. I'm not sure if he (R4) was really impulsive. On [DATE] at 11:06am, V12 (Registered Nurse/RN) said, I was working that day (R4's fall on [DATE]). When the code was called, I was giving treatment to one of my patients. I heard code called. Immediately ran down to assist with code. I got to the room, and they (V9 and V13) were performing CPR with Ambu bag, chest compressions. They is V9 and V13. Yes, the AED was on. No, not enough staff. We (facility) need another nurse and another CNA for the second floor for night shift. Some residents need extra attention. Some are confused and fall risks. Review of the facility assessment (4/2026) identifies the licensed nurse staffing ratio in post-acute (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	units as 1:20 (staff to resident). In long term care units, the staffing ratio is for licensed nursing is 1:25. For direct care staff, the staffing ratio is 1:12 (1:13 in long term care units) for day/evening shifts, and 1:9 on all units for night shift. On [DATE] at 10:45 AM, V35 affirmed V35 had not completed the morning medication pass and still had to pass medications to residents that were due at 8-9 AM. V35 stated medications are to be administered an hour before and an hour after the administration time. V35 explained V35's is assigned to care for at least 27 residents on V35's current assignment. V35 recalled beginning the medication pass promptly after receiving report after V35 arrived to V35's shift at 7:00 AM. V35 explained the staffing assignment V35 is assigned to has a lot of care needs, such as most residents require blood pressure to be taken before medication is administered, multiple diabetic residents that require blood sugar monitoring, residents that require supervision due to high fall risks, multiple residents that need breathing treatments, and most residents with overall more care needs than a typical nursing home unit. V35 expressed V35 tries V35's best to ensure medications are delivered timely, but with all the extra work and resident/family needs, it is not feasible or safe. Record review of V35's assignment provided by V2 (Director of Nursing) documents V35 was responsible for 34 resident's care (9 residents more than the staffing ratio indicated within the facility assessment to meet the resident's needs). Record review of R1's Medication Administration Record (MAR), dated [DATE], documents that V31 (Licensed Practical Nurse/LPN) administered R1's am medications scheduled for 7:30am, 8:00am, and 9:00am late. Record review of R1's Medication Administration Record (MAR), dated [DATE], documents that V31 (Licensed Practical Nurse/LPN) administered R1's am medications scheduled for 7:30am and 8:00am late. On [DATE] at 12:24pm, V31 (Licensed Practical Nurse/LPN) said, Ummm. I mean honestly I cannot recall those exact days ([DATE] and [DATE] R1's AM medications given late), but I do my best to administer all medications in a timely manner. Often times there are situations when residents have to get sent out, call lights have to be answered, and the Wi-Fi isn't the best, but I try to administer in a timely fashion. I cannot remember what happened those days ([DATE] and [DATE] R1's AM medications given late). It's all about prioritizing. I try to do the best I can. I have approximately around 23 other residents. It would be great, and ideal to have another nurse. Usually, I'm able to manage, but things always happen and get hectic, and medications may be a little late. The workload is doable and I'm usually able to pass in a timely fashion, but the call lights and help residents might need might come first. I have to prioritize. Medications that are time sensitive and prioritize the needs of the residents. Usually able to manage good but have to prioritize sometimes. On [DATE] at 1:23 PM, V2 (Director of Nursing) affirmed V2 is involved with the staffing levels in the facility. V2 recalled residents had complained about getting medications administered late. V2 in-serviced the staff when the residents complained about late medication administration. V2 affirmed medications should can be given an hour before or an hour after the medication is due. V2 affirmed since being the director of nursing, V2 has only completed medication pass on the dementia unit and had not attempted to complete medication pass for V35's unit (unit 2). V2 affirmed the facility is staffed according to census and acuity. V2 believed the staffing in the facility was sufficient to meet the resident's needs. Record review of R1's Medication Administration Record (MAR), dated [DATE], documents that V32 (Licensed Practical Nurse/LPN) administered R1's am medications due for 7:30am, 8:00am, and (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9:00am late. On [DATE] at 3:32pm, V32 (Licensed Practical Nurse/LPN) said, Previously, we (facility) had three nurses on the unit, but after the new company took over, staffing was reduced to two nurses. Because the unit is very busy and understaffed, medications are sometimes administered late. In my opinion, we (facility) need another nurse to safely manage the workload. I do not believe the level of supervision is adequate for residents who are considered high fall risks. Staffing assignments are split differently on day shift, but night shift coverage is not safe in my opinion. On [DATE] at 3:41 PM, V32 (Licensed Practical Nurse) affirmed V32 was familiar with V35 and stated V35 was a good nurse. V32 recalled being assigned to the assignment V35 was assigned to. V32 explained, The assignment requires the most care no matter what changes they make to the resident population or who comes and goes. At one point, there was 14 residents on that assignment that needed blood sugar monitoring, which is pretty much impossible when you have to get 14 blood sugars before someone eats lunch. I (V32) think we could at least use another nursing assistant, if not another nurse. So many things can happen. If there is ever a change in condition, you'd never be able to complete anything you need to, especially in the morning. I've been late passing meds or doing other tasks because I'll have to call 911 and send a resident out and there's so many residents to care for. I don't think there is enough time in the nursing assignments to accurately chart. Residents do complain to me that we don't have enough staff. I have heard them complain about waiting over an hour for call light to be answered, they complain the most about the night shift staffing. V32 further stated, Yes, I do recall times when coming in on my shift (days) residents have been excessively soiled and didn't get timely incontinence care. I have worked overnights, and I can't speak for a lot of the other units, but there's like 3 nurses and 3 aides. The unit 2 has like 50 residents assigned to one nurse on the night shift. We used to have 2 nurses for V35's assignment, but when the new company bought the building, they cut the nurse. I don't know why they cut the nurse, we need it. On [DATE] at 1:19pm, V10 (Certified Nursing Assistant/CNA) said, On [DATE] at 1:19pm, V10 (Certified Nursing Assistant/CNA) said, The 2 high risk fall residents were being monitored at the nurse's station the whole night. I was told one of them (residents) had Xanax or something discontinued which was why she was up all night. Yes, the residents were being monitored at the nurse's station from 11:00pm to 7:00am, the whole shift. No, I can't answer call lights if I'm monitoring residents at the nurse's station. Someone (staff) else would have to get the light. Can't remember the names (resident being monitored at the nurse's station). We could use another CNA at night, because some of these residents should be 1:1, but they (facility management) are not allowing them to be 1:1. R16's face sheet documents R16 is a [AGE] year-old resident with prior diagnoses, including but not limited to: systemic lupus erythematosus, osteomyelitis, type 2 diabetes mellitus, anemia in chronic kidney disease, obesity, sickle cell disease, chronic kidney disease, acquired absence of left and right legs, and osteoarthritis. R16's minimum data set ([DATE]) documents a brief interview of mental status summary score of 13, indicating R16 is cognitively intact. On [DATE] at 10:30 AM, R16 expressed that it takes a long time for call lights to be answered upwards of 20 minutes at a time on days an evening shifts. R16 explained night shift is the worst and takes a long time for them to address call lights. R16 explained the facility needs more CNAs on all shifts, as there is no way a day shift CNA can be assigned 15-17 residents and be able to complete good quality care. R16 affirmed R16's medications are usually administered late. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R16's medication administration audit (5/2025) documents multiple days and shifts that R14 received medications over an hour late. On [DATE], R16's 8:00 AM scheduled medications were administered after 10:20 AM. R14's face sheet documents R14 is a [AGE] year-old resident with diagnoses including: type 2 diabetes mellitus, morbid obesity, cardiomegaly, chronic obstructive pulmonary disease, atopic dermatitis, spinal stenosis, chronic diastolic heart failure, atrial fibrillation, hypothyroidism, fibromyalgia, major depressive disorder, and anxiety disorder. R14's minimum data set ([DATE]) documents a brief interview of mental status summary score of 14, indicating R14 is cognitively intact. R14's medication administration audit (5/2025) documents multiple days and shifts that R14 received medications over an hour late. On [DATE], R14's 8:00 AM scheduled medications were administered around or after 9:30 AM. On [DATE] at 1:00 PM, R14 stated the staff are not good about tending to R14's needs. R14 explained it can take a long time to get needs met, especially on third shift (overnight), It depends on who is working and with call offs. R14 recalled on [DATE] (the holiday) 3 certified nursing assistants called off, so it took a lot longer to get care. R14 affirmed R14 had received medications late in the past, 8 o'clock meds being administered at noon. R14 recalled the resident council bringing up the facility needing more staff to the administration many times, and nothing gets done. R14 affirmed the facility needs more staff to meet the resident's needs. R1's face sheet documents an admission date of [DATE] and diagnoses that include but are not limited to abnormalities of gait, unsteadiness on feet, muscle wasting and atrophy, lack of coordination, cognitive communication deficit, and low back pain. R1's minimum data (dated [DATE]) documents a brief interview of mental status summary score of 15 indicating R1 is cognitively intact. On [DATE] at 2:45 PM, R1 explained R1 does not use the call light because it is no use. R1 recalled usually waiting over an hour for R1's call light to be answered or the call light wouldn't be answered by the staff at all. R1 stated, I could be dead by the time the staff respond (to the call light). R1 explained the facility is very understaffed and sometimes gets medications administered late. R1 felt bad for the nurses from the staffing levels. R1 explained that night shift is the worst to get needs responded to. Staff cannot hear the call light and you'll wait over 45 minutes for them to come especially if they are working down another hall. Staff cannot see the call lights when we (residents) put them on. R1 believes the turnover rate is over 50% for staff because the work conditions of the staff. They get tired and overworked. All shift staffing is bad. Record review of R1's Medication Administration Record (MAR), dated [DATE], documents that V29 (Licensed Practical Nurse/LPN) administered R1's AM medications that are due for 8:00am and 9:00am late. Record review of R1's Medication Administration Record (MAR), dated [DATE], documents that V29 (Licensed Practical Nurse/LPN) administered R1's am medication for 8:00am late. On [DATE] at 3:30pm, V29 (Licensed Practical Nurse/LPN) said, I sometimes pass the medications late cause it gets busy, and we (facility) can use more help. Yeah, on 5/4 and 5/12 ([DATE]; (continued on next page)

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	145681	A. Building B. Wing	06/02/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[DATE]) I was late passing medications. There's a lot of residents and a lot to do. I try my best. I do feel like we (facility) could use more staff, especially to watch the residents that are confused and risk for falls. I sometimes pass the medications late cause it gets busy, and we (facility) can use more help. On [DATE] at 9:25am, V34 (Licensed Practical Nurse/LPN) said, Yeah, we (facility) can use more CNAs with the type of patients we are getting in. A lot of high fall risk residents. They (facility) don't give us (facility) extra staff to supervise the residents. We (facility) need more CNAs just for high-fall-risk residents because some of them (residents) need 1:1. On [DATE] at 11:56am, V24 (Medical Director) said, I think a delay in assessing the resident (R4) is the problem and is a big issue. If it took that long, that's on the facility. That's bad. Delay in care can be a serious problem. Staffing with all honesty is a concern. The staff is good. I think the amount of residents they have is a concern. I know the staff are having difficulties with the amount of residents assigned. R24's face sheet documents R24 is a [AGE] year-old resident and has active diagnoses (including but not limited to): chronic obstructive pulmonary disease, asthma, anxiety disorder, osteoarthritis, rheumatoid arthritis, bursitis of left elbow. R24's minimum data set ([DATE]) documents a brief interview of mental status summary score of 15, indicating R24 is cognitively intact. On [DATE] at 3:15 PM, R24 affirmed R4 has been a resident of the facility for 5 years. R24 believed the facility was better under the previous ownership. R24 explained staffing on all shifts are bad. R24 has had to put on the call lights on numerous times. The CNAs are lazy. R24 recalled activating the call light so her roommate can get incontinence care and recalled CNAs coming into the room, shutting off the light and coming back for over an hour. R24 explained that the resident council has brought up concerns about the call lights, nursing assistants not checking/supervising the residents as they should for over a year now and nothing changes. R24 affirmed R24's medications are usually administered late. R24 expressed staffing is terrible across all shifts, but the worst on third shift (night shift). R24 believed the facility needs more staff on all shifts across the facility. On [DATE] at 2:19 AM, V1 (Administrator) explained the purpose of the facility assessment is to identify what resources are needed to effectively care for the facility's residents. V1 reviewed the facility assessment and affirmed the staffing ratios in the facility assessment were correct and were the required staffing ratios to meet the resident's needs. V1 affirmed the facility assessment was last reviewed on 4/2026. V1 stated the facility used to run 9 total certified nursing assistants on night shift but recently added a 10th certified nursing assistant about a week ago to night shift. V1 affirmed the staffing ratio for night shift nursing assistants was correct and should be 1 certified nursing assistant to 9 residents, which would have the most staffing for certified nursing assistants. V1 affirmed the current facility census for [DATE] was 144 and 10 CNAs were scheduled to work that night. (A staffing ratio of 1 CNA to 9 residents would require 16 CNAs to be staffed at night to meet this ratio). The staffing ratio was discussed and compared to the census and V1 agreed the facility would need to be staffing 16 CNAs on the night shift to meet the staffing ratios outlined in the facility assessment. V1 was unsure why the facility was not staffing an additional 6 certified nursing assistants on the night shift. V1 stated, I'll have to look into that. V1 was unaware V35 was scheduled to care for 34 residents ([DATE]) and affirmed the staffing ratio is 1:25 for that assignment. V1 believed the staffing levels were adequate in the facility to meet the resident's needs. V1 affirmed the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staffing ratio in the facility assessment was accurate, and that the facility should have been staffed according to the facility assessment on [DATE]. The facility job description for the job title, Administrator (undated) documents the Administrator position directs the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities, to assure that the highest degree of quality care is maintained at all times. On [DATE] at 3:10 PM, staffing ratio in the facility assessment was reviewed with V2 and V2 indicated the staffing ratio sounded right. V2 (Director of Nursing) affirmed the facility is generally staffing between 9-10 certified nursing assistants at night. V2 affirmed that 9-10 CNAs does not meet the staffing ratio listed in the facility assessment. V2 denied being involved in the development or updating of the facility assessment. V2 believed the staffing within the facility was sufficient to meet the resident's needs. The facility job description for the job title, Director of Nursing (undated) documents the director of nursing is responsible for determining and maintaining staffing needs in the nursing department, concerning the operation of the nursing department ensuring that a sufficient number of nurses and CNAs are available for each shift and overseeing work assignments/scheduling and duty hours with the Staffing coordinator. Record review of facility policy titled, Staffing, dated 5/2025, documents, in part, To have appropriate numbers of staff available to meet the needs of the residents. Staffing is based on the IDPH formula for determining numbers and levels of staff. Staffing is then increased based on the needs of the resident population. A schedule is made on a monthly basis and reviewed on an ongoing basis. Staffing is supplemented as needed by outside agencies. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, 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 equal access to quality care regardless of diagnosis. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care. Review of Medicare's care compare system indicates the facility has a 1-star staffing rating indicating the facility's staffing levels are much below average. The facility is below both the Illinois and National Average for registered nurses hours per resident/day, nursing aide hours per resident/day, and total number of nurse staff hours per resident per day on the weekends. Total number of nurse staff hours per resident per day for the facility is 3 hours and 3 minutes (National average: 3 hours and 52 minutes, Illinois average: 3 hours and 29 minutes). Registered Nurse hours per resident per day for the facility is 37 minutes (National average: 41 minutes, Illinois average: 43 minutes). LPN (Licensed Practical Nurse) hours per resident per day is 46 minutes (National average: 52 minutes). Nurse aide hours per resident per day is 1 hour and 40 minutes (National average: 2 hours and 20 minutes, Illinois average: 2 hours and 7 minutes). Total number of nurse staff hours per resident per day on the weekend is 2 hours and 55 minutes (National average: 3 hours and 26 minutes, Illinois average: 3 hours and 6 minutes).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, facility failed to follow their medication administration policy and failed to ensure residents were free from significant medication errors. These failures affected one (R1) in a sample of six residents reviewed for medication administration. Findings include:R1's face sheet documents an admission date of 11/24/25 and diagnoses that include but are not limited to abnormalities of gait, unsteadiness on feet, muscle wasting and atrophy, lack of coordination, cognitive communication deficit, and low back pain.R1's BIMS (brief interview for mental status) score, dated 3/2/26, is 15 which indicates R1 is cognitively intact.R1 is a closed record. R1 is currently admitted to the hospital with a diagnosis of chest pain.R1's progress note, dated 5/16/ 26, documents, in part, Called (Hospital) ER (emergency room) for update on resident (R1), he (R1) was admitted with dx (diagnosis) of chest pain.Record review of R1's Medication Administration Record (MAR), dated May 4, 2026, documents that V29 (Licensed Practical Nurse/LPN) administered R1's following medications late: Metoprolol Succinate ER that was due for 8:00am was administered at 11:15am (2 hours and 15 minutes late); and Gabapentin and Apixaban that were due for 9:00am were administered at 11:16am (one hour and 16 minutes late). Record review of R1's Medication Administration Record (MAR), dated May 12, 2026, documents that V29 (Licensed Practical Nurse/LPN) administered R1's Metoprolol Succinate ER that was due for 8:00am was administered at 10:05am (1 hours and 5 minutes late).On 5/26/25 at 3:30pm, V29 (Licensed Practical Nurse/LPN) said, I sometimes pass the medications late cause it gets busy, and we (facility) can use more help. Yeah, on 5/4 and 5/12 (5/4/26; 5/12/26) I was late passing medications. There's a lot of residents and a lot to do. I try my best.Record review of R1's Medication Administration Record (MAR), dated May 8, 2026, documents that V32 (Licensed Practical Nurse/LPN) administered R1's following medications late: Insulin Aspart Injection due for 7:30am was administered at 10:47am (2 hours 17 minutes late); Metoprolol Succinate ER due for 8:00am was administered at 10:56am (1 hour and 56 minutes late); Gabapentin due for 9:00am was administered at 10:56am (56 minutes late); Apixaban due for 9:00am was administered at 10:49am (49 minutes late); and Lantus due for 9:00am was administered at 10:56am (56 minutes late).On 5/21/26 at 3:32pm, V32 (Licensed Practical Nurse/LPN) said, I have been here 6 years. Previously, we (facility) had three nurses on the unit, but after the new company took over, staffing was reduced to two nurses. Because the unit is very busy and understaffed, medications are sometimes administered late. In my opinion, we (facility) need another nurse to safely manage the workload.Record review of R1's Medication Administration Record (MAR), dated May 11, 2026, documents that V30 (Licensed Practical Nurse/LPN) administered R1's following medications late: Insulin Aspart Injection due for 7:30am was administered at 11:05am (2 hours 35 minutes late); Metoprolol Succinate ER due for 8:00am was administered at 11:06am (2 hour and 6 minutes late); Gabapentin and Apixaban due for 9:00am was administered at 11:07am (1 hour and 7 minutes late); and Lantus due for 9:00am was administered at 11:10am (1 hour and 10 minutes late).On 5/20/26 at 12:01pm, V30 (Licensed Practical Nurse/LPN), said, Ummm. that day (5/11/26 R1's AM meds documented late) the Wi-Fi was probably down. Wi-Fi comes in and out all the time here. Yeah, I gave them (R1's medications) on time. The Wi-Fi goes out a lot on both sides all the time. Unit 1 and 2 loses Wi-Fi. When the Wi-Fi is out, I can't computer chart and have to wait for the Wi-Fi to go back up. I'm not sure what I'm supposed to do when the Wi-Fi is out, and I cannot computer chart. I'm learning as I go. I am a new nurse.Record review of R1's Medication Administration Record (MAR), dated May 13, 2026, documents that V31 (Licensed Practical Nurse/LPN) administered R1's following medications late: Insulin Aspart Injection due for 7:30am was administered at 10:10am (1 hours 40 minutes late); Metoprolol Succinate ER due for 8:00am was administered at 10:54am (1 hour and 54 minutes late); Gabapentin and Apixaban due for 9:00am was administered at 10:56am (56 minutes late); and Lantus due for 9:00am was administered at 10:55am (55 minutes late).Record review of R1's Medication Administration Record (MAR), dated May 16, 2026, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documents that V31 (Licensed Practical Nurse/LPN) administered R1's following medications late: Insulin Aspart Injection due for 7:30am was administered at 10:04am (1 hours 34 minutes late); and Metoprolol Succinate ER due for 8:00am was administered at 10:04am (1 hour and 4 minutes late).On 5/20/26 at 12:24pm, V31 (Licensed Practical Nurse/LPN) said, Ummm. I mean honestly I cannot recall those exact days (5/13/26 and 5/16/26 R1's AM medications given late), but I do my best to administer all medications in a timely manner. Often times there are situations when residents have to get sent out, call lights have to be answered, and the Wi-Fi isn't the best, but I try to administer in a timely fashion. I cannot remember what happened those days (5/13/26 and 5/16/26 R1's AM medications given late). It's all about prioritizing. I try to do the best I can. I have approximately around 23 other residents. It would be great, and ideal to have another nurse. Usually, I'm able to manage, but things always happen and get hectic, and medications may be a little late. The workload is doable and I'm usually able to pass in a timely fashion, but the call lights and help residents might need might come first. I have to prioritize. Medications that are time sensitive and prioritize the needs of the residents. Usually able to manage good but have to prioritize sometimes.On 6/1/26 at 2:50pm, V2 Director of Nursing/DON) said, Facility's protocol if staff can't chart in the computer, then they (staff) go back to paper charting until system comes back up. There's also a back backup system in the back room to computer chart if there are issues with other computers. The medication is signed off immediately, once they (resident) swallow the medication. I expect staff to give medications on time. One hour before or one hour after the actual time the medication is due. They (staff) should let other nurses or management know if they (nurses) are busy and need some help. Giving heart medications late may have a bad affect on someone's blood pressure or heart rate. It depends on how late the med was given. Yes, blood thinning medications given late can have a bad outcome like blood clots or PEs. Late insulin can cause hypo or hyperglycemia. Depends on the resident and how late.Record review of facility policy titled, Medication of 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. 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.Record review of CMS's RAI (Resident Assessment Instrument) 3.0 Manual Chapter 3 MDS Items [N] (dated October 2025) documents in part the following: N0415: High-Risk Drug Classes: Use and Indication: Anticoagulant; Antiplatelet; Hypoglycemic including insulin; and anticonvulsant.Record review of facility policy titled, Physician Orders, dated 5/1/25, documents, in part, I. Medication orders specify the following: Time or frequency of administration. Documentation of the Medication Order: Each medication order is documented in the resident's medical record with the date and signature of the person receiving the order. The order is recorded on the physician order sheet in PCC and the Medication Administration Record (MAR) or Treatment Administrative Record (TAR).

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility's administration and quality assurance and performance improvement (QAPI) committee failed to make good faith attempts to correct known quality issues after a QAPI meeting was held in response to one resident's (R4) death, failed to disclose/provide QAPI committee records to the state survey agency to evaluate compliance with related QAPI regulations, failed to follow the facility's QAPI plan. These failures have the potential to affect all 145 residents that reside in the facility. Findings include: Facility census ([DATE]) documents 145 residents reside in the facility. R4's FRI (facility reported incident), dated [DATE], documents, in part, (R4) is incontinent of bowel and bladder; he (R4) has impaired mobility and requires assistance with ADL (activities of daily) care and transfers as W/C (wheelchair) is the primary source of transportation. (R4) was observed laying on the floor on his left side in front of the dresser, head towards the window, feet pointed towards the door, brief soiled with urine. He (R4) had non-skid footwear. After interviewing staff and meeting with IDT, it was determined that the cause of the fall was secondary to cardiac arrest. (R4) was last seen by the nurse at approximately 5:20am at which time he (R4) was lying asleep in bed. Sent to ER (emergency room). (R4) later expired at (hospital). R4's FRI (facility reported incident), date reported [DATE], documents, in part, (R4) is incontinent of bowel and bladder; he (R4) has impaired mobility and requires assistance with ADL (activities of daily) care and transfers as W/C (wheelchair) is the primary source of transportation. (R4) was observed laying on the floor on his left side in front of the dresser, head towards the window, feet pointed towards the door, He (R4) had non-skid footwear. R4 was taken to (Hospital) admitted to ICU with Cardiac Arrest, Laceration to Right side of forehead (eyebrow) with 3 staples and 3 sutures, there was no intracranial/subdural hemorrhages and Hypoxic Ischemic Encephalopathy. Xray report revealed 1. Acute bilateral pulmonary emboli within the right hear strain. 2. Acute L1 anterior vertebral body fracture. 3. Acute non-displaced right anterior 3-6 rib fracture. 4 Acute fracture C7-T1. (R4) expired on [DATE] 3:17pm. It was determined that the cause of the fall was secondary to Acute Bilateral Pulmonary Embolisms, and Cardiogenic Shock, STEMI. R4 has a history of CVA and Bilateral PE's caused him to collapse; he (R4) became unresponsive and ultimately arrested; and hit his head on the dresser when he fell causing left side eyebrow laceration causing 3 staples and 3 sutures, rib fractures 3-6, and C7-T1 fractures are consistent with the initiation of chest compressions and use of the [NAME] Chest Compression device as well as multiple rounds of CPR performed in ED. On [DATE] at 10:51 AM, V40 (Regional Director of Operations) affirmed V40 is a member of the governing body. V40 was aware of the incident and R4's death on [DATE]. V40 affirmed V40 was involved in the investigation process of the incident and was present in the facility the morning of [DATE] after the incident. V40 denied V40 was involved in a QAPI meeting that day. V40 recalled V40 did hear there was a possibility the root cause of R4's fall was trying to go to the bathroom. On [DATE] at 11:56am, V24 (Medical Director) said, He (V1/Administrator) just called me and told me about it (R4's fall on [DATE]). I don't know nothing about much going on. He (V1/Administrator) said that we (IDPH-State Survey Agency) might call him. I didn't know what happened until now. Can you explain it to me? I did not know nothing about it. I'm probably not going to be Medical Director much longer. I'm leaving end of month . Staffing with all honesty, is a concern. The staff is good. I think the amount of residents they have is a concern, but that's more of an Administrator question. They (staff) need to take care of the residents. I know the staff are having difficulties with the amount of residents assigned. This is the first time I'm hearing about staff supervising residents at the nurse's station. They (facility) don't tell me things like that. No, we haven't done a QAPI meeting for this incident (R4's fall on [DATE]). This one (R4's fall on [DATE]) they (facility staff) called me about 2 days ago. I did not know management and corporate came out the day of incident. They (facility management) try to do the bare minimum with me. I was never (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	notified that there were issues with call lights. First time hearing about this. I think they (staff) should be able to hear the call light if a resident needs them. Of course I expect them (staff) to follow the care plan. Or if there is an order for it. I didn't help with the root cause analysis of this incident (R4's fall on [DATE]) . They (facility staff) called me about this incident (R4's fall [DATE]) after you (IDPH) got there (facility). On [DATE] at 2:19 AM, V1 (Administrator) affirmed V1 is a member of the facility's QAPI committee. V1 explained after the incident, a QAPI meeting was held the same day to review the incident. V1 denied the medical director or any other physician attended the QAPI meeting. V1 recalled V2 (Director of Nursing), V40, and other members of the interdisciplinary team attended the meeting (this statement directly contradicts V40's statement indicating V40 was not present at the time of the meeting). V1 did not identify specifically the other IDT members that were in attendance. V1 explained the QAPI committee discussed the interviews obtained by the staff members, reviewed the chart and risk factors and identified areas of improvement with a plan to move forward. During the meeting, the committee identified quality issues including R4's room not being close enough to the nurse's station per the care plan, and the need for the staff to complete return demonstrations of code status to see how staff react to similar situations. V1 recalled completing the return demonstrations with the night shift staff that were working that night. V1 denied any staff completed return demonstrations with other nursing shifts. Surveyor inquired if an action plan/corrective action was completed to address the known quality deficiencies. V1 replied, No, we never did any action plan or any formal action. V1 denied that any audits were developed or identification of other residents at risk from not having a room close enough to the nurse's station when they required a room closer to the nurse's station. V1 denied any other QAPI meetings took place until the QAPI meeting was conducted with the abatement plan. V1 affirmed V1 believed the QAPI committee completed a good faith attempt to fix the identified quality issues. Surveyor requested clarification if V1 believed a good faith attempt occurred when the committee failed to identify other residents that are at risk from the deficient quality practices, no return demonstration audits were completed on all shifts, no action plan was developed, no audits or quality assurance processes were developed to monitor/ensure compliance with the deficient quality practices, V1 replied, yeah, I think we did a good faith attempt. V1 stated the purpose of QAPI is to identify data and trends and come up with ways to fix issues as well as track improvements. V1 affirmed the QAPI has a responsibility to correct and fix issues of known quality. On [DATE] at 3:10 PM, V2 (Director of Nursing) affirmed V2 is a member of the QAPI committee. V2 recalled being in attendance for the QAPI meeting that occurred after the incident on [DATE]. V2 affirmed V1 and V40 were the only members of the QAPI committee that attended the meeting. V2 denied any other members of the IDT attended, including the medical director or other physicians, the infection preventionist, or other members of staff (all of which are required to attend QAPI meetings). (this statement directly contradicts V40's statement indicating V40 was not present at the time of the meeting and directly contradicts V1's statement that members of the interdisciplinary team were present for the QAPI meeting). V2 explained that we (V1, V40) talked about things we could have done better, like having the resident moved closer to the nurse's station, answering call lights in a timely manner, and talking about who to notify when events like that happen. We talked about completing simulations for events like this, staff needed to show us what happened. We had V9 (Registered Nurse) and V13 (Licensed Practical Nurse, Nurse Supervisor) show us what happened and we didn't have concerns. We looked with restorative if they had that (room close to nurse's station) within the care plan. I don't really remember all of it, I know an audit was made. (This statement directly contradicts V1's interview that audits were not created). I don't recall if I ever saw the audit being completed, I would have to check. V2 explained the notification issues, there wasn't anything wrong it was more to remind them to call everyone. When surveyor asked about the quality issues related to the call light not being answered timely, V2 stated V10 (Certified Nursing Assistant) saw the call light on and didn't answer the call light because V9 (Registered Nurse) went to another room and it just went on right before V9 walked into a nearby (continued on next page)

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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.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room. V2 affirmed all staff were in-serviced on answering call lights timely after this meeting. V2 recalled the QAPI meeting multiple times to review data after the meeting related to the incident and V40 was not present for those meetings. (This statement directly contradicts V1's statement that no further QAPI meetings were held or any further data/audits were collected). Surveyor requested documentation of the audits completed and documentation of the QAPI committee's actions on [DATE]. V1 (Administrator) provided the QAPI plan on [DATE], that indicates V1 signed it on [DATE]. No other meeting sheet was provided to indicate which QAPI members attended the meeting on [DATE]. No other meeting minutes were provided to the surveyor or other related documentation that was discussed during the QAPI meeting on [DATE]. The QAPI plan provided documents V25 (Medical Director) was notified [DATE] at 3 PM. No further related documentation was provided to the survey team prior to the exit of the survey regarding further QAA meetings, audit tools, or other data collected as indicated by V2. Facility QAPI plan ([DATE]) documents VISION At [NAME] OF CRESTWOOD, we're bringing healthcare back to basics. Back to a place where people take care of people. That starts with our approach, our staff, and our residents. MISSION [NAME] OF CRESTWOOD puts people first. We spotlight each individual's needs and build custom care plans that help our residents rise up and get back on their feet. PURPOSE The purpose of QAPI in [NAME] of CRESTWOOD Facilities is to take a proactive approach to continually improve individualized patient care so that we may realize our vision to lead healthcare back to the basics where people take care of people. To do this, [NAME] of CRESTWOOD of shall promote individualized care plans helping our residents rise up and get back on their feet as part of the ongoing QAPI efforts. QAPI is an integral part of [NAME] of CRESTWOOD. It is a continuous process that aims to provide quality of care for our patients . 4. The focus of QAPI program is to improve processes instead of individual behaviors. Thus, the interdisciplinary team shall be encouraged to communicate any system gaps/breakdowns or opportunities without fear of punishment. 5. [NAME] of CRESTWOOD shall utilize multiple data sources to monitor performance, adverse events, feedback from patients/families/partner vendors and the like to ensure quality care and services are provided. 6. A systematic analysis of data shall serve as a guide in performing root cause analysis in order to identify and prioritize performance improvement projects. 7. Appropriate interventions to address issues/adverse events/negative outcomes shall be implemented. Failure Mode and Effects Analysis shall be done to ensure effectiveness and sustainability of any change . The QAPI program of [NAME] of CRESTWOOD shall have a GOVERNING BODY/EXECUTIVE LEADERSHIP that shall be composed of the following members: - Administrator - Administration - Director of Nursing - Assistant Director of Nursing -Medical Director The Executive Leadership team shall be tasked with ensuring execution of all components of the QAPI plan. B. QAPI top-level management leaders make up the QAPI Committee and shall be responsible and accountable in monitoring their respective department for opportunities for improvement, data gathering, interpretation, and presentation, as well as PIP development, implementation, and evaluation . Minutes of the meeting shall be documented by the QAPI Champion and filed in a binder or electronic record. Minutes and reports shall be kept by Administration.Agenda shall be composed of: Date of Meeting Names of Participants MinutesMinutes shall comprise of: Recap from previous meeting Current issues (include presentation of data, analysis, andcorrective actions) Decision (quorum must be met) Implementation of change discussion; delegation of task;follow-upESSENTIAL FUNCTIONS OF THE QAPI COMMITTEEa. The QAPI Committee shall be responsible for ensuring that high quality care isconsistently and effectively delivered to patients in accordance with best clinicalpractices, state and federal regulations.b. The QAPI Committee shall provide support to the employees by providing the necessaryresources to enable them to fulfill their roles.c. The QAPI Committee shall provide strategic guidance and hold employees accountablefor day-to-day activities.d. The QAPI Committee shall be responsible for data gathering and analysis as well asdevelopment of appropriate PIP that would encompass the goals and interventions.e. The QAPI Committee shall evaluate QAPI initiatives to ensure effectiveness andsustainability.f. The QAPI (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	committee shall meet on a monthly basis and as neededIV. FEEDBACK, DATA SYSTEMS, AND MONITORINGA. [NAME] of CRESTWOOD will be drawing data from multiple sources to monitor care andservices, as listed below:Nursing Home CompareCASPER Report- CarewatchPoint Click Care Data AnalyticsClinical Score CardsInternal MetricsB. Listed (but not limited to) are sources of data that shall be monitored through QAPI- Customer satisfaction ratings (survey report from residents, family, others)- Resident Council minutes/feedbackAdverse Events (falls, injuries, infection, etc.)/ Reportable cases- Department Health Surveys/ Accreditation SurveysComplaints/Grievance- Star ratings- Employee retentionPerformance Indicators . VI. SYSTEMATIC ANALYSIS AND SYSTEMIC ACTION . B. Root Cause Analysis Tools shall be utilized to evaluate the source of the problem/issues to ensure appropriate interventions are put in place .

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the quality assurance and performance improvement (QAPI) committee's monitoring of systemic compliance identified deficient practices with quality of care, failed to identify systemic deficient practices with the facility's malfunctioning call light system, failed to identify systemic deficient practices with insufficient staffing, failed to identify systemically deficient practices regarding root cause analysis of incident investigation/reporting. Additionally, the facility's quality assurance processes failed to correct repeated history of non-compliance regarding professional standards of care, quality of care, functioning call lights, and infection control. These failures affect all 145 residents that reside in the facility. Findings include: Facility census (5/18/2026) documents 145 residents reside in the facility. 1) Record review of CMS-2567 (survey exit date 4/23/2026) documents the facility was cited at F0919 for having a malfunctioning call light system. During this survey, concerns were identified with F0919 for the call light system in disrepair. This repeat deficiency demonstrates an overall failure of the facility's QAPI committee/program's responsibility of systemic monitoring and correcting deficient practices to ensure compliance with federal regulations. On 5/19/26 at 11:06am, V12 (Registered Nurse/RN) said, Call lights sound like an AI voice but disconnects cause of internet or something and most of the time there is no sound for the call lights. If that's not working you just gotta keep monitoring your lights. Honestly, the sound for the call lights doesn't work often. On 5/19/26 at 12:03pm, V19 (CNA) said, I do not recall there being any specific call light system or monitor in the back nurses' station that clearly indicated which call lights were on now or before. On 5/20/2026 11:05 AM, V20 (Unit Manager, Licensed Practical Nurse) affirmed V20 is the unit supervisor for unit two. V20 affirmed there is no panel or other system that notifies staff of a call light being activated other than a light outside the resident's door. V20 denied knowledge of any system the facility uses to track call light response times or rounding. On 5/20/2026 at 11:16 observed V14 (Staffing Director) sitting at the unit 2 nurse's station. V14 observed the nurse's station and affirmed there was no panel or other way staff know what call light is activated. Beeping was heard in the background of the nurse's station, but V14 was unsure what the beeping was from or if it was a call light. V20 gestured to powered off television (TV) and explained the call lights used to show on the television, indicating which resident's light had been activated. V14 recalled the TV last operating to show call lights over 2 months ago. V14 recalled issues with the call light system in the past, such as the alarms going off whenever any resident would activate the alarm at both nurse's stations. V14 explained staff would have to go to all the units throughout the facility to figure out which call light was on. V14 observed R4's old room from the nurse's station and affirmed R4's room was not near the nurse's station.On 5/26/26 at 2:02pm, V3 (Maintenance Director) said, I wasn't aware that R17's call light doesn't work. I'll check it (R17's call light) out now. On 5/26/26 at 3:06pm, V3 (Maintenance Director) said, There was a bad relay in main control box and wouldn't send a signal for light to turn on. I switched out the wire and traced from room to main box. It's (R17's call light) working now.R1's face sheet documents an admission date of 11/24/25 and diagnoses that include but are not limited to abnormalities of gait, unsteadiness on feet, muscle wasting and atrophy, lack of coordination, cognitive communication deficit, and low back pain.R1's BIMS (brief interview for mental status) score, dated 3/2/26, is 15 which indicates R1 is cognitively intact.On 5/26/2026 at 2:45 PM, R1 explained R1 does not use the call light because it is no use. R1 recalled usually waiting over an hour for R1's call light to be answered or the call light wouldn't be answered by the staff at all. R1 stated, I could be dead by the time the staff respond (to the call light). Staff cannot hear the call light and you'll wait over 45 minutes for them to come especially if they are working down another hall. Staff cannot see the call lights when we (residents) put them on. On 5/28/2026 at 2:19 AM, V1 (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(Administrator) denied knowledge on how long the call light system was in disrepair. V1 explained the system's wiring was in disrepair and had to be repaired so the call light would illuminate near the nurse's station and so the audible sound could be heard when the call lights are activated. On 5/28/2026 at 3:10 PM, V2 (Director of Nursing) confirmed V2 was aware of the call light system in disrepair and not having an audible alarm to notify staff. V2 denied telling administration or other responsible parties that the call light system was not working properly. V2 stated V2 didn't report anything wrong at the time because the call light system had not been functioning and having an audible alarm since V2 was a floor nurse working night shift. V2 stated that the call light not having an audible alarm was just the way things were, the staff knew it was just the way it was. Record review of facility's call light logs (quality assurance) for (12/2025-present) do not document any identification that the overall call light system was in disrepair. Isolated repairs for resident rooms were noted. There was no documentation of assessment of the overall system that was not directly related to the call light in the resident's room (such as audible alarming at the nurse's station). Record review of QAPI committee meeting minutes (1/2026-Present) do not document any identification that the overall call light system was in disrepair. On 5/27/26 at 11:56am, V24 (Medical Director) affirmed V24 is a member of the facility's QAPI committee. V24 denied knowledge of any issues with the call light system. On 5/28/2026 at 2:19 AM, V1 (Administrator) affirmed V1 is a member of the facility's QAPI committee. V1 denied knowledge on how long the call light system was in disrepair. V1 explained the system's wiring was in disrepair and had to be repaired so the call light would illuminate near the nurse's station and so the audible sound could be heard when the call lights are activated. V1 denied the call light malfunction was ever reviewed, discussed or identified by the QAPI committee prior to the survey. V1 stated the purpose of QAPI is to identify data and trends and come up with ways to fix issues as well as track improvements. On 5/28/2026 at 3:10 PM, V2 (Director of Nursing) affirmed V2 is a member of the facility's QAPI committee. V2 confirmed V2 was aware of the call light system in disrepair and not having an audible alarm to notify staff. V2 denied telling administration or other responsible parties that the call light system was not working properly. V2 stated V2 didn't report anything wrong at the time because the call light system had not been functioning and having an audible alarm since V2 was a floor nurse working night shift. V2 stated that the call light not having an audible alarm was just the way things were, the staff knew it was just the way it was. V2 denied the call light malfunction was ever reviewed, discussed or identified by the QAPI committee prior to the survey. No further documentation was provided that indicates the QAPI committee was aware of the systemic failure of the facility's call light system prior to the exit of the survey. 2) Review of Medicare's Nursing Home Care Compare system indicates the facility has a 1-star staffing rating indicating the facility's staffing levels are much below average. The facility is below both the Illinois and National Average for registered nurses hours per resident/day, nursing aide hours per resident/day, and total number of nurse staff hours per resident per day on the weekends. Total number of nurse staff hours per resident per day for the facility is 3 hours and 3 minutes (National average: 3 hours and 52 minutes, Illinois average: 3 hours and 29 minutes). Registered Nurse hours per resident per day for the facility is 37 minutes (National average: 41 minutes, Illinois average: 43 minutes). LPN (Licensed Practical Nurse) hours per resident per day is 46 minutes (National average: 52 minutes). Nurse aide hours per resident per day is 1 hour and 40 minutes (National average: 2 hours and 20 minutes, Illinois average: 2 hours and 7 minutes). Total number of nurse staff hours per resident per day on the weekend is 2 hours and 55 minutes (National average: 3 hours and 26 minutes, Illinois average: 3 hours and 6 minutes). Record review for facility's Daily Assignment Sheet, date 5/8/26 night shift (R4's fall), documents that V9 (Registered Nurse/RN), V12 (Registered Nurse/RN), V10 (Certified Nursing Assistant/CNA) and V19 (Certified Nursing Assistant/CNA) worked floor 2; and V42 (Certified Nursing Assistant/CNA) worked the locked unit on floor2. V13 (Registered Nurse/RN), V34 (Registered Nurse/RN), V37 (Registered Nurse/RN), V43 (Certified Nursing Assistant/CNA), V44 (Certified Nursing Assistant/CNA), V45 (Certified Nursing Assistant/CNA), V46 (Certified Nursing (continued on next page)

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On 5/20/2026 at 10:45 AM, V35 affirmed V35 had not completed the morning medication pass and still had to pass medications to residents that were due at 8-9 AM. V35 stated medications are to be administered an hour before and an hour after the administration time. V35 explained V35's is assigned to care for at least 27 residents on V35's current assignment. V35 recalled beginning the medication pass promptly after receiving report after V35 arrived to V35's shift at 7:00 AM. V35 explained the staffing assignment V35 is assigned to has a lot of care needs, such as most residents require blood pressure to be taken before medication is administered, multiple diabetic residents that require blood sugar monitoring, residents that require supervision due to high fall risks, multiple residents that need breathing treatments, and most residents with overall more care needs than a typical nursing home unit. V35 expressed V35 tries V35's best to ensure medications are delivered timely, but with all the extra work and resident/family needs, it is not feasible or safe. On 5/21/2026 at 3:40 PM, V32 (Licensed Practical Nurse) affirmed V32 was familiar with V35 and stated V35 was a good nurse. V32 recalled being assigned to the assignment V35 was assigned to. V32 explained that assignment requires the most care no matter what changes they make to the resident population or who comes and goes. At one point, there was 14 residents on that assignment that needed blood sugar monitoring, which is pretty much impossible when you have to get 14 blood sugars before someone eats lunch. I (V32) think we could at least use another nursing assistant, if not another nurse. So many things can happen. If there is ever a change in condition, you'd never be able to complete anything you need to, especially in the morning. I've been late passing meds or doing other tasks because I'll have to call 911 and send a resident out and there's so many residents to care for. I don't think there is enough time in the nursing assignments to accurately chart. Residents do complain to me that we don't have enough staff. I have heard them complain about waiting over an hour for call light to be answered, they complain the most about the night shift staffing. Yes, I do recall times when coming in on my shift (days) residents have been excessively soiled and didn't get timely incontinence care. I have worked overnights, and I can't speak for a lot of the other units, but there's like 3 nurses and 3 aides. The unit 2 has like 50 residents assigned to one nurse on the night shift. We used to have 2 nurses for V35's assignment, but when the new company bought the building, they cut the nurse. I don't know why they cut the nurse, we need it. R16's face sheet documents R16 is a [AGE] year-old resident with prior diagnoses, including but not limited to: systemic lupus erythematosus, osteomyelitis, type 2 diabetes mellitus, anemia in chronic kidney disease, obesity, sickle cell disease, chronic kidney disease, acquired absence of left and right legs, and osteoarthritis. R16's minimum data set (4/13/2026) documents a brief interview of mental status summary score of 13, indicating R16 is cognitively intact. On 5/26/2026 at 10:30 AM, R16 expressed that it takes a long time for call lights to be answered upwards of 20 minutes at a time on days an evening shifts. R16 explained night shift is the worst and takes a long time for them to address call lights. R16 explained the facility needs more CNAs on all shifts, as there is no way a day shift CNA can be assigned 15-17 residents and be able to complete good quality care. R16 affirmed R16's medications are usually administered late. R14's face sheet documents R14 is a [AGE] year-old resident with diagnoses including: type 2 diabetes mellitus, morbid obesity, cardiomegaly, chronic obstructive pulmonary disease, atopic dermatitis, spinal stenosis, chronic diastolic heart failure, atrial fibrillation, hypothyroidism, fibromyalgia, major depressive disorder, and anxiety disorder. R14's minimum data (continued on next page)

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R1's face sheet documents an admission date of 11/24/25 and diagnoses that include but are not limited to abnormalities of gait, unsteadiness on feet, muscle wasting and atrophy, lack of coordination, cognitive communication deficit, and low back pain.R1's minimum data (dated 3/2/26) documents a brief interview of mental status summary score of 15 indicating R1 is cognitively intact.On 5/26/2026 at 2:45 PM, R1 explained R1 does not use the call light because it is no use. R1 recalled usually waiting over an hour for R1's call light to be answered or the call light wouldn't be answered by the staff at all. R1 stated, I could be dead by the time the staff respond (to the call light). R1 explained the facility is very understaffed and sometimes gets medications administered late. R1 felt bad for the nurses from the staffing levels. R1 explained that night shift is the worst to get needs responded to. Staff cannot hear the call light and you'll wait over 45 minutes for them to come especially if they are working down another hall. Staff cannot see the call lights when we (residents) put them on. R1 believes the turnover rate is over 50% for staff because the work conditions of the staff. They get tired and overworked. All shift staffing is bad. R24's face sheet documents R24 is a [AGE] year-old resident and has active diagnoses (including but not limited to): chronic obstructive pulmonary disease, asthma, anxiety disorder, osteoarthritis, rheumatoid arthritis, bursitis of left elbow. R24's minimum data set (5/13/2026) documents a brief interview of mental status summary score of 15, indicating R24 is cognitively intact. On 5/27/2026 at 3:15 PM, R24 affirmed R4 has been a resident of the facility for 5 years. R24 believed the facility was better under the previous ownership. R24 explained staffing on all shifts are bad. R24 has had to put on the call lights on numerous times. The CNAs are lazy. R24 recalled activating the call light so her roommate can get incontinence care and recalled CNAs coming into the room, shutting off the light and coming back for over an hour. R24 explained that the resident council has brought up concerns about the call lights, nursing assistants not checking/supervising the residents as they should for over a year now and nothing changes. R24 affirmed R24's medications are usually administered late. R24 expressed staffing is terrible across all shifts, but the worst on third shift (night shift). R24 believed the facility needs more staff on all shifts across the facility. On 5/26/2026 at 3:30pm, V29 (Licensed Practical Nurse/LPN) said, I do feel like we (facility) could use more staff, especially to watch the residents that are confused and risk for falls. I sometimes pass the medications late cause it gets busy, and we (facility) can use more help. On 5/27/26 at 9:25am, V34 (Licensed Practical Nurse/LPN) said, Yeah, we (facility) can use more CNAs with the type of patients we are getting in. A lot of high fall risk residents. They (facility) don't give us (facility) extra staff to supervise the residents. We (facility) need more CNAs just for high-fall-risk residents because some of them (residents) need 1:1. On 5/27/26 at 11:56am, V24 (Medical Director) affirmed V24 is a member of the facility's QAPI committee. V24 affirmed staffing is a known concern within the facility. V24 stated, Staffing with all honesty is a concern. The staff is good. I think the amount of residents they have is a concern, but that's more of an Administrator question. They (staff) need to take care of the residents. I know the staff are having difficulties with the amount of residents assigned. On 5/28/2026 at 2:19 AM, V1 (Administrator) explained the purpose of the facility assessment is to identify what resources are needed to effectively care for the facility's residents. V1 reviewed the facility assessment and affirmed the staffing ratios in the facility assessment were correct and were the required staffing ratios to meet the resident's needs. V1 affirmed the facility assessment was last reviewed on 4/2026. V1 stated the facility used to run 9 (continued on next page)

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V1 stated, I'll have to look into that. V1 was unaware V35 was scheduled to care for 34 residents (5/20/2026) and affirmed the staffing ratio is 1:25 for that assignment. V1 believed the staffing levels were adequate in the facility to meet the resident's needs. V1 affirmed the staffing ratio in the facility assessment was accurate, and that the facility should have been staffed according to the facility assessment on 5/9/2026. V1 (Administrator) affirmed V1 is a member of the facility's QAPI committee. V1 denied insufficient staffing was ever reviewed, discussed or identified by the QAPI committee prior to the survey. V1 stated the purpose of QAPI is to identify data and trends and come up with ways to fix issues as well as track improvements. On 5/28/2026 at 3:10 PM, staffing ratio in the facility assessment was reviewed with V2 and V2 indicated the staffing ratio sounded right. V2 (Director of Nursing) affirmed the facility is generally staffing between 9-10 certified nursing assistants at night. V2 affirmed that 9-10 CNAs does not meet the staffing ratio listed in the facility assessment. V2 denied being involved in the development or updating of the facility assessment. V2 believed the staffing within the facility was sufficient to meet the resident's needs. V2 (Director of Nursing) affirmed V2 is a member of the facility's QAPI committee. V2 denied insufficient staffing was ever reviewed, discussed or identified by the QAPI committee prior to the survey. No further documentation was provided that indicates the QAPI committee was aware of the systemic failure of the facility's insufficient staffing prior to the exit of the survey. The facility job description for the job title, Administrator (undated) documents the Administrator position directs the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities, to assure that the highest degree of quality care is maintained at all times. The facility job description for the job title, Director of Nursing (undated) documents the director of nursing is responsible for determining and maintaining staffing needs in the nursing department, concerning the operation of the nursing department ensuring that a sufficient number of nurses and CNAs are available for each shift and overseeing work assignments/scheduling and duty hours with the Staffing coordinator. Facility QAPI plan (5/9/2026) documents VISION At [NAME] OF CRESTWOOD, we're bringing healthcare back to basics. Back to a place where people take care of people. That starts with our approach, our staff, and our residents. MISSION [NAME] OF CRESTWOOD puts people first. We spotlight each individual's needs and build custom care plans that help our residents rise up and get back on their feet. PURPOSE The purpose of QAPI in [NAME] of CRESTWOOD Facilities is to take a proactive approach to continually improve individualized patient care so that we may realize our vision to lead healthcare back to the basics where people take care of people. To do this, [NAME] of CRESTWOOD of shall promote individualized care plans helping our residents rise up and get back on their feet as part of the ongoing QAPI efforts. QAPI is an integral part of [NAME] of CRESTWOOD. It is a continuous process that aims to provide quality of care for our patients . 4. The focus of QAPI program is to improve processes instead of individual behaviors. Thus, the interdisciplinary team shall be encouraged to communicate any system gaps/breakdowns or opportunities without fear of punishment. 5. [NAME] of CRESTWOOD shall utilize multiple data sources to monitor performance, adverse events, feedback from patients/families/partner vendors and the like to ensure quality care and services are provided. 6. A systematic analysis of data shall serve as a guide in performing root cause analysis in order to identify and prioritize performance improvement projects. 7. Appropriate (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interventions to address issues/adverse events/negative outcomes shall be implemented. Failure Mode and Effects Analysis shall be done to ensure effectiveness and sustainability of any change . The QAPI program of [NAME] of CRESTWOOD shall have a GOVERNING BODY/EXECUTIVE LEADERSHIP that shall be composed of the following members: - Administrator - Administration - Director of Nursing - Assistant Director of Nursing -Medical Director The Executive Leadership team shall be tasked with ensuring execution of all components of the QAPI plan. B. QAPI top-level management leaders make up the QAPI Committee and shall be responsible and accountable in monitoring their respective department for opportunities for improvement, data gathering, interpretation, and presentation, as well as PIP development, implementation, and evaluation . Minutes of the meeting shall be documented by the QAPI Champion and filed in a binder or electronic record. Minutes and reports shall be kept by Administration.Agenda shall be composed of: Date of Meeting Names of Participants MinutesMinutes shall comprise of: Recap from previous meeting Current issues (include presentation of data, analysis, andcorrective actions) Decision (quorum must be met) Implementation of change discussion; delegation of task;follow-upESSENTIAL FUNCTIONS OF THE QAPI COMMITTEEa. The QAPI Committee shall be responsible for ensuring that high quality care isconsistently and effectively delivered to patients in accordance with best clinicalpractices, state and federal regulations.b. The QAPI Committee shall provide support to the employees by providing the necessaryresources to enable them to fulfill their roles.c. The QAPI Committee shall provide strategic guidance and hold employees accountablefor day-to-day activities.d. The QAPI Committee shall be responsible for data gathering and analysis as well asdevelopment of appropriate PIP that would encompass the goals and interventions.e. The QAPI Committee shall evaluate QAPI initiatives to ensure effectiveness andsustainability.f. The QAPI committee shall meet on a monthly basis and as neededIV. FEEDBACK, DATA SYSTEMS, AND MONITORINGA. [NAME] of CRESTWOOD will be drawing data from multiple sources to monitor care andservices, as listed below:Nursing Home CompareCASPER Report- CarewatchPoint Click Care Data AnalyticsClinical Score CardsInternal MetricsB. Listed (but not limited to) are sources of data that shall be monitored through QAPI- Customer satisfaction ratings (survey report from residents, family, others)- Resident Council minutes/feedbackAdverse Events (falls, injuries, infection, etc.)/ Reportable cases- Department Health Surveys/ Accreditation SurveysComplaints/Grievance- Star ratings- Employee retentionPerformance Indicators . VI. SYSTEMATIC ANALYSIS AND SYSTEMIC ACTION . B. Root Cause Analysis Tools shall be utilized to evaluate the source of the problem/issues to ensure appropriate interventions are put in place .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to adequately sanitize reusable durable medical equipment between patient use, failed to perform hand hygiene before preparing medications for administration and failed to have accurate signage posted for isolation precautions (R17), These failures affected four residents (R14, R17. R18 and R19) and has the potential to affect all 34 residents who receive medications from unit one medication cart. Findings include: Facility census report (5/21/2026) documents 19 residents receive routine blood pressure monitoring. R14's face sheet documents R14 is a [AGE] year-old resident with diagnoses including: type 2 diabetes mellitus, morbid obesity, cardiomegaly, chronic obstructive pulmonary disease, atopic dermatitis, spinal stenosis, chronic diastolic heart failure, atrial fibrillation, hypothyroidism, fibromyalgia, major depressive disorder, and anxiety disorder. On 5/20/2026 at 9:30 AM, began observing V35 complete medication pass. Observed V35 (Licensed Practical Nurse) withdraw an automatic wrist blood pressure machine from the medication cart to obtain R14's blood pressure. The blood pressure cuff/machine was not sanitized prior to V35 entering R14's room. V35 affirmed the blood pressure machine was V35's personal machine and not owned by the facility. V35 obtained R18's blood pressure and returned to the medication cart. The blood pressure cuff/machine was not sanitized after use. V35 placed the unsanitized cuff directly on the medication cart without a barrier, which caused the top of the medication cart (preparation area) to become contaminated. The medication cart was not sanitized after the cuff was placed on the top of the medication cart. R18's face sheet documents R18 is a [AGE] year-old resident with diagnoses including: non-traumatic intracerebral hemorrhage, type 2 diabetes mellitus, morbid obesity, hemiplegia of unaffected side, basal cell carcinoma, atopic dermatitis, chronic pain syndrome, atrial fibrillation, and hypertension. On 5/20/2026 at 9:55 AM, observed V35 (Licensed Practical Nurse) grab the unsanitized blood pressure machine from the medication cart to obtain R18's blood pressure. V35 obtained R18's blood pressure and returned to the medication cart. The blood pressure cuff/machine was not sanitized after use. V35 did not complete hand hygiene after obtaining the blood pressure reading. V35 withdrew R18's medications from the medication cart and placed the medications in a medication cup. V35 did not complete hand hygiene after medications were placed in a cup. V35 entered R18's room and administered medications. No hand hygiene was completed prior to administering the medications. R17's face sheet documents R17 is a [AGE] year-old resident with diagnoses including: Ogilvie syndrome, moderate protein calorie malnutrition, anemia, enterocolitis due to clostridium difficile, acute kidney failure, cachexia, hypoxemia, major depressive disorder, anxiety disorder, and unspecified psychosis. On 5/20/2026 at 9:58 AM, observed V35 grab the unsanitized blood pressure machine, and enter R17's room. A contact isolation sign with personal protective equipment was on R17's door. R17 did not wear any personal protective equipment prior to entering the room. V35 obtained R17's blood pressure and placed the unsanitized machine on the medication cart. The blood pressure cuff/machine was not sanitized after use. V35 did not complete hand hygiene after obtaining the blood pressure reading. V35 placed the unsanitized cuff directly on the medication cart without a barrier, which caused the top of the medication cart (preparation area) to become contaminated. The medication cart was not sanitized after the cuff was placed on the top of the medication cart. V35 withdrew R17's medications from the medication cart and placed the medications in a medication cup. V35 did not complete hand hygiene after medications were placed in a cup. V35 entered R17's room and administered medications. No hand hygiene was completed prior to administering the medications. V35 observed the contact isolation sign and confirmed the contact isolation sign was on the door. V35 stated the sign was old and R17 hadn't been on isolation in months. V35 stated the sign should have been taken down. R17's physician orders do not document an active order for contact isolation. R19's face sheet documents R19 is a [AGE] year-old resident with diagnoses including: chronic obstructive (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pulmonary disease, muscle wasting and atrophy, multiple sclerosis, type 2 diabetes mellitus, quadriplegia, osteoarthritis, and metabolic encephalopathy. On 5/20/2026 at 10:05 AM, observed V35 grab the unsanitized blood pressure machine from the medication cart to obtain R19's blood pressure. V35 obtained R19's blood pressure and returned to the medication cart. The blood pressure cuff/machine was not sanitized after use. V35 did not complete hand hygiene after obtaining the blood pressure reading. V35 placed the unsanitized cuff directly on the medication cart without a barrier, which caused the top of the medication cart (preparation area) to become contaminated. The medication cart was not sanitized after the cuff was placed on the top of the medication cart. V35 withdrew R19's medications from the medication cart and placed the medications in a medication cup. V35 entered R19's room and administered medications. R16's face sheet documents R16 is a [AGE] year-old resident with prior diagnoses, including but not limited to: systemic lupus erythematosus, osteomyelitis, type 2 diabetes mellitus, anemia in chronic kidney disease, obesity, sickle cell disease, chronic kidney disease, acquired absence of left and right legs, and osteoarthritis. On 5/20/2026 at 10:23 AM, observed V35 grab the unsanitized blood pressure machine from the medication cart to obtain R16's blood pressure. V35 obtained R16's blood pressure and returned to the medication cart. The blood pressure cuff/machine was not sanitized after use. V35 did not complete hand hygiene after obtaining the blood pressure reading. V35 placed the unsanitized cuff directly on the medication cart without a barrier, which caused the top of the medication cart (preparation area) to become contaminated. The medication cart was not sanitized after the cuff was placed on the top of the medication cart. V35 withdrew R16's medications from the medication cart and placed the medications in a medication cup. V35 entered R16's room and administered medications. On 5/20/2026 at 10:45 AM, V35 confirmed V35 did not sanitize the blood pressure cuff/machine between obtaining the blood pressures for each resident. V35 explained V35 typically sanitizes the blood pressure cuff after 3-4 residents get their blood pressure taken. When V35 has sanitized the cuff in-between each resident in the past, the residents complain that the cuff causes their skin to itch or they will break out. V35 affirmed hand hygiene should be performed before/after taking a blood pressure, and before/after medication administration. On 5/21/2026 at 1:23 PM, V2 (Director of Nursing) explained the nursing staff should be sanitizing durable, multi-use medical equipment, including blood pressure cuffs between each resident. Staff should be using things like bleach wipes to sanitize the equipment and allowing sufficient time for the chemicals to dry. V2 explained the purpose of sanitizing equipment between resident use is to prevent the spread of infections. V2 affirmed hand hygiene should be performed after medication administration and completing care. V2 confirmed R17 did not have active orders for isolation, and the sign should be enhanced barrier precautions. Facility policy titled, DISINFECTING REUSABLE EQUIPMENT (Reviewed 2/2025) documents the purpose of the policy is to provide guidance on how to clean reusable equipment between residents. The policy instructs staff to obtain bleach or disinfectant wipes and apply gloves. Take a pre-moistened disinfectant wipe and clean the entire surface of the equipment.Inspect to ensure all areas are clean. Allow product to remain on equipment according to manufacturer's recommendations. Remove and discard gloves. Sanitize hands. Repeat process between resident use. Facility policy titled, 5.2 Medication Administration (7/2024) documents staff should be washing hands before beginning medication administration, whenever the staff's hands are contaminated and if contact is made with the medication. Facility policy titled, Infection Control Program- General (revised 7/2025) documents 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 recommendations and guidance. The facility has established a policy to Identify, Record, Investigate, Control, Test, and Prevent infections in the facility. A sign will be provided outside the room for residents on transmission-based precautions indicating the type of precaution (Contact, Droplet, or EBP). As long as the type of infection is not included in the signage, the isolation sign is compliant with F583 in the SOM.Hand hygiene will be performed by staff and contracted workers before and after direct patient contact and after each situation that necessitates hand hygiene.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to have sufficient operating call light system; and failed to ensure two resident's (R17 and R25) call lights were working properly. These failures affected two (R17 and R25) of 7 residents reviewed for call lights but have the potential to affect 145 residents residing in the facility. Findings include: On 5/19/26 at 11:06am, V12 (Registered Nurse/RN) said in part, Call lights sound like an AI voice but disconnects cause of internet or something and most of the time there is no sound for the call lights. If that's not working, you just gotta keep monitoring your lights. Honestly, the sound for the call lights doesn't work often. On 5/20/2026 11:05 AM, V20 (Unit Manager, Licensed Practical Nurse) affirmed in part V20 is the unit supervisor for unit two. V20 affirmed there is no panel or other system that notifies staff of a call light being activated other than a light outside the resident's door. V20 denied knowledge of any system the facility uses to track call light response times or rounding. On 5/20/2026 at 11:16 observed V14 (Staffing Director) sitting at the unit 2 nurse's station. V14 observed the nurse's station and affirmed there is no panel or other way staff know what call light is activated. Beeping was heard in the background of the nurse's station, but V14 was unsure what the beeping was from or if it was a call light. V20 gestured to powered off television (TV) and explained the call lights used to show on the television, indicating which resident's light had been activated. V14 recalled the TV last operating to show call lights over 2 months ago. V14 recalled issues with the call light system in the past, such as the alarms going off whenever any resident would activate the alarm at both nurse's stations. V14 explained staff would have to go to all the units throughout the facility to figure out which call light was on. On 5/21/26 at 2:14pm, R6 said, When you press the call button, you expect staff to come. That's what it (call light) is for. On 5/21/26 at 3:32pm, V32 (Licensed Practical Nurse/LPN) said, Regarding the call light system, there is no audible sound at the nurses' station, so staff must physically look to see whether a call light is on. State surveyors previously came in and the system worked properly for a few weeks afterward and stopped working. The call light system hasn't been working properly for years. If a staff member is supervising residents at the nurses' station, they absolutely cannot leave the residents to answer call lights. On 5/26/26 at 1 PM, R17 indicated my call light has not been working for 2 weeks. They gave me the front desk telephone number so I can call from my cell phone, and they can page the CNA that is taking care of me. The maintenance guy told me they are working on fixing it because it's a system issue and no one has given me an update on when it will be fixed. Surveyor pushed R17's call light and the call light for the empty bed in R17's room and verified neither were operational. On May 26, 2026 at 12:30 AM the CNA came in to change my disposable brief and I never saw the CNA again the whole shift. I called the front numerous times about every 2-3 hours starting at 1 AM because I had bad diarrhea and needed my disposable brief changed. Every time I call, they pick up the phone and hang up. I called again at 5 a.m. and staff hung up again. I have been laying in diarrhea since 1 AM and it leaked onto the bed. Since no one answered my call, I dialed 911 (the fire department after they (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hung up on me at 5 a.m. The fire department called facility called facility to tell them a resident needs help. I could not stand laying in the diarrhea any longer, so I crawled out of bed and yelled for help. V35(Licensed Practical Nurse) came to help. She is very nice. My skin is sore and feels raw and painful because I was laying in diarrhea from 1 AM to 5 AM. On May 26, 2026 at 1:30 PM, R17 showed surveyor his personal cell phone dated May 26 and it captured R17 made 45 calls to the facility front by 7:01 AM. Surveyor called 911 dispatch center that provides response coverage for the facility's call(s) to verify 911 call from R17's cell phone number. Dispatch supervisor indicated they cannot share that information over the phone. On 5/26/26 at 2:02pm, V3 (Maintenance Director) said, I wasn't aware that R17's call light doesn't work. I'll check it (R17's call light) out now. On 5/26/26 at 3:06pm, V3 (Maintenance Director) said, There was a bad relay in main control box and wouldn't send a signal for light to turn on. I switched out the wire and traced from room to main box. It's (R17's call light) working now. In an email dated May 28, 2026, at 10:28 AM to the surveyor, documents in part: V1 indicated if there is any type of issue with call lights or any other equipment issues, staff are expected to notify management immediately. Management staff may either verbally notify the Maintenance Department or submit a work order through the facility's maintenance tracking system, TELS. Once the work order is entered into TELS, the system notifies Maintenance of the issue requiring repair or follow-up. Maintenance is then responsible for addressing the issue and closing out the work order in the system upon completion of the repair or corrective action. V1 indicated the call light was tested following the repair and confirmed to be functioning appropriately. Call light logs for the past 6 months (December 2025 to current) and no issues were noted from December 2025 through April 2026. Replacement and repairs were noted, On 5/28/2026 at 2:19 AM, V1 (Administrator) denied knowledge on how long the call light system was in disrepair. V1 explained the system's wiring was in disrepair and had to be repaired so the call light would illuminate near the nurse's station and so the audible sound could be heard when the call lights are activated. On 5/28/2026 at 3:10 PM, V2 (Director of Nursing) confirmed V2 was aware of the call light system in disrepair and not having an audible alarm to notify staff. V2 denied telling administration or other responsible parties that the call light system was not working properly. V2 stated V2 didn't report anything wrong at the time because the call light system had not been functioning and having an audible alarm since V2 was a floor nurse working night shift. V2 stated that the call light not having an audible alarm was just the way things were, the staff knew it was just the way it was. On 6/01/26 at 10:46am, with V3 (Maintenance Director), R25's call light and electrical box was observed not working, not attached to the wall, and without a required battery needed to function. V1 (Administrator) affirmed that R25's call light and electrical box was observed not working, not attached to the wall, and without a required battery needed to function. V3 said, I can't find the battery (battery to R25's call light). Maybe housekeeping swept it up. R25's face sheet documents diagnoses that include but are not limited to blindness right eye, paralytic syndrome, neuromuscular dysfunction, and epilepsy. R25's BIMS score, dated 4/9/26, is 13 which indicates R25 is cognitively intact. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R25's care plan documents, in part, Motorized Wheelchair: (R25) has impaired functional mobility related to old gunshot wounds. He requires a motorized wheelchair to move around. FALL: (R25) is at high risk for falls r/t (related to) recenthospitalization. On 6/1/26 at 10:47am, observed R25 sitting in a wheelchair, and R25 said, I'm not sure how long my call light has been broke. Sometimes it (call light) works, sometimes it (call light) doesn't. On and off. Oh yeah, I definitely use the call light. On 6/1/26 at 2:21pm, V50 (Licensed Practical Nurse/LPN) said, The call lights have improved. Faster response. Employees are answering it no matter who it is. Like housekeeper or even kitchen. The sounding is way more helpful. When I would be charting, I'd have to look up every so often to and see if the lights are on. On 6/1/26 at 2:31pm, V51 (Restorative Nurse) said, The call lights have a sound now which makes it much easier now to know when the residents need help. When you'd look down the hall and see a call light, you can only guess how long it's been on. Base it on the last time you checked. On 6/1/26 at 2:40pm, V52 (Certified Nursing Assistant/CNA) said, It's (answering call lights) easier now that we (staff) can hear the call lights. We (staff) didn't know when someone's light was on unless we (staff) went down the halls and looked at each light. On 6/1/26 at 2:58pm, V54 (Registered Nurse/RN) said, The sound now when a call light is on, is easier cause you can hear the light in the room and its loud so you know. You had to go searching and looking to see if call lights were on. Record review of facility policy titled, Call Light Response, dated 2/2026, documents, in part, To provide the staff with guidance on responding to residents' requests and needs. Report all defective call lights to the nurse supervisor or maintenance director promptly. Answer the patient or resident's call as soon as possible. If assistance is needed when you enter the room, summon help to the room.