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	06/30/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the resident's plan of care and accepted standards of practice for ostomy care by failing to monitor, measure, and document ileostomy output for one of one resident (R1) reviewed for ostomy care and services. This failure resulted in R1 having significant abdominal pain, being transported to the hospital, and diagnosed with a bowel obstruction.Findings include: R1's facility sheet shows diagnoses of colostomy status. R1's MDS dated [DATE] section H for bowel and bladder shows appliances- ostomy, bowel incontinence shows nine (9) Not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days.R1's care plan for R1 has potential risk for complications r/t (related to) altered elimination device for (bowel/bladder) elimination, as evidence by having colostomy, date initiated 5/1/2026. R1 will remain free from complication r/t device for altered elimination through next review. Interventions- check elimination device during routine care for appropriate fit leakage need for emptying. Irrigate ostomy as ordered. Monitor for signs and symptoms of complications and report to nurse abdomen for signs and symptoms distention results complaints of pain. Monitor ostomy site for swelling pain or redness around stoma site. Notify MD of any abnormal findings. Provide ostomy care per standards, assessing skin around stoma site for signs of irritation, breakdown, notify MD (medical doctor) of abnormal findings. Provide privacy during ostomy care, promoting resident dignity and reducing adverse feelings related to elimination devices.On 6/28/26 at 11:00am V4 (Certified Nursing Assistant/CNA) said she did not empty R1's ileostomy bag when she worked with R1 on 5/10/26 during the overnight shift. V4 said R1 emptied her own bag.On 6/28/26 at 11:17am V6 (Nurse Manager/LPN) said she received a call because she is one of the managers on the unit where R1 resided. V6 said she was made aware that R1 complained of abdominal pain, and refused testing. V6 said maybe the provider ordered an X-ray. V6 followed up with clarification and said R1 refused a KUB (kidney, ureter, and bladder diagnostic procedure). V6 said the provider did not give her an order for a KUB. V6 confirmed that R1 orders shows that the facility staff was managing and caring for R1's ostomy, not R1.On 6/27/26 at 12:31pm V1 (R1's Family Member) said on 5/11/26 he visited R1. Around 3:00pm to 4:00pm, R1 informed him that she had abdominal pain. He escorted R1 to the nurse station informed the nurse who stated they would call the physician. V1 said the nurse had not followed up with R1 prior to him leaving. V1 said later R1 called him crying and stated she wanted to go to the hospital. V1 returned to the facility and took R1 to the hospital. V1 said R1 was diagnosed with a bowel obstruction. V1 said he remembers the nurse stating that they could run test at the facility, and he stated why they didn't do that already, he told them that he was taking R1 to the hospital.On 6/28/26 at 2:08pm V8 (Licensed Practical Nurse/LPN) said she was R1's nurse on 5/11/26. V8 said she does recall that R1 was complaining of abdominal pain after dinner. V8 said she assessed R1's abdomen and R1 did not have any fluids in her ostomy bag. V8 said R1 told her that she had not had a bowel movement in 2-3 days. V8 said R1 rated her pain as 20 out of 20. V8 said she paged the provider, with no response. V8 said the manager on duty said the facility could do a KUB. V8 said the provider did not call her back and give her any orders for a KUB, that information was (continued on next page)

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

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F 0691 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	coming from the manager on duty. V8 said R1 was yelling out, asking when are they going to get her. V8 said R1 was asking about her son, because her son was returning to take R1 to the hospital. V8 said R1 decline pain medication. V8 said the Director of Nursing/DON was made aware and was returning to the facility to assist, but she doesn't recall seeing the DON. V8 said R1's son took R1 to the hospital, she escorted R1 to the car in a wheelchair. V8 said she documented that R1 refused testing at the facility, but the doctor/provider never gave orders for testing. V8 said that is not considered a refusal of testing. V8 said R1 left the facility around 7:00pm. V8 said she did not document that R1 ileostomy bag did not have any fluids in it and she did not document the assessment of R1's abdomen. V8 said she should have documented the assessment and the findings. V8 said she did not empty R1's ostomy pouch during her shift. V8 said when she texted the provider, she mentioned that R1 was complaining of abdominal pain, she did not mention her findings in the text.On 6/28/26 at 3:18pm V10 (LPN) said she did not empty R1's ileostomy bag during her shift on 5/11/2026. V10 worked with R1 during the morning shift.On 6/30/26 at 10:06am V16 (Nurse Practitioner) said he received a message from the nurse that R1 complained of abdominal pain and was sent to the hospital. V16 said the nurse did not give details of R1's pain rated 20-20 and the assessment of no fluids in the ileostomy pouch. V16 said he should have been notified right away. V16 said she should be made aware of all details so that he can make a competent decision on the care. V16 said the output of the ileostomy should be monitored and documented. V16 said he saw R1 that morning, she had no complaints at that time. V16 said he documented it at 3:31pm, but that is not the time he saw R1. V16 said R1's ostomy was chronic, and it is not uncommon that R1 cared for her ostomy, but the staff should have asked R1 about what was emptied from her ileostomy pouch and documented what she said also.On 6/28/26 at 12:10pm V5 (Physician) said the facility should be monitoring and documenting the output for an ileotomy. V5 said the providers review and use that information to identify concerns. R1's physician order sheet did not contain an for a KUB.R1's progress notes dated 5/11/26 completed by V8 (LPN) denotes resident complained of abdominal pain, 10 out of 10. Resident stated that she has not produced a bowel movement in 2-3 days. Provider was contacted. Resident refused treatment, including pain interventions and diagnostic testing. Resident opted to be transferred to the emergency room by her son in private vehicle. R1's care plan does not reflect that R1 will care for her ileostomy. R1's care plan does not reflect that R1 was educated on risk and benefits independently caring for her ileostomy site. R1's care plan does not reflect that R1 was educated on informing the facility of the output of her ileostomy site/pouch. The facility did not present any documentation that R1 refused to allow the staff to care for her ileostomy site.R1's progress notes dated 5/12/26 denotes in-part writer called (hospital name) to get follow up on resident; admitted to hospital; dx (diagnosis): small bowel obstruction.Facility ostomy care policy dated 1/2026 does not mention documentation monitoring the output.Facility policy dated 1/2026 titled comprehensive care plan denotes in part the facility must develop a comprehensive person-centered care plan for each resident. The care will include focused, measurable goals, and interventions specific to the residents medical, nursing, mental and psychosocial needs. The comprehensive care plan should drive the care and services provided for the residents and allow for the highest level of physical, mental and psychological function based on comprehensive MDS assessment.