

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2025
NAME OF PROVIDER OR SUPPLIER  Aliya of Glenwood		STREET ADDRESS, CITY, STATE, ZIP CODE  19330 South Cottage Grove Glenwood, IL 60425	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review , the facility failed to implement their abuse prohibition policy to ensure the safety of a resident when an employee is accused of abuse and was permitted to remain in the facility, the facility also failed to ensure a resident had an initial abuse screening and initial abuse care-plan and failed to revise the care-plan for 1 of 1 resident (R3) in a sample of 5 reviewed for Abuse. Findings include:On 8/19/2025 at 10:30am R3 said that on 8/5/2025 at about 12:30am, she requested pain medication from V8 (Nurse) and that V8 said she did not have any pain medication available, and she would administer the medication when available. Upon returning to her room R3 said she overheard the nurse at the station reading her chart out loud stating, I see why her legs are burned. R3 said she felt bad and did not come out of her room anymore that night. R3 reported this to V15 (Social Service), which she was told by V1 (Administrator) that V8 would not work on this unit anymore. On 8/17/2025 at 12:30am R3 said she ask the (Certified Nursing Assistant-CNA) to inform the nurse she needed pain medication, at about 2:30am V8 entered her room and informed her she did not have any medication and her medication would be delivered in the morning, R3 said she was surprised to see V8 working on the unit, she did not want to speak to her any longer and proceeded to lay in the bed until the day shift arrived feeling lied to and belittled. On 8/21/2025 at 12:30pm V14 (MDS/ Care plan Coordinator) said that R3 should have an abuse care-plan put in by the social service department and should have an abuse screening.On 8/21/2025 at 1:00pm V15 said that R3 informed her that V8 was overheard reading her chart out loud and refused to give her pain medication, V15 said I then put in a concern form for both accusations. V15 said that R3 does not have an initial abuse screening and should have one and does not have an initial abuse care plan and no care-plan updates for the following abuse accusations because she was auditing and updating all the abuse care-plans and had not gotten to her yet. On 8/21/2025 at 2:00pm V8 said that on 8/5/2025, the Certified Nursing Assistant-CNA informed her that R3 wanted pain medication, R3 then arrived at the nurse's station and asked why she was reading her chart out loud, I then informed R3 that she did not have any pain medication, and it would be delivered. I was informed by V1(Administrator) that I was accused of mental abuse by reading a chart out loud and not administering pain medication when a resident asks and was suspended, I was not informed that I could not work on that unit anymore that is why I worked that unit on 8/17/2025 I thought the allegations were unfounded my name was on the schedule for that unit.On 8/21/2025 at 10:00am V7 (Nurse scheduler) said she was informed on 8/8/2025 not to put V8 back on unit A and her name is there in error, I did not inform her to return to that unit. On 8/21/2025 at 1:40pm V2 (Director of nursing-DON) said that on 8/5/2025 V8 had been informed not to work on that unit anymore and had not been informed to work on A-unit that night and should not have worked on that unit. R3 should have an abuse screening upon admission, an abuse care-plan and care plan updates as needed. I expect the nurses to treat all residents with dignity and respect and administer medications as ordered. On 8/19/2025 at 1:00pm V1 said that on 8/5/2025 R3 had made a concern form that V8 was discussing her medical information and that V8 would not give her any pain medication. I educated V8, sent her home until the investigation was complete and then she returned with pay. V8 was informed not to work on unit A anymore and the Nurse Scheduler was also informed on 8/8/2025 not to place her on unit A, today I find out she was working on A unit again and was not told to not return. R3 should have an initial abuse screening, an abuse care plan, and updates as needed. I expect all residents to be treated with respect and dignity. I will start another abuse investigation. A resident information sheet dated 8/20/2025 indicates that R3 has a diagnosis of low back pain, venous thrombosis and embolism and post-traumatic stress syndrome with burns to bilateral lower extremities. An order summary report dated 8/20/2025 indicates an order date of 8/2/2025 for burn wounds to the bilateral lower extremities. Every shift staff is to cleanse with wound cleanser and gently pat dry, cover open areas with xeroform and abdominal dressing pads and wrap with rolled gauze. An order dated 7/31/2025 for oxycodone-acetaminophen oral tablet 5-325mg indicates to give 1 tab by mouth every four hours as needed for pain/discomfort. A care-plan dated 8/7/2025 focus for pain and discomfort/low back pain, wounds, DM, asthma intervention to administer pain meds and treatments as ordered. Facility Policy: Abuse Policy and PreventionAbuse PolicyThis facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse neglect exploitation misappropriation of property deprivation of goods and services by staff and</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on interview and record review the facility failed to effectively monitor and treat pain for a resident with bilateral burns to lower extremities for 1 of 1 resident (R3) reviewed for pain. Findings Include:On 8/19/2025 at 10:30am R3 said that on 8/17/2025 about 12:30am she informed the (Certified Nursing Assistant-CNA) that she needed some pain medication for her legs. At about 2:30am the night shift nurse entered her room and said she did not have any pain medication available and that it would be delivered in the morning. R3 said at that time her pain level was at an 8 out of 10. On 8/21/2025 at 1:00pm, V8 (Nurse) said she was R3's night nurse on 8/17/2025, the CNA informed me that R3 wanted pain medication. I did check for pain medication and R3 did not have any, I followed up with the pharmacy and the pharmacy indicated that the medication would be delivered in the early morning. It was 2:30am at that time, I offered R3 an alternative until delivery and R3 said no. I did not ask what R3's pain level was she did not want to talk to me any longer, I should have gotten it out of the convenience box, I don't know why I didn't.On 8/21/2025 at 1:00pm V2 (Director of Nursing-DON) said I expect all resident's medication to be administered as ordered and the medication to be retrieved from the convenience box immediately. I also expect for the nurses to ask each resident's pain level every shift and treat according to the physician orders.A resident information sheet dated 8/20/2025 indicates that R3 has a diagnosis of low back pain, venous thrombosis and embolism and post-traumatic stress syndrome with burns to bilateral lower extremities. An order summary report dated 8/20/2025 indicates an order date of 8/2/2025 for wounds related to burns to the bilateral lower extremities, every shift cleanse with wound cleanser and gently pat dry, cover open areas with xeroform and abdominal dressing pads and wrap with rolled gauze. An order dated 7/31/2025 for oxycodone-acetaminophen oral tablet 5-325mg indicates to give 1 tab by mouth every four hours as needed for pain/discomfort. A care-plan dated 8/7/2025 focus for pain and discomfort/low back pain, wounds, DM, asthma intervention to administer pain meds and treatments as ordered. Facility Policy; Pain Management Review date 1/2024General: To facilitate and provide guidance on pain observations and management, to facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our resident's the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement.Responsible partyNursing, DONGuideline: . Pain Management is multidisciplinary care process that includes the following:Effectively recognizing the presence of pain, Policy:2. pain will be assessed at least once every shift and documented on the EMAR using the pain scales appropriate for the patient. The following pain scales are available. a. numerical scale</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interview and record review the facility failed to ensure a resident's beta blocker medication was available for 1 of 3 residents (R1) and the facility failed to ensure that a resident's pain medication was available for 1 of 3 residents (R3) reviewed for medication administration in a sample of 5. Findings Include: On 8/19/2025 at 11:30am R1's electronic medication administration record was reviewed and the dates of 8/8-8/11/2025 Toprol XL 50mg, a beta blocker, was not administered. On 8/19/2025 at 1:45pm V4 (Nurse) said she was the nurse working on the following days of 8/8 - 8/11/2025 and that the medication was not available. V4 said she called the pharmacy and the pharmacy said they would deliver the medication as soon as possible, V4 said she should have retrieved the medication from the convenience box and did not. On 8/19/2025 at 2:00pm V2 (Director of Nursing-DON) said I expect all medications to be given to the resident's as ordered and retrieved from the convenience box if available. A resident information sheet dated 8/19/2025 indicates that R1 has a diagnosis of heart failure and hypertension. An order summary report dated 8/19/2025 documents an order for Toprol XL oral extended release 24-hour 50mg one tablet by mouth one time a day for Beta Blockers. An electronic medication administration record dated 8/19/2025 indicates the dates 8/8 - 8/11/2025 with V4 initials and NA - not available above the initials, an electronic medication administration record with the staff administration legend to indicate initials for 8/2025 V4 was identified. A care plan dated 8/19/2025 indicates R4 has a potential for altered cardiac function related to diagnosis of hypertension and heart failure and an intervention to administer medication as ordered. On 8/19/2025 at 10:30am R3 said that on 8/17/2025 about 12:30am she informed the (Certified Nursing Assistant-CNA) that she needed some pain medication and at about 2:30am the night shift nurse came to her room and said she did not have any pain medication available and that it would be delivered in the morning. Her pain level was an 8 out of 10 at the time. On 8/21/2025 at 2:00pm V8 (Nurse) said I was R3's night nurse on 8/17/2025. I did check for pain medication for R3 and she did not have any. I followed up with the pharmacy and the pharmacy indicated that the medication would be delivered in the early morning. It was 2:30am, I offered R3 an alternative until delivery and R3 said no. I should have gotten it out of the convenience box, I don't know why I didn't. On 8/21/2025 at 1:00pm V2 (Director of Nursing-DON) said I expect all resident's medication to be administered as ordered and the medication to be retrieved from the convenience box immediately. A resident information sheet dated 8/20/2025 indicates that R3 has a diagnosis of low back pain, venous thrombosis and embolism and post-traumatic stress syndrome with burns to bilateral lower extremities. An order summary report dated 8/20/2025 documents a date of 8/2/2025 for burn wounds to the bilateral lower extremities. Orders indicate every shift cleanse with wound cleanser and gently pat dry, cover open areas with xeroform and abdominal dressing pads, wrap with rolled gauze. An order dated 7/31/2025 for oxycodone-acetaminophen oral tablet 5-325mg give 1 tab by mouth every four hours as needed for pain/discomfort. A care-plan dated 8/7/2025 focus for pain and discomfort low back pain, wounds, DM, asthma intervention to administer pain meds and treatments as ordered. Facility Policy: Medication Administration review date 1/2024 General: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Level of Responsibility RN/LPNGuideline: 26. If medication is ordered, but not present, check to see if it was misplaced and then call the pharmacy to obtain the medication. If available, obtain it from the contingency or convenience box.</p>		