

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 12/13/2025
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their abuse policy and failed to protect one resident (R1) from repeated verbal and psychological abuse by R2. This failure affected one (R1) of three residents reviewed for abuse. These failures resulted in R1 experiencing ongoing fear and anxiety related to being R2's roommate. Findings include: R2's face sheet documents and admission date of [DATE] and diagnoses that include but are not limited to asthma, type 2 diabetes mellitus, and chronic kidney disease. R2's BIMS (brief interview mental status), dated [DATE] is 12 which indicates R2's cognition is moderately impaired. On [DATE] at 9:31am, R2 said, We (R1 and R2) had a disagreement a few days ago. They (facility staff) keep putting me in rooms that make me sick. The residents are way sicker than me. I'm not sick like all of them (other residents). I should have a private room or semi-private. Yeah, it was Saturday or Sunday ([DATE] or [DATE]) when our (R1 and R2) arguing got a little out of hand. His (R1) cough, his (R1) skin, and his (R1) hair is just nasty. I have to eat, and his nastiness is just no good for me. He's a disgusting fat pig. He needs to stay on his side of the room. I mean when he starts hacking, yeah, I called R1 nasty a** out. I don't call him names all the time, but it's happened a few. No, that's a lie. I never said that I would shoot anyone in the head. I came in with the BB gun. I had it ever since I was admitted here. Never took it (BB gun) out. They (facility staff) took my bag with the gun, and I called the police. I (R2) have a police report. R2 said, I've been in this room with R1 and R3 for about 3 weeks. R2's CHIRP (Criminal History Information Response Process), dated [DATE], documents, in part, Result: In Process. R2's care plan, dated [DATE], documents, in part, (R2) have a history of criminal behavior. (R2) have demonstrated stability during the admission screening process and does not appear to present at risk. I (R2) fit the criteria for an identified offender, with interventions, that document, in part, Appropriate supervision and observation. R2's (Name of Company) Live Scan Fingerprinting and Identity Services, dated [DATE], documents, in part, that R2 was fingerprinted on [DATE]. However, review of R2's electronic medical record (EMR) and interviews with facility staff revealed that R2's fingerprint results were not available and could not be located. R1's face sheet documents diagnoses that include but are not limited to chronic obstructive pulmonary disease, type 1 diabetes mellitus, and major depressive disorder. R1's BIMS (brief interview mental status), dated [DATE], is 15 which indicates R1 is cognitively intact. On [DATE] at 9:35am, R1 said, I (R1) never said anything about anyone saying that they were going to shoot me (R1) in the head. That's probably the one thing R2 hasn't said to me (R1). He (R2) did say that he's gonna slap me into next year and choke me to death. He (R2) moved in about 2 weeks ago. Nothing but problems. He doesn't like me. I (R1) think he's a germaphobe. I'm (R1) sick, I'm hospice, and I'm dying. There's nothing I (R1) can do. He (R2) wheeled past my bed the other day and kicked my bed so hard that my bed moved about 1 or 2 inches, and the bed was locked. The fight between us (R1 and R2) was real bad last Sunday ([DATE]). I (R1) went to turn up the air conditioner that is by his (R2) bed, cause it was hot as he** and he lost it. He was sitting in the doorway and started screaming, Don't go on my (R2) side of the room. Turn the air conditioner down. You fuc**** smell. He's (R2) not wrong, I am nasty because I'm dying and can't help it. I (R1) shower every day. I'm just sick. Oh yeah, V3 (Licensed Practical Nurse/LPN) and V4 (Nurse's Aide) know all about R2 going crazy on me (R1). V3 settled down R2. R2 is a scary guy. I can only take so much of him telling me I'm a fat faggot mother fuc***r. All the flies are in the room cause me (R1). He has a valid reason, but I'm sick and dying. I'm [AGE] years old. I don't need to be yelled at every day. I'm scared to death. Once he (R2) said that he (R2) was going to choke me to death. I'm (R1) scared to death. I'm (R1) constantly on edge because of him and I (R1) don't feel safe with him here. I'm scared of this guy (R2). I'm (R1) [AGE] years old and couldn't function myself out of a paper bag. Look. R1 pulls out of R1's sock, a facility menu, dated [DATE] (day after verbal altercation), that R1 wrote on documents, in part, CHOKIN TO DEATH; LIVING IN CHRONIC FEAR; R2. R1 said, I (R1) wrote on this and put it in my sock just in case R2 kills me (R1), so they know R2 did it. He's (R2) crazy. R1's active physician order, ordered date [DATE], documents, in part, Admit to Hospice Services for DX (diagnosis) of Respiratory Failure. R1's Abuse/Neglect Screening, dated [DATE], is 5 which indicates R1 is at high risk for potential future problems/ symptoms related to mistreatment. R1's care plan, dated [DATE], documents, in part, (R1) have been assessed for Risk of Abuse and Neglect, and I (R1) am at risk for abuse and Neglect, with interventions that documents, in part, Report any verbalization of abuse or neglect to administrator immediately. Immediately act and conduct abuse</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</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 provide a safe environment for residents residing in the facility and failed to perform a resident inventory check for one of three residents (R2) upon admission. This failure resulted in a weapon found in R2's possession due to facility not performing an inventory check. Findings include: Facility census, dated 12/12/2025, documents 137 residing in the facility. R2's face sheet documents admission to facility 10/30/2025 with diagnoses that include but are not limited to include but are not limited to asthma, type 2 diabetes mellitus, and chronic kidney disease. R2's BIMS (brief interview mental status), dated 11/05/25 is 12 which indicates R2's cognition is moderately impaired. R2's progress note, dated 12/10/2025, documents, in part, The resident (R2) returned from hospital and was immediately complaining of his missing black bag. The writer was busy with another resident while he (R2) was out in the hall yelling for nurses to return his bag. I explained to the resident that I was unaware of any missing items and that I will figure out what happened. The Resident called 911 for theft and police came out. The resident (R2) is heard yelling and blaming the shift nurses for theft. The officer managed to calm him down and the resident (R2) went into room. please follow up with social services about this behavior and situation. R2's Behavioral Assessment, dated 12/10/25, documents, in part, (R2) was observed with an unknown substance, smoking materials and contraband in his possession. SS (Social Services) conducted a 1:1 conversation educating the resident (R2) regarding the prohibition of contraband and unknown substance in the nursing facility. (R2) understood the education and the IDT (interdisciplinary team) has been made aware. R2's care plan, dated 11/10/25, documents, in part, (R2) have a history of criminal behavior. (R2) have demonstrated stability during the admission screening process and does not appear to present at risk. I fit the criteria for an identified offender, with interventions, that document, in part, Appropriate supervision and observation. On 12/12/2025 at 9:31am, R2 said (in part), I (R2) never said that I would shoot anyone in the head. I came in with the BB gun. I had it ever since I was admitted here. Never took it (BB gun) out. They (facility staff) took my bag with the weapon, and I (R2) called the police. I (R2) have a police report. On 12/12/25 at 10:39am, V9 (Infection Preventionist) said, The other day, maybe Tuesday (12/09/25), I (V9) was called to his (R2) room because R2's ankle was bleeding profusely. I (V9) couldn't get the bleeding to stop and told R2 I (V9) needed to send him out (hospital). R2 refused. I (V9) educated R2, and he agreed. R2 was adamant about telling me (V9) to make sure no one touches his (R2) things. R2 said it multiple times. It was kinda suspicious, so when I (V9) went to get his (R2) things, I (V9) smelled smoke. I (V9) wanted to make sure R2 wasn't smoking so I (V9) searched his things and found the BB gun. The BB gun was in R2's room. I (V9) locked it up in the office and reported it to the administrator. We (facility staff) then swept the entire building (checking for contraband). On 12/13/2025 at 10:19am, V1 stated, R2 did not have it (referring weapon) on admission and an inventory list was done. V1 further stated, she was unsure if R2 went out on pass, but he had to go to the hospital a few times. Surveyor asked if staff document when residents go out on pass. V1 stated, if he went out on pass it would have been documented in the progress notes. On 12/13/25 at 10:21am, V7 (Social Services Consultant) said, I'm the acting Social Services Director. I (V7) did have R2's contraband (BB gun). I (V7) attempted to find a working number for R2's sister to give it to her, even checked the hospital record, but was unable to get a working number for R2's sister. I (V7) gave the BB gun to the administrator. On 12/13/25 at 10:41am, V5 (Social Services Coordinator) said, I (V5) seen it (R2's BB gun). V7 (Social Services Consultant) discarded it (R2's BB gun). V9 (Infection Preventionist) originally had the gun and then gave it to V7. R2's BB gun was in an envelope, locked away, and was told V7 discarded it. That is all I (V5) know. On 12/13/25 at 10:56am, V1 (Administrator) said, R2's BB gun was discovered when R2 was preparing to go to the hospital. The IP (Infection Preventionist/V9) nurse noticed a smell of smoke and asked to see what was in R2's bag. Upon looking inside the bag, V9 found the BB gun. V9 contacted me, and I instructed V9 to take the item and secure it. V9 placed the BB gun in an envelope, took it to Social Services, and locked it in their office. There is no family contact information available for R2. As of yesterday, and to the best of my knowledge, the Social Services Consultant disposed of the BB gun. V1 said that the facility does not do routine checks of residents' belongings. V1 stated that the facility only checks resident's belongings if there's a suspicion. V1 did not report the BB gun to the Department because V1 did not consider it to be an actual weapon. V1 stated that no one else was aware of the BB gun, and it was not displayed, shown, or used in any manner. V1 said that the BB gun was not listed as part of R2's inventory on admission and R2 did not have it at the time of admission. V1 affirmed that resident's inventory</p>		