STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145758	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Glenwood	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to follow policy and procedures, failed to implement care plans, failed to follow physician orders, and failed to ensure that ordered dressing changes were provided for four (R1, R2, R3, and R4) of four residents reviewed for dressing changes.Findings include:R1's face sheet documents and admission date of 9/22/2025 and diagnoses that include but are not limited to displaced intertrochanteric fracture of right femur, Type 2 Diabetes Mellitus, heart failure, polyneuropathy, and end stage renal disease.R1's BIMS (brief interview mental status) score, dated 9/29/25, is 12 which indicates R1's cognition is moderately impaired.R1 no longer resides at the facility. R1 was discharged on 10/09/2025.R1's care plan, dated 9/24/25, documents, in part, (R1) was admitted to the facility for a skilled stay requiring physician ordered, medically necessary services including direct therapy services, skilled nursing care, management and evaluation of the patient care plan, observation and assessment of the patient's condition and/or teaching and training activities related to the reason for stay or in preparation to transition to a lesser care environment. She requires skilled services related to primary diagnosis of right femur fracture, with interventions, that document, in part, Provide skin treatments per MD (medical doctor) order. Follow plan of care for skin management. Provide therapy per MD orders.R1's physician order, ordered date 9/22/2025, documents, in part, Right hip: cleanse incision site with saline; pat dry; apply dry dressing daily and PRN; every day shift. R1's Treatment Administration Record, dated October 2025, documents, in part, Right hip: cleanse incision site with saline; pat dry; apply dry dressing daily and PRN everyday shift -D/C (discontinue) Date: 10/09/2025. Upon review, there were no nursing staff initials on 9/22/25, 10/02/25, 10/03/25, and 10/04/25, indicating that R1's dressing was not changed per physician's order.R2's face sheet documents diagnoses that include but are not limited to renal dialysis, chronic kidney disease, and type II Diabetes Mellitus.R2's BIMS (brief interview mental status) score, dated 11/18/25, is 9 which indicates R2's cognition is moderately impaired.R2's care plan, dated 9/17/25, documents, in part, (R2) is at risk for skin complications r/t right distal foot (TMA), left second toe arterial wound, with interventions that document, in part, Treatment as ordered to right distal foot (TMA) and left second toe.R2's care plan, dated 10/27/25, documents, in part, (R2) is at risk for complications related to diagnosis of osteomyelitis Right foot, with interventions that document, in part, Dressing changes as ordered if applicable. R2's physician order, order date 10/06/25, documents, in part, PICC (Peripherally inserted Central Catheter) lines/Midlines: Measure (specify arm/type of line) circumference upon admit and weekly with dressing changes every night shift every Sun for IV Document in Progress notes.R2's Treatment Administration Record, dated October 2025, documents, in part, Right distal foot (TMA): remove all black sponges from wound bed; cleanse with saline; pat dry; apply new black sponge and attach wound vac with settings of mmHG; changing three times a week on Mon Wed Fri and PRN (as needed) every day shift every Mon, Wed, Fri -D/C Date- 12/17/2025 2021. Upon review, there were no nursing staff initials on 10/01/25 (Wednesday), indicating R2's dressing was not changed per physician's order.R2's Treatment Administration Record, dated October 2025 and December 2025, documents, in part, PICC (Peripherally Inserted Central Catheters) lines/Midlines: Measure (specify arm/type of line) circumference upon admit and weekly with dressing changes every night shift every Sun for IV (intravenous). Document in Progress notes. Upon review, nursing staff initials are missing for the dates 10/12/25, 10/19/25, 11/07/25, and 11/21/25. Additionally, R2's progress notes contain no documentation indicating that the PICC line dressing was changed on these dates, indicating that the dressing change was not completed in accordance with the physician's order.R3's face sheet documents diagnoses that include but are not limited to renal dialysis, end stage renal disease, and disorder of muscle.R3's BIMS (brief interview mental status) score, dated 10/03/25, is 15 which indicates R3 is cognitively intact.R3's active physician order, dated 11/24/25, documents, in part, LEFT SHIN: cleanse with wound cleanser. apply collagen to the wound bed. skin prep peri wound and cover with calcium alginate and bordered gauze daily and PRN. every day shift for Venous ulcer.R3's care plan, dated 8/19/25, documents, in part, (R3) was admitted to the facility for a skilled stay requiring physician ordered, medically necessary services including direct therapy services, skilled nursing care, management and evaluation of the patient care plan, observation and assessment of the patient's condition and/or teaching and training activities related to the reason for stay or in preparation to transition to a lesser care environment. He requires skilled services related to primary diagnosis of hypertensive heart and kidney disease with ESRD (end stage renal disease), with interventions that document, in part, Provide skin