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	06/05/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to promote the residents' rights to be treated in a dignified manner during meal service. This affects four of four (R69, R3, R79, R76) residents reviewed for dignity during meal service in total sample of 54. R69 face sheet shows diagnosis of dementia. R3 face sheet shows diagnosis of dysphagia. R79 face sheet shows a diagnosis of neuromuscular dysfunction. R76 face sheet shows a diagnosis of dysphagia. During lunch observation on 6/02/2026 at 12:08 PM, R82 and R64 was observed being assisted with their meal, R69 was seated at the same table, R69 did not have a meal tray. R69 was watching R82 and R64 eat. R69 received her tray at 12:18PM.On 6/02/2026 1:03 PM R3 received his lunch tray in his room. V23 (Certified Nursing Assistant) was observed at 1:15 pm, feeding R3, V23 was standing while feeding R3.V24 (CNA) was also observed standing while feeding R79 at the bedside, R79 is R3's room mate. During lunch observation on 6/03/2026 at 12:10 pm, R26, R86 and R76 were at the same table for lunch, R26 and R86 was eating, R76 did not have a lunch tray, R76 was watching R86 and R26 eat their meal. R76 did not get her tray until 12:14pm.On 6/04/2026 at 1:00 PM V2 (Director of Nursing) said staff should be seated at eye level when assisting residents with meals and all residents at the table must be served their meal at the same time. Reviewed the Resident rights for people living in the Long-term Care facilities shows residents have the right to be treated with dignity and respect.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow its food storage policy to ensure dented canned goods were not stored or available for use. This has the potential to affect all 136 residents who receive meals from the facility kitchen Findings include: On initial tour in the kitchen on 06/02/2026 at 9:48 AM, there were six cans of six pound of fruit salad observed on the shelf in the dry storage with the none dented cans and there was one seven pound can of chocolate pudding stored in the emergency food supply.6/2/2026 at 9:50 AM, V31 (dietary Manager) said the dented cans should not be stored with the none dented cans, V31 said the staff can grab and use the canned food and dented cans could be contaminated with botulism. During the follow up visit in the kitchen on 6/3/26, and 06/04/2026 at 9:34 AM, the seven pound can of chocolate pudding remained stored in the emergency food supply.Dietary Policy and procedure manual dated 2026 denotes dented cans are not used and are stored in a separate area.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician orders were followed for the administration of a PRN psychotropic medication (lorazepam) for one resident. Specifically, the facility administered lorazepam over a 14-day period without obtaining the resident's informed consent prior to administration and continued administering the medication after 5/21/26 without obtaining a current physician order. This affected one of three residents (R79) reviewed for chemical restraints in a sample of 54 residents. Findings include: On 6/2/2026 at 2:39 PM, R79 said that he does not take lorazepam (psychotropic medication) and was unaware that the nursing staff were administering this to him. R79 said that he has not asked the nursing staff for lorazepam since the month of April and was unaware of V6 LPN (licensed practical nurse) administered lorazepam with his morning medications on 6/2/2026 at 9:00 AM. R79 said that he no longer trusts the nursing staff or the facility. R79 said that when he asks the nurses what medications they are giving him, they will not tell him. R79 said that he does get upset when the staff are not providing his care to meet his needs. R79 said that he does not want lorazepam because it makes him feel drowsy. R79 said he did give consent to receive Lorazepam when he first admitted to the facility in April because he did have some anxiety admitting to a new place. ˆ R79 said that he did not give consent to receive Lorazepam 0.5mg for the order period of 5/7/2026 through 5/21/2026 and he has not asked for the Lorazepam during the timeframe of 5/7/2026 through 5/21/2026. R79 said that he does not trust the nursing staff or the facility with administering his medications and he has asked social services to transfer him to another facility somewhere in Chicago.R79's POS (physician order sheet), dated 5/7/26, notes a new order for Lorazepam 0.5mg every twelve hours as needed from 5/7/2026 through 5/21/2026. R79's controlled drug form, dated 4/13/2026, documents lorazepam 0.5mg (milligrams) every twelve hours as needed for anxiety times 14 days. This form notes R79 received ten doses of Lorazepam 0.5mg during the timeframe of 5/7/2026 through 5/21/2026. R79's controlled drug form also notes R79 received six doses of lorazepam 0.5mg with no active physician order on 5/22/2026 at 1:00 AM, 5/26/2026 at 11:30 PM, 5/28/2026 at 9:00 PM, 5/31/2026 at 9:00 AM, 5/31/2026 at 9:00 PM, and 6/2/2026 at 9:00 AM. R79's medication administration record (MAR), dated 5/1/2026 through 5/31/2026, does not record any administered doses of Lorazepam 0.5mg. There is no documentation found in R79's progress notes related to signs/symptoms R79 was exhibiting, administration of lorazepam, or if the medication was effective in treating R79's symptoms. R79 minimum data sheet (MDS) dated [DATE], documents a Brief Interview for Mental Status (BIMS) of 15 out of 15. R79 is cognitively intact and able to make needs known. On 6/2/2026, at 1058 AM, V6 (LPN) said that she administered Lorazepam 0.5mg at 9:00 AM to R79. V6 said that she administered the last pill and needed to reorder the lorazepam 0.5mg. On 6/2/2026 at 9:10 PM, V20 (LPN) said that she would check the MAR to see if there is an active order before administering any as needed medications. V20 would check to see how often the as needed medication is given, administer the medication, sign the medication out the MAR, sign the controlled drug form, and monitor the effectiveness of the medication administered. On 6/4/2026, at 12:00 PM, V8 LPN said that when administering as needed medications, the nurse should check with the resident to see if they require the medication prescribed as needed, check the MAR for an active order, sign the medication out on the controlled drug form and document the administration on the MAR. V8 said that the nurse should follow-up for the effectiveness of the as needed medication administered for any positive or adverse reactions. V8 said that she would check for a change in condition, lethargy, altered mental status, nausea and vomiting, and drowsiness. V8 said that if the resident is administered an as needed medication without the nurse asking the resident may cause the resident to experience negative side effects of the medication. The facility's Medication Administration Policy, dated 02/2026, states in part, an order is (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required for administration of all medication, document as each medication is prepared on the medication administration record, document reason and response for any PRN (as needed) medication. The facility's controlled substance policy, dated 05/2025, notes in part, while a controlled substance is in use the nursing staff will maintain the following medication records: record each dose at the time of administration on the MAR noting date, time, initial of nurse administering dose, and if a PRN (as needed) order, document the effectiveness; on the controlled substance form note the date, time, signature (which includes minimum of first initials) of nurse who administered dose, and number of doses remaining.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, interviews, and record reviews, the facility failed to follow physician orders and obtain daily weights; failed to notify the physician of weight gain of more than 5 pounds for one resident with a diagnosis of heart failure. This affected one of three residents (R1) reviewed for weight monitoring related congestive heart failure in a sample of 54.Findings include:On 6/5/26 at 12:00 PM, R1 stated that staff are not weighing her daily.On 6/4/26 at 1:00 PM, V35 (restorative aide) and V36 (restorative nurse) were observed obtaining R1's weight via a mechanical lift device. R1's weight is 261.4 pounds today.On 6/4/26 at 10:35 AM, V21 (restorative nurse) stated that the restorative aides are responsible for obtaining all weights for residents. V21 stated that she reviews physician orders to see if any residents need more frequent weights than once a month. V21 stated that residents with orders for daily weights, she documents on paper but does not enter daily weights in the resident's EMR (electronic medical record). V21 stated that she was not instructed to enter the daily weights in the resident's record. V21 stated that she is unsure if previous restorative nurse was obtaining daily weights and documenting. When questioned how physician/nurse practitioner would know the resident's weight if not documented in the resident's EMR, V21 responded she is not sure.V21 was unable to provide documentation that R1 has been weighed daily.On 6/4/26 at 3:33 PM, V37 (cardiology nurse practitioner) stated that she would expect the nurses to obtain a resident's weight per physician orders. V37 stated that she would expect the nurse to notify her if R1 gains more than two pounds in one day or five pounds in one week. V37 stated that it is important to monitor residents with a diagnosis of heart failure for weight gain, fluid intake, and for edema (swelling) to ensure R1 is not retaining fluid.R1's medical record notes R1 was admitted to this facility on 10/10/2025 with a diagnosis of heart failure.R1's medical record does not document R1's weight was monitored daily.R1's BIMS (brief interview of mental status) score, dated 4/29/26, notes R1's score is 13 out of 15. R1 is able to make needs known.R1's POS (physician order sheet), dated 11/15/25, notes an order for daily weight: notify physician if > 2 pounds in 24 hours or 5 pounds in a week, weigh in the morning.R1's weight documentation notes the following:11/17/25, weighed 287.4 pounds.11/28/25, weighed 303.4 pounds. R1 gained 16 pounds in 11 days.There is no documentation found in R1's medical record noting the physician was notified of R1's weight gain2/5/26, weighed 264 pounds.2/11/26, weighed 277 pounds. R1 gained 13 pounds in 6 days.There is no documentation found in R1's medical record noting the physician was notified of R1's weight gain.R1's medical record notes R1's weights have not been obtained in the morning per physician orders. R1's weights have been obtained between 9:41 AM and 8:43 PM.Per the American Heart Association, sudden weight gain or loss can be a sign that your heart failure is getting worse. Weigh yourself at the same time each morning, before breakfast. This will help you to see actual changes in weight from day to day. Checking your weight is key to keeping an eye on your symptoms. Weight gain is one of the first signs of retaining fluid. If your weight goes up 2 pounds in one day or 5 pounds in one week, you should notify your physician.The facility's weight management policy, dated 01/2026, notes in part residents should be weighed using the same scale, at the same time of day and in the same way each time they are weighed. All weights, upon completion will be given to the DON (director of nursing).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that wound care treatments were implemented as ordered. This affected one of four residents (R3) reviewed for pressure ulcers in a sample of 54 residents. R3 care plan shows R3 has diagnosis of unspecified dementia, COPD, protein malnutrition, and lack of coordination. R3 MDS dated [DATE] section c for cognition shows BIMS score of five (cognitive deficits), section E for behaviors- rejection of care, 0 is documented (behavior not exhibited), section M for skin shows one stage 3 pressure ulcer, unhealed, M1200 for skin and ulcer treatment shows pressure reducing device for bed, nutrition or hydration interventions to manage skin problem, pressure ulcer/injury care and application of nonsurgical dressing.On 6/4/26 at 1:37pm R3 was observed resting in bed, awake and alert. R3 agreeable for wound observation. R3 was observed for wound care assisted by V27 (wound tech), V30 (wound care coordinator) with support of V29(wound care director). R3 was wearing an adult brief, R3 did not have a wound treatment dressing in place. R3 was observed with a wound to the sacrum the size of a half dollar, the wound bed was pink in color, the surrounding skin was R3 skin tone. V27 said he did not remove R3's treatment dressing.V30 said she did not remove R3's treatment dressing, R3 treatment is three time a week.V29 said she did not remove R3's treatment dressing.V23 (R3 CNA) said R3 did not have a wound treatment dressing on all day, V23 said she last changed R3 after lunch, with assist for V25 (CNA), V23 said R3 did not have a treatment dressing on at that time. V23 said she did not inform the nurse that R3 did not have a treatment dressing. V25 said R3 did not have a treatment dressing on when she assisted V23 with incontinence care for R3. V25 said she did not inform the nurse or anyone that R3 did not have a dressing on. At 2:04pm, V6 (R3's Nurse) said she did not remove R3 wound treatment dressing, and the aides did not inform her that the dressing was off. V6 said the aide should notify her if the treatment dressing comes off or when there's no treatment dressing on a wound, she should be made aware so that she can complete the wound treatment. R3's physician orders show orders for coccyx: cleanse with wound cleanser, pat dry and paint peri wound with betadine, apply calcium alginate with silver to the wound bed and cover with border gauze three times week, every day shift Monday, Wednesday, Friday to promote wound healing.R3's wound evaluation completed by the wound care provider dated 6/3/2026 denotes in-part patient has wound to his coccyx and a rash, wound site 4, stage three, full thickness, etiology-pressure, duration- greater than 98 days, care goal-decrease ulcer area, granulation 100%. Dressing treatment plan- primary dressing: alginate calcium with silver, apply three times per week and as needed: if saturated, soiled, or dislodged. For 30 days; sub skin application, apply once weekly for 7 days: do not remove or disturb the wound bed. Change the secondary dressing with care as per the recommendations. The skin substitute graft will be re-evaluated by the wound physician during the indication next visit. Secondary dressing- gauze island with border three times per week and as needed: if saturated, dislodged. For 30 days. Peri wound treatment- apply betadine three times per week and as needed: if saturated, soiled or dislodged. For 30 days. V2 (Director of Nursing) presents R3 current plan of care, dated initiated 11/2/2023 it is denoted that R3 care plan for actual skin alteration and is at risk for skin complication's r/t (related to) impaired mobility, incontinence, malnutrition and wound to coccyx. Interventions are to access/ record changes in skin, avoid skin to skin contact, educate resident/ family on causative factors and measures to prevent skin injury, follow facility protocols for treatment of injury. Identify/ document potential causative factors and eliminate/ resolve where possible. Low air loss mattress, minimize pressure over bony prominences, residents will be turned and repositioned q2 hours as tolerated.Facility policy titled skin care prevention dated 1/2025 denotes in-part all resident will receive appropriate care to decrease the risk of skin breakdown.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its Medication Administration policy and Controlled Substances policy by not administering PRN psychotropic medications in accordance with physician orders and by not documenting the effectiveness of the medication. This affected one of three residents (R79) reviewed for unnecessary medications in a sample of 54.Findings include:On 6/2/2026 at 2:39 PM, R79 said that he does not take lorazepam (psychotropic medication) and was unaware that the nursing staff were administering this to him. R79 said that he has not asked the nursing staff for lorazepam since the month of April and was unaware of V6 LPN (licensed practical nurse) administered lorazepam with his morning medications on 6/2/2026 at 9:00 AM. R79 said that he no longer trusts the nursing staff or the facility. R79 said that when he asks the nurses what medications they are giving him, they will not tell him. R79 said that he does get upset when the staff are not providing his care to meet his needs. R79 said that he does not want lorazepam because it makes him feel drowsy. R79 said he did give consent to receive Lorazepam when he first admitted to the facility in April because he did have some anxiety admitting to a new place. ^ R79 said that he did not give consent to receive Lorazepam 0.5mg for the order period of 5/7/2026 through 5/21/2026 and he has not asked for the Lorazepam during the timeframe of 5/7/2026 through 5/21/2026. R79's psychiatry note, dated 5/6/26, notes R79 presents with anxious and irritable mood, reporting recent emotional distress related to the loss of another nephew with whom he was very close. R79 endorsesfeelings of depression, frustration, and anger related to being unable to assist his family during this time. Plan: restart Lorazepam 0.5mg 1 tablet by mouth every 12 hours as needed for anxiety for14 Days.R79's POS (physician order sheet), dated 5/7/26, notes a new order for Lorazepam 0.5mg every twelve hours as needed from 5/7/2026 through 5/21/2026. R79's controlled drug form, dated 4/13/2026, documents lorazepam 0.5mg (milligrams) every twelve hours as needed for anxiety times 14 days. This form notes R79 received ten doses of Lorazepam 0.5mg during the timeframe of 5/7/2026 through 5/21/2026. R79's controlled drug form also notes R79 received six doses of lorazepam 0.5mg with no active physician order on 5/22/2026 at 1:00 AM, 5/26/2026 at 11:30 PM, 5/28/2026 at 9:00 PM, 5/31/2026 at 9:00 AM, 5/31/2026 at 9:00 PM, and 6/2/2026 at 9:00 AM. R79's medication administration record (MAR), dated 5/1/2026 through 5/31/2026, does not record any administered doses of Lorazepam 0.5mg. There is no documentation found in R79's progress notes related to signs/symptoms R79 was exhibiting, administration of lorazepam, or if the medication was effective in treating R79's symptoms. R79 minimum data sheet (MDS) dated [DATE], documents a Brief Interview for Mental Status (BIMS) of 15 out of 15. R79 is cognitively intact and able to make needs known. On 6/2/2026, at 1058 AM, V6 (LPN) said that she administered Lorazepam 0.5mg at 9:00 AM to R79. V6 said that she administered the last pill and needed to reorder the lorazepam 0.5mg. On 6/2/2026 at 9:10 PM, V20 (LPN) said that she would check the MAR to see if there is an active order before administering any as needed medications. V20 would check to see how often the as needed medication is given, administer the medication, sign the medication out the MAR, sign the controlled drug form, and monitor the effectiveness of the medication administered. On 6/4/2026, at 12:00 PM, V8 LPN said that when administering as needed medications, the nurse should check with the resident to see if they require the medication prescribed as needed, check the MAR for an active order, sign the medication out on the controlled drug form and document the administration on the MAR. V8 said that the nurse should follow-up for the effectiveness of the as needed medication administered for any positive or adverse reactions. V8 said that she would check for a change in condition, lethargy, altered mental status, nausea and vomiting, and drowsiness. V8 said that if the resident is administered an as needed medication without the nurse asking the resident may cause the resident to experience negative side effects of the medication. The facility's Medication Administration Policy, dated 02/2026, states in part, an order is required for administration of all (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication, document as each medication is prepared on the medication administration record, document reason and response for any PRN (as needed) medication. The facility's controlled substance policy, dated 05/2025, notes in part, while a controlled substance is in use the nursing staff will maintain the following medication records: record each dose at the time of administration on the MAR noting date, time, initial of nurse administering dose, and if a PRN (as needed) order, document the effectiveness; on the controlled substance form note the date, time, signature (which includes minimum of first initials) of nurse who administered dose, and number of doses remaining.