STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145983	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya on 87th	2940 West 87th Street Chicago, IL 60652

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 0686 Level of Harm - 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 follow its skin care prevention policies and procedures and failed to implement the resident's comprehensive care plan to prevent skin breakdown and wound development. This failure affected one (R1) of two residents reviewed for wound management and prevention, in a total sample of 35 residents. As a result of the facility's failure to provide timely and appropriate preventive skin care and incontinence management, R1 experienced a decline in skin integrity, evidenced by the development of a new Stage 2 pressure ulcer/injury and moisture-associated skin damage (MASD).Findings Include:On 2/4/26 at 11:09 a.m., R149 stated her roommate (R1) has not been changed since 4:00 a.m. R149 said, [R1's] been lying on that soiled diaper for hours. I've been awake since four in the morning and that was the last time the CNA [Certified Nursing Assistant] came in here to change her [R1]. They should know that she [R1] needs to be changed frequently because she has that tube feeding going and she [R1] soils herself a lot.On 2/4/26 at 11:16 a.m., R1's lying in bed alert and able to verbalize needs. R1 stated she's wet and needs to be changed. R1 said she does not remember when the last time her diaper was changed, but she feels like it's been a while. R1 said that she has a wound on her back and the wound dressing was changed yesterday morning.On 2/4/26 at 11:35 a.m., surveyor notified V6 (Certified Nursing Assistant) that R1 needs incontinence care. V6 said she will notify the CNA assigned to R1. On 2/4/26 at 11:40 a.m., V7 (Certified Nursing Assistant/CNA) stated [V7] is the CNA assigned to R1. V7 said she started at 6:00 a.m. and had not yet had the opportunity to check on R1.On 2/4/26 between 11:43 a.m. and 11:56 a.m., surveyor observed V7 (CNA) providing morning care to R1. During the observation, R1's incontinence brief and pad were noted to be saturated with urine and feces. R1's perineal area (inner thighs and groin) and perianal (buttocks) were heavily soiled with urine and feces. R1's sacral wound dressing was also soiled and not intact. Surveyor and V7 observed skin breakdown in R1's perianal area, with a scant amount of bleeding noted. Surveyor and V7 also observed an open wound on R1's left inner thigh located at the area corresponding to the edge of R1's incontinence brief. The wound was noted along the line of contact where R1's incontinence brief rests against R1's skin measuring approximately four centimeters (cm) in length and approximately less than 1 cm in width. V7 stated that the wound on R1's left inner thigh is new. V7 stated, That's from her [R1] diaper. It may be too tight on her [R1]. V7 also stated that the skin breakdown to R1's perianal area is new.On 2/4/26 at 12:11 p.m., V9 (Wound Care Coordinator/Licensed Practical Nurse) stated that R1's sacral wound dressing was last changed on 2/3/26, in the morning. V9 stated that V25 (Wound Physician) rounded on R1 with the wound care team on 2/3/26, and at that time no skin breakdown or open areas were noted on R1's left thigh or perineal area beside R1's current sacral pressure ulcer. V9 stated that R1's wound dressing should be changed as needed when soiled.On 2/4/26 at 12:15 p.m., V10 (Wound Care Nurse/Licensed Practical Nurse) stated that the last time she assessed R1 was on 2/1/26, and at that time no skin breakdown was noted other than R1's sacral ulcer.On 2/4/26 between 12:19 p.m. and 12:51 p.m., surveyor observed a wound care treatment/assessment conducted by V9 and V10 for R1. During the observation, R1's incontinence brief was noted to be soiled with feces, and no wound dressing was in place on R1's sacral wound. V9 (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 0686 Level of Harm - Actual harm Residents Affected - Few	measured R1's sacral wound as follows: 5.5 centimeters (cm) in length, 6.2 cm in width, 0.3 cm in depth, with 1.5 cm of tunneling. V9 and V10 assessed R1's perianal area and stated that R1 had developed new moisture-associated skin damage (MASD). V9 stated that MASD can develop rapidly when the skin is exposed to moisture. V9 and V10 also assessed R1's left thigh and stated that R1 had acquired a new pressure wound. V9 stated it caused by R1's shearing and friction from R1's incontinence brief and if the brief remained in place for several hours, it could result in the development of pressure wound. V9 measured the left thigh wound as 4.5 cm in length, 0.3 cm in width, and 0.0 cm in depth. V9 identified it as partial-thickness Stage 2 pressure ulcer.On 2/4/26 at 3:43 p.m., surveyor conducted a telephone interview with V26 (Certified Nursing Assistant). V26 stated that she was the CNA assigned to R1 during the night shift on 2/3/26, and that she left the faciity on 2/4/26, at 6:00 a.m. V26 stated that R1 had frequent bowel movements related to tube feeding and requires frequent incontinence care. V26 stated that R1 typically has bowel movements every one to two hours and requires frequent diaper changes. V26 stated that she last changed R1's incontinence brief at approximately 4:30 a.m., prior to leaving the facility, and that this was her last round with R1. V26 stated R149 saw V26 changed R1 because R149 was awake at that time and that whenever V26 changes R1, V26 would let R149 know. V26 stated that during her last round, [V26] did not observe excoriation to R1's perineal area and did not observe any additional wounds other than the existing sacral ulcer. V26 stated that R1 is a resident who requires incontinence care as frequently as every one to two hours, and that if care is not provided within this timeframe, skin breakdown may occur.On 2/5/26 at 9:00 a.m., V9 stated that upon admission, residents are assessed for risk of skin breakdown using the Braden Scale, which considers mobility, cognition, diet, immobility, and level of staff assistance. V9 stated that all residents at the facility are considered at risk for skin breakdown. V9 stated that a skin care plan is initiated upon admission. Preventive interventions include heel offloading, routine skin checks during care, repositioning, and application of skin barrier ointment with every incontinent episode. V9 stated these are standard interventions for residents at risk. V9 stated that incontinent residents are expected to receive incontinence care at least every two hours and be kept clean and dry, and that failure to provide care within this timeframe increases the risk of skin breakdown. V9 stated that low air loss (LAL) mattresses are used as a preventive measure and to promote wound healing, and that the wound care team updates skin care plans as needed. V9 stated that V25 rounds weekly and sees residents with Stage 2 pressure ulcers and higher, and may also see residents with complex wounds. V9 stated that R1 was admitted with a Stage 4 sacral pressure ulcer dated 8/16/25. Initial measurements were 11.0 cm length x 12.5 cm width x 0.0 cm depth, with 95% slough and 5% granulation tissue. Initial treatment included Medihoney three times per week and as needed. V9 stated that recent measurements dated 2/4/26, were 5.0 cm length x 3.5 cm width x 0.3 cm depth, and the wound remained Stage 4, with current treatment of Medihoney and alginate three times per week and as needed. V9 stated that during ADL (Activities of Daily Living) care, CNAs are expected to perform skin checks, and if abnormalities are observed, to report findings to the nurse or wound care team. V9 stated that skin assessments for R1 are performed every other day during wound treatment. V9 stated that on 2/3/26, during morning wound rounds at approximately 7:30 a.m., [V9] observed R1 with [V25] and noted only the sacral ulcer. V9 stated that at that time there was no excoriation of the buttocks and no open areas to the groin/thighs or perineal area. V9 stated that if any skin issues had been observed, they would have been addressed immediately. V9 stated that R1 experiences loose bowel movements and requires prompt incontinence care. V9 stated that R1 acquired new moisture-associated skin damage (MASD) to the perianal area and a Stage 2 pressure ulcer to the left inner thigh on 2/4/26. V9 stated that R1's left inner thigh wound was classified as pressure ulcer because it was believed to have resulted from shearing and friction caused by R1's incontinence brief. V9 stated that treatment for the MASD includes Triad cream daily and as needed, and treatment for the left inner thigh includes foam dressing three times per week and as needed. V9 stated that R1 requires frequent checks for stool (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	and urine, and that incontinence care should not exceed two hours to prevent skin breakdown.On 2/5/26 at 12:47 p.m., V3 (Director of Nursing) stated that staff are expected to provide incontinence care as soon as possible when a resident is incontinent. V3 stated that staff conduct routine rounds, alternating with nursing staff, to assess resident safety and needs. V3 stated that during rounds, staff are expected to ensure the resident is safe, safety precautions are in place, the call light is within reach, and resident needs are addressed. V3 stated that staff are expected to check residents for incontinence at least every two hours, and that residents who are incontinent require checks at least every hour. V3 stated that incontinence care should be provided promptly when needed. V3 stated R1 requires reminders and relies on staff to meet her needs. V3 stated that R1 requires assistance with all activities of daily living (ADLs) and can sit up in a chair but requires staff assistance for repositioning. V3 stated that R1 is incontinent of both bowel and bladder and requires staff assistance for incontinence care. V3 stated that R1 has a gastrostomy tube (G-tube) and that some residents with a G-tube may experience loose stools, requiring frequent monitoring. V3 stated that staff should check R1 at least every hour. V3 stated that R1 has fragile skin and is at risk for skin breakdown, and that delays in care could impact wound healing and development of new skin breakdown.On 2/6/26 at 9:49 a.m., V19 (Registered Dietitian) stated that R1 is NPO (Nothing by Mouth) and receives tube feeding with a high-fiber formula and may experience frequent loose stools due to R1 may not be absorbing the formula well due to her current medical conditions.On 2/6/26 at 3:01 p.m., surveyor conducted a telephone interview with V25 (Wound Physician). V25 stated he began providing wound care services at the facility in October 2025 and visits the facility once weekly. V25 stated that upon residents' admission from the hospital, the facility typically implements preventive measures, including dietitian involvement, protein supplementation, heel protection, low air loss (LAL) mattresses, and proactive skin-breakdown prevention. V25 stated that if a resident is incontinent of urine or stool and remains soiled or wet for several hours, skin breakdown can occur, even in the absence of a pre-existing wound. V25 stated that prolonged moisture exposure can also delay wound healing when an existing wound is present. V25 stated that he last evaluated R1 on Tuesday, 2/3/26, during wound rounds with the wound care team. V25 stated that at that time, R1 had a sacral pressure ulcer and was being treated with a wound vacuum-assisted closure (VAC), which was discontinued to support wound healing. V25 stated that during the 2/3/26, assessment, [V25] did not observe any additional skin breakdown other than the sacral ulcer. V25 stated that he documents any skin issues observed during assessments. V25 stated that he later spoke with the wound care team and was informed that new wounds had developed following his last assessment. V25 stated that R1 has multiple risk factors for skin breakdown, including bowel and bladder incontinence. V25 stated that R1's nutritional status was also a concern, noting [R1's] albumin level was low, and that the dietitian and wound care team were working to improve her protein intake. V25 stated that R1 is currently receiving tube feeding. V25 stated that if R1 were left soiled or wet for several hours, she could develop new skin breakdown and wounds as a result.R1's clinical records show an original admission date of 7/25/26 with listed diagnoses but not limited to cerebral infarction, gastrostomy status, flaccid hemiplegia affecting left nondominant side, and adult failure to thrive. R1's Minimum Data Set (MDS) assessment dated [DATE] revealed R1 has severely impaired cognition with BIMS (Brief Interview for Mental Status) of 7. It also reveals that R1 is always incontinent of bowel and bladder, is dependent on staff's assistance for perineal hygiene, bathing, and mobility, and is at risk of developing pressure ulcers/injuries. R1's comprehensive care plan documents in part: [R1] is at risk for and has an alteration in skin integrity related to self-care deficits, impaired mobility and comorbidities with one of the interventions that reads: Provide peri-area after each incontinent episode and apply barrier cream (date initiated 7/28/25). R1's care plan also documents in part: R1 is incontinent of bowel and bladder and one of the interventions reads: Provide incontinence care at routinely timely intervals. Keep skin clean, dry and moisturized (date initiated 7/28/25).R1's Wound Assessment Details Reports printed on 2/5/26 indicate R1 has stage 4 sacral pressure ulcer date (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	identified on 8/16/25, a facility-acquired stage 2 pressure ulcer on left inner thigh identified on 2/4/26 (measured as 4.50 cm length, 0.30 cm width, unknown depth), and facility-acquired MASD to perianal identified on 2/4/26. V25's visit report for R1 dated 2/3/26 documents existing stage 4 pressure ulcer with recommendation to keep area clean and dry and avoid direct pressure to the wound site.R149's clinical records show an original admission date of 6/20/23. R149's MDS dated [DATE] shows R149 is cognitively intact with BIMS of 15 and requires supervision with ADLs.On 2/10/26 at 11:06 a.m., V40 (Interim Administrator) emailed surveyor a Skin Condition document dated 2/4/26. The documentation, prepared by V41 (Regional Nurse Consultant), reads in part: On Wednesday February 4, 2025, during incontinence care, resident was noted with a skin alteration to the left inner thigh. At the time, this area was believed to be a stage 2 pressure ulcer. During the investigation it was noted to be an abrasion as per our in-house wound MD [Medical Doctor]. The abrasion has now healed. Additional documentation emailed to surveyor by V40 on 2/10/26, included V25's (Wound Physician) progress notes dated 2/10/26, which documented in part: 2/10/26 - Patient noted to have a wound to the left medial thigh, appears to be superficial abrasion that has epithelialized over and has now healed, no complex wound intervention indicated at this time.The facility's SKIN CARE PREVENTION policy and procedures dated 6/25 documents in part: All residents will receive appropriate care to decrease the risk of skin breakdown. Clean skin at time of soiling and at routine intervals.The facility's INCONTINENCE CARE policy and procedures dated 5/25 documents in part: Incontinence care is provided to keep residents as dry, comfortable and odor free as possible. It also helps in preventing skin breakdown.The facility's Certified Nurse Aide job description (undated) documents in part: Keep incontinent residents clean, dry and odor free; check every two hours to maintain. Review care plans daily to ensure provision of appropriate care.The Centers for Medicare & Medicaid Services (CMS) State Operations Manual (SOM), Appendix PP, F686 (Rev. 229; Issued April 25, 2025; Effective April 25, 2025; Implementation April 28, 2025) defines a Pressure Ulcer/Injury (PU/PI) as localized damage to the skin and/or underlying soft tissue, typically over a bony prominence or related to a medical or other device. The guidance states that a pressure injury may present as intact skin or an open ulcer, and that the appearance varies depending on the stage. The SOM further states that a pressure injury occurs as a result of intense and/or prolonged pressure, or pressure in combination with shear. The guidance notes that soft tissue damage related to pressure and shear may be influenced by moisture, nutrition, perfusion, co-morbidities, and the condition of the soft tissue.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to have sufficient staffing to provide adequate care and assistance for residents. This has the potential to affect all the residents residing in the facility.Findings Include:On 2/4/26 at 10:58 AM, R101 stated he's been in the facility for a year and a couple of months. R101 said facility is always short on staff. R101 said sometimes he does not get his medications on time and is mostly short on weekends. On 2/4/26 at 11:07 AM, V6 (Certified Nursing Assistant) started working in the facility full time for two years. V6 said she works morning shifts and every other weekend. V6 said sometimes facility is short on CNAs (Certified Nursing Assistants). V6 said morning shift needs five CNAs but sometimes there are only 4 CNAs working the floor. On 2/4/26 at 11:09 AM, R149 stated she's been in the facility for two years. R149 said sometimes facility is short nurses and CNAs on weekends. R149 said care is delayed sometimes and call lights answered more than 10 minutes. On 2/4/26 at 12:54 PM, R2 stated she's been in the facility for six months. R2 said sometimes facility is short staff mostly on weekends. R2 said her medications would be late more than an hour and staff are delayed on answering call lights would wait for 45 minutes sometimes can take up to two hours.On 2/5/26 at 9:58 AM, resident council meeting was held. R82, R94, R95, R149, and R203 were in attendance. They all stated that they do not feel like the staffing is always sufficient to provide the needs of the residents. All stated that facility has lack of staff. R149 stated, On the third floor we have 74 residents and sometimes there's only 2 or 3 CNAs from 10:00 PM to 6:00 AM. Call lights are not answered timely. Sometimes we have to wait more than an hour. R94 and R203 said they don't get changed timely when wet and soiled. R149 said that her roommate (R1) is only being changed once during the day and once in the evening.On 2/5/26 at10:49 AM, V18 (Staffing Coordinator) stated that she is responsible for scheduling both licensed nurses and certified nursing assistants (CNAs). V18 stated that the facility does not utilize agency staffing and uses a staffing application, which generates the master schedule and identifies open shifts. V18 stated that staffing assignments may vary by shift. V18 stated that the facility has three resident floors. V18 stated that staffing levels by shift are as follows: Morning shift: 5 CNAs on each floor and 2 nurses on each floor. Evening shift: 4 CNAs on the first floor, 5 CNAs on the second floor, 5 CNAs on the third floor, and 2 nurses on each floor. Night shift: 4 CNAs on each floor and 2 nurses on each floor. V18 stated that staffing is adjusted based on the facility daily census, which she calculates each morning. V18 stated that the staffing ratio described applies when the census is between 186 and 200 residents. V18 stated that the facility has a licensed bed capacity of 204. V18 stated that on the day of interview, the census was 192 residents. V18 stated that census is multiplied by 1.7 and divided by 7.5 hours, resulting in a total of 43 CNAs scheduled from 6:00 AM to 6:00 AM. V18 stated that licensed nurse staffing remains the same regardless of census, while CNA staffing may be reduced if the census is below 186, at which time 42 CNAs would be scheduled for the entire day. V18 stated that the facility maintains a minimum of 14 CNAs per shift and reported no issues with weekend staffing.R2's clinical records show an initial admission date of 7/11/25 and minimum data set (MDS) dated [DATE] shows R2 is cognitively intact with Brief Interview for Mental Status (BIMS) of 15.R82's clinical records show an initial admission date of 7/13/18 and MDS dated [DATE] shows R82 is moderately impaired with cognition with BIMS of 12.R94's clinical records show an initial admission date of 2/22/21 and MDS dated [DATE] shows R94 is moderately impaired with cognition with BIMS of 11.R95's clinical records show an initial admission date of 3/4/18 and MDS dated [DATE] shows R95 is cognitively intact.R101's clinical records show an initial admission date of 8/2/24 and MDS dated [DATE] shows R101 is moderately impaired with cognition with BIMS of 12.R149's clinical records show an initial admission date of 6/20/23 and MDS dated [DATE] shows R149 is cognitively intact with BIMS of 15.R203's clinical records show an initial admission (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	date of 5/11/23 and MDS dated [DATE] shows R203 is moderately impaired with cognition with BIMS of 10.Surveyor reviewed facility's timecard reports and showed inadequate CNA staffing on some days and multiple weekends from 7/1/25 to 9/30/25 and 1/24/26 to 1/25/26.PBJ (Payroll Based Journal) staffing data report FY (Fiscal Year) Quarter 4 2025 (July 1 - September 30) showed: TRIGGERED for Excessively low weekend staffing and one star staffing rating.A review of randomly selected facility census records revealed the following daily census totals: 7/4/25: 191 residents, 7/5/25: 186 residents, 7/6/25: 185 residents, 1/24/26 to 1/25/6: 198 residents, and 2/4/26: 191 residents residing in the facility.The facility's STAFFING policy dated 5/25 documents in part: To have appropriate numbers of staff available to meet the needs of the residents. Staffing is based on the IDPH [Illinois Department of Public Health] formula for determining numbers and levels of staff. Staffing is then increased based on the needs of the resident population.The facility's FACILITY ASSESSMENT TOOL dated 11/25 documents in part: Facility will utilize new CMS [Centers for Medicare & Medicaid Services] staffing rule to meet the requirements. Licensed Nurses (LN) includes RN [Registered Nurse] and LPN [Licensed Practical Nurse] providing direct care. Long term care units: 1:20 LN ratio (all shifts). Direct care staff: CNAs long term care units 1:12 ratio days, evenings, and nights.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to a.) ensure food items were properly labeled and dated, b.) store food items according to manufacturer recommendations, c.) discard expired food based on use by date and guidelines, d.) store food at least six inches off the floor. These failures have the potential to affect all 185 residents receiving food prepared in the facility's kitchen. Findings include:On 02/04/26 at 9:35 AM, during initial kitchen tour V17 (Dietary Manager) stated all items should be labeled with a delivery date, an open date and use by date. V17 stated it is important for food items to be properly labeled with an open and use by date, so the staff knows when to throw out the food items, so they do not get served to the residents. V17 stated the use by date differs depending on what the food item is and manufacturer storage guidelines are followed as listed on the product.On 02/04/26 at 9:40 AM, observed in the walk-in refrigerator 12 unopened 8-ounce cartons of whole milk labeled with best by date 02/02/26 which were mixed in with other cartons of whole milk labeled with best by date 02/14/26. V17 stated the cartons dated 02/02/26 must have been left over from an older delivery and mixed in with the newest delivery. V17 stated the whole milk cartons with the best by date 02/02/26 should have been thrown out on or before 02/02/26. V17 stated if the expired milk was to be served to a resident it could make them sick.On 02/04/26 at 9:45 AM, in the walk-in freezer the shelving units appeared to be less than six inches off the floor with many boxes of frozen food stored on the lowest shelf. Surveyor requested for Maintenance Department to be contacted to bring a measuring tape to the kitchen.On 02/04/26 at 10:35 AM, V30 (Maintenance Director) provided V17 with a measuring tape and V17 measured the distance from the floor to the bottom shelf. This distance was five inches in three of the six shelving units measured. V17 stated the distance should be at least six inches from the floor.On 02/04/26 at 9:48 AM, observed in the prep area the following opened items stored at room temperature (not refrigerated):Opened 1-gallon container of Barbeque Sauce labeled with delivery date 01/22/26 and opened date. 01/22/26. There was no use by date written on the product. On the container manufacturer printed For best flavor, refrigerate after opening.Opened 1-gallon Soy Sauce labeled with open date 09/17/25. There was no use by date written on the product. On the container manufacturer printed Refrigerate after opening for quality,On 02/04/26 at 9:55 AM, V17 stated all the items should be labeled with a use by date and the items should be stored in the refrigerator not left out at room temperature based on the manufacturer storage guidelines printed on the items.On 02/06/26 at 10:10 AM, V19 (Regional Registered Dietitian) stated the best by date on the milk means that it is the last day it is good to drink; the milk should be consumed on or before the best by date. V19 stated the milk should have been thrown out and not consumed. V19 stated if the expired milk was served to a resident, it could have gotten them sick. V19 stated it is the kitchen staff's responsibility to check the best-by dates on the milk and not serve any past the best by date. V19 stated when a shelf-stable item gets opened it should be labeled with an open and use by date. V19 stated the staff would know if the item needed to be refrigerated by checking the use-by guidelines posted in the kitchen and following the manufacture guidelines printed on the item. V19 stated the barbeque sauce, and the soy sauce should have been stored in the refrigerator after opening.On 02/04/26, facility provided list of diet orders for all residents in the facility. The diet order list indicates there are six residents receiving nothing by mouth (NPO). This was confirmed with the V19 (Regional Registered Dietitian).Facility provided policy titled Storage Periods, Use-By Guidelines undated documents in part, food should be stored properly and used within the appropriate time period to ensure safe and high-quality food is served, and the Use-By Guidelines Posted should be used to determine a use by date when labeling opened or unopened food that must be used within a certain time frame.Facility provided policy titled, Use-By Guidelines Handout documents in part, the following guide can be used to determine a use-by date when labeling opened or unopened food that must be (continued on next page)

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Aliya on 87th	2940 West 87th Street Chicago, IL 60652

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	used within a certain time frame.Facility provided handout titled, Use-By Guidelines - Posted which indicates in part, opened BBQ sauce refrigerate after opening, unopened milk adhere to best use-by date on carton, and opened soy sauce refrigerate after opening.Facility provided policy titled, Food Storage undated documents in part, food should be stored and prepared in a clean, safe, sanitary manner that complies with state and federal guidelines to minimize contamination and bacteria, and food is stored at least six inches from the floor.Facility provided policy titled, Cold Storage Areas undated which documents in part, store food products on slated shelves, six inches off the floor and away from the walls to allow proper air circulation.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure there was no trash on the ground surrounding the dumpster. This deficient sanitation practice has the potential to affect all 191 residents who reside in the facility.Findings include:On 02/04/26 at 10:45 AM, during initial tour of kitchen traveled outside with V17 (Dietary Manager) to view outside dumpster area. The lid of dumpster was closed. Observed a lot of trash, garbage and debris all around the ground near the dumpster including food scraps, empty cans of soda, used plastic cups, used gloves, used face masks, empty bottles of cleaning containers. V17 said, it is a mess out here and stated there should not trash all around the dumpster. V17 stated it is nasty and will attract rodents. V17 stated they want to keep rodents away from the facility, not attract them toward the building. Also, observed by the entry of the back door two bottles of used culture vials in a plastic bag. V17 stated looked at the vials and said, that is a hazard.On 02/06/26 at 8:14 AM, V42 (Environmental Services Director) stated the outside dumpster is used by housekeeping and dietary departments. V42 stated the housekeeping department is responsible for picking up garbage on the ground outside and to make sure the whole area around the dumpster is kept clean and free from trash. V42 said, the expectation is to clean up whatever we see. V42 stated if anything falls on the ground it should be picked up. V42 stated it is important to pick up the garbage on the ground so little critters like rodents and pests do not come close to the building. V42 stated the used culture bottles should have been put in the hazard compactor, it should not have been left on the ground.Facility provided policy titled, Trash Disposal undated documents in part, the dietary department should dispose of trash appropriately and maintain the dumpster area for cleanliness and prevention of rodents, purpose is to prevent the spread of infection and deter pests and rodents, and that no trash is on the ground surrounding the dumpster.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to (a) ensure staff cleaned and disinfected shared equipment between 3 (R29, R128, R181) residents use; (b) perform hand hygiene prior and place on a pair of gloves while obtaining one (R181) resident's blood glucose; (c) ensure proper Personal Protective Equipment (PPE) was worn by staff upon entry to resident's (R150) room on contact precautions; and (d) post an Enhance Barrier Precautions (EBP) sign for a resident (R135) with an indwelling medical device. The facility also failed to ensure proper Personal Protective Equipment (PPE) was worn by staff when providing high contact resident care activities to a resident (R1) on Enhanced Barrier Precaution (EBP). This failure has the potential to affect all 74 residents residing on the third-floor unit. The findings include: R150's admission record / face sheet showed admit date on 1/22/26 with diagnoses not limited to Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Type 2 diabetes mellitus, Chronic obstructive pulmonary disease, Enterocolitis due to clostridium difficile, Partial intestinal obstruction, Thrombocytopenia, Dementia in other diseases classified elsewhere, Primary generalized (osteo)arthritis, Other specified polyneuropathies, Malignant neoplasm of overlapping sites of left female breast, Other heart failure, Hypertensive heart disease with heart failure, Chronic kidney disease stage 3 unspecified, Gastro-esophageal reflux disease. MDS (Minimum Data Set) dated 1/19/26 showed R150's cognition was severely impaired. MDS indicated R150 was in isolation for active infectious disease. On 2/4/26 At 11:47AM R150's room observed with contact precautions by the door and PPE (Personal Protective Equipment) supplies by room entrance. Observed R150 sitting on the side of the bed, alert and verbally responsive. On 2/4/26 At 12:02 PM Observed V32 (Certified Nursing Assistant / CNA in training) went inside R150's room to pass meal tray without wearing proper PPE. V32 did not wear gloves and gown upon entry to R150's room. R150's door signage indicated Everyone must clean their hands, including before entering and when leaving the room; Providers, and staff must put on gloves and gown before room entry. Observed V32 went out of R150's room and did not perform hand hygiene. Observed V32 went inside other residents' rooms passing meal trays. V32 said she is CNA in training for almost a month and works with V33 (CNA). On 2/4/26 at 12:16PM V33 (CNA) said she is working with V32 (CNA in training). She said V32 can make the bed, answer call lights, pass water, pass meal trays. V33 said their room assignment is from room [ROOM NUMBER] to 107 with 12 residents. On 2/5/26 at 9:49AM V4 (IP / Infection Preventionist NURSE) said R150 is on contact precautions for C-diff stool. There should be a bin outside for PPE supplies, contact precautions signage to inform staff / visitor what to do. V4 said all staff / visitor should perform good hand hygiene, wear gown and gloves before entering the room on contact precautions to ensure no cross contamination for the safety of the residents and staff. She said C-diff is highly contagious so proper PPE should be worn. Going into the room of the resident with contact precautions, staff / visitor should wear proper PPE gown and gloves and remove PPEs before coming out of the room to prevent spread of infection or cross contamination. On 2/5/26 At 1:06PM V3 (DON / DIRECTOR OF NURSING) stated R150 has an order for contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precautions for C-diff stool. Staff are expected to implement contact precautions. V2 said Staff / visitor are expected to wear proper PPE (Gown and gloves) to go into the room of residents on contact precautions to help prevent spread of germs or cross contamination. R150's POS (Physician Order Sheet) dated 2/4/26 showed order not limited to: Contact isolation Diagnosis: C-diff. Care plan dated 1/23/26 showed in part: R150 is on contact isolation related to C-diff. Facility's daily assignment showed V33 (CNA) assignment is from room [ROOM NUMBER] to 107-2. Facility's midnight census report dated 2/4/26 showed 12 residents assigned to V33. Facility's list of isolation showed R150 on contact precautions for diagnosis of C-diff. Facility's Transmission Based Precautions policy dated 1/1/23 showed in part: Contact: Gloves and gown required upon entry to room, must be removed before exiting, followed by hand hygiene. Facility's Infection Prevention and Control Plan policy dated 7/2025 showed in part: Contact Precaution – intended to prevent transmission of infectious agents by direct or indirect contact with residents or the environment. Examples of infectious organisms requiring contact precautions are C-difficile. Use of a gown and gloves is necessary prior to room entry. Facility's contact precautions signage showed in part: Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: put on gloves and gown before room entry and discard before room exit. Findings include, Surveyor observed V15 [Licensed Practical Nurse] during medication administration: On 2/4/26 at 9:22 AM, V15 [Licensed Practical Nurse] placed the blood glucose machine in the glucose caddy [basket that held all the blood glucose supplies] and entered R181's room. V15 placed the glucose caddy on R181's bedside table. V15 placed on one glove onto her left hand and did not perform hand washing nor any usage of alcohol gel cleansing. V15 used the auto-disabling lancet on R181 finger for a blood return. However, R181 finger did not produce an adequate blood supply. V15 used her right un-gloved hand to rub R181 finger to produce the blood. V15 obtained R181 blood glucose sample that read 79mg/dl and wiped the blood off R181 finger with an alcohol wipe. V15 picked up the used blood-stained alcohol wipe, removed the used blood glucose strip out of the glucose machine with her right un-gloved hand and placed the items into her left gloved hand, removed the left hand gloved with the items in the glove and placed the glove into the garbage on her med cart. V15 took the glucose caddy off R181's bedside table and placed the caddy on top of the medication cart then placed the caddy into the bottom drawl of the medication cart. V15 did not wash her hands or use alcohol cleansing. At 9:31AM, V15 enter into R181's room with a wrist blood pressure device and placed the device on R181's left wrist, blood pressure resulted 165/79. V15 did not clean the blood pressure device before (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or after use. V15 placed the blood pressure device back on top of the medication cart. On 2/4/26 at 9:50 AM, V15 [Licensed Practical Nurse] entered R128's room with the uncleaned wrist blood pressure device and placed the cuff on R128's left wrist, resulting 117/64. V15 did not sanitize the device and sat the blood pressure device back on top of the medication cart. On 2/4/26 at 10:04 AM, V15 [Licensed Practical Nurse] entered R29's room with the unclean blood pressure device and placed the cuff on R29's left wrist, resulting in 112/63. V15 did not sanitize the device and sat the blood pressure device back on top of the medication cart. On 2/4/26, at 10:15 AM, V15 [Licensed Practical Nurse] stated, I should have used two gloves while obtaining R181's blood glucose. I don't know why I only used one glove; I was nervous. I forgot to clean the glucose caddy off, and the blood pressure device, I was rushing and was not thinking clear. If I don't wear two gloves, sanitize the glucose caddy and blood pressure device, it could potentially spread infection. On 2/5/26 at 1:00 PM, V3 [Director of Nursing] stated, Before obtaining a resident's blood glucose measurement, the nurse must wash their hands, gather equipment, a place on a pair of gloves. The glucose caddy should not enter the resident's room. The supplies should be removed from the glucose caddy to be taken into the resident's room. The blood pressure shared devices between residents must be sanitized between each use. If the nurse is not wearing a pair of gloves during blood glucose monitoring, and not sanitizing the blood pressure device between residents, it could potentially cause the spread of infections from one resident to another. Policy document in part Blood Glucose Monitoring dated 1/2025 Obtain needed equipment and supplies, such as gloves Perform hand hygiene and gloves. Routine Cleaning and Disinfection dated 1/2025 It is the policy of this facility to ensure the provision of routine cleaning and disinfection In order to provide a safe, sanitary environment and to prevent development and Transmission of infections to the extent possible. Resident's chairs, blood pressure cuffs, chairs etc Findings include: On 02/04/26 at 11:53 AM, observed R135 sitting in bed with two nephrostomy tubes draining light yellow color liquid into collection bags. R135 stated the staff always wears gloves and a mask when they come in to empty her bags, but they do not wear a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/04/26 at 11:55 AM, upon leaving R135's room observed that there was no Enhanced Barrier Precautions (EBP) signage posted outside R135's room. Did not find an EBP sign on the floor near R135's doorway or inside her room. On 02/04/26 at 12:01 PM, V21 (Registered Nurse) stated R135 has bilateral nephrostomy tubes and there should be an Enhanced Barrier Precaution sign posted outside R135's door. V21 stated the purpose of posting the EBP sign outside R135's door is to inform anyone going into the room that the resident is on EBP, so they wear the appropriate personal protective equipment (PPE). V21 stated the potential problem with the EBP signage not being posted outside R135's room is that people will not perform hand hygiene or wear appropriate PPE which can be an infection risk for R135 because staff/visitors coming into R135's room can transmit bacteria to her. On 02/04/26 at 12:03 PM, V20 (1st Floor Unit Manager/Licensed Practical Nurse) stated if the EBP sign is not posted outside R135's room that means if a CNA (Certified Nursing Assistant) went into R135's room to give her care the CNA would not know they needed to wear PPE before giving care. V20 stated everyone entering and leaving the room should be doing hand hygiene and for staff doing direct care activities such as emptying nephrostomy tubes they need to wear gown and gloves. V20 stated it is important for the staff to wear the appropriate PPE to protect R135 because she has an indwelling medical device and is at a higher risk for acquiring an infection. On 02/05/26 at 9:35 AM, V4 (Infection Preventionist/2nd Floor Unit Manager/LPN) stated EBP are needed if a resident has any indwelling medical catheter such as nephrostomy tube to reduce the risk of the staff introducing infection into the openings. V4 stated residents on EBP have an EBP signage outside their door to make the staff aware that the resident's immune system is compromised and what PPE they need to wear. V4 stated if the staff are doing any kind of resident care, they need to wear a gown and gloves and do hand hygiene before and after entering the room. V4 stated if the EBP signage is not posted outside the resident's room the staff could be inadvertently exposing the resident to an outside organism, bacteria and/or infection. V4 stated R135 has bilateral nephrostomy tubes and is on the EBP list. V4 stated R135 should have had an EBP sign posted outside her door. On 02/06/26 at 8:25 AM, V3 (Director of Nursing) stated the purpose of the EBP signage is to let anyone who comes into the room know what PPE they should be wearing when they take care of the resident. V3 stated anyone with nephrostomy tubes should be on EBP and should have EBP signage posted outside their door. V3 stated the potential problem if the EBP sign is not posted is then the staff coming into care for the resident could contaminate the resident if they do not perform hand hygiene and wear a gown and gloves when performing ADL activities. R135's diagnosis included but not limited to Malignant Neoplasm of Endometrium, Other Hydronephrosis, Other Obstructive and Reflux Uropathy, Generalized Abdominal Pain, Chronic Kidney Disease Stage 2, Unspecified Protein-Calorie Malnutrition, Urinary Tract Infection, Sepsis, Other Artificial Openings of Urinary Tract Status, Congestive Heart Failure. R135's Order Summary Report dated 02/04/26 documents in part drain nephrostomy tubes PRN as needed for urinary drainage, monitor bilateral nephrostomy tubes every shift for signs/symptoms of infection and functionality/placement every shift for infection control monitoring, R135's MDS (Minimum Data Set) from 01/16/26 documents in part, R135 has an indwelling catheter and requires partial/moderate assistance with toileting hygiene, shower/bathing self and transfers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R135's care plan documents in part (R135) has the potential risk for complications related to bilateral nephrostomy tubes and (R135) is on enhanced barrier precautions per applicable infection prevention and control standards and regulation with goal to prevent the spread of infection and intervention to maintain precautions as indicated. Reviewed Enhanced Barrier Precautions List provided by facility on 02/05/26 which lists R135 name and reason for EBP is listed as indwelling. Facility provided policy titled, IC - Enhanced Barrier Precautions (EBP) dated 01/2026 which documents in part, EBP are indicated for wound and/or indwelling medical devices and an EBP sign should be posted for each resident on EBP. Facility provided copy of Enhanced Barrier Precautions sign by the U.S. Department of Health and Human Services Center for Disease Control and Prevention which documents everyone must clean their hands, including before entering and when leaving the room and providers/staff must also wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use – central line, urinary catheter, feeding tube, tracheostomy. Findings Include: On 2/4/26 at 11:16 AM, an enhanced barrier precautions signage was noted posted on R1's door that reads in part: Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing brief or assisting with toileting. On 2/4/26 from 11:43 AM to 11:56 AM, surveyor observed V7 (Certified Nursing Assistant) provided morning care to R1. V7 wiped R1's face, arms, and upper body. V7 changed R1's incontinence product, changed R1's gown and incontinence pad. V7 did not wear protective personal gown the entire time [V7] provided morning/incontinence care to R1. Surveyor asked V7 if she was aware what type of transmission-based precaution R1 is on. V7 stated R1 is on enhanced barrier precaution but was not aware that [V7] was supposed to wear gown while providing care to R1. V7 stated she is assigned to approximately 13 to 15 residents on the third floor but still helps with attending to others residents' needs for the entire floor. On 2/5/26 at 9:25 AM, V4 (Infection Preventionist/Licensed Practical Nurse) stated that residents who have any opening such as central lines, any wounds, tube feeding, and indwelling catheters are placed on EBP. V4 said the purpose of EBP is to ensure that staff don't infect the residents and that infection is not introduced into their openings. V4 said staff should be wearing gowns, gloves and masks when doing high contact activities such as incontinence care, whenever they are touching the patient, during bathing, changing diaper, wound care, and enteral tube feeding care. V4 said if staff does not wear the proper PPE, it would increase the risk of infection to the resident and other residents they take care of and also would put employees at risk for infections. V4 said R1 is on EBP for wounds and tube feeding. On 2/5/26 at 12:47 PM, V3 (Director of Nursing) stated that staff are required to wear appropriate personal protective equipment (PPE), including gloves and gowns, when providing personal care such as dressing, bathing, grooming, wound care, or any activity involving direct contact with the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V3 stated that proper PPE use is important to prevent the spread of bodily fluids and potential cross-contamination to staff and other residents. The facility's IC-enhanced Barrier Precautions (EBP) policy dated 1/25 documents in part: EBP requires the use of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [Multidrug-resistant Organisms] and XDROs [Extensively Drug-Resistant Organisms] to staff hands and clothing. High-contact resident care activities requiring gown and glove use among residents that trigger EBP use include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing brief or assisting with toileting, Wound care. The facility's residents' roster dated 2/4/26 shows a total of 74 residents residing on the third floor.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy to develop a comprehensive person-centered care plan for each resident. This failure affected 2 (R104 and R178) residents on anticoagulant medication use in a sample of 35. The findings include:R104's admission record / face sheet showed admit date on 4/29/25 with diagnoses not limited to Paroxysmal atrial fibrillation, Type 2 diabetes mellitus, Hypertensive heart disease with heart failure, Presence of cardiac pacemaker, Other heart failure, Primary generalized (osteo)arthritis, End stage renal disease, Hypertensive heart and chronic kidney disease, Atherosclerotic heart disease of native coronary artery, Dependence on renal dialysis, Gout, Mixed hyperlipidemia.On 2/04/2026 At 11:57AM R104 observed up and about, ambulatory with cane with steady gait. Alert and oriented x 3, verbally responsive, stated he is getting blood thinner medication. R104's POS (Physician Order Sheet) dated 2/5/26 showed order not limited: Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth every 12 hours for Thrombosis.MDS (Minimum Data Set) dated 11/4/25 showed R104 received anticoagulant medication.Reviewed R104's EHR (Electronic Health Record), no care plan was found for anticoagulant medication use. R178's admission record / face sheet showed admit date on 4/16/25 with diagnoses not limited to Heart failure, Alcoholic cirrhosis of liver without ascites, Alcohol dependence, Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, Other arterial embolism and thrombosis of abdominal aorta.R178's POS dated 2/5/26 showed order not limited to: Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth every 12 hours.MDS dated [DATE] showed R178 received anticoagulant medication.Reviewed R178's EHR (Electronic Health Record), no care plan found for anticoagulant medication use. On 2/5/26 At 1:06PM V3 (DON / DIRECTOR OF NURSING) said Residents on anticoagulant medication, care plan should be completed. She said care plan is a generalized plan of care of the residents that includes interventions to guide staff how to care for the residents. She said if there is no care plan completed there is no discussed plan of care / interventions for the residents.On 2/6/26 At 9:40PM V36 (MDS DIRECTOR) she said part of her responsibility is to do care plan as well. She said Care plan provides patient's centered care, individualized for each resident based on their needs. V36 said care plan is done by IDT (Interdisciplinary Team). It can include problems / concerns, medications such as insulin, anticoagulant medication. She said Care plan includes goals and interventions. V36 said residents on anticoagulant medication should have a care plan because of the Potential or risk for bleeding. She said care plan helps the staff to care for the residents. Reviewed R104 and R178 EHRs with V36 and said both residents are on anticoagulant medication and care plan should be in place. Reviewed R104 and R178's care plan with V36, no care plan found for anticoagulant medication use.Facility's Comprehensive care plan policy dated 5/1/25 showed in part: The facility must develop a comprehensive person-centered care plan for each resident. The care plan will include a focus, measurable goal, and interventions specific to the resident's medical, nursing needs. The comprehensive care plan should drive the care and services provided for the resident and allow for the highest level of physical, mental, and psychosocial functions based on the comprehensive MDS assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145983	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya on 87th	2940 West 87th Street Chicago, IL 60652

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure timely incontinence care was provided to one (R1) out of two residents reviewed for activities of daily living (ADL) care in a final sample of 35. Findings Include:On 2/4/26 at 11:09 a.m., R149 stated her roommate (R1) has not been changed since 4:00 a.m. R149 said, [R1's] been lying on that soiled diaper for hours. I've been awake since four in the morning and that was the last time the CNA [Certified Nursing Assistant] came in here to change her [R1]. They should know that she [R1] needs to be changed frequently because she has that tube feeding going and she [R1] soils herself a lot.On 2/4/26 at 11:16 a.m., R1's lying in bed alert and able to verbalize needs. R1 stated she's wet and needs to be changed. R1 said she does not remember when the last time her diaper was changed, but she feels like it's been a while. R1 said that she has a wound on her back and the wound dressing was changed yesterday morning.On 2/4/26 at 11:35 a.m., surveyor notified V6 (Certified Nursing Assistant) that R1 needs incontinence care. V6 said she will notify the CNA assigned to R1. On 2/4/26 at 11:40 a.m., V7 (Certified Nursing Assistant/CNA) stated [V7] is the CNA assigned to R1. V7 said she started at 6:00 a.m. and had not yet had the opportunity to check on R1.On 2/4/26 between 11:43 a.m. and 11:56 a.m., surveyor observed V7 (CNA) providing morning care to R1. During the observation, R1's incontinence brief and pad were noted to be saturated with urine and feces. R1's perineal area (inner thighs and groin) and perianal (buttocks) were heavily soiled with urine and feces. R1's sacral wound dressing was also soiled and not intact.On 2/4/26 at 3:43 p.m., surveyor conducted a telephone interview with V26 (Certified Nursing Assistant). V26 stated that she was the CNA assigned to R1 during the night shift on 2/3/26, and that she left the faciity on 2/4/26, at 6:00 a.m. V26 stated that R1 had frequent bowel movements related to tube feeding and requires frequent incontinence care. V26 stated that R1 typically has bowel movements every one to two hours and requires frequent diaper changes. V26 stated that she last changed R1's incontinence brief at approximately 4:30 a.m., prior to leaving the facility, and that this was her last round with R1. V26 stated R149 saw V26 changed R1 because R149 was awake at that time and that whenever V26 changes R1, V26 would let R149 know.On 2/5/26 at 12:47 p.m., V3 (Director of Nursing) stated that staff are expected to provide incontinence care as soon as possible when a resident is incontinent. V3 stated that staff conduct routine rounds, alternating with nursing staff, to assess resident safety and needs. V3 stated that during rounds, staff are expected to ensure the resident is safe, safety precautions are in place, the call light is within reach, and resident needs are addressed. V3 stated that staff are expected to check residents for incontinence at least every two hours, and that residents who are incontinent require checks at least every hour. V3 stated that incontinence care should be provided promptly when needed. V3 stated R1 requires reminders and relies on staff to meet her needs. V3 stated that R1 requires assistance with all activities of daily living (ADLs) and can sit up in a chair but requires staff assistance for repositioning. V3 stated that R1 is incontinent of both bowel and bladder and requires staff assistance for incontinence care. V3 stated that R1 has a gastrostomy tube (G-tube) and that some residents with a G-tube may experience loose stools, requiring frequent monitoring. V3 stated that staff should check R1 at least every hour. V3 stated that R1 has fragile skin and is at risk for skin breakdown, and that delays in care could impact wound healing and development of new skin breakdown.On 2/6/26 at 9:49 a.m., V19 (Registered Dietitian) stated that R1 is NPO (Nothing by Mouth) and receives tube feeding with a high-fiber formula and may experience frequent loose stools due to R1 may not be absorbing the formula well due to her current medical conditions.R1's clinical records show an original admission date of 7/25/26 with listed diagnoses but not limited to cerebral infarction, gastrostomy status, flaccid hemiplegia affecting left nondominant side, and adult failure to thrive. R1's Minimum Data Set (MDS) assessment dated [DATE] revealed R1 has severely impaired cognition with BIMS (Brief Interview for Mental Status) of 7. It also reveals that R1 is always (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinent of bowel and bladder, is dependent on staff's assistance for perineal hygiene, bathing, and mobility, and is at risk of developing pressure ulcers/injuries. R1's comprehensive care plan documents in part: [R1] is at risk for and has an alteration in skin integrity related to self-care deficits, impaired mobility and comorbidities with one of the interventions that reads: Provide peri-area after each incontinent episode and apply barrier cream (date initiated 7/28/25). R1's care plan also documents in part: R1 is incontinent of bowel and bladder and one of the interventions reads: Provide incontinence care at routinely timely intervals. Keep skin clean, dry and moisturized (date initiated 7/28/25).R149's clinical records show an original admission date of 6/20/23. R149's MDS dated [DATE] shows R149 is cognitively intact with BIMS of 15 and requires supervision with ADLs.The facility's SKIN CARE PREVENTION policy and procedures dated 6/25 documents in part: All residents will receive appropriate care to decrease the risk of skin breakdown. Clean skin at time of soiling and at routine intervals.The facility's INCONTINENCE CARE policy and procedures dated 5/25 documents in part: Incontinence care is provided to keep residents as dry, comfortable and odor free as possible. It also helps in preventing skin breakdown.The facility's Certified Nurse Aide job description (undated) documents in part: Keep incontinent residents clean, dry and odor free; check every two hours to maintain. Review care plans daily to ensure provision of appropriate care.

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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's orders for R129's IV (intravenous) dressing, failed to ensure that R129's IV dressing was secure and intact, failed to perform hand hygiene while handling R129's IV dressing, and failed to address R129's IV site in the comprehensive care plan for 1 out of 1 resident reviewed for IVs out of a total sample of 35 residents. Findings include: R129's ?Order Summary Report' documents in part that facility may insert a midline or PICC (peripherally inserted central catheter) line on 01/23/2026. There is an active order to Monitor [intravenous] insertion site, ensure dressing and placement is intact every shift. Notify [medical doctor] of any abnormalities every shift. The order date was 1/26/2026. There was an additional order to monitor the right arm for signs and symptoms of infection, infiltration, and/or dressing placements every shift dated 12/22/2025. R129's ?Order Summary Report' did not have any current medications or fluids to be administered intravenously. R129's ?Care Plan Report' did not include a focus on R129's intravenous line. On 2/04/2026 at 11:33 AM, R129 was sitting in the day room. R129 had an intravenous line near the crease of the right arm (antecubital). The medial side of the dressing was peeling off. The date on the dressing read 1/24/26. On 2/04/2026 at 11:34 AM, V11 (Activity Director for the second floor) stated the date on the dressing was 1/24/26. On 2/05/2026 at 11:05 AM, R129 was sitting in the day room. R129's intravenous line remained with a date of 1/24/26. The dressing was not intact on the medial side. On 2/05/2026 at 11:10 AM, R129's Medication Administration Record (MAR) documents in part that nursing staff including V15 (Nurse) charted monitoring the right arm for signs and symptoms of infection, infiltration, and/or dressing placements. However, the dressing remained with a date of 1/24/26 and was not intact. On 2/05/2026 at 11:14 AM, V15 (Licensed Practical Nurse-LPN) stated R129 was getting an antibiotic at some point. V15 stated doesn't know why R129 remained with intravenous line. V15 stated no due medications or fluids to R129's intravenous line during morning shift. V15 did not know when the last time staff used R129's intravenous line. V15 stated the facility has V27 (IV Nurse) who usually deals with residents PICC lines and midlines. V15 was not sure who oversaw changing of intravenous line dressings. V15 stated maybe the overnights. V15 stated normally, the overnight nurse would reinforce the intravenous dressing if it were coming loose. V15 stated most intravenous dressings should be changed every 72 hours overall but was not sure what the facility protocol was. V15 was not sure if LPNs could change the dressings. At 11:17 AM, surveyor and V15 went to observe R129's intravenous dressing. V15 did not perform hand hygiene or don gloves (V15 was charting at the nurses' station prior to this interview). With bare hands, V15 touched R129's single lumen and intravenous dressing stating the dressing was coming off on one side. V15 read the dressing date as 1/twenty something/26. After interview, V15 then went to the nurses' station. On 2/05/2026 at 11:22 AM, V4 (Second Floor Unit Manager and Infection Preventionist) stated staff nurses do the intravenous dressing changes. V4 stated nurses are to follow the physician orders which show up on the residents' MAR. The nurses are supposed to change the dressing when it's due, date it, and sign it. During a follow-up interview, at 11:49 AM, V4 stated R129 needed the intravenous line for antibiotics but R129 is no longer on it. V4 and surveyor observed R129's intravenous dressing. V4 stated nursing staff should have addressed R129's intravenous dressing. V4 stated nurses are to change the dressing every seven days and as needed when dressing is not intact. V4 stated staff should also perform hand hygiene and wear personal protective equipment including gloves while handling intravenous lines. On 2/05/2026 at 1:10 PM, V3 (Director of Nursing) stated R129 has a midline intravenous line. V3 did not know when it was last used. V3 stated nursing staff are to change the transparent dressing every seven days or as needed when the dressing is not intact. V3 stated any nurse that has a license can change the intravenous dressings. V3 stated V27 (IV Nurse) is a contracted company to insert midlines and PICC lines; however, when it comes to dressings and pulling the intravenous lines out, it is the facility nurses' duties. Attempted telephone interview with (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V27 on 2/05/2026 at 11:34 AM, 11:36 AM, and 11:42 AM; however, no answer. Facility's Midline Catheter-Dressing Change policy (date 1/2023) documents in part: The catheter insertion site is a potential entry site for bacteria that may cause a catheter related infection. This policy provides guidance on completing a midline catheter dressing change. The policy reads to perform dressing changes every seven days or when the integrity of the dressing has been compromised such as when it is loose. Staff are to perform assessment of venous access at least once every shift when not in use. Assessment is to include the integrity of the transparent dressing. Facility's Comprehensive Care Plan policy (1/2023) documents in part: The facility must develop a comprehensive person-centered care plan for each resident. The care plan will include a focus, measurable goal, and interventions specific to the resident's medical, nursing, mental, and psychosocial needs. The comprehensive care plan should drive the care and services provided for the resident and allow for the highest level of physical, mental, and psychosocial function based on the comprehensive MDS assessment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record reviews, the facility failed to provide one-to-one (1:1) feeding assistance for two residents (R84 and R192) with aspiration and swallowing precautions and failed to include the aspiration and swallowing precautions in their comprehensive care plan for two out of a total sample of 35 residents.Findings include: R84's ?admission Record' documents in part diagnoses of Parkinson's disease, lack of coordination, and dementia. R84's speech therapy discharge summary signed by V37 (Speech Language Pathologist) on 10/02/2025 documents in part: Compensatory Strategies/Positions: close supervision and the following swallowing precautions: only feed when alert, upright at 90 degrees for all intake, aspiration precautions, monitor for [signs and symptoms] aspiration related illness, alternate liquids and solids, slow rate, 'monitor for pocketing', provide oral care, discontinue feeding and clear mouth if [patient] demonstrates pocketing or [signs and symptoms] aspiration and notify nurse/[medical doctor]. R84's 1/02/2026 Quarterly MDS (Minimum Data Set) assessment documents in part that R84 had severely impaired cognition during the assessment period. R84 had loss of liquids and solids from mouth when eating or drinking. R84 was on a mechanically altered diet. R84 needed supervision or touching assistance when eating. R84's ?Order Summary Report' documents in part dietary orders for mechanical soft-textured diet with thin liquids. R84 has an order for 1:1 (one-to-one) assist with aspiration and swallowing precautions. The order date for the dietary orders was 9/09/2025. R84's ?Order Summary Report' also had a separate order for 1:1 feeder three times a day active since 12/08/2024. R84's ?Care Plan Report' documents in part focuses for R84's nutritional risk, impaired memory, and potential complications with Parkinson's including but not limited to dysphagia and drooling. However, R84's comprehensive care plan does not contain focuses or interventions related to R84's aspiration and swallowing precautions. R192's ?admission Record' documents in part diagnoses of traumatic brain injury, dementia, and mild cognitive impairment. R192's speech therapy discharge summary signed by V37 (Speech Language Pathologist) on 8/29/2025 documents in part: Compensatory Strategies/Positions: [speech language pathologist] recommends diet advancement to [patient] to [mechanical] soft/thin with 1:1 assistance and the following precautions: upright at 90 degrees for all intake, aspiration precautions, monitor for [signs and symptoms] aspiration related illness, alternate liquids and solids, slow rate, monitor for pocketing, 1:1 assistance. R192's 11/04/2025 Quarterly MDS assessment documents in part that R192 had severely impaired cognition during the assessment period. R192 needed partial/moderate assistance with eating. R192 was on a mechanically altered diet. R192's ?Order Summary Report documents in part dietary orders for mechanical soft texture with thin liquids. R192 has an order for 1:1 assist with swallowing precautions. The order date for the dietary orders was 8/19/2025. R192 also had a separate order for 1:1 feed with meals for nutritional intake active since 6/30/2025. R192's 1/29/2026 progress note by V39 (Nurse Practitioner) documents in part strict aspiration precautions related to dysphagia. R192's ?Care Plan Report' documents in part a focus for R192 being malnourished. Intervention includes providing 1:1 feeding assist (initiated 7/01/2025). However, R192's comprehensive care plan did not contain focuses on aspiration or swallowing precautions. During random lunch observations on 2/04/2026 at 12:09 PM, V12 (Nurse Manager) dropped off R192's lunch tray in front of [R192]. R192's meal ticket on the tray read 1:1 assist, swallowing precautions. R192 began eating. No staff sat 1:1 with R192 during the lunch meal. During same lunch observation, R84 was eating at the nearby table. R84's meal ticket on the lunch tray read 1:1 assist, aspiration precautions, swallowing precautions. No staff sat 1:1 with R84. V13 (Certified Nurse Aide) was standing in between the two tables. At 12:21 PM, V13 stated [V13] was watching everyone on that side of the room to make sure residents weren't sleeping or trying to get up from their chairs unassisted. V13 stated [V13] was not doing 1:1 feeding assist because role was to watch everyone in the room. At approximately 12:36 PM, R192 put (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tissue onto the plate, put hands under the blanket that was across [R192's] lap and brought it up to the chest. R192 closed eyes and stopped touching food from meal tray. R192 ate half of the turkey pot pie, half of the vegetable medley, half of the pudding and a cookie from V11 (2nd floor Activity Director). No staff provided 1:1 assist to R192 during continuous observations of R192's lunch meal. At approximately 12:42 PM, R84 finished all of lunch meal. No staff provided 1:1 assist to R84 during continuous observations of R84's lunch meal. On 2/05/2026 at 1:15 PM, V3 (Director of Nursing) stated 1:1 assist with feeding means a staff member should sit down and help feed the resident during meals. V3 stated residents that require 1:1 feeding assist are residents who need more assistance during meals to make sure they eat. V3 also stated it can be for safety reasons such as aspiration precautions when residents are at risk for aspirating food or water. Attempted telephone interview with V37 (Speech Language Pathologist) on 2/06/2026 at 12:22 PM; however, no answer. Survey team received facility's Feeding Assistance policy (1/2023) as it applies to residents who are unable to feed themselves. Policy did not address residents who require 1:1 feeding assistance with aspiration or swallowing precautions. Facility's Comprehensive Care Plan policy (1/2023) documents in part: The facility must develop a comprehensive person-centered care plan for each resident. The care plan will include a focus, measurable goal, and interventions specific to the resident's medical, nursing, mental, and psychosocial needs. The comprehensive care plan should drive the care and services provided for the resident and allow for the highest level of physical, mental, and psychosocial function based on the comprehensive MDS assessment.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review the facility failed to place oxygen cannula tubing in a bag when not in use for one (R78) of two residents reviewed for respiratory care in a sample of 35. Findings include:On 02/04/26 at 11:30 AM, observed in R78's room oxygen tubing attached to an oxygen concentrator with the nasal cannula end of the tubing lying in an opened drawer. The nasal cannula was lying on top of an opened bag of cookies, and a used plastic urinal bottle was hooked on the edge of the opened drawer close to the nasal cannula. The nasal cannula was not stored in a bag or container. The oxygen concentrator was not turned on and R78 was not in the room.On 02/04/26 at 11:33 AM, V20 (1st Floor Unit Manager/Licensed Practical Nurse) came into R78's room and observed the uncovered nasal cannula tubing in the open drawer and stated the oxygen tubing should be stored in a bag when not in use for infection control reasons. V20 stated the oxygen tubing should not be touching other things because the nasal cannula tubing goes directly into the resident's nose. V20 stated she is going to throw the oxygen tubing set out and get a new one for R78 to use. On 02/06/26 at 8:22 AM, V3 (Director of Nursing) stated when not in use the oxygen tubing should be stored in a plastic bag to protect it and keep it from not being infected. V3 stated putting the oxygen tubing in a plastic bag when not in use is a protective measure for infection control reasons.On 02/06/26 at 12:54 PM, observed R78 sitting in wheelchair at bedside in room. Observed R78's nasal cannula tubing wrapped around the grab bar of his bed. The oxygen tubing was not in a plastic bag or covered in any way. The oxygen concentrator was not on. R78 stated he turns his oxygen on/off when he feels like he needs it. R78 stated the last time he used his oxygen was last night. R78 stated no one told him that he should store the tubing in a plastic bag or container when not in use. R78 stated he just wraps it around the bed rail when he is not using it.R78's diagnosis included but not limited to Anemia in Other Chronic Diseases Classified Elsewhere, Pleural Effusion, Encounter for Screening For Malignant Neoplasm Of Prostate, Hypertensive Heart Disease Without Heart Failure, Heart Failure, Other Artificial Openings Of Urinary Tract Status, Secondary Malignant Neoplasm Of Bone, Insomnia.R78's Order Summary Report printed 02/05/26 document in part, oxygen at two liters/minute PRN per nasal cannula, maintain oxygen saturation at 92% or greater as needed for SOB dated 01/20/26.R78's MDS (Minimum Data Set) dated 01/22/26 indicates intact cognition based on BIMS (Brief Interview for Mental Status). R78's oxygen care plan dated 02/05/26 documents in part R78 has oxygen therapy related to congestive heart failure. Facility provided policy titled Oxygen Safety/Use dated 05/2025 which documents in part, oxygen sources will be provided that ensure ready access and safe distribution of oxygen to patients/residents and oxygen tubing will be changed weekly and appropriately stored to prevent contamination when not in use.