STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146053	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Palos Park	12220 South Will Cook Road Palos Park, IL 60464

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 - 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 follow physician orders pertaining to pressure ulcer prevention and failed to follow the facility's pressure ulcer policy. These failures affected one resident (R1) out of a sample of three residents reviewed for pressure ulcers. Findings include: R1's face sheet documents in part the following diagnoses: Metabolic encephalopathy, dysphagia, protein-calorie malnutrition, unspecified dementia, cognitive communication deficit, local infection of the skin, cellulitis of the right lower limb, Parkinson's disease, and major depressive disorder. R1's minimum data set (3/11/2026) documents in part a brief interview of mental status (BIMS) summary score of 00, indicating that R1 has severe cognitive impairment. R1's hospital records prior to readmission [DATE]) documents in part that R1 was seen by a podiatrist in the hospital for a Right Heel Ulceration and documents the following: Plan: Recommend ongoing palliative wound care right heel wound. No debridement is required at this time. Recommend daily dressing change and offloading with heel protector boot at all times.R1's physician orders document an active order (3/12/2026) for Foam Boots to right and Left foot daily to relieve pressure every day shift for pressure relief. Foam boots to right and left foot daily to relieve pressure. R1's medication review report (3/12/2026) documents that V4 (Podiatrist) gave a written order for Foam boots to feet -- No Pressure, - Dressing (Change) daily gauze and silvadine cream, -daily foot washing; then dressing, - Patient to (return to office) in 2 to 3 weeks.R1's progress note completed by R1's nurse practitioner (3/19/2026) documents an instruction to offload both heels. R1's Braden Score for Predicting Pressure Sore Risk (3/4/2026) documents a score of 14, indicating a moderate risk of developing a pressure ulcer. R1's wound summary report (4/7/2026) documents in part that R1 has an unstageable pressure ulcer to the right heel that is 3.5 cm x 4 cm. On 4/6/2026 at 12:28 PM, R1 was observed in the dining room in a wheeled recliner sleeping. R1's had a heel protector boot cushion attached to R1's right foot. R1's right foot was observed wrapped in a gauze dressing under the boot cushion. No heel boot was observed on R1's left lower foot and R1's heel was lying on the recliner. This observation was confirmed with V6 (Restorative Nurse). V6 stated, Yeah, he has a wound on his foot. That's why there's the boot. R1 was unable to be aroused for interview. R1 was transferred to R1's room for an interview with V3 (Wound Care Nurse). On 4/6/2026 at 12:51 PM, surveyor and V3, Wound Care Nurse observed R1 in R1's room sleeping. R1 was unable to be aroused and unable to participate in interview. R1's heel protector was still not applied to the left heel. V3 walked by the windowsill of the room, grabbed a heel protector boot and attached it to R1's left foot. V3 stated, I got it from the windowsill, yeah (R1) is supposed to have both boots on. I don't know why it wasn't on (R1)'s foot, I guess they (staff) didn't put it on. V3 explained that the purpose for the boots being on was to offload pressure to R1's heels. V3 confirmed that R1 had an active wound to R1's right foot and is at risk for pressure ulcers. On 4/6/2026 at 1:58 PM, V2 (Director of Nursing) affirmed that facility staff should be following physician orders. V2 confirmed there was active orders for R1 to be wearing foam boots to right and left feet. V2 stated, Yes, (R1) should have been wearing a left boot too, I don't know why the left boot was not on. V2 affirmed that the boot is to help offload pressure to R1's heel and prevent injury. R1's care plan (revised 4/7/2026) identifies that at risk for skin complications r/t advanced (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 - Minimal harm or potential for actual harm Residents Affected - Few	age, decreased mobility, incontinent of bowel and bladder, and other comorbidities. An intervention of Protect heels. Apply heel protector boots while in bed was created on 4/7/2026 by V3 (Wound Care Nurse) and revised on 4/7/2026 by V6 (Restorative Nurse). This care plan was revised after the original observation on 4/6/2026 of R1 not wearing heel protectors in the dining room and does not reflect the physician orders for heel protectors to both feet and professional standards of wound prevention. There is no indication on the care plan that it is R1's or V18's (R1's Family Member's) preference to wear the boots only in bed. On 4/7/2026 at 4:20 PM, V18 (R1's Family Member) explained that V18 has a pressure ulcer on V18's right foot and is at risk for pressure ulcers. V18 affirmed that the facility doesn't always provide the right care and stated, I have to put signs in the room to remind them (facility staff) what to do. (R1) won't be in the right wheelchair, won't have boots (heel protectors) on (R1's) feet, it's very frustrating. I am (R1's) voice and I try to advocate for (R1) as best I can. On 4/8/2026 at 9:03 PM, V5 (Podiatrist) affirmed that V5 and V4 are the providers managing R1's wound care and sees R1 in the office every couple of weeks. V5 affirmed that the facility should be following physician orders when they are given to the facility. V5 explained, Yes, (V4) wrote that order. The order means no pressure, period. They (staff) need to avoid putting any sort of pressure any bony prominences, including the heels. I would expect (R1) to be wearing the heel boots on both feet at all times or have the pressure offloaded by some means. The purpose of the boots is to redistribute and offload pressure from the heels which helps to prevent pressure ulcers.On 4/8/2026 at 10:00 AM, observed wound care performed to R1's right foot by V3 and V8 (Senior Wound Care Coordinator, Licensed Practical Nurse) in R1's room. V3 was observed removing both heel protectors and laid both of R1's heels directly on the bed (not offloaded). V3 soiled dressing, placed a piece of gauze to R1's bed and placed R1's heel directly on the gauze. V3 lifted the foot briefly to redress the wound, but set the heel back onto the bed when the dressing was completed. At 10:15 AM, V3 finished dressing the wound and a skin check was completed by surveyor, V3 and V8. R1's heels were still not offloaded during the skin check. During the skin check, R1 was turned to the left and right side lying position, where R1's ankles laid directly on R1's shin of the opposite leg, causing pressure to both bony prominences. At 10:28 AM, the skin check was completed and R1's foam heel protectors were reapplied to both feet. V3 and V8 both confirmed that R1's heels were not offloaded during the dressing change. V3 stated, yeah, we could have put a pillow, rolled up blanket or something underneath so that the heels weren't directly on the bed and were offloaded. Observed hand written signs in the room from V18 that state (R1) is recovering from an infection . Make sure green boot are on (R1's) feet . and PLEASE Keep (R1's) Right [NAME] Boot on even when he is in bed. Thank You. V8 confirmed the observation of the signs in the room. On 4/8/2026 at 12:47 PM, V12 (Certified Nursing Assistant) affirmed that V12 was assigned to care for R1 on 4/6/2026 and regularly cares for R1. V12 explained, On (4/6/2026), I remember taking care of (R1). I got R1 all cleaned up, got (R1) shaved. I don't remember putting on the foot boot to both feet, but I did put a boot on the foot with the wound. (R1's) family gets really upset if the boot isn't on but they get more upset when its the foot with the wound versus the other one. V12 denied any knowledge of the physician orders that require both heel boots to be on or knowledge of the care plan that instructs staff to apply foot protector boots to both feet. V12 stated, Yeah, I only applied the one boot to the foot with the wound. I'm sorry. Facility policy titled, Skin Care Prevention (Reviewed 6/2025) documents in part, All residents will receive appropriate care to decrease the risk of skin breakdown .6. Unless contraindicated, elevate heels off bed surface and avoid skin-to skin contact .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to perform wound care in a manner that prevented contamination and failed to follow the wound care facility policy. These failures affected one resident (R1) of three residents reviewed for infection control. R1's face sheet documents in part the following diagnoses: Metabolic encephalopathy, dysphagia, protein-calorie malnutrition, unspecified dementia, cognitive communication deficit, local infection of the skin, cellulitis of the right lower limb, Parkinson's disease, and major depressive disorder. R1's minimum data set (3/11/2026) documents in part a brief interview of mental status (BIMS) summary score of 00, indicating that R1 has severe cognitive impairment. R1's medication review report (3/12/2026) documents that V4 (Podiatrist) gave a written order for Foam boots to feet -- No Pressure, - Dressing (Change) daily gauze and silvadine cream, -daily foot washing; then dressing, - Patient to (return to office) in 2 to 3 weeks.R1's nurse practitioner's progress note (3/19/2026) documents that R1 was treated for right heel cellulitis during a hospital stay from 2/23/2026-3/4/2026 and was prescribed antibiotics for the infection. R1's physician order sheet documents an active order (3/27/2026) for Amoxicillin-Pot Clavulanate Tab 875-125 mg, give 1 tablet by mouth every 12 hours for right heel cellulitis, right foot infection for 10 days with a stop date of 4/7/2026. R1's Braden Score for Predicting Pressure Sore Risk (3/4/2026) documents a score of 14, indicating a moderate risk of developing a pressure ulcer. R1's wound summary report (4/7/2026) documents in part that R1 has an unstageable pressure ulcer to the right heel that is 3.5 cm x 4 cmOn 4/6/2026 at 12:51 PM, V3 (Wound Care Nurse, Licensed Practical Nurse) affirmed that R1 has had cellulitis to the right heel wound and is currently receiving antibiotics to treat the infection. On 4/8/2026 at 9:03 PM, V4 (Podiatrist) affirmed that V5 and V4 are the providers managing R1's wound care and sees R1 in the office every couple of weeks. V4 was unsure how R1's heel got infected. V4 explained, Our skin has a lot of bacteria on it. It's very easy for a wound to get contaminated and cause infection. On 4/8/2026 at 10:00 AM, observed wound care performed to R1's right foot by V3 and V8 (Senior Wound Care Coordinator, Licensed Practical Nurse) in R1's room. V3 was observed removing the soiled dressing, placed a piece of gauze to R1's bed and placed R1's heel directly on the gauze. The soiled gauze was covered with yellow and bloody drainage that covered approximately 25% of the entire dressing. V8 confirmed the dressing had serosanguinous drainage and purulent drainage. V8 stated that the purulent drainage could be from the slough on the wound bed or from infection. V3 lifted R1's leg and irrigated the round with normal saline. V8 instructed V3 to pat the wound dry with gauze. V3 patted the wound in a circular motion from the outside skin of the wound to the inside of the would bed several times over to dry the wound. While V3 was patting the wound dry, V8 exclaimed, stop, no . no stop! You have to go from the inside out! No stop!. V3 did not follow the instructions from V8, discarded the dressing, and left to perform hand hygiene in R1's bathroom. V8 confirmed (V3) went from the skin outside of the wound to the inside wound bed. (V3) should have patted the wound dry from inside of the wound bed to the outside skin to prevent infection. V8 explained that would care should always be completed from clean to dirty. V8 confirmed that V8 is in a regional role, and that V8 is not present when V3 completes wound care on a regular basis. V3 returned to the resident to begin applying the new dressing. V8 instructed V3 to stop and reirrigate the wound. V3 irrigated the wound and patted the wound dry from the inside of the wound to the outside in a circular motion. V3 confirmed that V3 patted the wound dry from outside the wound to the inside of the wound bed. V3 confirmed that by not following clean technique, V3 introduced bacteria to the wound bed which could cause infection. On 4/8/2026 at 1:18 PM, V2 (Director of Nursing) affirmed then when a wound is cleansed, it should be cleansed using clean technique. V2 explained that clean technique is cleansing from the inside out and explained that going from outside the wound to in can introduce bacteria into the wound bed which can cause infections.Facility policy titled, Wound Dressing Policy (12/2024) documents in part, It is the policy of this facility to do wound dressing changes using clean (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	techniques with packaged wound dressings and materials. These will be used in conjunction with good hand hygiene technique. To ensure a safe and effective procedure for changing wound dressings. To provide an appropriate type of protective wound covering that facilitates the healing process . 3. Change the dressing using clean technique according to physician orders. Frequency ofwound dressing changes and the type of wound dressing will be specified in the physician's orders .