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	05/11/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to respect a resident's (R1) right by tampering with a camera in the resident's room. This failure affected one resident in a sample of 9. R1 is [AGE] years old with diagnosis not limited to: Metabolic Encephalopathy, Moderate Protein-Calorie Malnutrition, Acute Respiratory Failure With Hypoxia, Adult Failure To Thrive, Chronic Kidney Disease, Retention of Urine, Acute Cystitis Without Hematuria, Syncope and Collapse, Thoracic Aortic Aneurysm, Anemia, Obstructive And Reflux Uropathy, Constipation, Hypothyroidism, Dementia, Insomnia, Parkinson's Disease, Major Depressive Disorder. R1's 4/2/26 BIMS score is 00 (meaning the resident is not cognitively intact). R1's 11/10/25 care plan documents in part: R1's POA (Power of Attorney) prefers to have camera in her brother's room. On 5/8/26 at 12:38 pm R1 was observed. R1 was clean but was not able to be interviewed. On 5/8/26 at 2:00 pm V1 (Administrator) said regarding R1, she was informed on 4/17/26 that a staff member (V12) moved and turned the camera and the employee reported the incident to her. V1 said, V12 was under the impression she needed to give consent to be on the camera. She moved the camera to provide privacy to R1 and thought she needed to give consent herself to be on the camera. She does not work in the facility often, but she works in corporate, she was not aware of the law that was passed in general that a person can't obstruct the camera in residents' room. V1 said, she was not aware she was not supposed to do that, now she is since the incident. V1 said, now as a part of new hire orientation, new staff they sign the form about the law related to the camera and they did in-service with all the staff. V1 said, there is a sign on the residents' door that says there is a live recording in use. On 5/9/26 at 8:27 am V14 (R1's Sister) said on 4/17/26 a corporate wound care nurse of the company, she came and as soon as she saw the camera, she flipped it around to face the wall, this is someone from the corporate and she moved the camera. V14 said, she called V1 right away and after 10 minutes they turned it around to face R1. V14 said, she called V1 and said this is the 3rd time they moved/tampered with the camera, that is a federal violation. V14 said, this is the responsibility of V1 to educate their staff and especially for V12 being from corporate she should know the law. V14 said, the minute V12 walked in the room, she saw the camera, she turned it to face the wall, this is unacceptable from someone who works in corporate. On 5/9/26 at 8:54 am V12 (Corporate Wound Care Director) with V1 (Administrator) present said, she went in to provide care to R1, and she noticed there was a camera there and she turned the camera (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	slightly from the patient to provide privacy to the patient and herself. V12 said, after a couple of minutes one of the nurses on duty came in and she informed V12 that R1's sister is on the phone and is threatening that she will call IDPH due to the camera being moved, so V12 turned the camera back on the resident. V12 said, after providing care she reported this to V1, and she (V1) informed her she should have not moved the camera due to the resident rights. V12 said, she did not follow up with R1's nurse prior to moving the camera if she could move it. V12 said, she was not informed of the law in Illinois, she thought there needs to be 2 party consent, camera was turned away from R1 for 2 minutes. V1 said, she educated V12 she should have not moved the camera. V12 said, she apologized as it was not done as a malicious intent. V1 said, there are cameras in the building so V12 was on camera prior to entering R1's room. On 5/8/2026 at 11:26am during tour of building with V3, Maintenance Director, observed signage outside of R1 and other residents' room that the resident had video surveillance camera in place, informing anyone that entered the room they would be on camera. On 5/9/2026 at 11:52am observed signage at entrance of door of residents that had camera in room stating, monitor in progress. Facility's (4/17/26) in-service for V12 documents in part: Sec. 40. Obstruction of electronic monitoring devices. (a} person or entity is prohibited from knowingly hampering, obstructing, tampering with, or destroying an electronic monitoring device installed In a resident's room without the permission of the resident or the Individual who consented on behalf of the resident in accordance with Section15 of this Act. RESIDENTS' RIGHTS for People in Long-Term Care Facilities documents in part: You have a right to purchase and use an electronic monitoring device after providing notice to the facility using the Electronic Monitoring Notification and Consent.