STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146058	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Evanston	1300 Oak Avenue Evanston, IL 60201

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 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide appropriate treatment and services for an indwelling urinary catheter for one resident (R1), resulting in a 4-hour period without nursing assessment or intervention when the catheter was not draining urine, leading to bladder distention and a traumatic bleeding insertion site injury that required immediate hospitalization. Findings include: R1 is a [AGE] year-old resident with a Brief Interview for Mental Status (BIMS) score of 15/15, and medical diagnosis including but not limited to paraplegia, complete; encounter for fitting and adjustment of urinary device; cystitis, unspecified with hematuria; hydronephrosis with ureteropelvic junction obstruction; acute kidney failure, unspecified; and calculus of kidney with calculus of ureter.On 02/18/2026 at 1:00 PM, R2 said R1 called him from the hospital one night when he was asleep and said V3 (LPN), a nurse from another floor, went to his room to change his catheter because his own nurse, V4 (RN), refused to do it. R2 said R1 told him after V4 refused to change his catheter, V3 took over an hour to change it, used the wrong catheter, and blood came out.On 02/19/2026 at 11:15 AM, R1 said on 02/04/2026, he requested a new catheter because his urine was overflowing. R1 said at about 11:45 PM, V3- LPN (Licensed Practical Nurse) inserted a new catheter, and V4-RN (Registered Nurse) gave him no explanation why she could not do it. R1 said no urine came out, R1 then asked V3 if it was put in correctly, to which V3 replied, yeah, give it some time, just drink water. R1 said at 12:20 AM, he still had no urine output; so, he pushed his call light for help, but no one responded. R1 said at 12:27 AM, he called the building phone number, which rung at the nurse's stations after-hours, but no one answered. R1 said at 12:31 AM, he called the building line for a second time, and V3 answered, and asked R1 to give him 25 minutes and he'd be there. R1 said at 2:02 AM, he called the building line a third time, and no nurse answered, however, V3 arrived in R1's room and said, I'm sorry, I fell asleep. R1 said at 2:54 AM, he called the building line a fourth time, then heard V3 and V4 discussing in the hallway who would, fix the problem. R1 said V3 said to him, let's make her (V4) do her job. R1 said V4, then, entered his room, deflated his catheter's balloon, and blood gushed into and on top of the catheter bag. R1 said, it was like I was urinating blood, and added V4 got startled and called V3 back into his room. R1 said at about 3:27 AM, he called the building line a fifth time because blood had gushed into the catheter bag, all over the sheets, on his diaper, and all over him. R1 said when V3 saw him, he said, oh wow, then heard him tell V4 in the hallway, it wasn't bleeding when I left; call the DON. R1 said both nurses then reentered his room, and he told them not to touch him but to call the ambulance. R1 said paramedics arrived after he called 911, and said to him, let's hurry up and get you out of here; let's get your vitals in the car; let's go now. This Surveyor asked R1 how he obtained such precise phone call times, and R1 said they were all recorded on his cell phone.On 02/24/2026 at 2:25 PM, V3-LPN said on 02/04/2026 he was working on his own floor at night, and super busy, (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: 146058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Aliya of Evanston		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Oak Avenue Evanston, IL 60201	

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 0690 Level of Harm - Actual harm Residents Affected - Few	when he was asked by V4 to insert an indwelling catheter for R1 on V4's floor.On 02/24/2026 at 11:36 AM, V7 (CNA) said that on 02/04/2026 he had been doing his rounds, when R1 pushed his call light; so, he went to R1's room at about 11:00 PM; then, R1 told him he wanted to see V4. V7 said he told V4 about it, and she went to his room, then came back out.In separate interviews on 02/19/2026 at 11:42 AM and 02/24/2026 at 10:42 AM, V1 (Administrator) said she was not aware of the severity of R1's injury until reading R1's hospital diagnosis of traumatic urethral bleeding during a clinical meeting. V1 said R1 called 911 himself on 02/05/2026. V1 said she asked V4 if R1's indwelling catheter was out the morning of 02/05/2026, and she said she could not get in to see because there were a lot of paramedics in R1's room, but when R1 was placed on the gurney, she did see blood in the catheter line. V1 said she asked V4 why she had not told anyone about the severity of R1's event, and V4 replied, you don't know he does this? V1 said she didn't know V4's mindset and did not feel V4 thought R1's event of 02/05/2026 was an emergent situation. V1 said V4 resigned a few days later.On 02/24/2026 at 4:53 PM, V9 (Nurse Practitioner) said she believed R1's new indwelling catheter was inserted, but not all the way in and in the wrong place, by V3, on 02/04/2025. V9 said there were no nursing progress notes by either V3 or V4 detailing what happened to R1 on 02/04/2026 and 02/05/2026 between 11:30 PM and 3:00 AM, which could have provided essential information of R1's care that night and morning.On 02/18/2026 at 2:09 PM, V2 (Director of Nursing) said on the morning of 02/05/2026, she got a call from the nurse on duty, V4, saying R1 called 911, and we (along with V3) reinserted his catheter. V2 said the next day, she gave V3 a re-competency to make sure he knew how to insert a catheter. V2 said V4 was not available, so she did not re-competency her. V2 said she was not sure what caused R1's bleeding. V2 said V4 told her she told V3 she was not comfortable with male catheters; so, she asked him for help. V2 said R1's diagnosis from the hospital said urethral bleeding. V2 said V3 and V4 should have documented the event better than they did.On 02/24/2026 at 5:33 PM, V10 (Medical Director) said V3 and V4 should have documented R1's catheter care on 02/04/2026 and 02/05/2026 because, if you're going to be accused of something, it's a good idea to document.On 12/19/2026 at 11:30 AM, Surveyor reviewed video footage R1 shared on his cellphone and claimed he took the morning of 02/05/2026, as soon as V4 had deflated his catheter balloon and had stepped out to get V3. The video, lasting about sixteen seconds, was recorded from the perspective of a person lying down on a bed, and displayed blood on the person's diaper and significant blood inside a catheter bag and tubing.On 02/24/2026 at 9:21 AM, Surveyor called V4 but there was no answer. A voicemail message was left, with no reply.R1's hospital progress notes by V11 (Attending Radiologist) on 02/05/2026 at 7:45 AM, contained the following remarks:1. CT scan results 02/05/2026: Patient (R1) presenting with traumatic indwelling catheter insertion at SNF, bleeding continuously in ED, with CT abdomen/pelvis with contrast showing indwelling catheter balloon inflated in the bulbar urethra with free air and extravasation consistent with active bleeding. A large amount of blood is also present in the urinary bladder which is distended. The bladder also contains air, presumably related to indwelling catheter placement.2. Hgb (Hemoglobin) dropped from 13.2 to 6.5.3. Patient became hemodynamically unstable with hypotension and tachycardia consistent with hemorrhagic vs. less likely septic shock, initially not fluid responsive, temporarily required Levo and ICU admission.R1's entire nursing progress notes documenting R1's catheter care of 02/04/2026 and 02/05/2026 were as follows:1. Progress Note, 02/05/2026 4:19 AM, V4: R1 sent out to hospital for indwelling catheter reinsertion.2. Progress Note, 02/05/2026 11:12 AM, V12 (LPN): R1 sent to hospital via 911 by self.3. Progress Note, 02/05/2026 7:29 PM, V13 (LPN): hospitalized .4. Progress Note, 02/05/2026 7:30 PM, V12: Writer called hospital. R1 is admitted for Traumatic Urethral Bleeding.Reviewed R1's electronic medical health record, including progress (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Aliya of Evanston		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Oak Avenue Evanston, IL 60201	

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 0690 Level of Harm - Actual harm Residents Affected - Few	notes. No documentation of R1 having ever removed his own indwelling urinary catheter was found.R1's care plan, dated 12/18/2025, included the following interventions: Catheter monitoring and care as ordered; monitor and document intake and output as per facility policy; monitor for signs/symptoms of discomfort on urination and frequency; monitor/document for pain/discomfort due to catheter; and 10/08/2025 R1 was transferred to hospital due to hematuria on urine; returned to facility with stent placement.Reviewed R1's active medication orders, noting one anticoagulant medication, Enoxaparin Sodium, which R1 was prescribed to prevent blood clots.Reviewed a progress note from 10/08/2025 by V14 (Nurse): R1's indwelling catheter was changed, no urine drainage into bag, blood observed draining, catheter was removed, bleeding stopped, peri care complemented for resident, advice to wait few minutes before insertion of catheter again, but resident called 911 to be sent out. At 1:53 AM, medics arrived (5), transported resident to hospital, face sheet taken along with them. At 2:00 AM, POA notified via a phone call. DON notified via a text message.The facility's Catheterization of the Urinary Bladder Guideline, last reviewed 05/01/2025, states in part, chart in the progress notes the size, procedure, urine color, amount, consistency, odor and resident response, and if the output for the shift is less than 200cc, the nurse should check the catheter for any kinks or leaks. If this is not the problem the physician or nurse practitioner should be notified of the low output.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Aliya of Evanston		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Oak Avenue Evanston, IL 60201	

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 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure nursing staff possessed and demonstrated the competencies necessary to timely recognize, assess, and respond to a resident's acute change in condition and urgent call for help. This resulted in actual harm (significant bleeding requiring emergency hospitalization) for one resident (R1) who experienced a traumatic complication from an indwelling catheter insertion. R1 is a [AGE] year-old resident with a Brief Interview for Mental Status (BIMS) score of 15/15, and medical diagnosis including but not limited to paraplegia, complete; encounter for fitting and adjustment of urinary device; cystitis, unspecified with hematuria; hydronephrosis with ureteropelvic junction obstruction; acute kidney failure, unspecified; and calculus of kidney with calculus of ureter.On 02/18/2026 at 1:00 PM, R2 said R1 called him from the hospital one night when he was asleep and said V3 (LPN), a nurse from another floor, went to his room to change his catheter because his own nurse, V4 (RN), refused to do it. R2 said R1 told him after V4 refused to change his catheter, V3 took over an hour to change it, used the wrong catheter, and blood came out.On 02/19/2026 at 11:15 AM, R1 said on 02/04/2026, he requested a new catheter because his urine was overflowing. R1 said at about 11:45 PM, V3 inserted a new catheter, and V4 gave him no explanation why she could not do it. R1 said no urine came out, then asked V3 if it was put in correctly, to which V3 replied, yeah, give it some time, just drink water. R1 said at 12:20 AM, he still had no urine output; so, he pushed his call light for help, but no one responded. R1 said at 12:27 AM, he called the building phone number, which rung at the nurse's stations after-hours, but no one answered. R1 said at 12:31 AM, he called the building line for a second time, and V3 answered, and asked R1 to give him 25 minutes and he'd be there. R1 said at 2:02 AM, he called the building line a third time, and no nurse answered, however, V3 arrived in R1's room and said, I'm sorry, I fell asleep. R1 said at 2:54 AM, he called the building line a fourth time, then heard V3 and V4 discussing in the hallway who would, fix the problem. R1 said V3 said to him, let's make her (V4) do her job. R1 said V4, then, entered his room, deflated his catheter's balloon, and blood gushed into and on top of the catheter bag. R1 said, it was like I was urinating blood, and added V4 got startled and called V3 back into his room. R1 said at about 3:27 AM, he called the building line a fifth time because blood had gushed into the catheter bag, all over the sheets, on his diaper, and all over him. R1 said when V3 saw him, he said, oh wow, then heard him tell V4 in the hallway, it wasn't bleeding when I left; call the DON. R1 said both nurses then reentered his room, and he told them not to touch him but to call the ambulance. R1 said paramedics arrived after he called 911, and said to him, let's hurry up and get you out of here; let's get your vitals in the car; let's go now. This Surveyor asked R1 how he obtained such precise phone call times, and R1 said they were all recorded on his cell phone.On 02/24/2026 at 2:25 PM, V3 said on 02/04/2026 he was working on his own floor at night, and super busy, when he was asked by V4 to insert an indwelling catheter for R1 on V4's floor.On 02/24/2026 at 11:36 AM, V7 (CNA) said that on 02/04/2026 he had been doing his rounds, when R1 pushed his call light; so, he went to R1's room at about 11:00 PM; then, R1 told him he wanted to see V4. V7 said he told V4 about it, and she went to his room, then came back out.In separate interviews on 02/19/2026 at 11:42 AM and 02/24/2026 at 10:42 AM, V1 (Administrator) said she was not aware of the severity of R1's injury until reading R1's hospital diagnosis of traumatic urethral bleeding during a clinical meeting. V1 said R1 called 911 himself on 02/05/2026. V1 said she asked V4 if R1's indwelling catheter was out the morning of 02/05/2026, and she said she could not get in to see because there were a lot of paramedics in R1's room, but when R1 was placed on the gurney, she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Aliya of Evanston		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Oak Avenue Evanston, IL 60201	

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 0726 Level of Harm - Actual harm Residents Affected - Few	did see blood in the catheter line. V1 said she asked V4 why she had not told anyone about the severity of R1's event and V4 replied, you don't know he does this? V1 said she didn't know V4's mindset and did not feel V4 thought R1's event of 02/05/2026 was an emergent situation. V1 said V4 resigned a few days later.On 02/24/2026 at 4:53 PM, V9 (Nurse Practitioner) said she believed R1's new indwelling catheter was inserted, but not all the way in and in the wrong place, by V3, on 02/04/2025. V9 said there were no nursing progress notes by either V3 or V4 detailing what happened to R1 on 02/04/2026 and 02/05/2026 between 11:30 PM and 3:00 AM, which could have provided essential information of R1's care that night and morning.On 02/18/2026 at 2:09 PM, V2 (Director of Nursing) said on the morning of 02/05/2026, she got a call from the nurse on duty, V4, saying R1 called 911, and we (along with V3) reinserted his catheter. V2 said the next day, she gave V3 a re-competency to make sure he knew how to insert a catheter. V2 said V4 was not available, so she did not re-competency her. V2 said she was not sure what caused R1's bleeding. V2 said V4 told her she told V3 she was not comfortable with male catheters; so, she asked him for help. V2 said R1's diagnosis from the hospital said urethral bleeding. V2 said V3 and V4 should have documented the event better than they did.On 02/24/2026 at 5:33 PM, V10 (Medical Director) said V3 and V4 should have documented R1's catheter care on 02/04/2026 and 02/05/2026 because, if you're going to be accused of something, it's a good idea to document.On 12/19/2026 at 11:30 AM, Surveyor reviewed video footage R1 shared on his cellphone and claimed he took the morning of 02/05/2026, as soon as V4 had deflated his catheter balloon and had stepped out to get V3. The video, lasting about sixteen seconds, was recorded from the perspective of a person lying down on a bed, and displayed blood on the person's diaper and significant blood inside a catheter bag and tubing.On 02/24/2026 at 9:21 AM, Surveyor called V4 but there was no answer. A voicemail message was left, with no reply.R1's hospital progress notes by V11 (Attending Radiologist) on 02/05/2026 at 7:45 AM, contained the following remarks:1. CT scan results 02/05/2026: Patient (R1) presenting with traumatic indwelling catheter insertion at SNF, bleeding continuously in ED, with CT abdomen/pelvis with contrast showing indwelling catheter balloon inflated in the bulbar urethra with free air and extravasation consistent with active bleeding. A large amount of blood is also present in the urinary bladder which is distended. The bladder also contains air, presumably related to indwelling catheter placement.2. Hgb (Hemoglobin) dropped from 13.2 to 6.5.3. Patient became hemodynamically unstable with hypotension and tachycardia consistent with hemorrhagic vs. less likely septic shock, initially not fluid responsive, temporarily required Levo and ICU admission.R1's entire nursing progress notes documenting R1's catheter care of 02/04/2026 and 02/05/2026 were as follows:1. Progress Note, 02/05/2026 4:19 AM, V4: R1 sent out to hospital for indwelling catheter reinsertion.2. Progress Note, 02/05/2026 11:12 AM, V12 (LPN): R1 sent to hospital via 911 by self.3. Progress Note, 02/05/2026 7:29 PM, V13 (LPN): hospitalized .4. Progress Note, 02/05/2026 7:30 PM, V12: Writer called hospital. R1 is admitted for Traumatic Urethral Bleeding.Reviewed R1's electronic medical health record, including progress notes. No documentation of R1 having ever removed his own indwelling urinary catheter was found.R1's care plan, dated 12/18/2025, included the following interventions: Catheter monitoring and care as ordered; monitor and document intake and output as per facility policy; monitor for signs/symptoms of discomfort on urination and frequency; monitor/document for pain/discomfort due to catheter; and 10/08/2025 R1 was transferred to hospital due to hematuria on urine; returned to facility with stent placement.Reviewed R1's active medication orders, noting one anticoagulant medication, Enoxaparin Sodium, which R1 was prescribed to prevent blood clots.Reviewed a progress note from 10/08/2025 by V14 (Nurse): R1's indwelling catheter was changed, no urine drainage into bag, blood observed draining, catheter was removed, bleeding stopped, peri care complemented for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146058	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Evanston	1300 Oak Avenue Evanston, IL 60201

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 0726 Level of Harm - Actual harm Residents Affected - Few	resident, advice to wait few minutes before insertion of catheter again, but resident called 911 to be sent out. At 1:53 AM, medics arrived (5), transported resident to hospital, face sheet taken along with them. At 2:00 AM, POA notified via a phone call. DON notified via a text message.The facility's Catheterization of the Urinary Bladder Guideline, last reviewed 05/01/2025, states in part, chart in the progress notes the size, procedure, urine color, amount, consistency, odor and resident response, and if the output for the shift is less than 200cc, the nurse should check the catheter for any kinks or leaks. If this is not the problem the physician or nurse practitioner should be notified of the low output.