

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Aliya of Oak Lawn		STREET ADDRESS, CITY, STATE, ZIP CODE 6300 West 95th Street Oak Lawn, IL 60453	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>44570</p> <p>Based on interview and record review, the facility failed to protect residents from mental abuse and intimidation by staff. This failure affected three of three residents (R2, R7 and R8) living in the facility at the time of this survey and reviewed for mental abuse.</p> <p>Findings include:</p> <p>R2, R7 and R8 were interviewed on 9/30/24 during a complaint survey conducted in the facility. These residents expressed concerns regarding staff telling the residents not to speak with the Survey Team or participate with survey activities during a licensure survey that was conducted in the facility from 9/9/24 to 9/12/24. R2, R7 and R8 asked to keep their identities confidential regarding this concern in fear that the staff would retaliate or refuse to provide care.</p> <p>At 3:45pm, R7 stated during the survey of 9/9/24, staff informed R7 not to speak with the State Agency surveyors. R7 stated, that when a nursing staff member is upset with R7, R7 don't get care as requested or the nursing staff takes longer to answer the call light. R7 stated when one staff is mad, staff tell the other staff members who exhibit the same behavior of not providing care as needed. R7 stated, the nursing staff comes into the room, and don't tell us their names, so I can't tell you who they are specifically.</p> <p>At 3:54pm R8 stated the staff told me not to talk to the surveyors. R8 stated, the CNA (Certified Nursing Assistant) pointed to a Surveyor passing the door and told me to shut up, not to talk to them. I felt like I was a child when they said that to me. I was afraid if I didn't do as they said, the CNA would be mean to me.</p> <p>At 3:56pm, R2 was observed alert coherent and lying in bed. R2 mentioned that during the survey of 9/9/24, CNAs came into the room and requested R2 not to cooperate with the survey team or else the CNA would get in trouble and lose their jobs in the facility.</p> <p>R2, R7 and R8 did not disclose the identity of the staff members.</p> <p>(continued on next page)</p>		

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>V3 (Assistant Director of Nursing) and V19 (Regional Clinical Consultant) were informed of this allegation 10/1/24 at 1:22pm as V1 Administrator was not available. V3 and V19 stated they were unaware on any concerns of this nature voiced by any residents in the facility and that they would follow up. At 4:00pm V3 stated the administrative staff had begun an investigation which included speaking to residents about any concerns with staff mistreatment and provided copies of Resident's Rights booklets to all Residents in the facility.</p> <p>On 10/2/24 at 10:35AM V1 (Administrator) was interviewed over the phone and stated V3 did inform V1 about the allegation and initiating an investigation into the concern. V1 stated if the allegation included specific staff members, they would be immediately suspended pending an allegation of mental abuse. Currently with the information provided, the facility is educating staff and Residents of their Rights and following up with each resident to determine if they will come forward with any additional complaints about staff.</p> <p>Resident's Rights booklet (no revision date) states in part; You have the right to complain to your facility and to get a prompt response. Your facility may not threaten or punish you in any way for asserting your rights or contacting outside organizations and advocates including the following agencies: Illinois Department of Public Health.</p> <p>Facility document titled: Compliance/False Claims Act/Ethics Program and Code of Conduct revised 2/13 states in part: Respect resident rights at all times. [Don't] Mistreat a resident in any way.</p> <p>Abuse Policy revised 10/22 states in part; Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Even if the resident might not comprehend disparaging comments, verbal or mental abuse might have taken place if the intent was willful and the content abusive. Verbal or mental abuse is just that much more harmful if the intent was willful, the content abusive, and the resident indicates that possible verbal or mental abuse occurred, proceed with abuse investigation procedures and interviews.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46344</p> <p>Based on interview and record review, the facility failed to ensure a resident's phone was not stolen by a visitor of the facility. This failure applied to one (R3) of three residents reviewed for misappropriation of property.</p> <p>Findings include:</p> <p>R3 is a [AGE] year-old female who originally admitted to the facility on [DATE] and later discharged home on 9/6/2024. Admission nurses note dated 8/16/2024 indicated resident is alert and oriented x(times) 3.</p> <p>Facility Reported Incident dated 8/23/2024 shows that R3 had reported their cell phone was missing and believes a visitor for another resident took it from her room. V9 (family member) stated they received a phone call from an unknown male that was attempting to access the passcode to R3's phone. V9 reported that V12 (family member) identified himself and was later found out to be R6's family member that was visiting the day of 8/23/24.</p> <p>On 10/1/2024 at 1:50PM, V9 was interviewed regarding incident on 8/23/24. V9 stated we kept calling R3's phone but she was not answering. I received a call from an unknown number, but the caller identification said V12's name. V12 stated he was trying to help R3 with her phone and he needed the passcode. I originally thought V12 was an employee and unfortunately, I did give him the passcode.</p> <p>V9 stated R3 told me that she was sleeping on 8/23/24 and she remembers seeing a young male that she did not know walk out of her room. I was extremely concerned for her safety and well-being because someone was in her room unsupervised that should not have been. A mobile payment application of R3's was hacked and stolen close to \$300 from it. At no point was the phone or money reimbursed by the facility. I feel as if there was no resolution done by the facility. The police were called, and a report was filed. They informed me that they believe a family member of R6's who lived next door to R3 was the one that took the phone (V12).</p> <p>At 2:35PM, V8 (Director of Customer Experience) was interviewed. V8 stated I was the manager in the building at night on 8/23/24. I received a call from V16 (family member) saying that R3's phone had been misplaced and that R3 needed some assistance. I interviewed R3 who said she believes her phone was stolen and she said she saw a man exiting her room earlier that day. R3 stated she did not know who this man was as they were not familiar looking and not wearing uniforms. R3 is alert and oriented.</p> <p>V8 stated visitors should be visiting the resident they are there to see and are not to be going in other resident's room. V8 stated we do not have escorts for visitors, but the CNA's and nurses are present in the hallway and should be supervising. I later did an in-service to the staff to ensure visitors are signing in and out of the visitor log and identifying themselves.</p> <p>Reviewed visitor log for 8/23/24, it is to be noted that V12 (family member) was not on the visitor log that day.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/2/2024, V1 (Administrator) was interviewed regarding the incident with R3 on 8/23/24. V1 stated I was informed on 8/23/24 that R3 had gotten her cell phone and during my investigation it was founded that V12 was believed to have stolen it when visiting R6. I interviewed R6 who acknowledged that V12 was their family member and had visited earlier that day. V12 apparently went down the hall, went into R3's room, and took her cell phone. I later found out that about \$300 was taken from one of her (R3) account as well.</p> <p>V1 stated visitors should be visiting the residents they are there to see and at no time should they be entering another resident's room. We do not have security or cameras currently, and there is no situation where visitors can be monitored all of the time.</p> <p>Police report dated 8/23/24 was received and reviewed by this surveyor.</p> <p>Abuse Policy dated 10/2022 states in part but not limited to the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.</p> <p>Misappropriation of resident property (theft) is the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. Any missing money, jewelry, watches, smart phones, tablets, computers, or large fixed property such as radios or TVs should be considered and treated as a possible theft.</p>		