STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145087	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Oak Lawn	6300 West 95th Street Oak Lawn, IL 60453

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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** 40066 Based on observations, interviews, and records reviewed the facility failed to provide bathroom/toileting assistance to 2 (R1 and R8) dependent residents. This failure affected 2 of 3 residents reviewed for toileting assistance. The findings include: A. On 2/18/25 at 10:34AM R8's call light on, lit, beeping. At 10:39AM call light remains on. A staff member entered the room and R8's family requested assistance to take R8 to the washroom. Staff member left to get nursing assistance. At 10:40AM V4, Certified Nursing Assistant/CNA, entered R8's room and stated I got to get help and V4 left R8's room. At 10:53AM the surveyor asked V14, R8's family if they had been assisted. V14 stated the CNA said she is coming back she has to get help. R8 in the bed. At 11:04AM V14 stated we are still waiting, he (R8) has to have a bowel movement and they need 2 staff to help him. R8 stated yes, I gotta go. The call light has been turned off and is not lit or beeping anymore. The surveyor was standing outside of R8's room within hearing distance and in sight of the door. On 2/18/24 at 11:02AM V4, CNA, stated the computer system shows us the level of assistance needed by the resident, therapy will tell us, or the off going CNA will tell us. On 2/18/25 at 11:08AM V15, Nurse, stated he, R8, can't stand, the family has been told he is a mechanical lift. V15 stated he will just have to go and we will have to change his diaper. The surveyor left the unit after interviewing V15. R8 was still in his bed and had not been assisted to the toilet. The surveyor observed R8 waiting 34 minutes for assistance in using the washroom to have a bowel movement. On 2/19/25 at 12:53PM V4 stated on 2/18/25 R8's granddaughter stated R8 wanted to use the toilet, I told her he is a more than one person assist. V4 stated R8 can't stand at all. V4 stated I left the room and went to find an aide to help me, I didn't find one. V4 stated I told the nurse, V15, then we went and got him on the toilet. V4 stated V15 helped me get R8 into the bathroom V4 stated when I got in the room R8 was in wheelchair. V4 stated I didn't put R8 in the wheelchair. V8 stated I could have offered a bed pan. V4 stated R8 is a 2 person assist, not a mechanical lift. V4 stated we stood R8 up and he pivoted onto the toilet. V4 stated she assisted R8 onto the toilet in like 10 minutes from when she had entered the room. (The surveyor spoke with V15 at 11:08AM and R8 had not been assisted. V4 was in R8's room at 10:40AM.) (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/25 10:47AM V10, Assistant Administrator, stated a resident can get on the toilet from a mechanical lift or use a side commode. V10 stated for R8 a solution is not to let him be incontinent and then change him. V10 stated if the resident can use the toilet staff are expected to assist. V10 stated the staff could have offered a bed pan to R8. R8's diagnosis includes, but are not limited to Disc Disorder with Myelopathy, Cognitive Communication Deficit, and Dementia. Functional Abilities and Goals dated 2/12/25 identifies on admission R8 is dependent on staff for toileting hygiene. Transfers requires partial to moderate assist. Actual toilet transfers were not attempted at the time of the assessment. The assessment does not indicate R8 requires a mechanical lift for transfers, nor does R8's care plan. CNA charting (Documentation Survey Report) for 2/18/25 shows R8 was incontinent of bowel and bladder at 12:36PM, documented by V4. B. R1's diagnosis include, but are not limited Benign Neoplasm of Left Ovary, Unsteadiness on Feet, Protein-Calorie Malnutrition, and Post Surgical Aftercare Following Surgery on the Genitourinary System. R1 admitted to the facility on [DATE]. R1's cognitive score is 12, moderately impaired. On 2/18/25 at 10:28AM R1 stated the bed was really wet and I had had a bowel movement in the bed. R1 stated it was miserable and uncomfortable waiting for help. R1 stated they just didn't come to help me when I asked after lunch. On 2/18/25 at 12:59PM V9, R1's family, stated I went to visit R1 on 2/7/25 and when I got there R1 grabbed my hand and was crying, saying I don't want to be here. V9 stated the staff had not cleaned R1 up after lunch and she had been left that way for some time. V9 stated I talked to V10, Assistant Administrator, about my concerns for that day. On 2/18/25 at 1:15PM V6, CNA, stated I had just gotten here on 2/7/25, it was around 2:38PM-2:40PM. V6 stated R1's daughter stated my mom has been waiting to be changed. V6 stated R1 was not on my set, but I went to change her. V6 stated R1 was soaking wet and in feces, it looked like it was there for quite a bit. V6 stated the sheets were a little brown and had been there for some time. V6 stated the sheets and R1's gown was so wet, so the sheet got wet, and it changed to a brown color where it was. V6 stated I told the nurses, V11 was one of them. On 2/19/25 10:47AM V10, Assistant Administrator, stated I did not speak to V6 about R1's care. V10 stated V9 did not report concerns except about a meal try not picked up. V10 stated I expect staff to check and change residents regularly and change as needed. V10 stated visible indications that a patient has not been changed can include if the patient has wet clothing or the bed is wet. V10 stated the color of the sheets is different, the smell is strong. V10 stated the sheets change color to a tinted brown to yellow shade. V2, LPN, and V11, RN, working on 2/7/25 both stated they don't remember R1, or any concerns reported to them related to R1. R1's care plan dated 2/5/25 states rounding at a minimum of every 2 hours and prompt or assist for change on position, toileting, offer fluids, and ensure resident is warm and dry. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's MDS assessment dated [DATE] for Functional Ability (Section GG) identifies R1 is dependent for toileting hygiene. Requires substantial to maximal assistance with bed mobility and transfers, including toilet transfers. Bowel and Bladder assessment (Section H) identifies R1 is occasionally incontinent of urine and frequently incontinent of bowel R1's CNA charting (Documentation Survey Report) for 2/7/25 bowel/bladder continence, eating, and bed mobility nothing documented for 6:30am-2:30pm shift. The facility Certified Nurse's Aide basic function states, in part, to provide assigned resident with routine daily nursing care in accordance with established nursing care procedures. 5. Keep incontinent residents clean, dry, and odor free. 6. Assist residents with bowel and bladder functions. 8.Keep residents dry, changing clothes and gown when wet or soiled. 9.Make beds and change linens when soiled. 15. Maintain records accurately and timely. 16. Chart timely and accurately in (computer system.)

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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. 40066 Based on interviews and records reviewed the facility failed to monitor and provide supervision during a smoking break. This affected two of three residents (R2, R3) reviewed for supervision. This failure resulted in a resident to resident-to-resident altercation. The findings include: The facility reported investigation dated 2/6/25 states R2 and R3 were in disagreement and exchanged words. On 2/18/25 at 11:16AM R3 stated R2 didn't like what I was saying to her. R3 stated R2 was calling me a B*%ch N*&&#% (derogatory, cursing, racist words). R3 stated R2 was standing and lost her balance. R3 stated R2 did not fall but lost her balance. R3 stated I did not push her; I waved her hand out of my face. On 2/19/25 at 9:35AM R2 stated on Thursday 2/6/25 I was outside on the smoking patio, after the 1:00PM smoking time opened. R2 stated R3 came to me and stated he didn't like the way I treat him. R2 stated I told R3 to leave then, if you don't like it go and I was pointing to the door. R2 stated instead R3 came at me and lifted me by my shirt and threw me, I hit the wall and went running inside and told the activity staff right away. R2 is in her 50's with diagnoses including Legal Blindness and Depression. R3 is in his 50's with diagnoses including Post Traumatic Stress Disorder and Major Depressive Disorder. On 2/18/25 at 11:34AM V3, Social Services, stated R3 was placed on wellbeing checks for an altercation with another patient. V3 stated I heard R2's and R3's versions of the story. V3 stated R2 claimed they exchanged words. R3 stated R2 put her finger in his face. V3 stated I was made aware by being called into the office and notified by V5, Director of Nursing/DON. V3 stated both R2 and R3 have cussed staff out in the past. V3 stated R2 has periods of agitation, she is verbally aggressive with staff and can be with residents when things don't go her way. On 2/19/25 at 9:50AM V11, Registered Nurse/RN, stated smoking is done by activity department. V11 stated there is a time for smoking. V11 stated the residents have a designated places to smoke and are monitored. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/25 at 11:29AM V12, Activity Aide, stated for smoking one of us, activity staff, watch the residents. V12 stated the residents smoke outside the north dining room area, on the patio, or they go out for fresh air. V12 stated it depends on the weather if I will go outside and watch them smoke or watch from the window. V12 stated on 2/6/25 R3 and R2 were outside. V12 stated I was at the door watching them, from inside. V12 stated I had patients inside doing my activity. V12 stated I turned around talking to the other patients. V12 stated R2 ran in the door saying, you better come get him (R3), he put his hands on me. V12 stated my back was turned and I didn't see what happened. V12 stated R2 was hollering and screaming. V12 stated I asked R2, who put his hands on you. V12 stated R2 replied R3, and I want to press charges, he put his hands on me. V12 stated R2 was screaming and using profanity. V12 stated R3 came to the door and stated, you all better get her. V12 stated R2 said he pushed her against the wall. V12 stated I had seen them talking but I didn't see him put his hands on her. V12 stated then V13, Activity Director, came and took R2 in the office to calm her down. V12 stated the other activity aid was off that day. V12 stated V13 was in an office not in the area when it happened. On 2/19/25 at 11:42AM V13, Activity Director, stated I was in my office and heard the commotion. V13 stated I was told R2 and R3 were on the patio. V13 stated R2 said R3 muffed me he like pushed her. V13 said this occurred during smoke break. V13 said if we are not outside with the residents, then we are in the area watching. V13 said for this incident it was not effective supervision. On 2/19/25 at 12:24PM V5, Director of Nursing, stated on 2/6/25 I was told there was a commotion with R2. V5 said R2 wanted the police called and complained about her shoulder hurting. V5 stated at baseline R2 has argumentative moments, they are verbal, she antagonizes the other residents and stirs up things. V5 stated R2 said R3 was acting funny. V5 said the staff told me R3 doesn't do things like this. On 2/20/25 at 11:33AM V16, Social Services, said we have a smoking contract for smokers we have a designated area. V16 said the activities will open the smoking time and staff should be present when smoking. I don't know if they will require increased supervision with smoking if the resident violates the smoking contract. V16 said in the past R2 has been caught with a lighter in her room. V16 said after R2 was caught smoking in a non-designated area we updated the care plan. On 2/20/25 at 12:03PM V17, Psychiatry Nurse Practitioner, stated I was asked to see R2 and R3 because they had an altercation. V17 said R3 said R3 came up to him and got in his face. V17 said R2 said R3 was the instigator. On 2/20/25 at 1:21PM V10, Assistant Administrator, said R3 stated R2 called him negative, derogatory, and racist words and had her finger in his face. V10 said R3 said he moved R2's hand out of his face. V10 said I was not told R2 lost balance during the altercation. V10 said R2 came in yelling and then she went back to smoke. V10 said residents should not be putting hands on other residents. V10 said there were not staff that saw what happened. V10 said staff should be outside with the residents to try to stop situations from escalating. V10 said smoke monitoring is done by activity department. R2's care plan dated 1/14/25 identifies she will be monitored or placed in the supervised smoking program. R2 demonstrates noncompliance with safe smoking regulations, smoking at non-designated times, smoking in rooms and other non-designated areas. Care plan identifies R2's memory is impaired and has difficulty with decision making, insight, logic, planning and organization of thoughts. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Safe Smoking Evaluation dated 1/24/25 identifies R2's non-compliance with smoking policy is a moderate problem. R2 is potentially unsafe smoker. R3's care plan created 9/19/25 and updated on 2/7/25 identifies he is verbally aggressive and displays agitation episodes towards staff and other residents. Interventions include intervene when behavior is observed. Statements taken from related to the incident document by V13 identifies R2 yells and screams when she wants. V12 written statement identifies R2 has a temper and argues with other residents. (Occurrence date on form is 3/7/25. V7, Administrator, stated the statements should be dated for February.) The facility Smoking Policy dated January 2024 states, in part, some residents may require more intensive supervision staff supervision while smoking. These residents smoke separately from other residents, under the supervision of a staff member specifically designated to assist them. Behaviors that may trigger additional supervision while smoking include but are not limited to using smoking materials in an inappropriate manner. Smoking is permitted only in designated areas.