

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 03/09/2025
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>38796</p> <p>Based on observation, interview, and record review the facility failed to follow the resident food preference for one of 3 residents (R2) reviewed for food preference not being followed.</p> <p>Findings include:</p> <p>On 3/8/25 at 9:21am R2 was observed in the bed, R2 stated he did not eat his meal. At 9:30am R2 observed alert to person, place, date, and situation. R2 stated he refuses to go hungry because the facility can't get his meal right. R2 stated when he requests the regular meal, he gets a salad (substitute), and when the aides bring the wrong meal. R2 stated someone comes reviews the menu with him daily and they continue to get it wrong.</p> <p>At 9:23am surveyor observed R2 breakfast tray with assist from V9 (CNA), V9 stated he was R2's aide, and R2 ate most of his meal. V9 retrieved R2 tray and there were two boiled eggs (uneaten), 2 slices of bacon (uneaten), unopened milk, bowl of hot cereal (uneaten) noted on R2's (tray that was being sent back to the kitchen). V9 said he stated R2 ate his meal because R2 usually eats his meal, V9 stated he did not review what R2 ate before he placed the tray to be returned to the kitchen.</p> <p>R2 meal ticket was retrieved from the breakfast tray, it is denoted that R2 dislikes are bacon, cereal, mushrooms, and scramble eggs.</p> <p>R2 care plan denotes dietary consult to modify meal and snack plan related to known food allergies or intolerances, and honor food preferences.</p> <p>On 3/9/25 at 9:35am V10 (Dietary Manager) said R2 meal ticket shows R2 has a dislike for bacon, V10 stated R2 should not receive food items that he dislikes.</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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>38796</p> <p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observation, interview, and record review the facility failed to have a functioning call light system and failed to develop an effective plan for the residents to call for assistance on the North unit, this affects 28 of 28 resident (R1, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, and R30) reviewed for functioning call system.</p> <p>Findings include:</p> <p>On 3/8/25 at 11:12am V4 (Administrator) stated the call light system is not working in the North unit. V4 stated the call light system has not been working for one week, and that the part to fix the issue has been ordered. V4 stated the facility has implemented hand bells, and frequent rounding for residents.</p> <p>3/8/25 at 11:22am V1 (Maintenance Assistant) stated the call light system is not working and the call lights system on the North unit has not been working for 3 to 4 weeks. V1 stated there's an electrical issue, and it's bigger than replacing a part. V1 stated the facility has implemented frequent rounding and hand bells for the residents to use.</p> <p>3/8/25 at 11:32am R1 observed alert to person, place, time, and situation. R1 stated she yells out for help when she needs something. R1 stated she cannot use the hand bell that the facility put in place. R1 stated she must yell loud, and she also hears other residents yelling out for assistance. R1 stated she shouldn't have to yell out for help. R1 face sheet denotes in-part R1 has diagnosis of multiple sclerosis, and quadriplegia.</p> <p>R1 soft touch call light was pressed, the light did not come at the bedside, the light did not come on at the doorway, there were no sound activated at the nurse station.</p> <p>3/8/25 at 11:13am R29, observed alert to person, place and situation stated the staff don't respond to that bell when he uses it, it doesn't work!</p> <p>3/8/25 V8 (Nurse Manager) identified R1, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, and R30 all residing on the North unit that use/ activate a working call light.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3/8/25 at 2:23pm V6 (Maintenance Director) stated the call lights system on the North unit stop working on 2/14/25. V6 stated the button that the resident press to activate the light and sound at the nurse station is not working. V6 stated the company informed him that there is a shortage in the main power line on the north unit. V6 stated that the call light was not working to the administrator on 2/14/25. V6 present logbook documentation for call light system, twenty-four resident rooms on the north unit failed during the week of 2/14-2/18, twenty-four resident rooms on the north unit failed during the week of 2/18-2/22, twenty-four resident rooms on the north unit failed during the week of 2/23-2/27, and twenty-four resident rooms on the north unit failed during the week of 3/3-3/8. During a follow up interview on 3/9/25 at 10:45am with V6, V6 stated the call lights are for resident to use when they need assistance. The facility should always have a functioning call light system. It's the method for the residents to summons the staff when they need help or care.</p>		