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	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Oak Lawn	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to follow their abuse policy and prevent resident-to-resident sexual inappropriateness. This affected two of three residents (R1 and R2) reviewed for abuse. This failure resulted in R2 touching, groping and fondling R1 inappropriately resulting in R1 feeling helpless, scared, tearful and feeling uncomfortable. Findings Include:R1 was admitted to the facility with diagnoses of reduced mobility and functional quadriplegia. R1s Minimal data set (MDS) section C (cognitive patterns) dated 7/14/25 documents: a score of fifteen which indicates cognitively intact. Section GG (functional abilities) documents: R1's is dependent on staff to roll left to right, sit to lying and lying to sitting on the side of bed. R1's care plan initiated on 07/13/2025 documents: ABUSE/NEGLECT: My comprehensive assessment reveals a history of suspected abuse and/or neglect or factors that may increase my susceptibility to abuse/neglect AEB/as evidenced by on 08/18/25 R1 was touched inappropriately by another male resident. Nursing note dated 8/18/25 documents: Writer heard resident (R1) yell out for help, writer got up to go to the yelling. Writer observed R1 in his bed with another resident near the bedside. Resident (R1) stated, he did not know what he was doing or if he (R2) was touching him because he couldn't feel it. On 8/23/25 at 2:45pm, R1 who was assessed to be alert and oriented to person, place and time, said he was in bed when R2 entered his room via wheelchair. R1 said, R2 rolled on the side of his bed, stopped his wheelchair, stood up, lifted R1's gown and ripped opened R1's adult brief. R1 said, R2 put his hand around his penis and started rubbing it. R1 said, he was scared, he yelled for help and R3 saved his life. R1 said, he felt uncomfortable. R1 said, he does not have sexual activities with men. R1 said, he is not like that. R1 said, the facility needs security. On 8/20/25 at 11:15am, R3 who was assessed to be alert and oriented to person, place and time, said R1 was yelling for about four minutes. R3 said, he walked to R1's room. R3 said, he saw R2 standing up on the side of R1's bed with his right hand on R1's penis moving up and down while holding his (R2's) penis while moving his left hand moving back and forth. R3 said, R2 is aware of his behavior. R3 said, R2 rolls through the hallway looking for bedbound residents. R2 does not bother residents that can walk. R2 has touched other bedbound residents before. R2 waits and watches until staff is not looking, go into resident's room and touch them inappropriately. R3 said, R1 is contracted with his arms up by his head and his legs are stuck open, knee up and apart. R1 could only yell for help. R3 said, V6 (certified nursing assistant/CNA) was the first to enter R1's room. On 8/20/25 at 2:12pm, video watched with V1 (administrator), V4 (assistant administrator) and V14 (director of nursing/ DON). V1 said, the video time is an hour ahead. R1 was seen entering R2's room at 11:17am per the recording time on the video but it was actually 12:17 per V1. R2 was seen exiting R1's room at 11:19am per the recording time on the video but it was actually 12:19 per V1. On 8/20/25 at 12:26pm, V6 (cna) said, said when she entered R1's room. R1 was observed with his gown up. R2 pulled up R1's gown, pushed R1's adult brief to the side and touched R1's penis. R3 called the nurse. V6 said, she had to fix R1's adult brief and pull down R1's gown. V6 said, R1 was crying when she entered his room. V6 said, R1 reported not feeling safe at the facility and wanting to die. V6 said, R1 reported he has never been touch by a man before. V6 said, R1 reported R2 had his hand in R1's adult brief touching his penis. Nursing note dated 8/20/25 documents: Patient (R1) is going to be admitted for sexual assault.On 8/26/25 at 1:34pm, V5 (nurse) said, she was the reporting nurse for R1. V5 said, she was aware that R1 has a history of inappropriate touching other residents. V5 said, R1 reported, that R2 touch his anus. Nursing note dated 7/17/25 documents: RN (V5) noticed resident (R2) kept going into another resident room. The resident (R2) is trying to inappropriately touch the other resident and tell him he loves him. On 8/26/25 at 2:45pm, V12 (R2's power of attorney/POA) said, R2 has dementia and a history of same sex relationships. V12 said, she received a call about R2's incident with R1. V12 said, she has received calls from the facility prior to R1's incident about R2 inappropriate touching other residents. V12 said, the facility has been so patient with R2. Now the facility is acting like they do not have any patience with R2, like they can tolerate R2 anymore. R2 will do the same thing at any facility. The current facility found a new facility for R2 but they refused to accept him after R2's recent inappropriate touching incident with R1.R2's Behavior note created on 8/18/25 documents: Behavior Description: Inappropriately touching another resident. Behaviors: resident (R2) observed inappropriately touching a resident (R1). Nursing note dated 8/18/25 documents: Writer heard a resident (R1) yell out for help, writer got up to go to the yelling. Writer observed above resident (R2) in his wheelchair bending and reaching over to a resident (R1) in bed. Resident (R2) being petitioned to the hospital for inappropriate sexual behavior towards his peer. On 8/20/25 at 1:45pm, V2

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow its abuse policy by not reporting an allegation of abuse to the regulatory state agency within 24 hours. This affected two of three residents (R1, R2) reviewed for abuse policy. Findings Include:R2's Behavior note created on 8/18/25 at (12:49) documents: Behavior Description: Inappropriately touching another resident. Behaviors: resident (R2) observed inappropriately touching a resident (R1). Nursing note dated 8/18/25 documents: Writer heard a resident (R1) yell out for help, writer got up to go to the yelling. Writer observed above resident (R2) in his wheelchair bending and reaching over to a resident (R1) in bed. Resident (R2) being petitioned to the hospital for inappropriate sexual behavior towards his peer. On 8/20/25 at 3:45pm, V1 (administrator) said, if she is aware of an abuse allegation it should be reported to Illinois Department of Public Health within two to twenty-four hours. V1 said, she was informed of R1's incident by V4 (assistant administrator) followed by V14 (director of nursing) on 8/19/25. V1 said, R1's incident should have been reported if staff felt like it was abuse. V1 said, she did not report the incident due to being off but V4 should have because she was in the building. On 8/23/25 at 2:45pm, R1 who was assessed to be alert and oriented to person, place and time, said he was in bed when R2 entered his room via wheelchair. R1 said, R2 rolled on the side of his bed, stopped his wheelchair, stood up, lifted R1's gown and ripped opened R1's adult brief. R1 said, R2 put his hand around his penis and started rubbing it. R1 said, he was scared, he yelled for help and R3 saved his life. R1 said, he felt uncomfortable. R1 said, he does not have sexual activities with men. R1 said, he is not like that. R1 said, the facility needs security. On 8/20/25 at 11:15am, R3 who was assessed to be alert and oriented to person, place and time, said R1 was yelling for about four minutes. R3 said, he walked to R1's room. R3 said, he saw R2 standing up on the side of R1's bed with his right hand on R1's penis moving up and down while holding his (R2's) penis while moving his left hand moving back and forth. R3 said, R2 is aware of his behavior. R3 said, R2 rolls through the hallway looking for bedbound residents. R2 does not bother residents that can walk. R2 has touched other bedbound residents before. R2 waits and watches until staff is not looking, go into resident's room and touch them inappropriately. R3 said, R1 is contracted with his arms up by his head and his legs are stuck open, knee up and apart. R1 could only yell for help. R3 said, V6 was the first to enter R1's room. On 8/20/25 at 12:26pm, V6 (cna) said, said when she entered R1's room. R1 was observed with his gown up. R2 pulled up R1's gown, pushed R1's adult brief to the side and touched R1's penis. R3 called the nurse. V6 said, she had to fix R1's adult brief and pull down R1's gown. V6 said, R1 was crying when she entered his room. V6 said, R1 reported not feeling safe at the facility and wanting to die. V6 said, R1 reported he has never been touched by a man before. V6 said, R1 reported R2 had his hand in R1's adult brief touching his penis. On 8/20/25 at 2:12pm, video watched with V1 (administrator), V4 (assistant administrator) and V14 (director of nursing/ DON). V1 said, the video time is an hour ahead. R1 was seen entered R2's room at 11:17am per the recording time on the video but it was actually 12:17 per V1. R2 was seen exiting R1's room at 11:19am per the recording time on the video but it was actually 12:19 per V1. Facility timeline documents: At 12:19, V6 (cna) was noted running from the east nurses' station area towards R1's room. V8 (cna) came from room [ROOM NUMBER] and noted walking towards R1's room. R3 was noted talking and pointing into R1's room while standing in the hallway. R2 out of R1's room with V7 (nurse) behind him. At 12:22pm, V14 (therapy director), V15 and R3 walked over to administrators' office to report that R2 was noted in R1's room standing over R1 by the foot of the bed. On 8/26/25 at 1:34pm, V5 (nurse) said, she was the reporting nurse for R1 on 8/18/25. V5 said, R1 reported, that R2 touch his butt hole. Facility reportable date of the incident 8/19/25 documents: Time of incident: 2:30pm: Sexual: Describe Alleged Incident: Nurse Practitioner who reported the resident, R1 reports to her that another resident (R2) was sexually inappropriate towards him, Hospital Paperwork dated 8/19/25 documents: Patient (R1) present to emergency department for evaluation after an assault. Emergency Department diagnoses: Sexual assault of adult.Police report dated 8/19/25 documents: office responded to nursing home in regard to a criminal sexual abuse report. R1 was lying in bed alone. While laying down, R2 entered R1's room in a wheelchair. R1 rolled his wheelchair next to R1's bed and came to a stop. R2 then stood up and opened R1's diaper. R1 related that R2 placed his right hand in R1's adult brief and began to groan. R1 does not have any sense of feeling below the waist and did not know exactly what R2 was doing to his genitals. R1 began to call for a nurse while R2 was moving his hand around R1's genitals. R3 entered the room and began to shout at R2 to

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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. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to effectively monitor and supervise a resident with a diagnosis of dementia from wandering into another resident's room without permission and sexually touching another resident. This affected two of three residents (R1, R2) reviewed for supervision of resident with dementia.Findings Include:On 8/23/25 at 2:45pm, R1 who was assessed to be alert and oriented to person, place and time, said he was in bed when R2 entered his room via wheelchair. R1 said, R2 rolled on the side of his bed, stopped his wheelchair, stood up, lifted R1's gown and ripped opened R1's adult brief. R1 said, R2 put his hand around his penis and started rubbing it. R1 said, he was scared, he yelled for help and R3 saved his life. R1 said, he felt uncomfortable. R1 said, he does not have sexual activities with men. R1 said, he is not like that. R1 said, the facility needs security. On 8/20/25 at 11:15am, R3 who was assessed to be alert and oriented to person, place and time, said R1 was yelling for about four minutes. R3 said, he walked to R1's room. R3 said, he saw R2 standing up on the side of R1's bed with his right hand on R1's penis moving up and down while holding his (R2's) penis while moving his left hand moving back and forth. R3 said, R2 is aware of his behavior. R3 said, R2 rolls through the hallway looking for bedbound residents. R2 does not bother residents that can walk. R2 has touched other bedbound residents before. R2 waits and watches until staff is not looking, go into resident's room and touch them inappropriately. R3 said, R1 is contracted with his arms up by his head and his legs are stuck open, knee up and apart. R1 could only yell for help. R3 said, V6 was the first to enter R1's room. On 8/20/25 at 2:12pm, video watched with V1 (administrator), V4 (assistance administrator) and V14 (director of nursing/ DON). V1 said, the video time is an hour ahead. R1 was seen entered R2's room at 11:17am per the recording time on the video but it was actually 12:17 per V1. R2 was seen exiting R1's room at 11:19am per the recording time on the video but it was actually 12:19 per V1. On 8/20/25 at 12:26pm, V6 (cna) said, said when she entered R1's room. R1 was observed with his gown up. R2 pulled up R1's gown, pushed R1's adult brief to the side and touched R1's penis. R3 called the nurse. V6 said, she had to fix R1's adult brief and pull down R1's gown. V6 said, R1 was crying when she entered his room. V6 said, R1 reported not feeling safe at the facility and wanting to die. V6 said, R1 reported he has never been touched by a man before. V6 said, R1 reported R2 had his hand in R1's adult brief touching his penis. Nursing note dated 8/20/25 documents: Patient (R1) is going to be admitted for sexual assault.On 8/26/25 at 1:34pm, V5 (nurse) said, she was the reporting nurse for R1. V5 said, she was aware that R1 has a history of inappropriate touching other residents. V5 said, R1 reported, that R2 touch his butt hole. Nursing note dated 7/17/25 documents: RN (V5) noticed resident (R2) kept going into another resident room. The resident (R2) is trying to inappropriately touch the other resident and tell him he loves him. On 8/26/25 at 2:45pm, V12 (R2's POA) said, R2 has dementia and a history of same sex relationships. V12 said, she received a call about R2's incident with R1. V12 said, she has received calls from the facility prior to R1's incident about R2 inappropriate touching other residents. V12 said, the facility has been so patient with R2. Now the facility is acting like they do not have any patience with R2, like they can tolerate R2 anymore. R2 will do the same thing at any facility. The current facility found a new facility for R2, but they refused to accept him after R2's recent inappropriate touching incident with R1.R2's Behavior note created on 8/18/25 (12:49) documents: Behavior Description: Inappropriately touching another resident. Behaviors: resident (R2) observed inappropriately touching a resident (R1). Nursing note dated 8/18/25 documents: Writer heard a resident (R1) yell out for help, writer got up to go to the yelling. Writer observed above resident (R2) in his wheelchair bending and reaching over to a resident (R1) in bed. Resident (R2) being petitioned to the hospital for inappropriate sexual behavior towards his peer. On 8/20/25 at 2:31pm, V3 (nurse practitioner) said, she was informed on Monday 8/18/25 that another resident touched R1. V3 said, she saw R1 on Tuesday. V3 said, R1 reported R2 lifted his gown and grabbed his penis. R1 reported he can't get erect because he is parlayed. R1 said, he was not gay. R1 was crying. V3 said, she suggested R1 go to the hospital. On 8/20/25 at 12:39pm, V8 (cna) said, she heard R3 telling R2 to get out of R1's room. R1 is contracted with his hands stuck behind his head. R1's legs are contracted opened. V8 said, R1 is dependent on staff for assistance. R2 is a wander. R2 should not have been in R1's room. Hospital Paperwork dated 8/19/25 documents: Patient (R1) present to emergency department for evaluation after an assault. R1 does not feel safe. Emergency Department diagnoses: Sexual assault of adult. Per emergency service: R1 was manually grouped by another resident, allegedly witness by another resident. (8/21/25) Case manager spoke with patient (R1) at bedside who was alert and orient time four declined to discharge to