

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 10/08/2025
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility neglected to follow established clinical protocols, manufacture's guidance, internal training guidelines, and to follow their policy and procedures outlined in the Subacute Rehabilitation (SAR) Long-Term Acute Care (LTAC) Ventricular Assist Device (VAD) Training Manual, Heart Failure (HF) Left Ventricular Assist Device (LVAD) HF-LVAD HeartMate-3 Patient Guide, VAD Emergency Guide, LVAD Pocket Reference Guide. This affected one of one resident (R1) reviewed for providing services for a resident utilizing a LVAD. This neglectful practice resulted in R1 LVAD batteries not being monitored or changed when reached 50% capacity, R1 batteries depleted the pump stopped, R1 sent to hospital for cardiac arrest, R1 expired. The Immediate Jeopardy which began on [DATE] when R1's Left Ventricular Assist Device batteries were not changed resulting in depletion of the external batteries and internal back up battery then the heart pump stopped running. Subsequently R1 was found unresponsive, sent to emergency room for cardiac arrest, resuscitation efforts unsuccessful, R1 expired. V5 (Administrator) was notified of the immediate Jeopardy on [DATE] at 3:13pm The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE], but non-compliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: R1's face sheet diagnoses encounter for surgical aftercare following surgery on the Circulatory System, unsteadiness on feet, Cognitive Communication Deficit, Type 2 Diabetes Mellitus without complications, Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Congestive Systolic Heart Failure, Ventricular Tachycardia, and presence of heart assist device. R1's Minimum Data Set (MDS) dated [DATE] shows Brief Interview for Mental Status (BIMS) score of 11 (Cognitive Deficits). R1's progress note dated [DATE] denotes in-part, [AGE] year-old male admitted to facility Alert (A) x Orient (O) x3 sometimes forgetful, NKA (No Known Allergies), room air. PMHX: (past medical history) Coronary Artery Disease (CAD) status post (s/p) Coronary Artery Bypass Grafting (CABG) and stent with End Stage Heart Failure with ejection fraction (EF) 15% (heart failure s/p Implantable Cardioverter-Defibrillator (ICD) HeartMate 3 on 8/2021, COPD without oxygen, Type 2 Diabetes Mellitus (DM), End Stage Renal Failure (ESRF) stage 3. Head to toe assessment completed, Pupils' Equal Round Reactive Light Accommodation (PERRLA), lungs clear, active Range of Motion (ROM) for all extremities, left upper arm fracture (refusing to wear sling), active bowel sounds, last bowel movement (BM) 07/2024. Skin intact, drive line insertion site Left Lower Quadrant (LLQ) with anchor on (RLQ Right Lower Quadrant, scattered bruising, drive line dressing change Monday, Wednesday, Fridays (M, W, F). LVAD needs to be checked twice a day (BID). RN (Registered Nurse) spoke with LVAD nurse (name noted) giving numbers in case of needing to be contacted, (phone number listed) during office hours, after hours, or emergency number (phone number listed). Resident very pleasant and cooperative, cell phone, shoes, clothes, LVAD batteries (6), LVAD battery charger, LVAD wall power unit, battery holders (4) all at bedside within reach. Call light, bed controller, and TV remote within reach next to resident. R1's emergency room records dated [DATE] denotes in-part patient coming from the nursing home, report from Emergency Medical Service (EMS), noted an unwitnessed cardiac arrest. The patient has an LVAD (Left Ventricular assist device). According to EMS when they arrived Cardiopulmonary Resuscitation (CPR) was in progress. EMS continued CPR. Assessment of the patient HeartMate 3 shows that the patient is on battery backup, that there is no power to this his unit. CPR continued. The patient's HeartMate 3 was connected to power source and began operating. Of note the advance health care team stated that the patient had been on battery backup for over 300 minutes prior to arrival. On [DATE] at 1:10pm, V13 (emergency room Nurse) stated R1 arrived at the hospital for cardiac arrest, with EMS (Emergency Medical Service.) V13 stated that R1's Left Ventricular Assist Device's, batteries and the backup battery were dead upon arrival to the Emergency Room. V13 explained that the LVAD system is designed to pump blood to the heart because R1 has heart failure. V13 said the batteries should never be allowed to deplete. The event log file for R1's LVAD system denotes in part: the event log captured low voltage advisory and few voltage hazard events on battery power 9/15 at 3:55am through 4:20am, then the patient changed to charged batteries. Also noted a lone low flow event 09/15 at 3:56am with flow noted at 2.0. looked to be patient related as this was associated with elevated Pulsatility Index (PI) values. Further low voltage advisory events on battery power noted 09/16 at 12:59 which progressed into low voltage hazard events 09/16 at 3:28am. Battery power depleted 09/16 at 4:51am</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their baseline care plan policy and develop an individualized baseline plan of care to include physician orders for a left ventricular assist device for a resident. This affected one of two residents (R2) reviewed for care plans and LVAD. R2 was admitted to the facility on [DATE], R2 face sheet shows diagnosis of chronic systolic congestive heart failure, atrial fibrillation, and presence of heart assist device. R2 facility census shows admission date 09/12/2025 and discharge date [DATE]. R2 progress notes show R2 sent to hospital for change in condition on 09/15/2025. R2 third eye health note dated 09/13/2025 at 10:09am denotes in-part patient name-R2. Initial stabilization visit, [AGE] year-old male admitted from the hospital after hypoglycemic event with sepsis currently on Bactrim DS twice a day for two more days past medical history of hypertension diabetes mellitus. Patient was admitted to the facility today and is awaiting full H and P (history and physical) and review by primary team. The nurse consulted third eye health to assess the patient to review discharge medication and orders and to ensure safe transition of care. Review of available paperwork and consultation with patient nurse was completed to identify high risk medication while awaiting evaluation by primary team. Physical exam findings per nurse and video observation physical exam medication review hospital discharge orders reviewed and updated as appropriate condition is stable medication review medication orders reviewed clarifications made see orders medication orders review no clarifications made patient is at risk for polypharmacy recommend that primary team review medications and eliminate unnecessary medications antibiotics diabetes repeated falls. Does the patient have any acute symptoms or any additional conditions that were addressed? today no. Orders available documentation review orders and medications approved until patient is evaluated by primary team obtain and review current relevant hospital documentation and orders with primary team when available start house start probiotics for 10 days twice a day. Fall precautions per facility policy. Point of care glucose checks three times a day before meals and at bedtime. Notify a clinician of any change in condition. Disposition: of stay at facility. Audio and video with patient and nurse present. Statement of medical necessity- yes. Sign date September 13, 2025 9:05 AM, provider V28.R2 initial stabilization visit completed by the provider, does not address the plan of care for R2's LVAD. Review of R2 physician order sheet for September 2025 there are no orders noted for R2 LVAD, no orders for VAD parameters every shift, no orders for controller and power module self-test to be performed every morning. 09/30/2025 V6 presents the admission evaluation, stating that the baseline care plan is included in the admission evaluation, V6 said there are no specific plan of care for R2's LVAD. During a follow-up interview on 10/3/25 at 4:46pm V6 (Director of Nursing) said she is now the LVAD preceptor for LVAD's, she is working with V5 (Administrator) to establish an order set for patients with an LVAD. R2 admission evaluation dated 09/12/2025, completed by the Nurse denotes in-part disease conditions contributing to admission- heart failure, devices- other-LVAD. Cardiovascular, ventricular assist device- yes is checked. Review of the baseline plan of care included in the admission evaluation, there are no goals or interventions noted specifically for the LVAD, there are no orders for checking/monitoring the alarms, system, or batteries. Review of R2 comprehensive plan of care with V12 (MDS coordinator), V12 stated that she edited/ revised the care plan during this survey on 09/18/2025 to include the LVAD, V12 stated she knew the surveyor was reviewing for LVAD's. V12 was asked, what's the specific goals and interventions for the patient with the LVAD, V12 said the floor nurse are supposed develop a plan of care for baseline care needs upon admission within 24 hours, and the MDS team will review the comprehensive plan of care after. V12 did not give a response of what the baseline care needs are for a resident with an LVAD. V12 said she should not edit a resident record after they have discharged from the facility. On 09/24/2025 at 11:44am V17 (ADON-Assistant Director of Nursing) said she was the preceptor for LVAD training. Staff should monitor the blood pressure, ensure orders are in place, complete daily weights, be attentive by being alert to alarms from the monitor. V17 omitted what orders should be in-place for a patient with an LVAD. Facility policy titled baseline care plan dated 01/2023 last revision date 01/2025 denotes in-part to provide The staff with guidance on completion of comprehensive person-centered care baseline care planning. The facility will develop and implement A baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care. The baseline care plan will be developed within 48 hours of residence admission into the facility. The baseline care plan will include at a minimum of the following necessary information to properly care for a resident</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review the facility failed to follow professional standards of care for residents requiring LVAD (Left Ventricular Assist Device). This affected two of two residents reviewed for LVAD. This failure resulted in the facility failure to assess and monitor the battery level for R1 LVAD and failure to intervene when the batteries depleted and failed to ensure R2 had physician orders in place in the medical record. 1. R1 face sheet diagnosis of encounter for surgical after care following the circulatory system, unsteadiness on feet, type 2 diabetes mellitus, ventricular tachycardia, presence of heart assist device, cognitive communication deficits, COPD, acute and chronic congestive systolic heart failure. R1 MDS dated [DATE] shows BIMS score of 11 (cognitive deficits)Skin intact, drive line insertion site LLQ (left lower quadrant) with anchor on RLQ (right lower quadrant, scattered bruising, drive line dressing change M, W, F (Monday, Wednesday, Fridays). LVAD (left ventricular assist device) needs to be checked BID (twice a day). R1 emergency room records dated [DATE] denotes in-part patient coming from the nursing home report from EMS noted an unwitnessed cardiac arrest. The patient has an LVAD (Left Ventricular assist device). According to EMS when they arrived CPR was in progress EMS continued CPR. Assessment of the patient heartmate shows that the patient is on battery back up that there is no power to this his unit. CPR continued. The patient heartmate was connected to power source and began operating. Of note the advance health care team stated that the patient had been on battery backup for over 300 minutes prior to arrival. [DATE] at 1:10pm V13 (emergency room Nurse) stated R1 arrived at the hospital for cardiac arrest, with EMS (emergency medical service.) V13 stated that R1 Left Ventricular Assist Device, batteries and the backup battery was dead upon arrival to the emergency room. V13 explained that the LVAD system is designed to pump blood to the heart because R1 has heart failure. V13 said the batteries should never be allowed deplete. The event log file for R1'S LVAD system denotes in part the event log captured low voltage advisory and few voltage hazard events on battery power 9/15 at 3:55am through 4:20am then the patient changed to charged batteries. Also noted a lone low flow event 09/15 at 3:56am with flow noted at 2.0. Looked to be patient related as this was associated with elevated PI values. Further low voltage advisory events on battery power noted 09/16 at 12:59 which progressed into low voltage hazard events 09/16 at 3:28am. Battery power depleted 09/16 at 4:51am which enabled the EBB (emergency backup battery) in the controller and ran the VAD at the low limit of 5200 RPM until the EBB depleted as well on 09/16 at 6:48am resulting in the VAD turning off. Unable to determine the time the VAD was off due to the timestamp being reset to [DATE] once the power was restored to the VAD. On [DATE] at 2:43pm V19 (LPN) said he was R1's nurse on the 3:00pm -11:00pm pm shift on [DATE], he was orientating a new nurse V18 (LPN). V19 said he checked R1 LVAD, he checked the connections, he checked the batteries, and the aide assessed the vital signs. V19 said this was completed prior to him discharging an unrelated resident, that resident was discharged around 8:00pm. V19 said both of R1 LVAD external batteries had three green bars. V19 said he did not change R1 batteries at that time. V19 said he did not change R1 LVAD batteries during his shift, V19 said he did not plug R1 LVAD to the wall outlet prior to him leaving his shift. V19 said he left at 11:30pm. V19 said he reported to V3 (RN) the oncoming nurse to monitor R1 because R1 had an LVAD and R1 was an elopement risk. V19 said R1 has cognitive deficits. V19 said V18 completed all of the documentation for R1 because V18 was in orientation. V19 said he did not get training at [NAME] Oak Lawn for LVAD patients. V19 said V18 documented N/A -alarms and system check for LVAD, that was an error, the time is correct. V19 said N/A was for the dressing change, the facility did not have the correct dressing for R1 LVAD, and he did check the batteries and ensured the drive lines was connected. V19 said he did not complete a system check for R1 LVAD during his shift. V19 said he worked with LVAD patients in the past at another facility and he would complete a system check of the LVAD, V19 describes there's a button on the controller, and you press it, and it will take you through all the system in the controller. V19 said he did not plug R1 LVAD into the wall outlet because R1 could let him know when he's going to bed, and could request to be plugged in. Facility presents timecard for V19 denoting V19 punched out at 12:45am on [DATE]. This supports that V19 had the opportunity to change R1's LVAD external batteries during his shift, V19 remained on duty for 7 hours after he observed R1 LVAD batteries at three bars. [DATE] at 12:42pm V18 (LPN) said he was on orientation and V19 was the preceptor, V18 said his shift was on [DATE] on the 3:00pm- 11:00pm shift, V18 he did not get training at [NAME] Oak Lawn for LVAD patients. V18 said he observed V19 check R1 LVAD</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to provide appropriate, person-centered care and treatment to ensure the highest practicable physical, mental, and psychosocial well-being of 1 of 1 resident's (R1) reviewed with a Left Ventricular Assist Device (LVAD), who was found unresponsive. The facility failed to follow its own emergency response protocol, resulting in a failure to identify that R1's LVAD system had stopped functioning due to depleted batteries, contributing to cardiac arrest and subsequent death. The Immediate Jeopardy which began on [DATE] when the facility failed to follow their policy/practice/protocol to check the Left Ventricular Assist Device for functioning, if the device is running during an emergency when a resident R1 was observed unresponsive contributing to cardiac arrest and subsequent death. V5 (Administrator) was notified of the Immediate Jeopardy on [DATE] at 3:13pm The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE], but non-compliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: R1's face sheet diagnoses of encounter for surgical after care following the Circulatory System, unsteadiness on feet, Type 2 Diabetes Mellitus, Ventricular Tachycardia, presence of heart assist device, Cognitive Communication Deficits, COPD, Acute and Chronic Congestive Systolic Heart Failure. R1's MDS dated [DATE] shows BIMS score of 11 (Cognitive Deficits). Physician order sheet shows orders for full code. R1's progress note dated [DATE] denotes in-part, [AGE] year-old male arrived at facility skin intact, drive line insertion site Left Lower Quadrant (LLQ) with anchor on Right Lower (RLQ) Quadrant, scattered bruising, drive line dressing change Monday-Wednesday-Friday (M, W, F). LVAD needs to be checked twice a day (BID). Registered Nurse spoke with LVAD nurse (name) giving numbers in case of needing to be contacted, (phone number listed) during office hours, after hours or emergency number (phone number listed). Resident very pleasant and cooperative, cell phone, shoes, clothes, LVAD batteries (6), LVAD battery charger, LVAD wall power unit, battery holders (4) all at bedside within reach. R1's emergency room records dated [DATE] denotes in-part patient coming from the nursing home report from EMS noted an unwitnessed cardiac arrest. The patient has an LVAD (Left Ventricular Assist Device). According to EMS when they arrived CPR was in progress EMS continued CPR. Assessment of the patient HeartMate 3 shows that the patient is on battery backup that there is no power to this his unit. CPR continued. The patient HeartMate 3 was connected to power source and began operating. Of note the advance health care team stated that the patient had been on battery backup for over 300 minutes prior to arrival. On [DATE] at 1:10pm, V13 (emergency room Nurse) stated R1 arrived at the hospital in cardiac arrest, with Emergency Medical Service (EMS). V13 stated that R1 Left Ventricular Assist Device, batteries and the backup battery were dead upon arrival to the emergency room. V13 explained that the LVAD system is designed to pump blood to the heart because R1 has heart failure. V13 said the batteries should never be allowed to deplete. The event log file for R1's LVAD system denotes in part battery power depleted 09/16 at 4:51am which enabled the EBB (emergency backup battery) in the controller and ran the VAD at the low limit of 5200 RPM until the EBB depleted as well on 09/16 at 6:48am resulting in the VAD turning off. Unable to determine the time the VAD was off due to the timestamp being reset to [DATE] once the power was restored to the VAD. On [DATE] at 10:01am, V2 (CNA) said she was going to assess R1's vitals and observed R1 with no pulse, V2 said she notified V1 (LPN), and immediately returned to start CPR on R1. V2 said she remember getting tired when doing chest compressions and she switched out with V1. V2 said when they were in the room, she heard someone say that the LVAD was not plugged up and some said that's okay as long as the batteries are attached. V2 said she doesn't know the name of the person because she is fairly new to the facility. V2 said she did not check the LVAD, and she did not check the batteries. V2 said she has not had any training for emergency response to a patient with an LVAD. On [DATE] at 4:09p.m, V1 (LPN) said she was made aware by V2 that R1 was not responding, V1 said she got V4, (RN) attention, and they rushed into the room. V1 said she assisted with chest compressions and bagging R1 when V2 got tired. V1 said she did not check R1, LVAD for function, she did not check the batteries. V1 said V9 (LPN), V4 (RN), V20 (LPN), and V21 (LPN) all responded to the code blue for R1. V1 said she did not receive training on emergency response to a patient with an LVAD. On [DATE] at 2:10pm, V4 (RN) said she was R1's nurse for the morning shift of [DATE], V4 said when she heard the code blue she ran to get the crash cart. V4 said she did not assist with CPR efforts for R1 the</p>		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their facility assessment and ensure that staff received in-service and training to provide care and service for residents with a left ventricular assist device. This affected two of two resident reviewed (R1, R2). 1.R1's face sheet indicates diagnoses of encounter for surgical after care following the circulatory system, unsteadiness on feet, Type 2 Diabetes Mellitus, Ventricular Tachycardia, presence of heart assist device, cognitive communication deficits, COPD, Acute and Chronic Congestive Systolic Heart Failure. R1's MDS dated [DATE] shows BIMS score of 11 (cognitive deficits).2. R2 was admitted to the facility on [DATE], R2 face sheet shows diagnoses of Chronic Systolic Congestive Heart Failure, Atrial Fibrillation, and presence of heart assist device.On 09/17/2025 11:13am V3 (RN) said she did not receive training at the [NAME] Oak Lawn nursing home for LVAD. On 09/17/2025 at 1:33pm V9 (LPN) said she did not received training on emergency response to a patient with an LVAD at the [NAME] Oak Lawn.On 09/17/2025 at 2:10pm V4 (RN) said she V4 said she has not received any training on LVAD system at the [NAME] Oak Lawn. During this interview, V4 was asked to demonstrate how to check the LVAD batteries to determine the capacity, V4 picked up the gray battery, V4 could not identify where the button was located on the battery to determine if the battery was charged. V4 was observed to flip the battery over and over, V4 did not identify the button on the front of the battery to check the battery capacity. V4 stated she did not check R1's LVAD system or batteries when rounding on R1 upon the start of the shift on 9/16/25.On 09/17/2025 at 4:09p.m V1 (LPN) said she did not received training on emergency response to a patient with an LVAD.On 09/18/2025 at 10:01am V2 (CNA) said she has not received any training on LVAD system at the [NAME] Oak Lawn. On 09/18/2025 at 12:41pm V6 (Director of Nursing) stated that her expectation is that the Nursing staff follow the facility policy when caring for a resident with a LVAD systems. V6 said she does not have any documentation that the staff received LVAD training in July 2025. V6 said she is learning during this survey that staff did not received training for the LVAD. On 09/18/2025 at 2:17pm V15 (Medical Doctor/ Medical Director) V15 stated that there should be at least one Nurse on duty that is trained on the LVAD. On 09/19/2025 at 12:12pm V11 (CNA) said she did not get training at the [NAME] Oak Lawn nursing home for LVAD. On 09/24/2025 at 11:44am V17 (ADON-Assistant Director of Nursing) said she was the preceptor for LVAD training. V17 said all Nursing staff should have training for the LVAD, V17 said she would like the training to consist of return demonstration to allow for hands on training, V17 said watching videos is not enough training to learn about the LVAD. On 09/24/2025 at 2:43pm V19 (LPN) said he did not get training at [NAME] Oak Lawn for LVAD patients. On 09/24/2025 at 12:42pm V18 (LPN) said he, V18 he did not get training at [NAME] Oak Lawn for LVAD patients. On 09/25/2025 V21 (LPN) said she can't remember if she responded to the code blue for R1. V21 said she remember that the training was offered in July, she doesn't recall the participating in the training. On 09/26/2025 at 1:48pm V20 (LPN) said she did not received training on emergency response to a patient with an LVAD at [NAME] oak lawn.The Facility Assessment Tool dated 08/29/2025 denotes in-part our resident profile, diseases/conditions, physical and cognitive disabilities- categories-heart/circulatory system, congestive heart failure. Decisions regarding caring for residents with conditions not listed above, facility resources including but not limited to staff skill sets and material resources. Mandatory in-services related to specific diagnoses or equipment, involvement of Medical Director, corporate resources. Services and care the facility offers based on our residents' needs, resident support needs, other special needs, dialysis, hospice, ostomy care, tracheostomy care, bariatric care, palliative care, end of life care, LVAD. Provide person-centered/directed care: Psycho/social/spiritual support: Identify hazards and risks for residents. Training topics, competencies: general staff-Abuse, Neglect and Exploitation. Nurses- Left Ventricular Assist Device.</p>		