STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145983	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya on 87th	2940 West 87th Street Chicago, IL 60652

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on observation, interviews, and review of records the facility failed to ensure proper supervision and monitoring was provided to 1 (R1) out of 3 residents reviewed for risk of elopement. Facility also failed to establish preventive measures for recurrent of elopement to the same resident (R1). These failures are not in accordance with elopement and out on pass policies of facility. Failures affected 1 resident (R1) who was able to leave premises of facility without authorization or awareness of facility staff. Findings include: R1 is [AGE] years old, initially admitted on [DATE] in the facility. R1's medical diagnosis includes cerebral infraction, diabetes mellitus, dementia, and pathological gambling. Facility document titled State Report of Abuse Allegation reads: On 12/29/2024 R1 was unable to be found in the facility. Facility suspected daughter (V4) took R1 out. Final addendum reads that it was determined that R1 was assisted in exiting the facility into the casino but does not mention who took R1. Social Service Quarterly assessment dated [DATE] documents R1 as high risk of elopement. Elopement assessment dated [DATE] documents that R1 as high risk of elopement, and Community Skill Evaluation dated 12/29/2024 documents that R1 needs supervised outside pass privilege due to display of forgetfulness, requires cues. R1 diagnosis includes dementia with agitation. On 01/28/2025 at 11:20 AM, at the floor where R1 was located elevator was seen with numeric pad. Per V8 (Unit Manager Nurse) in order to use elevator code is needed. Multiple residents were seen wearing wander guard (equipment that is place on a person extremities wrist or ankle that will alarm when that person goes near the elevator). R1 was at the dining room, V8 volunteered to get R1 and brought her to her room. R1 had a hard time focusing on specific dates during conversation. R1 was asked about the time when she went to casino on 12/28/2024 or 12/29/2025. R1 stated that V4 (Family of R1/Daughter) picked her up, then said there was a time V6 (Friend of R1) picked her up because she has a van or a car that used to go to casino. R1 cannot determine the date and time of the incident. R1 kept saying Christmas time. R1 stated that V6 picked her up then she stayed with V4 for the night, and that in the morning V4 brought her back to the facility. R1 also stated that she took her wander guard or alarm on her leg when she left the facility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145983	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER: Aliya on 87th		STREET ADDRESS, CITY, STATE, ZIP CODE: 2940 West 87th Street Chicago, IL 60652	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/2025 at 11:46 AM, V2 (Director of Nursing) stated that a friend or family member took R1 out of the facility. V2 was asked who the person who assisted R1 out of the facility based on their investigation. V2 stated she was not sure and was not able to provide specific name. V2 stated that it was not clear who took R1 out of the facility. V2 was informed that R1 was mentioning the name V6 (Friend of R1) that took her out on pass in the past. V2 stated that facility staff was not aware that R1 left the facility during the incident (12/28/2024 to 12/29/2024), and that R1 needs to be signed out every time she leaves facility. On 01/28/2025 at 11:59 AM, V4 (Family of R1/Daughter) was asked about the incident dated 12/28/2024 to 12/29/2024. V4 stated that V6 (Friend of R1) did not picked R1 from the facility. V4 stated that she called V6 (Friend of R1) and said that she did not pick up R1 in the facility. V4 stated that V3 (Licensed Practical Nurse) called her asking if R1 was with her. I (V4) replied to V3 that R1 was not with her and to check all rooms and the place where R1 plays cards. V4 stated that she called multiple persons that are friends with R1, and a friend of R1 told her that R1 was at the casino. V4 stated that she asked V3 how did R1 get there (casino)? and I (V4) called the police. V4 stated that she went downtown at the casino and met V2 (Director of Nursing) and V3 (Licensed Practical Nurse). V4 stated that facility staff (V2 and V4) took R1 back to facility. V4 was asked how R1 was able to go from facility to the casino. V4 stated that she thinks she rode the bus. On 01/28/2025 at 12:23 PM, V1 (Administrator) provided a modified State Report of Abuse Allegation that now added V6's (Friend of R1) name as the person who was with R1. But none of documentation on R1's progress notes documents that R1 was picked up by V6 or any person when she leaves the facility on 12/28/2024 or 12/29/2024. V1 was informed that according to V4 (Family of R1/Daughter) V6 did not picked up R1 on 12/28/2024 or 12/29/2024. V1 stated that V4 was just upset that R1 did not want to give her money when she asked. V1 stated that we spoke to V6 confirming that she picked up R1 that day. On 01/28/2025 at 01:11 PM, V3 (Licensed Practical Nurse) who was taking care of R1 when R1 eloped the facility. V3 stated that last time she saw R1 was in her room after dinner about 5:30 PM to 6:30 PM. It was during endorsement with another nurse for change of shift around 10:30 PM that she noticed R1 was not in the building. V3 stated that she called V4 (Family of R1/Daughter) asked if she took R1. V4 replied no and she would call V6 (Friend of R1) if she knew where R1. Then V4 called back and said that R1 was not with V6. V3 stated that she then called the code yellow and search all over the building but cannot find R1. V3 stated that she informed her supervisor and V2 (Director of Nursing) who stated that she was on her way to the facility. V3 then called informing her that R1 was at the casino. At that time V1 (Administrator), V2 and her (V3) went to the casino. Both her and V2 went to the 2nd floor and saw V3 and V6 with R1. R1 went back to the facility from the casino. V3 was asked how did R1 able to leave without any of the staff knowing when there is a code needed to use the elevator? V3 replied that all the family and staff know the code. V3 was asked how then did R1 able to go from facility to casino? V3 replied, I cannot answer that, I am not sure if somebody was with R1 when she left the facility. I did not see her leave. V3 stated that the right process or procedure for any resident to go out on pass is to inform the front desk. Then go to the floor and let the nurse know the resident will go out on pass. Sign out the resident and sign in when resident comes back. Per V3, R1 was wearing wander guard but it was not effective all the time. V3 stated that wander guard cannot be heard if staff are not within proximity, like when attending a resident inside the room, and that wander guard does not always work. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/28/2025 at 2:17 PM, V2 (Director of Nursing) clarified that the family member on the final report refers to V4 (Family of R1/Daughter). V2 was informed that V4 denies that V6 (Friend of R1) took R1 out of the facility that day. V2 stated that it was established during the investigation that V6 took R1 out of the facility that day. V2 stated that R1's wander guard was in placed because staff at the desk heard the alarm due to wander guard. V2 was asked if a facility staff heard the alarm due to wander guard why did the staff not go after hearing the alarm? V2 stated that was the reason the particular staff got terminated. V2 stated that facility staff was not aware that R1 left the facility. V2 was given a copy of R1's full care plan. After review, V2 stated that social services need to address why R1 does not have any changes on the care plan related to elopement. On 01/28/2025 at 03:10 PM, V7 (Minimum Data Set Coordinator) stated that care plan needs to be reviewed and modified during scheduled assessment annually and quarterly, and if something goes on or something happened like a fall, there is a need to review or modify the care plan. Like new pressure ulcer needs to be address by Wound Care Team, elopement needs to be address by Social Services what interventions need to do so that it will not re-occur. V7 after review of R1's full care plan stated, Yes, that is the only one I see about the wander guard for elopement. This care plan needs to be reviewed or modified. On 01/29/2025 at 09:09 AM, V6 (Friend of R1) stated that on that particular date 12/28/2024 or 12/29/2025 she did not take R1 out of facility. V6 stated that she always signs out R1 every time she takes R1 out. V6 was asked was there a time that she was present in a casino when facility staff Director of Nursing or any of the nurses fetched R1 to go back in the facility. V6 stated that they were mistaken that it never happened. V6 stated that she thinks R1 went by herself, R1 can go to the casino by herself. V6 said, My take is that R1 shouldn't get out of the building by herself. Staff wasn't paying attention that is why R1 was able to leave without someone noticing her. Out on Pass policy dated 02/2024, reads: It is the policy of this facility that residents may leave the facility that residents may leave the facility unsupervised/supervised for specific length of time as ordered by the attending physician and in accordance with their plan of care. Social services will assess residents and determine for eligibility of unsupervised/supervised passes. If appropriate for an unsupervised or supervised pass, doctor will be notified and will determine if resident is appropriate for community pass. Doctor will provide an order. Resident must sign out prior to leaving the facility and must sign back in upon returning to facility. Elopement policy dated 01/2023, reads: Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. Resident who are at risk of eloping are closely supervised to keep them safe in their environment, while allowing them to move freely about the safe environment. Resident at risk of elopement will be closely monitored. All facility staff are responsible for responding to a door/elevator alarm immediately. This response will include visual check of the immediate vicinity surrounding the door/elevator that tripped the alarm, including the stairwells and outside area. The facility has a plan of care of an elopement of a resident from the facility. This enables the missing resident to be found as quickly as possible and to maintain the resident's safety, dignity, and privacy.