

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 04/18/2025
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)
<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342</p> <p>Based on observations, interviews, and record reviews the facility failed to notify a resident's responsible party about a room change prior to being moved to a new room on a different unit within the facility. This affected one (R1) of one resident reviewed for resident rights.</p> <p>Findings include:</p> <p>R1 was initially admitted to 1st floor nursing unit on 12/03/24 and has diagnosis which includes but not limited to Neurocognitive Disorder with Lewy Bodies, Type 2 Diabetes Mellitus, Cerebral Infarction, Personal History of Transient Ischemic Attack, Unspecified Dementia With Other Behavioral Disturbance, Age-Related Osteoporosis, Unspecified Severe Protein Calorie Malnutrition, Difficulty Walking, Lack of Coordination, Dysphasia, Generalized Anxiety, Unspecified Psychosis.</p> <p>R1's MDS (Minimum Data Set) assessment dated [DATE] documents in part, resident is rarely/never understood. BIMS (Brief Interview for Mental Status) was not able to be conducted.</p> <p>R1's electronic health record (EHR) lists R1's daughter, V16 as R1's Power of Attorney.</p> <p>Per R1's EHR's Census List indicates R1's room was change from the 1st floor to the 2nd floor on 04/07/25. A nursing note on 04/07/25 time stamped 14:48 documented in part, received resident at 2:30 PM from the first floor . Upon initial review of R1's EHR on 04/15/25 there was no documentation in R1's record indicating R1's POA was notified about the room change and/or the reason for the room change. Upon later review of R1's EHR V13 (Social Service Coordinator) entered a late entry progress note time stamped 04/15/25, 14:45:38 backdated to 04/07/25, 19:20:00 which documented in part, this worker informed daughter (V16) due to dementia dx (diagnosis) and by (R1) being considered a long-term resident, is the reason why (R1) was moved to the 2nd floor .</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 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/16/25 at 11:46 AM, via phone interview V16 (R1's Power of Attorney) stated she did not receive any notification either verbally or in writing about R1 being moved from the 1st floor to the 2nd floor. V16 stated she found out about the move when another family member came to visit R1 on 04/07/25 around 4:30 PM and the family member could not find R1 on the 1st floor. V16 stated the residents in the 1st floor day room are the ones who informed the family member that R1 had been transferred to a different unit, not the staff. V16 stated on that same day (04/07/25) she had called the facility around 3:15 PM to get an update on her mom (R1) and the nurse did not mention anything about R1 being moved to a different unit. V16 stated they transferred my mother (R1) to a new floor, and V16 received no notification about the change which is why V16 knew nothing about it. V16 stated the 2nd floor is a dementia unit and if the facility had notified her about their decision to change R1 to the dementia unit before it happened, she (V16) would have had the opportunity to express her concerns so the facility could understand her reasoning for why she preferred R1 to stay on the 1st floor. V16 stated they could have a discussion about it, but the facility made the move without even notifying her (V16) before they moved R1.</p> <p>On 04/15/25 at 3:20 PM, V13 (Social Service Coordinator) stated the resident's family/POA/guardian are notified when a resident will be transferred to a different room or unit and this notification is documented in the resident's EHR in a progress note section by a social service staff member. V13 stated the facility can let the family know about the transfer the day before and/or the day of but the family/POA must be notified prior to when the transfer occurs. V13 stated the only time they do not notify the family is if the resident is responsible for themselves, and/or they do not have a Power of Attorney or guardian. V13 stated it is important to notify the POA/guardian about the room change so the family/POA/guardian is aware of the change. V13 stated on 04/07/25 in the afternoon, R1's family member came in to visit R1 and by that time R1 had already been transferred to the 2nd floor. V13 stated R1's family member who was visiting then called V16 (R1's POA) and then V16 called V13. V13 stated V16 was upset that R1 was transferred to the 2nd floor but V13 stated she had educated them when R1 was initially admitted that the 1st floor was not for long-term placement so V13 felt the family knew this transfer was coming eventually even if they did not know the specific day/time it was going to happen. V13 stated notification of the transfer was not addressed prior to the change happening.</p> <p>On 04/16/25 at 10:00 AM, V14 (Social Service Director) stated we normally figure out the room/unit the resident will be transferred to and then we notify the POA/guardian/next of kin verbally by telephone before the transfer occurs and we also notify them in writing by giving them a form called Notification of Room Change form. V14 stated the Notification of Room Change form specifies the date the notification was given and the reason for the room change. V14 stated it is important that the facility notify the POA/guardian ahead of the move when a change is going to be made so that they are aware that their loved one is going to be moved.</p> <p>On 04/17/25 at 9:10 AM, V2 (Director of Nursing) stated a resident's POA/guardian or responsive party should be notified verbally prior to the transfer and written documentation can be provided later when the POA/guardian is in the building. V2 stated it is important that they are notified ahead of time so they know where their loved one will be located before they come to visit the resident, so they know where to find them. V2 stated this is a resident's right and they should be provided with an explanation of why the transfer will be happening. V2 stated notification should be documented somewhere in the EHR about the verbal notification to the resident's responsible party about the pending transfer. V2 stated all documentation should be done in the EHR, the facility does not keep paper records and therefore, if it is not in the EHR there is no proof that it was done.</p> <p>(continued on next page)</p>		

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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/17/25 at 12:59 PM, V1 (Administrator) stated for any resident getting transferred to a different room the POA/guardian should be notified before the transfer/change happens. V1 stated that is part of resident rights. V1 stated the notification can be done verbally in which case the conversation should be documented in the progress note section to prove that it happened. V1 stated if it is not documented in the resident's EHR there is no proof that it happened. V1 stated it was an oversight that R1's POA was not called ahead of time and V13 should not be backdating information in the progress notes. V1 stated it is his expectation that she (V13) enters the information in EHR when it occurs.</p> <p>R1's Notification of Room/Roommate Change form dated 04/07/25, 12:44 is blank for the section on notification for the name of the resident/resident's representative notified, date written notification provided and reason for change.</p> <p>Facility provided policy titled, Room Change/Transfer within Facility dated 01/2025 documents in part, to assure the resident and/or their representatives are appropriately notified of room transfers, when a resident is being moved to a new room at the request of the facility, the residents, family or resident representative shall receive an explanation in writing of why the move is required.</p> <p>Facility provided document titled, Illinois Long-Term Care Residents' Rights for People in Long-Term Care Facilities documents in part, you have the right to be told in advance and in writing if your room is being changed and you have the right to receive notice, including the reason for the change before your room or roommate in the facility is changed.</p>		