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	12/12/2025

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 0600 Level of Harm - Minimal harm or potential for 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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, facility failed to follow their policy to ensure residents are free from physical and verbal abuse by not providing necessary care, resulting in a staff worker being physically rough during activities of daily living (ADL) care and being verbally abusive to one resident (R1) out of three residents reviewed for abuse in a sample of four.Findings include:On 12/09/2025, surveyor observed R1, R2 and R3 share a room. On 12/09/2025 at 10:00 AM, surveyor observed R1 in his room. R1 stated that this past Saturday night a CNA comes into my room because apparently the light was on. She comes in and says, What is it that you want?. R1 replied saying, I don't like to be treated that way. The CNA then says, I don't have time to fool around with you. I have other patients to see. Are you going to be pushing that call button all night because I don't have time for you? R1 replies saying that the call button wasn't even near him and that he didn't push the call button. R1 stated that he told her to get the F*** out. The CNA then says, Don't be cursing at me. R1 stated that the CNA left and came with the nurse and the nurse says I shouldn't curse at the CNA. And as soon as the nurse left, the CNA says, B**** let me change you. R1 then states that the CNA grabbed him and pulled him. R1 stated that he told her to leave him alone. The CNA then says, What are you going to do now? R1 stated that the CNA grabbed his leg and threw it. R1 stated that the CNA began making sexual comments at him about having erectile dysfunction and how his dad should F*** his mom. R1 stated that he repeatedly kept asking her to leave. R1 stated that the CNA then began hitting his chest, stomach, arm because he wouldn't turn for her. She then grabbed his arm and turned him. R1 stated that he felt horrible at the incident. R1 stated that he called for help from his roommate and his roommate opened the curtain. R1 stated that as soon as he opened the curtain the CNA stopped and left. R1 stated that he doesn't know who that CNA or nurse was.On 12/09/2025 at 10:10 AM, surveyor observed R2 in his room. R2 was sitting on his wheelchair next to his bed. R2 stated that he witnessed V3 (Certified Nursing Assistant) being rough with R1. R2 stated that on the night of the incident between R1 and V3 (Certified Nursing Assistant), the curtain that separated his bed from R1's bed, was closed. So, the CNA didn't realize he was behind the curtain. R2 stated that he heard the CNA yell and curse at R1. R2 stated that R1 yelled his name when the CNA was being rough with him. R2 then looked over to see what was happening and he saw the CNA take R1's legs and throw it.On 12/09/2025 at 10:15 AM, surveyor observed R3 in his room. R3 was laying on his bed watching TV. R3 stated that he heard yelling between the resident and CNA, but he didn't see what was happening. R3 stated that he tries to stay out of it. R3 stated that both V3 and R1 was yelling back and forth. R3 stated that he has concerns of being abused by staff members. R3 stated that he gets water and drinks from the staff throughout the day.On 12/09/2025 at 12:23 PM, V1 (Administrator) stated that he is familiar with R1. V1 stated R1 reported that the CNA was rough during ADL care during 3:00 PM to 11:00 PM shift Saturday 12/06/2025. V1 stated that the CNA was V3 (Certified Nursing Assistant). V1 stated that R1 didn't report it to the nurse till later. V1 stated that R1 reported the incident to V5 (Licensed Practical Nurse) later in the night. V1 stated that V5 (Licensed Practical Nurse) then called him around 01:30 AM on 12/07/2025 to notify him of the incident. V1 stated that he spoke to R1 and R1 told him that the CNA was rude to him and rough during activities of daily living (ADL) care. During patient care, the CNA was rough moving his legs and body. V1 stated that he spoke to the R2. V1 stated that R2 told him that he heard their interaction, and when he opened the curtain, R2 saw the CNA moving R1's legs roughly. V1 stated that V3 is currently on suspension pending the investigation. V1 stated that he submitted the initial immediately has he found out of the incident. V1 stated that R1 has not made any abuse allegations in the past.On 12/10/2025 at 1:10 PM, V2 (Director of Nurse) stated that she is familiar with R1. V2 stated she is not familiar with the incident specifically but something along the lines that the CNA was rude and rough. But V1 had reported it. V2 stated the CNA was V3 (Certified Nursing Assistant). V2 stated that V3 (Certified Nursing Assistant) should have stopped care, notified the nurse. Let the nurse take over the situation, or if the nurse wanted to switch off the patients. There should have not been any arguing to begin with. No residents should be abused in this facility. V2 stated that she doesn't have any reason to believe R1 is lying about the situation. He has not made any abuse allegations in the past.On 12/10/2025 at 2:39 PM, V3 (Certified Nursing Assistant) stated that he is familiar with R1. V3 stated that she was R1's CNA on 12/6/2025 from 3:00 PM to 11:00 PM. V3 stated that she went in to change R1 and R1 was being disrespectful. V3 stated that she was called very horrible names. V3 stated that she let him disrespect her. V3 stated that the nurse stated to R1 that R1 was talking to her very disrespectfully. V3 stated that she did not yell back at the

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record reviews, facility failed to ensure activities of daily living (ADL) are provided for dependent residents by getting them out of bed for one (R1) out of three residents reviewed for ADL care in a sample of four. Findings include: On 12/09/2025 at 10:00 AM, surveyor observed R1 in his room. Surveyor did not see R1's wheelchair in his room or near his room. R1 was lying in bed still with his night gown on. R1 stated that he wants to get out of bed, but they won't put him in his wheelchair. R1 stated that he doesn't know where his wheelchair is.On 12/10/2025 at 10:30 AM, surveyor again observed R1 lying in bed with the same night gown on. R1 stated that he wants to get out of bed, but no one has gotten him up. R1's Minimum Data Sheet Section C (12/5/2025) documents in part: R1 has a Brief Interview of Mental Status (BIMS) score of 12. R1 is cognitively intact.On 12/10/2025 at 11:15 AM, V5 (Licensed Practical Nurse) stated that she is familiar with R1. V5 stated that R1 can get out of bed but he usually refuses to get out of bed.On 12/10/2025 at 11:58 AM, V7 (Restorative Nurse) stated that she is familiar with R1. V7 stated that R1 has poor trunk control. V7 stated that R1 has weakness on one side so he has a Geri chair. V7 stated that R1 does have a Geri chair, and it was in a storage room near his room. They are getting him up right now. V7 stated that all residents should be getting up unless they refuse. V7 stated that any care or order that they carry out they are expected to document it in the residents' plan of care.On 12/10/2025 at 12:10 PM, V9 (Assistant Director of Nurse) stated that she is familiar with R1. V9 stated that the expectation is to get up the residents. But the residents have right to say no. The CNA will notify the nurse and social worker if the resident refuses to get up out of bed. V9 stated that the nurse will do education on importance of getting up out of bed so they don't develop wounds. Any time a resident refuse to get up out of bed, there is supposed to be documentation of resident's decision and education provided. V9 stated that R1 usually refuses getting out of bed.On 12/10/2025 at 1:10 PM, V2 (Director of Nurse) stated that she is familiar with R1. V2 stated that the expectation is to get up all the residents out of bed. V2 stated that the residents have right to say no. V2 stated that when a resident refuses to get up then the CNA will notify the nurse and social worker, and they will do education on importance of getting up out of bed, so they don't develop wounds. Any time a resident refuse to get up out of bed, there is supposed to be documentation of resident's decision and education provided.Reviewed R1's progress notes from 12/05/2025 to 12/09/2025. No documentation of resident refusal or education on the importance of getting out of bed, provided.Reviewed R1's Bed Transfer care POC from 11/12/2025 to 12/11/2025. No documentation of refusal for getting out of bed, on 11/16/2025, 11/18/2025, 11/26/2026, 11/27/2025, 11/29/2025, 11/30/2025, 12/2/2025, 12/3/2025, 12/4/2025, 12/7/2025, 12/8/2025, 12/9/2025 and 12/10/2025.Facility did not provide any policies specific to the importance of getting residents out of bed.

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F 0689 Level of Harm - 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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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, facility failed to follow their policy to ensure residents are free from accidents and hazards by planning for preventative strategies and facilitate as safe as an environment as possible for one (R4) out of three residents reviewed accidents and hazards in a sample of four. This failure resulted in R1 sustaining an acute subdural hematoma to the left frontotemporal region of her head.Finding include:R4's Minimum Data Sheet Section C (12/8/2025) documents in part: R4 has a Brief Interview of Mental Status (BIMS) of 10. R4 is mildly cognitively intact.R4's Facesheet documents in part: R4 has a medical diagnosis of cerebrovascular disease, delirium due to known physiological condition, difficulty in walking and unspecified lack of coordination.Per R4's Facesheet R4 was admitted to facility on 11/6/2025.R4's fall risk assessment on 11/7/2025 documents in part: R4 scored a fall risk assessment of 23. 10 or above is high fall risk.On 12/11/2025 at 11:16 AM, V11 (Falls Coordinator/Licensed Practical Nurse) stated that she is familiar R4. Fall risk assessments are quarterly and post fall. V11 stated that the initial assessment is completed upon admission. If they score above 10, they are a high fall risk, and if they are below a 10, then we put standard fall precautions in place. V11 stated that R4 did not fall on 12/8/2025 but instead had a seizure overnight.On 12/11/2025 at 11:18 AM, V7 (Restorative Nurse) stated that R4 was a high fall risk. High fall risk interventions include floor mats in place, increased rounding, high staff supervised area such as dining room during activities because the expectation is to monitor them frequently. V7 stated that herself and V11 investigate all falls that take place. V7 stated that R4 fell on [DATE]. V7 stated that V7 was found sitting in front of her wheelchair in her bedroom. V7 stated that the incident happened at noon. V7 stated that activities go on during the day. This was an unwitnessed fall. V7 stated that R4's nurse on 11/29/2025 was V16 (Licensed Practical Nurse). We redirected her to use her wheelchair. She was a high fall risk upon admission. V7 stated that R4 went out on the 11/29 and came on the 12/6. She was added to the fall star program which was the added intervention after R4 came back to the facility. V7 stated that R4 did not fall on 12/8/2025, but instead had a seizure where she slouched in her wheelchair.On 12/11/2025 at 12:59 PM, V14 (Licensed Practical Nurse) stated that she is familiar with R4. V14 stated that she was R4's nurse the night she was sent out on 12/8/2025. V14 stated that she doesn't remember R4 having floor mats or seizure preventative bed bolsters. On 12/8/2025 around 9:30 PM, R4 had a seizure in the cafeteria. She was in the wheelchair when she had the seizure. She fell into her chair. The CNA told her that R4 was slumped over in her chair. R4 stayed in the wheelchair. We took her out of her chair and moved her into the Geri chair so she doesn't keep slumping over. V14 stated that she notified the doctor about R4's uncontrolled tremors. V14 stated that the doctors were suspecting seizures, so they told her to just monitor R4 through the night. Her vitals were normal.On 12/11/2025 at 2:00 PM, V2 (Director of Nursing) stated that she is familiar R4. V2 stated that on 11/29/2025, R4 did not fall in her room but instead fell in the dining room during lunch hours. V2 stated that R4 was being monitored by a CNA but that CNA was asked to help feed a resident. As she went to feed another resident, she took her eyes off R4 and in that moment R4 had fallen. V2 stated that V16 was R4's nurse that day R4 had fallen. V2 stated that as that CNA went to feed that other resident, another staff member or the nurse should have monitored R4 in the dining room. The nurse was at her medication cart in the hallway.On 12/12/2025 at 12:25 PM, V17 (Certified Nursing Assistant) stated that she was not R4's CNA on 11/29/2025 when fell in the dining room. V17 stated that she was in the dining room cutting up another resident's food. V17 stated that it was her assigned task that day to monitor the residents in the dining room. V17 stated that as she was cutting up another resident's food, she heard another resident say R4 is standing up. V17 stated that she was the only staff in the dining room at that time. V17 stated that by the time she got to R4, she had already fallen.On 12/12/2025 at 12:28 PM, V18 (Nurse Practitioner) stated that she was R4's nurse practitioner. V18 stated that she had already left the facility when R4 had fallen. V18 stated that she was notified of the fall after she left. V18 stated that she did not see R4 when she was readmitted in the facility. V18 stated R4 came back with hospital records. V18 stated that from R4's hospital record, it looks like R4 had an acute subdural hematoma overlying left frontotemporal region. V18 stated that it looks like they ordered a repeat Computed Tomography (CT) scan of the head, and they usually do that when they see something small. V18 stated that the hospital did document that it was acute subdural hematoma, but she is not hundred percent sure that it resulted from the fall. V18 stated that signs and symptoms of subdural hematoma can be change in mental status, not responding physical or verbal stimuli