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	04/10/2026

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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility a.) failed to provide a proper transfer for a dependent resident that required a two person assist with a mechanical lift, b.) failed to communicate a resident's mode of transfer to a new employee and c.) failed to educate a staff of how to properly transfer a resident. This failure resulted in one (R4) resident sustaining an impacted transverse fracture of the right humeral neck and the greater tuberosity during the resident transfer from the wheelchair to the bed.Findings Include:R4 was admitted to the facility on [DATE] with diagnosis not limited to Dementia, Anxiety Disorder, Peripheral Vascular Disease, Gastrostomy, Hyperlipidemia, Major Depressive Disorder, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Need for Assistance with Personal Care, Reduced Mobility, Disorder of Brain and Unspecified Displaced Fracture of Surgical Neck of Right Humerus, Initial Encounter for Closed Fracture. R4's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 09 indicating moderate impairment. Section GG Functional Abilities: Mobility Devices: Wheelchair, Chair/bed-to-chair transfer: Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. or, the assistance of 2 or more helpers is required for the resident to complete the activity.R4's Care Plan document in part: Focus: R4 is at risk for alteration in Comfort. 03/12/26 readmitted to facility with right humerus fracture. Focus: R4 has history of Cerebral Vascular Accident (Stroke). Focus: ADL (Activities of Daily Living): R4 requires assistance with daily care needs r/t (Related to) Right side hemiplegia/hemiparesis and COPD (Chronic Obstructive Pulmonary Disease). Interventions: Mechanical lift with two assists for transfers. Date Initiated: 01/04/25. Focus: FALL: R4 is at high risk for falls r/t generalized weakness and left side hemi. Date Initiated: 01/14/26. Interventions: Currently uses manual wheelchair for mobility needs. Mechanical lift with two assists for transfers. Date Initiated: 01/14/26. Focus: Potential for falls, R4 at HIGH risk for injury from falls. Date Initiated: 01/16/26. Focus: SKILLED/ADL: R4 has a Self-care deficit r/t Hemiparesis, hemiplegia and CHF (Congestive heart failure). Interventions: Use mechanical lift for all surface-to-surface transfers.R4's Physician order document in part: Order: Right Humerus, 2+ Views / Right Elbow, 2 Views / Right Shoulder, Complete, 2+ Views / Right Wrist, 2 Views / Right Forearm, 2 Views / Right Hand, 2 Views Completed Imaging X-Ray 03/11/26 00:00. 1. Non weight bearing to right arm, use of sling for comfort. 2. Non weight bearing right upper extremity shoulder immobilizer for comfort. 3. Elevate and ice right upper arm extremity. Every shift for comfort measures.Radiology Results Report dated 03/11/26 document in part: Right Humerus, 2+ Views / Right Elbow, 2 Views / Right Shoulder, Complete, 2+ Views / Right Wrist, 2 Views / Right Forearm, 2 Views / Right Hand, 2 Views. Right Humerus 2+ Views. Clinical information: Pain. Findings: Right Humerus examination reveals impacted transverse fracture of the humeral neck and the greater tuberosity. Impression Right Humerus: Fracture of the humeral neck and greater tuberosity. Findings: Right Elbow: Examination reveals mild soft swelling. Findings: Right Shoulder examination reveals slightly impacted transverse fracture of the humeral neck and the greater tuberosity. Findings Right Wrist examination reveals soft tissue swelling. Findings: Right Forearm examination reveals mild soft tissue swelling. Findings: Right Hand examination reveals mild soft tissue swelling.Progress note dated 03/10/26 22:00 (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 0677 Level of Harm - Actual harm Residents Affected - Few	medical records it was determined that during transfer, R4 grabbed the quarter rail. Xray showed slightly non-displaced fracture of the humerus.On 04/07/26 at 12:53 PM V10 (R4's Family Member) stated on 03/10/26 R4 complained to the nurse that her arm was hurting severely. R4's arm was broken, and they wanted to send R4 to the hospital. No one knew what happened. They said R4 fell out the bed but R4 was immobile. After I did some further investigations myself, I found out that it was poor transfer and they handled R4 incorrectly. They were doing the investigation but would never tell me who it was. R4 said no one dropped her and she did not fall out of the bed. R4 is very verbal and direct. I found out that R4 was mishandled when I met with, V35 (3rd floor Unit Manager) and V1 (Administrator).On 04/07/26 at 11:55 AM V8 (Restorative Director) stated R4 has had falls in the facility but none recently with injuries. R4's last fall according to risk management was 12/19/24. The injury of unknown origin, briefly R4 had a fracture but it was not due to a fall. R4 is max assistance and 2-person assistance for all transfers. R4 follows verbal commands, has a gastric tube, a history of Cardiovascular Accident, non-ambulatory and on oxygen.On 04/08/26 at 12:28 PM Per telephone interview V38 (Certified Nurse Assistant/Activity Aide) stated On 03/09/26 R4 was not in any pain and did not say anything was wrong with her. R4 is transferred using the mechanical lift with 2 persons assistance. You can find the transfer status in Point Click Care, log in and go under Kardex or you can ask restorative.On 04/08/26 at 01:11 PM V13 (Licensed Practical Nurse) stated I worked on 03/09/26 and R4 had no complaints of pain. R4 is a total assist and has a gastric tube. R4 is probably transferred using a mechanical lift but I am not 100% sure.On 04/08/26 at 11:54 AM Per telephone interview V39 (Certified Nurse Assistant) stated R4 is transferred using the mechanical lift with 2 or more assists. I was there that morning on 03/10/26 and R4 did not complain of pain. We got R4 up in the wheelchair using the mechanical lift. R4 is verbal, will make her needs known and will let you know if she is in any pain.On 04/07/26 at 03:38 PM V26 (Certified Nurse Assistant) stated I have worked here for 1 month. I don't have a permanent floor, but I mainly work on the third and sometimes on the second floor. I know R4 but I was not assigned to her. I put R4 in bed using my gait belt. It was about 1:45 PM and R4 was in the hallway. It was one of the female nurses that ask me to put R4 in bed because R4 had been up all day and was tired. R4 was in a wheelchair, and I took her into the room, put my gait belt around her and proceeded to stand and pivot. R4 grabbed on the bedrail, let it go then grabbed me and I sat R4 on the bed. When I was about to exit the room, R4 said my arm hurt. I went and notified the female nurse. The nurse said okay, I will go and assess her. The nurse did not tell me how the resident was supposed to be transferred. That was my first or second day on the floor. I was not aware that R4 was a 2 person assist with a mechanical lift. I was aware R4 was injured when they started investigating.On 04/07/26 at 03:19 PM V25 (Registered Nurse) stated I am one of the nurses that take care of R4. R4 has a gastric tube, wheelchair bound, needs staff assistance for transfers, alert and oriented x2. I am not sure how R4 is transferred but I know R4 needs staff assistance for transfers. On 03/10/26 when I came on the shift doing rounds and passing medications R4 complained of pain to her arm, and I gave her pain medication. I believe it was the right arm. R4 was in bed when I initially saw her. Subsequently, when I was passing medication that night R4 complained of more pain. The doctor ordered an Xray, so I called for a Stat Xray and endorsed it to the oncoming nurse.On 04/08/26 at 04:17 PM Per telephone interview V49 (Registered Nurse) stated I received during report R4 complained of right arm pain. The previous nurse ordered an Xray and asked me to look for the results. I received the report and received an order to send R4 to the hospital for evaluation. R4 never complained of pain to her arm before that day. I received the in-service about transfers in February. Sometimes there are things that I miss out on because I am part time. When we attend an in-service, we have to sign a sheet to verify we attended and do a return demonstration.On 04/08/26 at 12:06 PM Per telephone interview V42 (Certified Nurse Assistant) stated R4 is a 2-person assist with a mechanical lift and would be considered a total. R4 did not complain of pain prior to her injury to her right arm.On 04/08/26 at 10:50 AM Per telephone interview V18 (Former Director of Nursing) stated V25 (Registered Nurse) called me and said R4 was (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	having pain. V25 gave R4 pain medication and R4 was still complaining. V25 called telehealth and they ordered a different pain medication and to get an Xray. The Xray came back with the impression of a fracture. The nurse called the doctor and was given an order to send R4 out for evaluation. During the investigation V29 (Licensed Practical Nurse) asked V26 (Certified Nurse Assistant) to put R4 in bed. V26 used the gait belt when transferring R4 to bed, R4 grabbed the side rail, V26 sat R4 on the bed then got R4 the rest of the way in bed. After V26 placed the rest of R4's body in bed R4 complained of pain to the arm. I don't remember which arm. V26 made R4 comfortable and said that he went and told the nurse. When I was doing the investigation V29 (Licensed Practical Nurse) said she did not know anything about R4's pain. The only person that called me about R4's pain was V25 (Registered Nurse). V26 said he told the nurse but didn't remember her name. R4 was supposed to be transferred using the mechanical lift with 2-person assistance and R4 was not properly transferred from the wheelchair to the bed. When not using the right device to transfer a resident there is a potential for injury.On 04/08/26 at 09:40 AM V29 (Licensed Practical Nurse) stated I was told the next day about R4 going out for her right arm due to the Xray that she had for a fracture to the right upper humerus. When R4 came back from the hospital R4 had a sling to be applied when out of bed and an ice pack was applied to the shoulder. R4 is alert and oriented x1 to name.On 04/08/26 at 10:37 AM V35 (3rd floor Unit Manager) stated R4 was complaining of pain and discomfort to her arm. The nurse got an Xray, received the results and R4 went to the hospital. R4 returned to the facility with a sling and ice. R4 is a mechanical lift with 2 people assist. The protocol for knowing how to properly transfer the residents is by looking at the Kardex under task or the staff should ask the nurse how to transfer the resident. If the resident is improperly transferred it can potentially cause an injury.On 04/08/26 at 04:05 PM Per telephone interview V47 (Nurse Practitioner/Physical Therapy) stated I know R4, she was referred to therapy. In my professional opinion if a resident is transferred using improper transfer techniques, there is a potential for injury. If the proper transfer techniques were used the injury could have been avoided. On 04/08/26 at 12:23 PM V1 (Administrator) stated we identified there was an issue with the resident transfer. We did the reeducation of the staff, the monitoring of the residents and we did an in-service. The PNC (Past Noncompliance) we identified with the staff, and we did a QA (Quality Assurance) form to make sure it does not happen again. The staff go to the Kardex to see what type of care needs to be provided for the residents. The failure that was recognized, the transfers of using a mechanical lift. During the investigation the root cause of the resident we noted transfer technique was the failure and the completion date was 03/13/26. The incident happened on 03/10/26 and we did competencies for the sit to stand and mechanical lift. Restorative did the in-services. When we were doing the investigation we noted R4's transfer was improper.On 04/08/26 at 01:20 PM V8 (Restorative Director) stated I did not see R4's report. I had to do the in-service about how to properly transfer, stand pivot, gait belt use and mechanical lift. We do a return demonstration.On 04/08/26 at 01:34 PM V1 (Administrator) stated all of the certified nurse assistants and nurses were in-serviced on proper transfers. On 04/08/26 at 02:11 PM V1 (Administrator) stated all staff should have been in-serviced. R4's Initial document request was emailed to V1 (Administrator) on 04/07/26 at 12:20 PM. The second request for R4's documents was emailed to V1 on 04/07/26 at 02:36 PM requesting R4's progress notes dated 03/10/26-03/12/26 and entire incident reportable dated 03/10/26 with interviews. On 04/08/26 at 02:54 PM surveyor asked V1 (Administrator) why she just presented the past noncompliance. V1 responded, yesterday was the first day of the survey and all the questioning that we were getting interviewed on that. We did recognize the issue and started working on it. On the first day of the survey, we are trying to figure out the complaint. Does it make a difference, we did our in-services and our QA (Quality Assurance) forms that are still ongoing. The completion date is 03/13/26 ongoing with in-services and QA. Surveyor asked V1 how the transfer status policy includes the certified nurse assistants. V1 responded, this is more or less the transfer of the residents. It is common sense despite, if the transfer status policy does not state it there. On orientation and orientation on the floor my staff are (continued on next page)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide a safe environment for one [R3] of five [R7, R9, R10, R11] residents reviewed for falls. This failure resulted in R1 falling from the bed, sustaining an open area to back of head, bleeding, sent to emergency department via 911 and was admitted to the hospital diagnosed with a blunt head trauma. Findings include, R3's clinical record indicates in part: R3 was admitted on [DATE] and discharged to the hospital on 1/29/26 and did not return. R3's medical diagnosis of encephalopathy, unsteadiness on feet, dysarthria asthma, glaucoma, urinary tract infection, acidosis, anxiety, age related cataract, psoriasis, bilateral osteoarthritis, spinal stenosis, and acute cystitis. R3's minimum data set [MDS] dated 1/11/26, section [GG] indicates the following in part: R3 has impaired upper extremity range of motion. R3 requires full/extensive assistance from staff for ADL care, toileting, bed mobility, dressing and eating. MDS section [C] indicates R3 is severely cognitive impaired. R3's Hospital Emergency Department Document dated: 1/29/26-R3 Admitting diagnosis: Blunt Head Trauma; Fall from bed.Blut head trauma following fall from bed. R3's admission Fall Risk assessment dated [DATE] document in part:R3 is a high fall risk due to decrease in mobility and R3 was noted confused. R3's Care plan indicates in part:R3 requires assistance with daily care needs related to generalized weakness. Staff will anticipate and meet all of R3's needs on a daily basis through next review such as clean, dry, grooming, turning and repositioning R3. R3's Progress Notes in part:1/29/2026 7:00 PM Medical Practitioner Note [V20]Post fall assessment, ER transferR3 was seen as a nursing request for a post fall assessment. Per the nurse, she had the patient falling out of bed with CNA in attendance. Upon assessment, the patient was noted with frank bleeding from the back of her head. The patient is alert and oriented x 1. 1/29/2026 10:19 PM V33 [Licensed Practical Nurse]Nursing observations, evaluations, and recommendations are: The resident [R3] rolled out of the bed during care and sustained an open area at the back of her head.Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: Transfer the resident [R3] to the nearest hospital via 911. 1/30/2026 5:13 AM, NursingNote: Hospital called in concern of resident. Spoke with E.R. representative who informed the writer that R3 is still awaiting a bed and will be admitted with Blood head trauma and fall from bed. On 4/6/26 at 4:00 PM, V5 [R3's Family Member] stated, On 1/29/26 at 9:36PM, I received a phone call from the facility's nurse. The nurse told me while R3 was being changed, R3 was turned and kept rolling off the bed and R3 was bleeding from the back of her head. Nurse said R3 was sent to the hospital emergency room for further assessment. Later, I received a phone call from the hospital emergency department, and I was told R3 was being admitted from the nursing home. R3 had fallen from the bed and sustained a head injury but did not require sutures. I requested for R3 not to return back to that nursing facility. At the time R3 fell, her hair was braided to the scalp. Later at the new nursing facility R3 braids were taken down and there were two open areas draining with pus, oozing out of her scalp. The new nursing facility failed to keep R3's head wounds clean. Later, 2/18/26, R3 passed away. On 4/10/26 at 9:55 AM, V32 [Certified Nurse Assistant] stated, I have been a certified nurse assistant for eighteen years. I have been working at this facility for over a year. I have been assigned to R3 often. R3 is confused and needs total assistance. R3 was resting on air mattress due to her wound. R3 did not have side rails. R3 was a one person assist. I was providing incontinent care on R3. I rolled R3 to her other side to clean her up, when she kept rolling off the mattress on other side of the bed fell onto the floor. I ran around the bed, and R3 was alert, bleeding from the back of her head. I called the nurse. The nurse applied pressure to the bleeding and called 911. The bed was steady and there was no problem with the mattress. I rolled R3 to her other side, away from me, but she kept rolling so fast and fell off the bed before I could reach her. I knew I should have rolled R3 towards me, but it would have been hard to clean up all the feces. I (continued on next page)

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	04/10/2026

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

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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	should have got another staff member to assist me. A resident has never rolled off the bed with me during incontinent care. On 4/8/26 at 10:18 AM, V33 [Licensed Practical Nurse] stated, I was in the room caring for R3's roommate when I heard R3 hit the floor. I turned around and saw V32, ran to the other side of the bed and I saw R3 on the floor. V32 said she turned R3 to clean her, and she kept rolling off the bed. R3 was bleeding from the back of her head, I applied pressure and called 911. I could not see exactly the wound or opening because R3 had braids. R3 was admitted to the hospital due to her fall. On 4/7/26 at 2:20PM, V9 [Restorative Nurse] stated, R3 requires max assistance with ADL care and bed mobility. R3 was here for about three weeks and had a decline in her mobility. R3 lost her upper body strength. R3 fell on 1/29/26, during second shift. V32 [Certified Nurse Assistant] was providing incontinent care, when V32 turned R3 to the other side away from her [V32] when R3 kept rolling and fell off the air mattress. V32 received education on turning and repositioning during incontinent care. Nursing staff know to aways turn the resident towards them to prevent the resident from falling off the bed. 4/8/26 at 9:50 AM, V3 [Director of Nursing] stated, I just started working here two weeks ago. I am not aware of R3's fall incident. Generally speaking, while one nursing staff member is providing incontinent care, staff members should always roll the residents toward them not away from them. If the staff member rolls the resident away from them, it could potentially cause the resident to roll off the bed. On 4/7/26 at 3:00 PM, V1 [Administrator] stated, I was not the administrator in January 2026. However, the facility policy and regulations read we only have to report an incident if the resident requires sutures or staples. No, there was no IDPH report completed related to R3's fall dated 1/29/26. Policy in part:Fall Prevention and Management dated 7/2025.This facility is committed to maximizing each resident's physical, mental, and psychosocial well-being. The facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible.