

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/28/2024
NAME OF PROVIDER OR SUPPLIER Aliya of Evanston		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Oak Avenue Evanston, IL 60201	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22499</p> <p>Based on interview and record review the facility failed to thoroughly investigate an allegation of sexual abuse for 1 of 5 residents (R1) reviewed for abuse in the sample of 5.</p> <p>The findings include:</p> <p>The facility abuse allegation dated 11/8/24 states, Around 8:30 AM Administrator received call from nurse that resident reported CNA (V4) hit him in the shoulder- full body assessment completed, no bruising noted, investigation started</p> <p>Final: After interviewing staff and residents abuse cannot be substantiated because there was no evidence observed by nurse that CNA hit resident. Resident is mildly confused and is a poor historian.</p> <p>On 12/27/24 at 9:50AM, R1 stated, (V4- CNA) told me he was a boxer and he kept like fake swinging at me. I reported it several times and no one would listen. Then I got transferred over here from (Facility with the same name, different city location) and about a month later he got transferred over here too. That night (11/8/24) he threw a couple of cross punches at me and he hit me on the arm. (Surveyor asked R1 why V4 hit him) He hit me on the arm, you know like guys do. Then that same night he was changing me and he was fondling my balls and started hitting my penis back and forth. I told him to stop. I heard he got fired. I heard they had a meeting with him and then they fired him- I haven't seen him since. (Asked R1 to describe V4) He is Indian, medium build, good physique. R1 stated he had no issues with anyone else.</p> <p>R1's Face Sheet shows he was admitted to the facility on [DATE] with diagnoses including Bipolar and Dementia.</p> <p>On 12/27/24 at 2:45 PM V4 (CNA) stated, I used to care for him when he was on the first floor. Then I went on vacation for a month. One the first floor, we had a routine. We would transfer him with the (Mechanical Lift) and he was always trying to get out of the bed or the chair. One time I had to grab him to keep him from falling on the floor and he said I grabbed him too tight. He asked me if I was a boxer. Then when he moved to the second floor he saw me and he said he recognized me and said that I am a boxer. I told him I am not a boxer. That night about 6:30 AM I changed his diaper and he was dirty, everything was fine. Then I got a call and they said (R1) said that I touched his penis. That was in November. I have not talked to (V1- Administrator) today. He said I punched him on the shoulder and I touched his penis. I had to stay home for a week and then they said I could come back but I do not work with (R1) anymore. I have never been accused of abuse before.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 12/27/24 at 11:10 AM V1 (Administrator) stated, It was a Friday morning and the nurse called me about 8:30 AM and told me that (R1) had reported to her that (V4) had punched him. He said it happened about 6:30 AM and his shift ended at 7:00 AM so he was not in the facility. I spoke to (V4), he told me he did provide care about 6:30 AM but said he didn't hit (R1). I spoke to (R1) and he told me that (V4) had punched him on the shoulder. I asked him why and he said he just hit me and then he left. I reported it to my boss, (V3- Regional Director of Operations) and I sent the initial report to (State Department). I had the nurse do a skin check and look for physical signs of abuse. (R1) said that (V4) hit him pretty hard so I would think there would be some redness or bruising but the nurse didn't see anything. (V4) said- I didn't hit him. I suspended (V4) right away while we did the investigation. I interviewed other residents and no one had any complaints about (V4) or about abuse in the facility. (V4) still works here I just don't have him work on the same floor as (R1). We did not substantiate the abuse- there was no evidence of abuse and no pattern and no one saw anything. At 12:00PM V1 stated, I don't believe (V4) and (R1) were together in another facility. There is no (Facility with the same name in the city mentioned), It does not exist. (V4) mentioned that he did change (R1) but (R1) never said anything about him touching is penis. This is the first I am hearing about that.</p> <p>The facility Incident Report of 12/27/24 states, Around 11:45 AM on 12/27/24 surveyor mentioned to me that (R1) reported that (V4) had played with his genitals on 11/8/2024. Surveyor said resident described employee as Indian, and that CNA followed resident from (Facility with the same name in another city). (Facility with the same name in the city mentioned) does not exist.</p> <p>The facility policy entitled Abuse Policy and Prevention Program dated 10/2022 states, Internal Investigation: 1. All incidents will be documented, whether or not abuse , neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected.</p> <p>2. Any Incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation.</p>		