STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146058	A. Building B. Wing	03/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Evanston	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41925 Based on interview and record review, the facility failed to ensure resident (R3) was free of abuse from (R2). This failure affected two of two (R2, R3) residents reviewed for abuse causing emotional distress. Findings include: According to the Electronic Health Record (EHR) R3 had diagnoses including osteoarthritis of knee, type 2 diabetes mellitus, morbid obesity, hyperlipidemia, sleep apnea, and long-term use of hypoglycemic agents. The Minimum Data Set (MDS) dated [DATE] showed R3's cognition was intact. On 3/28/2025 at 10:27 AM, R3 stated that sometime in the morning of February 26, 2025, while he was standing by the microwave in the dining room, R2 rolled in his wheelchair right past him so R3 started to move to the side to give way when R2 stated Don't move, it's not something I would have done to you Master. I was just reversing roles. R3 responded saying You mean, I'm supposed to be your slave? R3 stated that R2 alluded to him as a slave. R3 stated he was very upset and distraught about the incident so he went downstairs to the receptionist and was telling the receptionist what happened, and that the receptionist said that V2, Former Administrator, was not in the building yet but that she would inform him as soon as V2 arrives. On 3/28/2025 at 4:14 PM, V5, (Receptionist), confirmed that R3 had reported the incident to her on the same day. V5 stated that upon hearing R3's complaint, she immediately informed V2, (Former Administrator), when he arrived. V5 recalled that V2 assured her that he would speak with both R3 and R2 and address the issue. A progress note by V7, (Registered Nurse), dated 2/26/2025, indicated that R2 had been referred for an inpatient psychiatric evaluation due to escalating non-compliant behaviors and episodes of aggression. The note specifically mentioned that R2 had been vocalizing racial slurs and insults towards other residents, creating a significant safety concern. V7 also documented that R2 had verbalized self-harm and instigated altercations with other residents. The behavior was reported as alarming and required immediate assessment for inpatient psychiatric evaluation. (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	On 3/28/2025 at 1:05 PM, V2, (Former Administrator), acknowledged that he had not been made aware of the allegations regarding R2's comments to R3. V2 stated that, had he known about the incident, it would have been treated as an abuse allegation, and an investigation would have been initiated immediately. However, no formal investigation or report regarding this specific incident was provided by the facility. On 3/28/2025 at 2:28 PM, V7, (Registered Nurse), explained that although she did not witness the altercation between R2 and R3, she had observed R2 vocalizing racial slurs towards other residents and staff members. V7 noted that R2 had a preference for being cared for by specific ethnicities and would make derogatory remarks regarding other ethnicities. V7 stated that she took these comments seriously and that's why team decided to have him referred to in patient psychiatric care. On 3/28/2025 at 4:24 PM, V1, (Administrator), confirmed that no formal report or investigation had been initiated regarding the incident involving R3 and R2. V1 stated that had the incident been reported to her, she would have ensured that an investigation was conducted and appropriate action was taken. R2's history of aggression, including vocalizing racial slurs and engaging in other disruptive behaviors, was well-documented, yet no preventive measures or immediate interventions were put in place to protect R3 or other residents from harm. While the receptionist (V5) reported the incident to the former Administrator (V2), there is no clear documentation that the incident was reported and investigated and effectively addressed, nor was the current Administrator (V1) aware of the incident until after the fact. An undated facility Abuse Policy and Prevention Program policy documents in part: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. VII. 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. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41925 Based on interview and record review, the facility failed to report an allegation of abuse to the State Survey Agency. This failure affected one (R3) of one resident reviewed for Abuse. Findings include: According to the Electronic Health Record (EHR) R3 had diagnoses including osteoarthritis of knee, type 2 diabetes mellitus, morbid obesity, hyperlipidemia, sleep apnea, and long-term use of hypoglycemic agents. The Minimum Data Set (MDS) dated [DATE] showed R3's cognition was intact. On 3/28/2025 at 10:27 AM, R3 stated that sometime in the morning of February 26, 2025, while he was standing by the microwave in the dining room, R2 rolled in his wheelchair right past him so R3 started to move to the side to give way when R2 stated Don't move, it's not something I would have done to you Master. I was just reversing roles. R3 responded saying You mean, I'm supposed to be your slave? R3 stated that R2 alluded to him as a slave. R3 stated he was very upset and distraught about the incident so he went downstairs to the receptionist and was telling the receptionist what happened, and that the receptionist said that V2, Former Administrator, was not in the building yet but that she would inform him as soon as V2 arrives. On 3/28/2025 at 4:14 PM, V5, Receptionist, confirmed that R3 had reported the incident to her on the same day. V5 stated that upon hearing R3's complaint, she immediately informed V2, Former Administrator, when he arrived. V5 recalled that V2 assured her that he would speak with both R3 and R2 and address the issue. On 3/28/2025 at 1:05 PM, V2, Former Administrator, stated that he had not been made aware of the allegations regarding R2's comments to R3. V2 stated that, had he known about the incident, it would have been treated as an abuse allegation, and an investigation would have been initiated immediately. No formal investigation or report regarding this specific incident was provided by the facility. On 3/28/2025 at 4:24 PM, V1, Administrator, confirmed that no formal report or investigation had been initiated regarding the incident involving R3 and R2. V1 stated that had the incident been reported to her, she would have ensured that an investigation was conducted and appropriate action was taken. An undated facility Abuse Policy and Prevention Program policy documents in part: Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours after the allegation Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours after the allegation

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41925 Based on interview and record review, the facility failed to investigate an allegation of abuse. This failure affected one (R3) of one resident reviewed for abuse. Findings include: According to the Electronic Health Record (EHR) R3 had diagnoses including osteoarthritis of knee, type 2 diabetes mellitus, morbid obesity, hyperlipidemia, sleep apnea, and long-term use of hypoglycemic agents. The Minimum Data Set (MDS) dated [DATE] showed R3's cognition was intact. On 3/28/2025 at 10:27 AM, R3 stated that sometime in the morning of February 26, 2025, while he was standing by the microwave in the dining room, R2 rolled in his wheelchair right past him so R3 started to move to the side to give way when R2 stated Don't move, it's not something I would have done to you Master. I was just reversing roles. R3 responded saying You mean, I'm supposed to be your slave? R3 stated that R2 alluded to him as a slave. R3 stated he was very upset and distraught about the incident so he went downstairs to the receptionist and was telling the receptionist what happened, and that the receptionist said that V2, former Administrator, was not in the building yet but that she would inform him as soon as V2 arrives. On 3/28/2025 at 4:14 PM, V5, Receptionist, confirmed that R3 had reported the incident to her on the same day. V5 stated that upon hearing R3's complaint, she immediately informed V2, Former Administrator, when he arrived. V5 recalled that V2 assured her that he would speak with both R3 and R2 and address the issue. On 3/28/2025 at 1:05 PM, V2, Former Administrator, stated that he had not been made aware of the allegations regarding R2's comments to R3. V2 stated that, had he known about the incident, it would have been treated as an abuse allegation, and an investigation would have been initiated immediately. On 3/28/2025 at 4:24 PM, V1, Administrator, confirmed that no formal report or investigation had been initiated regarding the incident involving R3 and R2. V1 stated that had the incident been reported to her, she would have ensured that an investigation was conducted and appropriate action was taken. No formal investigation or report regarding this specific incident was provided by the facility. An undated facility Abuse Policy and Prevention Program policy documents in part: VII. 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. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation.