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	05/07/2025

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41156 Based on interview and record review the facility failed to follow discharges policy and change in resident condition policy by not informing the resident in advance of planned hospital transfer (Involuntary Petition), failed to obtain a physicians order for a transfer and failed to document the transfer in the medical record. This failure affects one resident (R1) of three residents reviewed for resident rights. Finding Include: R1 was admitted in the facility on 10/30/24. A [AGE] year old male resident with a BIMS of 15/15. R1 has diagnoses of but not limited to osteoarthritis of Right hip, Type 2 Diabetes, Morbid obesity, and Nicotine Dependence. R1 has a BIMS of 15 (Intact Cognition). On 5/6/25 at 11:32AM, R1 reported that he was sent out last April at 3:30AM, R1 stated he was sound asleep in his room when this night nurse woke him up and said he is going to the hospital. He refused to go because no one told him why he was being transferred to a hospital. R1 reported calling 911 because he wanted the police to get involve and have everything on the record. The police came and explained to him that he is being transferred for a psych evaluation and that R1 can return. R1 changed his mind and ended up going to the hospital. And stated that there was nothing wrong with him and that he was sent right back to the facility. Nursing Progress Note dated 4/13/25 at 3:29AM reads in part: EMS arrived at 2:49am and proceeded to R1's room. They tried convincing R1 to go with them for which R1 blatantly refused. R1 himself went ahead and called 911 and stated that R1 is about to be taken out against R1's own will. The cops called the nurse's station and writer explained the situation to them. They asked if they could come over to help move him out, writer responded in the affirmative. The cops arrived at 3:20am and told R1 that he will have to be restrained if he did not comply. After much talking and convincing, he eventually dressed up and left at 4am this morning. On 5/6/25 at 1PM V1 stated that she received a call on Saturday (4/12/25) afternoon from her Manager on duty and V6 (Receptionist) stating that R1 was verbally aggressive towards other residents in the dining area. V1 stated we followed our protocol, investigated and reported the incident to IDPH (Illinois of Department Health). The Nurse and the Social worker informed the resident, it's just that they forgot to document. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 3:45PM V6 (Receptionist) stated that the restorative nurse told V6 that R1 was verbally aggressive towards her and other residents. V6 called V1 (Administrator) and as V6 made V1 aware of the situation, R1 was still aggressive at the time and V1 can even hear R1 in the background when V6 was giving report to V1. V1 said V1 will email V6 the petition. V6 received the petition and gave it to the nurse (V3) before 6pm, R1 was already on one to one monitoring with V3 in the dining room. On 5/6/25 at 12:30PM, V2 (Director of Nursing) stated that their process is that resident's with behaviors, social services will assess the resident and have a talk with the administrator and decide if an involuntary petition is necessary. We'll then get an order from the doctor to send the resident out for evaluation. The nurse is to inform the resident and POA (Power of Attorney) or the responsible party and document in resident's chart. Behaviors shall be documented in the chart also. On 5/6/25 at 2:30PM V3 stated that she called the doctor and received an order to send the resident out via involuntary petition, V3 informed R1 but states I just forgot to document. Facility Reported Incident dated 4/12/25, reads in part: Allegedly R1 made inappropriate statements toward 2 residents. Summary of investigation: on 4/12/25, following scheduled activities, R1 and 2 other residents stayed in the day room waiting for smoke break. The three residents were having conversations about economy and the cost of different items. The discussion became intense between the residents, R1 began to use vulgar language while speaking to the other residents. R1 became verbally aggressive to staff members. Staff immediately separated the other residents from the day room. R1 was placed in 1:1 with staff until transportation arrived. CNA stated we walked in to see what was going on, and R1 just attacked me. Resident interview stated it was a intense conversation but then he just started yelling. Activity Aide interviewed stated that she was in the day room the entire time, R1 became angry at the incoming staff. Resident's Involuntary Petition dated 4/12/25, V6 signed the form, V3 signed as the witness. There was no signature for R1, also the form reads in part: sister was informed and that R1 is experiencing an increase in symptoms. R1 is becoming agitated and verbally aggressive with peers and staff. R1 is difficult to direct. R1 poses a threat to self and others in the facility. On 5/7/25 at 10:30AM, V5 (SSD) stated that R1 does not have a POA (Power of Attorney). R1 is responsible to self. R1 has one emergency contact but not listed as a POA. Reviewed of Progress Note (April 2025) and there is no documentation in R1's chart with any behavior, nor contacting the doctor and getting an order to send the resident out to the hospital. Facility unable to provide nurse's documentation regarding doctor's order and informing R1 of the hospital transfer. Discharge Policy with a review date of 1/2025, reads in part: To establish a plan on how to discharge a resident from the facility to home, another facility or the hospital. Hospital Transfer: notify the physician regarding a change in resident status and obtain an order for transfer to the hospital. This maybe direct admit or an emergency room admission. Inform the resident and resident's responsible party of the transfer. Document in Progress Notes that condition of the resident, who was notified of the transfer, where the resident is going, mode of transportation, disposition of resident belongings and medications, notification to all parties of the discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change in Resident Condition Policy with a review date of 1/2025, reads in part: It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician and resident's responsible party of a change in condition. POLICY: Nursing will notify the resident's physician or nurse practitioner when: There is a significant change in the resident's physical, mental or emotional. It is deemed necessary or appropriate in the best interest of the resident. Once the physician has been notified and a plan developed, the nursing or social service staff will alert the resident and family of the issue and any physician orders. The communication with the resident and their responsible party as well as the physician will be documented in the resident's medical record or other appropriate documents. Facility provided Resident Rights Booklet, reads in part: As a long-term care resident in Illinois, you are guaranteed certain rights, protections and privileges according to state and federal laws. Your rights to participate in your own care. You may be informed, in advance of changes to the plan of care.