STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA ON 87TH	**2940 WEST 87TH STREET , CHICAGO, Illinois, 60652**

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S0000	Initial Comments Complaint Investigation: 25811814/IL2686832 25811999/IL2689332	S0000		12/16/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and	S9999		12/16/2025

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

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S9999	Continued from page 1 mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidence by: 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. Findings 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 Face sheet 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.	S9999		

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S9999	Continued from page 2 Per R4's Face sheet 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 11/29/2025. 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.	S9999		

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S9999	Continued from page 3 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, involuntary muscle movement, also patients can have seizure depending on where the subdural is. V18 R4 was sent out on 12/9/2025 because R4 did have a change in mental status. V8 stated that she assessed R4. R4 was breathing and had a pulse but was not responsive to stimuli. V18 stated that when did a sternal rub then R4 responded by pushing her hand away. V18 stated that subdural hematomas are typically causes from some sort of injury. There are some cases where subdual hematomas can be spontaneous, but they are usually from sort of injury.	S9999		

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S9999	Continued from page 4 R4's fall care plan does not contain appropriate interventions for someone who is a high fall risk. R4's care plan documents in part: Keep room free of clutter. Round at a minimum of 2 hours. Per R4's risk management report on 11/29/2025, R4 fell on 11/29/2025 in the dining room. V16's statement states that R4 fell while attempting to get up out of her wheelchair without assistance after multiple attempts of redirection had been given. R4 requires extensive staff assist with all transfer and uses a wheelchair for mobility. R4 observed on floor in dining room. Written statement by R5 quotes, “I was sitting in the back eating my lunch. I looked over and she was leaning on the side of her wheelchair again after the CNA helped her to scoot back. Next thing I know is she was on the floor”. Mild swelling noted to bilateral sides of face. R4's hospital record on 11/29/2025 documents in part: Diagnosis, acute subdural hematoma overlying left frontotemporal region, right eye hematoma. Plan repeat Computed Tomography (CT) of head scan at 6 hours. Facility’s fall prevention policy (07/2025) documents in part: 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 preventative strategies, and facilitate as safe an environment as possible. Residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk. A score of 10 or greater indicates the resident is at “high risk” for falls. "A"	S9999		