

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057893		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/26/2025	
NAME OF PROVIDER OR SUPPLIER ALIYA OF OAK LAWN				STREET ADDRESS, CITY, STATE, ZIP CODE 6300 WEST 95TH STREET , OAK LAWN, Illinois, 60453			
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S0000	Initial Comments Complaint Investigations: 2594715/2597832 2594408/2597875		S0000			09/10/2025	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240e) 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 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. Section 300.3240 Abuse and Neglect		S9999			09/10/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to follow their abuse policy and prevent resident-to-resident sexual inappropriateness. This affected two of three residents (R1 and R2) reviewed for abuse. This failure resulted in R2 touching, groping and fondling R1 inappropriately resulting in R1 feeling helpless, scared, tearful and feeling uncomfortable. Findings Include: R1 was admitted to the facility with diagnoses of reduced mobility and functional quadriplegia. R1s Minimal data set (MDS) section C (cognitive patterns) dated 7/14/25 documents: a score of fifteen which indicates cognitively intact. Section GG (functional abilities) documents: R1's is dependent on staff to roll left to right, sit to lying and lying to sitting on the side of bed. R1's care plan initiated on 07/13/2025 documents: ABUSE/NEGLECT: My comprehensive assessment reveals a history of suspected abuse and/or neglect or factors that may increase my susceptibility to abuse/neglect AEB/as evidenced by on 08/18/25 R1 was touched inappropriately by another male resident. Nursing note dated 8/18/25 documents: Writer heard resident (R1) yell out for help, writer got up to go to the yelling. Writer observed R1 in his bed with another resident near the bedside. Resident (R1) stated, "he did not know what he was doing or if he (R2) was touching him because he couldn't feel it." On 8/23/25 at 2:45pm, R1 who was assessed to be alert and oriented to person, place and time, said he was in bed when R2 entered his room via wheelchair. R1 said, R2 rolled on the side of his bed, stopped his wheelchair, stood up, lifted R1's gown and ripped opened R1's adult brief. R1 said, R2 put his hand around his penis and started rubbing it. R1 said, he was scared, he yelled for help and R3 saved his life.		S9999				

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S9999	Continued from page 2 R1 said, he felt uncomfortable. R1 said, he does not have sexual activities with men. R1 said, he is not like that. R1 said, the facility needs security. On 8/20/25 at 11:15am, R3 who was assessed to be alert and oriented to person, place and time, said R1 was yelling for about four minutes. R3 said, he walked to R1's room. R3 said, he saw R2 standing up on the side of R1's bed with his right hand on R1's penis moving up and down while holding his (R2's) penis while moving his left hand moving back and forth. R3 said, R2 is aware of his behavior. R3 said, R2 rolls through the hallway looking for bedbound residents. R2 does not bother residents that can walk. R2 has touched other bedbound residents before. R2 waits and watches until staff is not looking, go into resident's room and touch them inappropriately. R3 said, R1 is contracted with his arms up by his head and his legs are stuck open, knee up and apart. R1 could only yell for help. R3 said, V6 (certified nursing assistant/CNA) was the first to enter R1's room. On 8/20/25 at 2:12pm, video watched with V1 (administrator), V4 (assistant administrator) and V14 (director of nursing/ DON). V1 said, the video time is an hour ahead. R1 was seen entering R2's room at 11:17am per the recording time on the video but it was actually 12:17 per V1. R2 was seen exiting R1's room at 11:19am per the recording time on the video but it was actually 12:19 per V1. On 8/20/25 at 12:26pm, V6 (cna) said, said when she entered R1's room. R1 was observed with his gown up. R2 pulled up R1's gown, pushed R1's adult brief to the side and touched R1's penis. R3 called the nurse. V6 said, she had to fix R1's adult brief and pull down R1's gown. V6 said, R1 was crying when she entered his room. V6 said, R1 reported not feeling safe at the facility and wanting to die. V6 said, R1 reported he has never been touch by a man before. V6 said, R1 reported R2 had his hand in R1's adult brief touching his penis. Nursing note dated 8/20/25 documents: Patient (R1) is going to be admitted for sexual assault. On 8/26/25 at 1:34pm, V5 (nurse) said, she was the reporting nurse for R1. V5 said, she was aware that R1 has a history of inappropriate touching other residents. V5 said, R1 reported, that R2 touch his anus. Nursing note dated 7/17/25 documents: RN (V5) noticed resident (R2) kept going into another resident room.	S9999					

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S9999	Continued from page 3 The resident (R2) is trying to inappropriately touch the other resident and tell him he loves him. On 8/26/25 at 2:45pm, V12 (R2's power of attorney/POA) said, R2 has dementia and a history of same sex relationships. V12 said, she received a call about R2's incident with R1. V12 said, she has received calls from the facility prior to R1's incident about R2 inappropriate touching other residents. V12 said, the facility has been so patient with R2. Now the facility is acting like they do not have any patience with R2, like they can tolerate R2 anymore. R2 will do the same thing at any facility. The current facility found a new facility for R2 but they refused to accept him after R2's recent inappropriate touching incident with R1. R2's Behavior note created on 8/18/25 documents: Behavior Description: Inappropriately touching another resident. Behaviors: resident (R2) observed inappropriately touching a resident (R1). Nursing note dated 8/18/25 documents: Writer heard a resident (R1) yell out for help, writer got up to go to the yelling. Writer observed above resident (R2) in his wheelchair bending and reaching over to a resident (R1) in bed. Resident (R2) being petitioned to the hospital for inappropriate sexual behavior towards his peer. On 8/20/25 at 1:45pm, V2 (social service) said, she was made aware, R2 inappropriately touched R1 during the morning meeting. V2 said, she was informed, R2 opened R1's adult brief and had his hand in R1's brief. R1 reported he felt uncomfortable because he was not a homosexual. On 8/20/25 at 2:31pm, V3 (nurse practitioner) said, she was informed on Monday 8/18/25 that another resident touched R1. V3 said, she saw R1 on Tuesday. V3 said, R1 reported R2 lifted his gown and grabbed his penis. R1 reported he can't get erect because he is paralyzed. R1 said, he was not gay. R1 was crying. V3 said, she suggested R1 go to the hospital. On 8/20/25 at 11:49am, V10 (restorative aide) said, she was instructed to move R1 to a different room. V10 said, R1 requested that she stay with him because R1 reported being scared. V10 said, she was informed R1 was inappropriately touched by R2. On 8/20/25 at 11:59am, V11 (cna) said, she saw R1 crying. V11 said, she asked R1 was he okay. V11 said, R1 replied, please don't leave him. V11 said, R1 was scared to be left alone. V11 said, R1 is contracted and dependent on staff for assistance. V11 said, she was informed R2 took off R1's adult brief.		S9999				

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S9999	Continued from page 4 On 8/20/25 at 12:12pm, V7 (nurse) said, she heard a resident yelling help, help, help. V7 said, staff started running towards the yelling. R1 was in bed on his back. R2 was standing by R1's bed, reaching under R1's gown. R1's adult brief was loose. V7 said, R1 reported he didn't know what R2 was doing. On 8/20/25 at 12:39pm, V8 (cna) said, she heard R3 telling R2 to get out of R1's room. R1 is contracted with his hands stuck behind his head. R1's legs are contracted opened. V8 said, R1 is dependent on staff for assistance. R2 is a wander. R2 should not have been in R1's room. Hospital Paperwork dated 8/19/25 documents: Patient (R1) present to emergency department for evaluation after an assault. R1 does not feel safe. Emergency Department diagnoses: Sexual assault of adult. Per emergency service: R1 was manually grouped by another resident, allegedly witness by another resident. (8/21/25) Case manager spoke with patient (R1) at bedside who was alert and orient times four, declined to discharge to long term care facility, states he just left a facility where he was molested. Police report dated 8/19/25 documents: office responded to nursing home in regard to a criminal sexual abuse report. R1 was lying in bed alone. While laying down, R2 entered R1's room in a wheelchair. R1 rolled his wheelchair next to R1's bed and came to a stop. R2 then stood up and opened R1's diaper. R1 related that R2 placed his right hand in R1's adult brief and began to groan. R1 does not have any sense of feeling below the waist and did not know exactly what R2 was doing to his genitals. R1 began to call for a nurse while R2 was moving his hand around R1's genitals. R3 entered the room and began to shout at R2 to stop. Abuse policy dated 10/2022 documents: The facility affirms the right of our residents to be free from abuse, neglect or exploitation. Sexual abuse includes but is not limited to sexual harassment, sexual coercion or sexual assault including non-consensual or non-competent to consent sexual activity. (A)		S9999				