STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145681	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Crestwood	13259 South Central Avenue Crestwood, IL 60418

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on interviews and record reviews, the facility failed to follow their interventions of ensuring residents were adequately supervised who were identified as high risk for falls when left unattended, failed to modify fall prevention interventions post fall and failed to ensure a resident who is at high risk for falls whom repeatedly exhibited unsafe behaviors when in a reclining chair, was safely positioned in a reclining chair and adequately supervised during care. This failure applies to three of three (R1, R2 and R3) residents reviewed for accidents and resulted in R1 sustaining a facial fracture and intracranial hemorrhage from a fall. Findings include: 1. R1 is a [AGE] year-old female with a diagnoses history of Dementia, Insomnia, Muscle Wasting and Atrophy, and a history of falling who was admitted to the facility 07/04/2023. R1's Functional Abilities Minimum Data Sets dated 07/09/2024, 10/09/2024, 01/07/2025, and 03/30/2025 document she is dependent on staff for all activities of daily living and mobility activities. R1's current Fall care plan initiated and created 12/08/2024 documents she is at risk for falls due to functional deficits with the intervention initiated and created on 04/06/2025 of staff to monitor resident frequently to ensure proper reposition and safety in chair or bed. R1's current ADL (Activities of Daily Living) care plan initiated and created 12/16/2024 documents she requires assistance with daily care needs related to dementia, and muscle wasting and atrophy at multiple sites with interventions including one person assistance with bathing, toileting, dressing, and eating; and the intervention initiated 03/31/2025 and revised 04/14/2025 of mechanical lift with two-person assistance for transfers. R1's Restorative Comprehensive assessment dated [DATE] documents her fall risk factors included a history of falls or post fall fracture in the past 1-6 months, a fall risk score of 10 or above indicates high fall risk, and a final score for her of 21. R1's progress notes from February - April 2025 document multiple observations of behaviors. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 04/06/2025 at 4:47 AM created by V8 (Registered Nurse) on 04/06/2025 at 6:28 AM documents she had a fall at 4:47 AM. CNA (Certified Nursing Assistant) notified writer that resident was in the chair and she turned to get blanket and resident tried to get up and fell , hitting head on bed. Resident assessed by this writer and noted cut to right cheek and under chin. Resident also noted bleeding from nose and mouth. Physician made aware and stated to send resident out to the hospital emergency room . R1 sent out via ambulance. R1's progress note dated 4/6/2025 at 12:01 PM documents she was admitted at Christ Hospital with a facial fracture and Intracranial hemorrhage. R1's Fall Risk Management Incident Report dated 04/06/2025 documents that at 4:47 AM she had a fall, V9 (Certified Nursing Assistant) reported that while she was providing care and placed R1 in a chair she turned around to grab something and the resident fell from the chair to the floor hitting her head on the bed, she was observed with bleeding in her face including from the nose and mouth and complained of pain; she requires total assistance with activities of daily living and transfers and the root cause of her fall is noted as having poor trunk control, and when placed in her geriatric chair by staff she fell out of the chair head first hitting the bed frame then the floor; her mental status was documented as not being oriented or oriented to person only; predisposing factors were noted to include confusion and impaired memory, gait imbalance, and weakness; the physician was notified and ordered she be sent out to the hospital emergency room for evaluation and her Power of Attorney [NAME] Fields was also notified; Interventions implemented in response to the fall included monitor her frequently to ensure proper repositioning and safety in chair. The facility's Incident Investigation report received 04/15/2025 documents on 04/06/2025 at approximately 4:47 AM R1 was observed on the floor in her bedroom by the facility aide and was unable to verbalize what occurred in the room. R1 was admitted to the Hospital with a facial fracture and intracranial hemorrhage. It is determined that R1 attempted to get up from her wheelchair and had a fall. Staff were interviewed and reported that R1 was sitting in the wheelchair and attempted to get up and fell forward. Witness statement from V9 (Certified Nursing Assistant) dated 04/06/2025 documents she was assigned to work with R1, when finished putting on R1's clothes she transferred her to the chair and then turned around to get a plastic bag to place the dirty linen in which was on the other bed in the room and heard a noise then turned her head and observed R1 on the floor. V9 stated she immediately called the night nurse and told her that R1 had fallen. Witness statement from V8 (Registered Nurse) dated 04/06/2025 documents the CNA (Certified Nursing Assistant) informed her at 4:47 am that R1 fell from her wheelchair, the CNA reported that she turned around to grab something and R1 fell when trying to get up; R1 fell forward out of chair. On 04/16/2025 at 10:23 AM V11 (Certified Nursing Assistant) stated she has worked with R1. V11 stated she would position R1 in her (Reclining) chair at a slightly tilted angle because if the chair is lowered too far back it could be considered a restraint. V11 stated R1 would like to sit straight up on the edge of her (Reclining) chair. V11 stated when R1's (Reclining) chair was tilted back she would sometimes attempt to sit up however if her chair is tilted back she couldn't get up. V11 stated R1 would attempt to sit up once or twice when receiving incontinence care. V11 stated she uses a sit to stand most of the time to transfer R1 and needs assistance with transferring her. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/16/2025 at 11:15 AM V6 (Therapy Director) stated (Reclining) and Geriatric chairs are used for reclining due to cognition and for residents who require two-person assistance or a mechanical lift. V6 stated there should not be one person assistance for residents who use a (Reclining) or Geriatric chair. On 04/16/2025 at 11:54 AM Observed with V7 (Minimum Data Set Director) when a care planned intervention of keep clean and dry was entered in the facility's electronic medical record system to R1's care plan; the intervention was automatically categorized as initiated and created for the date it was entered of 04/16/2025. Observed in the facility's electronic medical record system the intervention in R1's care plan of mechanical lift with two-person assistance for transfers was categorized as initiated 03/31/2025 and revised 04/14/2025. On 04/16/2025 at 1:47 PM V5 (Restorative Nurse) stated the mechanical lift was implemented for R1 due to the extensiveness of her fall and her total dependence. V5 stated since R1 is totally dependent, she should be a two-person assistance however she feels one person assistance is adequate to transferring R1. V5 stated a (Reclining) chair should be reclined and if it is reclined it is not impossible but highly unlikely that the resident will fall out of it. V5 stated she isn't sure if R1's (Reclining) chair was reclined on the day she fell because she fell forward and injured her face which may indicate the chair was in an upright position however she couldn't confirm this. On 04/16/2025 at 2:41 PM V3 (Vice President of Clinical) stated if a mechanical lift is being used there should be two people assisting. V3 stated mechanical lifts are used for resident's who require total assistance and are dependent however this intervention is used on a case-by-case basis. V3 stated what could have been done differently to prevent R1's fall was having the necessary items close by so the staff would have what they needed for the resident. On 04/17/2025 at 12:09 PM In response to surveyor's request for information on what behaviors was R1 being monitored for and documented as being observed by staff in several behavior progress notes between February 02 and April 03, 2025 V1 (Administrator) replied per the CNA's (Certified Nursing Assistant) R1's behavior can range from swinging her arms in the air to leaning forward. On 04/15/2025 at 3:20 PM V5 (Restorative Nurse) stated R1 requires full assist with all activities, she can lift either of her arms and has range of motion but can't lift her arms on cue, and doesn't do anything on her own. V5 stated R1 is 79 pounds and light however we have her in a (Reclining) chair because her trunk support isn't there and for this reason shouldn't be sitting up in a wheelchair. 2. R2 is a [AGE] year-old female with a diagnoses history of Central Nervous System Cancer, Muscle Wasting and Atrophy, Morbid Obesity, Spinal Stenosis, and Stage 3 Chronic Kidney Disease who was admitted to the facility 01/31/2025. On 04/16/2025 AT 9:12 AM Observed R2 in the unit 2 Long Term Common/Dining Area without other residents present and staff walking around the surrounding area. Observed R2 sitting in a (Reclining) chair slightly reclined. R2 stated she had fallen out of bed 2-3 months ago onto a mat, then fell again about a month later while sitting on the edge of her bed when she started to slide and couldn't stop herself. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Current Fall Care Plan initiated and created on 01/31/2025 documents she is at high risk for falls related to repeated falls with an intervention initiated 02/08/2025 including staff to monitor resident frequently to ensure safety. R2's Fall Risk Assessment Incident Report dated 02/05/2025 documents she was observed on the floor in the dining room and reported she was trying to sit up in the wheelchair; the root cause was determined to be she has poor thought process, very impulsive, and stood up from her wheelchair and fell with an intervention implemented of encouraging staff to continue to monitor and redirect her; there was no one identified to have witnessed the fall. R2's Fall Risk Assessment Incident Report dated 02/08/2025 documents she was observed on the floor near her bed during rounds and reported she was trying to get out of the bed and she sustained an abrasion on her right knee; there was no one identified to have witnessed the fall; the root cause was determined to be her having poor thought process and being very impulsive with an intervention implemented of encouraging staff to continue to monitor and redirect her. R2's Fall Risk Assessment Incident Report dated 02/27/2025 documents she was observed on the floor next to her bed and she reported she needed to get up and she slid on her bottom; her assigned CNA (Certified Nursing Assistant) reported she left he with her breakfast tray; the root cause was determined to be poor though process and being very impulsive with an intervention implemented of educating staff to bring her to the common area for close monitoring. 3. R3 is an [AGE] year-old male with a diagnoses history of Dementia, Generalized Muscle Weakness, and Difficulty Walking who was admitted to the facility 11/30/2024. R3's Current Fall Care Plan initiated and created on 12/09/2024 documents he is at risk for falls due to diagnoses of functional deficits, muscle weakness, and dementia with interventions created on 01/22/2025 of staff to monitor him frequently. R3's Fall Risk Assessment Incident Report dated 01/19/2025 documents he had an unwitnessed fall, with an intervention implemented of staff monitoring him more frequently. R3's Fall Risk Assessment Incident Report dated 02/01/2025 documents he was in the common area and slid out of his chair onto his buttock, while V12 (Certified Nursing Assistant) was observing in the dining room he stood up from his chair in the day room and was observed sitting on the floor with an intervention implemented of staff monitoring him more frequently. R3's Fall Risk Assessment Incident Report dated 03/16/2025 documents he was observed sitting on the floor on his buttocks in front of the (Reclining) chair in the dining room and when he was asked what happened he stated he slid out of the chair, there was no one identified to witnessed the fall; an intervention was implemented of reminding staff to monitor him more frequently; he was not receptive to education due to a diagnosis of dementia. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Fall Risk Assessment Incident Report dated 03/20/2025 documents he stood up from the (Reclining) chair and fell on to his buttocks in the dining room and the fall was unwitnessed; the writer of the report was alerted by the CNA (Certified Nursing Assistant) that he stood up from the (Reclining) chair and fell on to his buttocks in the dining room; the root cause was determined to be R3 standing up out of his chair unassisted and not making safe decisions due to dementia with an intervention implemented of reminding staff to monitor him more frequently. On 04/15/2025 at 3:53 PM V5 (Restorative Nurse) stated she is the fall coordinator. V5 stated she and physical therapy perform assessments to determine if residents need to use a (Reclining) chair. V5 stated residents are assessed for (Reclining) chair use on admission and if there are any significant changes in their physical ability. V5 stated upon admission therapy screens all residents and will give recommendations and she performs a follow up assessment and most of the time she uses their recommendations because they are more skilled in that area. V5 stated R2 and R3 use (Reclining) or geriatric chairs. V5 stated if a resident can't sit up safely or doesn't have proper trunk control in a wheelchair, they are placed in a (Reclining) or Geriatric chair. V5 stated the restorative assessment is used to determine if a resident needs a (Reclining)/Geriatric chair. V5 stated when R1 is sitting in the (Reclining) chair it should be tilted back and should not be sitting up for because of her poor trunk control. On 04/16/2025 at 12:23 PM V5 (Restorative Nurse) stated R3 is at high risk for falls. V5 stated R3 had an unwitnessed fall on 01/19/2025 that occurred in the hall and it was his first fall in the facility since his admission in November. V5 stated R3's first few falls were attempts to self-transfer or get up on his own. V5 stated fall interventions are updated after reviewing fall incidents and when needed. V5 stated the intervention implemented after this fall was for staff to monitor R3 more frequently. V5 could not explain what more frequently meant and stated every one to two hours was adequate monitoring for him. V5 stated R3's next fall was on 02/01/2025 where he slid out of a chair in the common area, and this was witnessed by V12 (Certified Nursing Assistant) who was written up for not actively attending to him during sitting time. V5 stated sitting time includes staff monitoring in the dining/common areas for 30-minute intervals. V5 stated R3's next fall was on 03/16/2025 in the common area when he got out of his chair. V5 stated the intervention implemented was reminding staff to monitor him more frequently because he was not receptive to education on asking for assistance due to his dementia. V5 stated R3's next fall was on 03/20/2025 when he stood up out of his chair in the dining room and the intervention was staff being reminded to monitor him. V5 stated she doesn't know how to answer the surveyors question of was R3 being adequately supervised however he should have been. V5 stated she doesn't believe there were any other interventions required for R3 and in order to move you have to be raising up to do so if there was someone there watching him they should be intervening when he attempts to ambulate or transfer. V5 stated R2 fell on [DATE] in the dining room when she slid from her wheelchair while trying to sit up in the chair. V5 stated the intervention for this fall was encouraging staff to monitor and redirect the resident. V5 stated R2 fell on [DATE] and was observed on the floor in her room near her bed during rounds. V5 stated R2 is at high risk for falls and she attempts to transfer herself. V5 stated the intervention for this fall was to have a floor mat in place when in bed. V5 stated R2 had a fall on 02/27/2025 in her room while sitting on the edge of her bed. V5 stated the CNA (Certified Nursing Assistant) had left the room to get her clothes from another area and when she returned R2 was on the floor and reported that she wanted to get out of bed. V5 stated the intervention for this fall was educating staff to bring her to the common area for close monitoring and she shouldn't have been left because she tries to get things on her own. V5 stated the CNA was educated not to leave R2 by herself. V5 stated it had already been established that R2 would attempt to self-transfer prior to this last fall for R2. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's Fall Prevention and Management Policy, dated January 2023 documents: The facility is committed to maximizing each residents physical well-being. The facility will facilitate as safe an environment as possible. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed.