STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145684	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Homewood	940 Maple Avenue Homewood, IL 60430

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review the facility failed to follow policy procedures, failed to ensure that resident risk assessments were completed, and failed to ensure that a risk assessment was accurate for one of four residents (R4) reviewed for falls. Findings include:R4's (1/2/26) post fall risk assessment determined a score of 7 (at risk) however section G: Falls, Accidents, Fractures; was not answered (the responses were blank) therefore incomplete. History of falls and/or fracture in the past 6 months? include the current fall incident (was not selected). The assessment was conducted post fall therefore this response should have been selected. This selection adds 10 additional points to the score [Scoring a 10 or higher makes resident High Risk for falls]. On 3/25/26 at 12:51pm, surveyor inquired about concerns with R4's (1/2/26) post fall risk assessment. V2 (Director of Nursing) stated, Letter G is not checked, it's gonna throw the score off. Surveyor inquired what the score should have been if accurately assessed. V2 responded, It would be 17.The fall prevention and management policy (reviewed 3/2026) states the facility will identify and evaluate those residents at risk for falls. A fall risk evaluation will be completed on admission, readmission, and quarterly, significant change and after each fall.

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow policy procedures and failed to ensure that required diagnoses/interventions were included in the baseline care plan for one of four residents (R2) reviewed for falls.Findings include:R2 was admitted to the facility on [DATE] with diagnoses including history of falling and fracture of right pubis. R2 fell at the facility on 2/17/26.R2's (2/14/26) Physician Order Sheets include non-weight bearing to right leg for right pelvic fracture. R2's (2/15/26) care plan states resident is high risk for falls related to reduced mobility and poor safety awareness [right pelvic fracture is excluded]. Interventions include bed in lowest position, keeping frequently used items within reach, placement of call light within reach and staff to assist as needed [non-weight bearing and transfer requirements are excluded].On 3/23/26 at 11:28am, surveyor inquired about R2's fall plan of care. V2 (Director of Nursing) reviewed R2's baseline care plan and responded, Resident is at high risk for falls due to reduced mobility and poor safety awareness. Surveyor inquired about R2's fall prevention interventions. V2 replied, Bed in lowest position. Keep frequently used items within reach. Staff to assist as needed. Promote placement of call light within reach and assess resident ability to use. Surveyor inquired if R2 was supposed to be getting out of bed - with pelvic fracture. V2 responded, That would depend on his (R2) weight bearing status based upon his ortho recommendation prior to coming to us (facility). V2 subsequently reviewed R2's hospital records (received prior to admission) and stated, Weight bearing, says non-weight bearing right leg. Surveyor inquired if non-weight bearing right leg or pelvic fracture were included in R2's baseline care plan. V2 responded, I (V2) don't see that in here.The baseline care plan policy (revised 3/17/26) states the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care. 2.) The baseline care plan will be developed within 48 hours of a resident's admission into the facility. 3.) The baseline care plan will include at a minimum the following necessary information to properly care for a resident. B.) Fall risk.

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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. Based on observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that required fall prevention interventions were on the care plan, failed to implement fall prevention interventions, failed to ensure that risk assessments were accurate, failed to ensure that staff were aware of resident falls/injury, failed to ensure that staff were aware of resident transfer requirements, and/or failed to provide supervision to four of four residents (R2, R3, R4, R5) reviewed for falls. These failures resulted in the following serious injuries; R5's (3/16/26) fall with sustained head laceration - requiring staple repair and R4's (2/6/26) fall with sustained eyelid laceration. The facility also failed to ensure that physical assessments (post fall) were accurate.Findings include:The (1/23/26-3/23/26) Facility Falls Incident log affirms that 42 falls occurred - within 2 months.The Falls Incident log affirms that R5 fell on 3/13/26 and 3/16/26. R5's diagnoses include anxiety, restlessness, agitation, hemiplegia and hemiparesis. R5's (3/19/26) functional assessment affirms resident requires substantial/maximal assistance with rolling left and right and sitting on side of bed. Chair/bed to chair transfer was not attempted due to medical condition or safety concerns. R5's (3/13/26) fall risk assessment determined a score of 24 (high risk). R5's (3/13/26) incident report states 10:44am, CNA (Certified Nursing Assistant) observed patient on the floor, when entering the room writer observed patient on the floor next to the bed sitting upright on the right, leaning on right hip. Resident states that he was trying to go to the bathroom. No injuries observed at time of incident. Predisposing factors confused, gait imbalance, incontinent. Interventions: received a winged mattress to recognize parameters of bed. [Witnesses are excluded]. R5's (3/16/26) incident report states 11:50am, writer was notified by one of the CNAs that resident was on the floor in his room. Resident was observed laying on his right side out of the floor mats facing the nightstand. He was awake, verbally responsive with no change in level of consciousness noted but was observed to have some bleeding on the right side of head (parietal area). Area was assessed and a laceration was noted. When resident was asked what happened, he stated I just felt like it, so I rolled out of bed and hit my head. Predisposing situation factors: resident always attempting to get out of bed [Witnesses are excluded].R5's (3/13/26) care plan states the resident is at high risk for falls, interventions: (3/13/26) wing mattress. (3/16/26) ultra-low bed, ultra-low floor mat while resident is in bed [provide supervision is excluded]. On 3/23/26 at 1:24pm, R5 was observed in the therapy gym sitting (upright) in a specialty wheelchair and unattended by staff. V7 (Occupational Therapist Assistant) was present, however her (V7) back was facing R5 - while accessing the computer. Surveyor inquired about R5's fall prevention interventions. V7 stated, We (staff) have him (R5) at a max assist for ADL (Activities of Daily Living) transfer, he (R5) stands up with us (therapy staff). I (V7) think he (R5) has floor mats in his room. Surveyor inquired about R5's fall prevention interventions while in the therapy gym. V7 responded, Just us supervising him. Surveyor inquired why R5 was unattended by staff in the therapy gym. V7 replied, It's just line of sight, I (V7) was just checking a note really quick. Surveyor inquired if V7 was aware that R5 fell twice this month. V7 stated, I was not aware of that. Surveyor inquired how resident falls are communicated to staff. V7 responded, Typically through nursing. R5's (3/19/26) BIMS (Brief Interview Mental Status) determined a score of 4 (severe impairment).On 3/23/26 at 1:28pm, surveyor inquired if R5 recently fell. R5 stated, I think so. Surveyor inquired if R5 was injured when he fell. R5 responded, On my head and pointed towards the right side. Four (4) staples were noted to R5's right (parietal) head. On 3/23/26 at 1:33pm, V8 (LPN/Licensed Practical Nurse) affirmed that she's (V8) assigned to R5. Surveyor inquired about R5's fall prevention interventions. V8 stated, We (staff) make sure we put him in a chair with staff monitoring him. Surveyor inquired if R5 recently fell. V8 responded, I'm (V8) aware that he (R5) fell last week, I (V8) got a report that he has a head injury. Surveyor inquired about R5's head injury. V8 replied, There's um they did a suture. Surveyor inquired (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	if R5's laceration required a suture or staple(s) repair. V8 stated, Suture. Surveyor inquired if V8 assessed R5 today. V8 responded, I did however staples (not sutures) were observed on R5's head. On 3/26/26 at 1:27pm, surveyor inquired about R5's functional status. V23 (CNA) stated, He (R2) cannot walk and cannot stand. We (staff) have to have his (R5) bed in the lowest position, and he has to have mats on the side of his bed. He can't ambulate at all. Surveyor inquired about R5's (3/16/26) fall. V23 responded, I (V23) was walking past his room, and he was on the floor, so I told the Nurse. Surveyor inquired if floor mats were in use when R5 fell (on 3/16/26). V23 replied, Yes, when I saw him, he was lying on the floor where there wasn't any mat and his head was by the nightstand.On 3/26/26 at 1:44pm, surveyor asked if R5 can transfer himself and/or walk. V22 (RN/Registered Nurse) responded, No, he (R5) cannot walk, and I (V22) don't think he can transfer himself without assistance. Surveyor inquired about R5's (3/16/26) fall. V22 replied, The CNA came to me (V22) and said that the resident (R2) was on the floor. I immediately went in there and he was on the floor lying on his right side. The floor mat is in place, but his body was not inside the mat. Surveyor inquired how could R5 roll out of bed if a winged mattress was in use? V22 responded, He always tries to put 2 legs outside of the bed hanging, we (staff) always have to reposition him. Surveyor inquired how R5 injured his head. V22 replied, Theres a nightstand near where he fell so he might have hit his head on the nightstand.___The Facility Falls Incident log affirms that R4 fell on 1/27/26, 1/31/26, and 2/6/26. R4's diagnoses include seizures, lack of coordination, muscle wasting/atrophy and history of falling. R4's (1/7/26) functional assessment affirms the resident is dependent on staff for sit to stand and chair/bed to chair transfers. R4's (1/2/26) post fall risk assessment determined a score of 7 however history of falls and/or fracture in the past 6 months - include the current fall incident was not selected (as warranted) - this selection adds 10 additional points [Indicating high fall risk]. R4's (1/27/26) incident report states 2:00pm, incident location: Nursing Station. Resident had a seizure; resident was sitting in a wheelchair at the nurse's station. Resident fell out of wheelchair onto the floor and hit the left side of her temple. Bleeding noted to left side of head. Notes: laceration noted to left side of head with moderate bleeding. R4's (1/27/26) hospital history & physical affirms abrasion (not laceration) to left upper forehead and 2x2 centimeter hematoma were noted. R4's (1/31/26) incident report states 9:00pm, CNA reported that the patient was lying on the floor. Observed patient laying on right side of the floor mat next to her bed. Patient stated that she was getting up to go to another room. No apparent injury. [Witnesses are excluded].R4's (2/6/26) incident report states 5:00pm, incident location: Nursing Station. Observed that the patient was on the floor face down in front of her wheelchair. There was a small skin tear noted to the right eye lid under her eyebrow, there was a small amount of blood. The patient has a small skin laceration to the right upper eye lid. The resident stated that she was getting up to go to another room. Injuries observed at time of incident: Laceration, face [Witnesses are excluded].R4's (2/7/26) history & physical affirms she (R4) had a small laceration under her left eyebrow which is incongruent with the right side - which was documented. R4's (1/2/26) care plan states the resident is at high risk for falls related to reduced mobility, recent falls and poor safety awareness, interventions: staff to assist as needed. Perform frequent rounding and provide prompt assist for change in position/toileting.On 3/23/26 at 1:56pm, V10 (LPN) affirmed that she's (V10) assigned to R4. Surveyor inquired about R4's fall prevention interventions. V10 stated, She (R4) has the floor mats, keep the bed in lowest position, in the morning we get her (R4) up, make sure she has the soft helmet on and call light within reach [frequent rounding was excluded]. Surveyor inquired how R4 transfers from the bed to wheelchair. V10 responded, As far as transferring her, I'm (V10) not 100% sure, you (surveyor) would have to ask the aide. R4's (1/7/26) BIMS determined a score of 13 (cognition intact).On 3/23/26 at 1:59pm, R4 stated I (R4) did fall when I was in my room. I lost my balance, I was trying to reach for something, and I fell. Surveyor inquired about facility call light response time. R4 responded, Sometimes I have to wait until they're (staff) finished with another person. Surveyor inquired if R4 was over medicated while in the facility. R4 replied, He (Physician) changed it (medication) because it was a little too strong, so I'm (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(R4) doing better now. On 3/26/26 at 3:05pm, surveyor inquired about R4's (2/6/26) fall /injury. V24 (RN) stated, She (R4) was sitting in the chair (at the nurse's station) I (V24) looked up and she was face down on the floor. When we (staff) got her up and sat her back down, I know she had a laceration on her right eye. Surveyor inquired about R4's fall prevention interventions. V24 responded, Low bed and the mats [frequent rounding was excluded].___ On 3/7/26, IDPH (Illinois Department of Public Health) received allegations that R2 needed help on 2/17/26 and no one came. R2 attempted to get out of bed - to reach for the urinal and fell. R2 was on the floor for about 15 minutes.On 3/23/26 at 8:17am, V3 (Family) stated that (R2) fell at home (prior to admission) broke his hip and was non-weight bearing. He (R2) was at the facility for 3 nights; he fell and was sent to (hospital). R2 did not return to the facility. R2's diagnoses include Parkinson's disease with dyskinesia, muscle wasting/atrophy, cognitive communication deficit, type II diabetes mellitus, chronic kidney disease, hypertension, benign prostatic hyperplasia, history of falling, and (2/14/26) fracture of superior rim of right pubis.R2's (2/17/26) BIMS (Brief Interview Mental Status) determined a score of 15 (cognition intact).R2's (2/17/26) functional assessment affirms impairment in range of motion on both upper extremities and one lower extremity. Resident requires partial/moderate assistance with toileting and substantial/maximal assistance with chair/bed to chair transfer. Walking was not attempted due to medical condition or safety concerns. R2's (2/17/26) fall risk assessment determined a score of 24 (high risk).R2's (2/14/26) Physician Order Sheets include non-weight bearing to right leg for right pelvic fracture. R2's (2/15/26) care plan states resident is at high risk for falls related to reduced mobility and poor safety awareness [fractured right pubis is excluded]. Interventions include bed in lowest position, keep frequently used items within reach, placement of call light within reach and staff to assist as needed [non-weight bearing is excluded].R2's progress notes state (2/14/26) Patient was admitted , diagnosis status/post fall right pelvic fracture. (2/17/26) Writer went to answer call light and observed resident on the floor sitting on the side of bed toward the end of the bed on his buttocks. Resident stated he fell trying to get to the washroom. Writer assessed resident from head to toe, observed medium size knot with redness to top left head. Resident stated he hit his head. New orders to send resident to ER. (2/18/26) Writer reviewed hospital paperwork and resident was admitted for fall and non-acute pelvic fracture. R2's (2/17/26) incident report states writer went to answer call light and observed resident on the floor sitting on the side of the bed toward the end of the bed on his buttocks. Resident stated he fell trying to get to the washroom. [Witnesses are excluded].On 3/23/26 at 11:28am, surveyor inquired about R2's plan of care V2 (Director of Nursing) reviewed R2's care plan and stated, Resident is at high risk for falls due to reduced mobility and poor safety awareness. Surveyor inquired about R2's fall prevention interventions. V2 responded, Bed in lowest position, keep frequently used items within reach [R2's urinal was not within reach]. Surveyor inquired if R2 was supposed to be getting up out of bed with a fractured pelvis. V2 replied, That would depend on his (R2) weight bearing status based upon his ortho recommendation prior to coming to us (facility). V2 reviewed R2's hospital records and stated, Weight bearing says non-weight bearing right leg. Surveyor inquired if non-weight bearing (right leg) was on R2's care plan. V2 reviewed R2's care plan and stated, I don't see that in here.On 3/26/26 at 10:49am, surveyor inquired about R2's functional status. V18 (Physical Therapy) stated, During the evaluation (2/16/26) his (R2) bed mobility is like partial/moderate assistance 25-50% assistance. With the sit to stand I understand he is non-weight bearing and need a lot of assistance - maximal assistance 75% with the caregiver. On 3/26/26 at 11:38am, surveyor inquired about R2's functional status. V5 (Registered Nurse) stated, The CNA transferred him (R2) with one person assist. Surveyor inquired if R2 was non-weight bearing. V5 responded, I (V5) would have to look and see and affirmed she (V5) was unsure. Surveyor inquired about R2's fall prevention interventions. V5 replied, I would have to look in the system to see what his fall precautions are. Surveyor inquired about R2's (2/17/26) fall. V5 stated, He (R2) told me (V5) that he was trying to get to the washroom, and he fell. He had like a knot on his head and redness, so I asked him if he hit his head. He said yeah. Surveyor inquired if R2 had a fracture diagnosis - prior to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	falling. V5 responded, No, I can't really recall.___R3's diagnoses include legal blindness, multiple sclerosis, weakness, restlessness and agitation. R3's (10/30/25) BIMS determined a score of 9 (moderate impairment).R3's (1/30/26) functional assessment affirms resident requires substantial/maximal assistance with rolling left and right. Transfers were not attempted due to medical condition or safety concerns. R3's (1/30/26) fall risk assessment determined a score of 14 (high risk). R3's (2/19/24) care plan states the resident is at high risk for falls related to generalized weakness, potential medication side effects, multiple sclerosis, legally blind, muscle weakness, and failure to thrive, interventions: floor mats while in bed. On 3/23/26 at 2:05pm, R3 was lying asleep in bed. A floor mat was adjacent to R3's bed (near the wall) however the floor mat (between the beds) was folded and angled away from - the foot of bed. The over-bed table (placed beneath the bed) was impeding ability to place the floor mat near R3's bed. On 3/23/26 at 2:08pm, surveyor inquired about R3's fall prevention interventions. V11 (LPN) responded, The mat and I (V11) usually stay here (in the hallway) from time to time. I got 30 patients, but I try to keep an eye on. Surveyor inquired about the location of R3's floor mat (between the beds). V11 subsequently entered the room and replied, It should be bedside, uh next to the bed and affirmed that it was not. Surveyor inquired if R3 rolled out of bed right now (between the beds) where would she (R3) land? V11 stated, If she rolls out? she would be on the floor. On 3/23/26 at 2:10pm, V12 (Assistant Director of Nursing) entered R3's room, unfolded the floor mat, and placed it near R3's bed after V11 moved R3's over-bed table out of the way. On 3/26/26 at 12:52pm, surveyor inquired about potential harm to a resident that falls. V21 (Medical Director) stated, It depends, they (residents) can have injuries; fractures, laceration, bleeds or other medical conditions if they're on a blood thinner.The fall prevention and management policy (reviewed 3/2026) states this facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive 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. A fall risk evaluation will be completed on admission, readmission, and quarterly, significant change and after each fall. Residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk.