STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145936	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Highwood	50 Pleasant Avenue Highwood, IL 60040

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** Based on observation, interview, and record review the facility failed to provide personal care in a safe manner and failed to supervise a resident on the patio to prevent a fall for 2 of 3 residents (R2, R3) reviewed for safety and supervision in the sample of 6. This failure resulted in R2 experiencing a fall from her bed on 3/11/26 during cares and sustaining a left femur fracture. The findings include:1. R2's face sheet showed she was admitted to the facility 1/28/2017 with diagnoses to include multiple sclerosis, anxiety disorder, hypertension, bipolar disorder, and paraplegia. R2's 6/9/2026 facility assessment showed she has no cognitive impairment, requires substantial to maximum assist for bed mobility, and is dependent on staff for transfers.R2's care plan initiated 8/20/2018 showed, I require assistance with bed mobility related to paraplegia, multiple sclerosis, osteoporosis, low back pain, cramps, and spasms. Interventions. Provide 1-2-person extensive assist.R2's care plan initiated 3/11/26 showed, I choose to refuse using the hoyer lift saying ?I don't like it', despite encouragement and redirection from staff.R2's care plan initiated 3/16/26 showed, the resident has displaced comminuted fracture of shaft of left femur.R2's care plan initiated 5/10/2018 showed, . ADL (activities of daily living) self-care deficit. Bed Mobility: Extensive assistance, One/two person physical assist; Transfer: total assist, Two plus persons physical assist.R2's care plan initiated 3/11/26 showed, [R2] is high risk for falls related to paraplegia, multiple sclerosis, osteoporosis, low back pain. Interventions: 3/11/26 Educate resident on safety awareness, educate on instructions of mechanical lift.R2's care plan initiated 2/6/2017 showed, I am at risk for injury related to weakness from Multiple Sclerosis. Assist with mobility as needed.R2's care plan initiated 9/10/2017 showed, I have an alteration in musculoskeletal status (Osteoporosis, paraplegia), potential for injury, pain, and other complications.R2's care plan initiated 2/8/2017 showed, I have Multiple Sclerosis affecting my mobility.R2's care plan initiated 9/10/2017 showed, I have paraplegia, and it affects my mobility and ADLs . Assist with ADLs and locomotion as required.The facility's State Report of Patient Incident with reported date 3/14/26 showed, . Fall with Serious Injury. On 3/11/26 at approximately 9:00 AM, resident was observed to have had a witnessed fall. No injuries observed. Resident declined pain. Resident stated to have pain to lower back on 3/12. On 3/13, resident was observed with edema on left knee and left ankle. Denied pain and declined x-ray. Resident agreed to have x-ray after further encouragement. Xray on left knee yielded mildly displaced fracture of the distal shaft of the femur. Summary of Investigation. Alert and oriented x 3, 2 person assist via mechanical lift. History of Multiple Sclerosis, age related osteoporosis, bipolar disorder, paraplegia, cramp and spasm. Resident was in bed in a supine position on top of mechanical lift sling. Resident quickly and unexpectedly grabbed the mechanical lift bar causing an imbalance which resulted in her rolling to the floor. Incident occurred too quickly for staff to intervene. Assisted to bed using 2-person mechanical lift. Resident had no prior history of sudden movement such as grabbing the mechanical lift bar. This investigation included education completed 3/11/26 through 3/13/26 for staff titled Use of Mechanical Lifts. The CNA (Certified Nursing Assistant) that was assisting R2 prior to her fall (V3) and the CNA who responded to the fall (V8) both received additional training on all transfers on 3/12/26.On 6/26/26 at (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	11:37 AM, R2 said she was in bed and V3 CNA was helping her when she was rolled out of the bed and onto the floor. R2 said she broke her leg that day.R2's 3/13/26 Nursing Note showed, Resident was readmitted back to facility post visit ER in [acute care hospital] . discharge diagnosis: fracture of the digital left femur and proximal Left tibia and proximal left fibula; verbal report was received from ER nurse. verbalizing the long post mold fiberglass splint was applied to the left leg. resident was referred to follow up with [orthopedic physician] in 2 weeks post hospital ER visit. On 6/26/26 at 9:32 AM, V3 CNA said she passed R2 her tray in the morning and she was moving about a lot and was excitable. V3 said she asked R2 if she wanted to transfer and she asked V8 for assistance with the transfer. V3 said she was putting the sling under R2 by herself and when she pushed R2 over to place the sling under her she started to move her hands a lot which caused her to roll out of bed and onto the floor. V3 said V8 was in the room standing in the corner with R2's wheelchair. V3 said she hadn't worked on R2's hall much and wasn't very familiar with her. V3 said she was sent home after R2's falls because when things like this happen, they have to investigate. V3 said this was just an accident. On 6/26/26 at 9:40 AM, V8 CNA said, [V8] asked me for help to transfer [R2] but I was in another room. I told her after I finished taking care of my patient I would come help. When I got inside the room to help, [R2] was on the floor next to the bed. The hoyer lift was next to [R2] she was not connected to it. She does move around a lot. She was mad when I went in there. I think she just rolled out of the bed.On 6/26/26 at 9:47 AM, V6 CNA said, We always need 2 people to do cares because [R2] is always leaning to the left, all the time, even in the wheelchair. We use two for people who are hard to do cares on, she is hard, so I normally use two people.On 6/26/26 at 11:02 AM, V5 (Previous Director of Nursing) said, I was making my rounds and the CNA said she was prepping the resident to transfer her to the chair. [R2] was on the floor, almost face down on the leg of the lift. I guess they had put her onto the sling, and they were positioning the mechanical lift above her. I guess she grabbed the bar, and it turned, and she went off the bed. It was just the one CNA putting her on the sling. I think she grabbed the bar and turned. The reason she got suspended was because of the investigation, not all CNAs are suspended for falls, just if there may be an issue with the transferring or something like that.On 6/26/26 at 12:55 PM, V2 DON (Director of Nursing) said [R2] rolled out of the bed during care. It could be an impulse from a resident that causes it and they can't predict what the resident is going to do. With [R2] being paralyzed, it puts her at an increased risk for rolling out of bed. It is okay to use one assist for her. If she is difficult to provide care for, they should ask for help but if the resident can roll over like that, one assist is fine. When the transfer process occurs, we would have the two CNAs. To prevent it from happening again we are emphasizing that the resident is a high fall risk. and understanding that she is a fall risk. We are reinforcing patient safety.The facility's policy and procedure with review date 5/1/26 showed, Activities of Daily Living. General: A program of activities of daily living is provided to prevent disability and return of maintain residents at their maximal level of functioning based on their diagnosis. The ability of each resident to meet the demands of daily living is determined by a Licensed Nurse.The facility's policy and procedure with revision date of 5/27/26 showed, Fall Prevention and Management. General: 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 preventative strategies, and facilitate as safe an environment as possible. 2. R3's face sheet showed he was admitted to the facility 4/9/25 with diagnoses to include chronic congestive heart failure, primary osteoarthritis, hypertensive heart disease, cellulitis of left upper limb, and spinal stenosis. R3's facility assessment dated [DATE] showed he has moderate cognitive impairment, requires moderate assistance for most cares, and utilizes a wheelchair for mobility.R3's care plan initiated 6/20/26 showed, Resident is at high risk for falls. Educated resident safety precaution while using wheelchair. Ensuring resident wheelchair anti-tipping device is working properly. Encourage appropriate use of wheelchair. Alteration in musculoskeletal status related to arthritis-multiple sites, spinal stenosis, carpal tunnel syndrome, flexion deformity.On 6/26/26 at 11:41 AM, R3 said, I got (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	lucky because I was wheeling myself outside, the grass was growing up behind the patio cement, I backed up my wheelchair and went off the edge of the patio. I was trying to get back up on the cement and I flipped my whole wheelchair backwards, and hit my head on the brick work. We had nobody on duty out there. There was no staff outside at all. They brought down two nurses and the two of them tipped me back up. they have got to do something about that, because it is too easy to drive off of the edge of the cement.On 6/26/26 at 11:14, V4 Activity Aide said, [R3] fell outside on the patio. I was in the activity room, but I was preparing for the next activity. When it happened, I was in the storage room that is in the activity room. I heard a resident, [R7] call me to let me know that a resident had fallen outside. I quickly went outside to check and [R3] was on his back with his head in the plants, and his wheelchair still under him. At the time, when he fell, the other activity aide that was there was bringing down residents for the next activity. I told her that [R3] had fallen, so she went upstairs and got a nurse. Two nurses came down. Both nurses and the other activity aide helped him back up in his chair, took him upstairs immediately to get checked. Usually there is someone out supervising the patio, but I was preparing the next activity, and the other aide was helping me bring down more residents.On 6/26/26 at 11:44 AM, R7 said she witnessed R3's fall. R7 said R3 backed himself up and he was stuck in the purple flowers. He kept going back and forth with his wheelchair and when I went to get help, he had already fallen backwards. I went to go tell the activity aide right away. When I went to get them, I was in the hall going toward physical therapy when V7 (Activity Aide) was coming off the elevator.R7's face sheet showed she was admitted to the facility 7/12/21 with diagnoses to include Type 2 Diabetes, obstructive sleep apnea, bipolar disorder, and spinal stenosis. R7's facility assessment dated [DATE] showed she is cognitively intact.On 6/26/26 at 11:54 AM, V9 LPN (Licensed Practical Nurse) said, I was on the floor and I didn't realize that [R3] was outside, no one notified me that he was outside. I was sitting down to chart. one of the activity aides had come up to the floor. She said [R3] had fallen outside. We went downstairs and there were a lot of residents outside. [R3] was on the right side of the patio with the wheelchair tipped over. I ran over there and I asked him if he hit his head, he said yes, his neck was tilted to the side, he was all over the place. As I was assessing [R3] I was trying to get a report from activities as to what happened. The two girls in activities didn't know what happened. [R3] said he was trying to get out of the way for someone, and he pushed his wheelchair too far back and got stuck in the bushes. I [V9] was told there were no staff out on the patio. I expressed my anger and said that is unacceptable, there is multiple people out here, I was mad. There needs to always be someone out there on the patio. The verbal residents told me [R3] was lying on the floor for a good 10 minutes. They were the two twin girls on that day. As far as where they were, I have no idea.