STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145983	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Aliya on 87th		STREET ADDRESS, CITY, STATE, ZIP CODE 2940 West 87th Street Chicago, IL 60652	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, facility failed to follow their policy and did not notify resident's legal representative/guardian about a fall incident for one resident (R1) in the final sample of 8 residents reviewed for quality care/treatment.On 1/20/2026 during complaint investigation for allegation of quality care, record review, and interviews showed in part, that R1's legal guardian was not notified of R1's fall incident on 4/8/2025, and instead, R1's second emergency contact was left a phone message, and no other notification was documented.On 1/20/2025 at 10:05 AM, confirmed that R1 no longer resides in the facility.R1 was discharged [DATE].On 1/20/2026, R1's admission record sheet showed in part that R1 was admitted to the facility on [DATE] from acute care hospital and that R1's contacts information included, but not limited to a family member as a second emergency contact and V25 (Legal Guardian/Case Manager) as R1's state appointed legal guardian and a case manager.R1's admission record (12/23/2024) showed in part R1's diagnosis included but not limited to Dementia without behavioral disturbance; Difficulty in walking; Lack of coordination; Dysphagia; Protein-calorie malnutrition; Dehydration; Muscle Weakness; Hypertensive heart disease; Iron Deficiency and Adult Failure to thrive.R1's Care plan (Initiated 12/24/2025) showed in part, that R1's had a surrogate decision maker and as of 3/31/2025, R1 had appointed state guardian and to contact adult guardianship division.R1's Progress notes (3/31/2025 at 13:14 AM), documented by V30 (Social Worker) showed in part that V30 was notified that R1 has been appointed a public guardian with notes documenting the guardian's information.R1's Progress notes (4/9/2025 at 02:10 AM), documented by V7 (LPN), showed in part that R1 was sent out to the emergency room). Progress notes do not show documentation that R1's legal guardian was notified of R1's fall or transfer to hospital.R1's Progress notes (4/9/2025 at 02:19 AM), documented by V7 (LPN), showed in part that V7 left voice message with R1's second emergency contact about R1's fall and that R1 was in the hospital for observation. Progress notes do not show documentation that R1's legal guardian was notified of R1's fall.R1's Progress notes (4/9/2025 at 6:12 AM), documented by V18 (LPN), showed in part a noted that V7 called hospital and R1 is on the way back to facility and that CT Scan was negative. Progress notes do not show documentation that R1's legal guardian was notified of updated status.R1's Progress notes (4/9/2025 at 6:40 AM), documented by V18 (LPN), showed in part, that R1 returned from hospital with no additional new orders and that R1 had alteration of skin to left eyebrow without redness or swelling, no pain, stable vital signs and that safety measures were maintained. Progress notes do not show documentation that R1's legal guardian was notified of updated status or the fall incident. No other documentation of legal guardian notification was noted in R1's progress notes related to R1's 4/8/2025 fall incident.On 1/20/2025 at 3:02 PM, V15 (LPN), stated that if resident has a fall incident, V15 should notify resident's first emergency contact and if resident has a legal guardian on file, then V15 should notify the legal guardian of incident first, before other emergency contact and document (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the notification in the resident's electronic record. V15 was not sure if R1 had a fall on 4/8/2025 because the incident happened so long ago but V15 recalled R1's fall on 5/10/2025 where R1 ended up with left hip fracture. On 1/21/2026 at 9:05 AM, V7 (LPN) stated, that V7 is somewhat familiar with R1 and after presenting V7 with V7's progress notes, V7 recalled R1 having a fall incident on 4/8/2025 around 11 PM. V7 stated R1 was found lying on the left side in the bathroom, when V7 responded to a call light bell. V7 stated, that when came to the room, R1 was observed by V7 on the floor in the bathroom and said that R1 did not remember what happened, when R1 stand up from using a bathroom. V7 stated, that R1 had a minimal skin tear on R1's left eyebrow and V7 cleaned it and applied gauze dressing. V7 stated, that V7 notified the physician, and the resident was sent out to the emergency room for evaluation. V7 stated, that V7 thinks that V7 called the legal guardian, but is not sure and confirmed when looking at the charted progress notes, that V7 did not documented the notification to legal guardian on file but documented leaving message with the second emergency contact instead. V7, when presented and looked at R1's admission Record with R1's contact information, then stated that V7 should have contacted the legal guardian and document in R1's chart. V7 stated, that if resident has a power of attorney (POA) or a legal guardian contact information on file, the legal guardian or the POA should be notified with any resident's changes. V7 also said, that when resident is received back from hospital, the legal guardian should also be notified with an update and conversation should be documented.On 1/21/2026 at 10:48 AM, V18 (LPN), stated, that V18 does not remember R1's 4/8/2025 fall incident, because it was long time ago and R1 was in the facility only for short time. V18 stated, that if R1's progress notes showed, that V18 documented that R1 came back from hospital, then legal guardian should be notified, but is not sure that V18 notified R1's legal guardian with the update status. V18 stated, that when resident returns from hospital, the legal guardian should be still notified about resident's status and the conversation should be documented.On 1/21/2026 at 11:35 AM, V20 (Second Floor Unit Manager), stated, that when resident have a fall, the nurse should notify the physician, the nursing director or V20 and the legal guardian . V20 stated, that the if resident has a legal guardian on a file and emergency contact, the legal guardian should be always notified first and then the emergency contact and the notification should be documented in the resident's chart. V20 also stated, that the legal guardian should be notified with changes or updates on resident any time of the day and should be left a message if notification is in late hours. V20 is not familiar with R1, and is not aware of R1's falls, because V20 just started working at the facility on the end of April of 2025 and the resident was discharged few days after.On 1/21/2026 at 12:10PM, V22 (Third Floor Unit Manager/LPN), stated that when resident has a fall, the nurse should assess resident and check vital signs, place resident safely back to bed and then notify the physician, the resident family and the nursing director or the unit manager. V22 stated, that if resident has a legal guardian appointed, then the guardian should be notified before the family and the notification should be documented in resident's chart. V22 also stated, that notification should be also documented when resident returned from a hospital.On 1/21/2026 at 12:19 PM, V23 (Social Work Director) stated, that resident's legal guardian should be notified first, then notify the next emergency contact on the list of contacts. V23 stated, that there should be a documentation in resident's chart if the nurse tried to contact or left message with the legal guardian. V23 stated, that V23 is not familiar with R1, because the resident was discharged prior V23 started working at the facility.On 1/21/2026 at 1:55 PM, V2 (Director of Nursing/DON) stated, that V2 is somewhat familiar with R1 and that R1 was a resident with Dementia diagnosis and that R1 loved to move around. V2 stated, that R1 could not ambulate without assistance, but was attempting to get up. V2 stated, that V2 was notified of R1's (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fall on 5/10/2025 at 8 Am by V15 (Licensed Practical Nurse/LPN) and was informed that R1 was found lying on the floor in R1's room, on the right side, next to R1's bed. V2 stated, that V2 was not familiar if R1 had a fall on 4/8/2025 but is aware of the fall incident with injury on 5/10/2025. V2 was presented a progress note documentation and a risk assessment about R1's fall on 4/8/2025 and then V2 stated, that the fall on 4/8/2025 was not needed to be reported to the agency because the resident did not have a serious injury, but the fall on 5/10/2025 should be reported to the state agency and presented initial and final incident report from 5/10/2025. V2 confirmed that R1 had two falls in the facility and one with injury and stated, that the legal guardian should be notified first before emergency contact. V2 stated, that the legal guardian should be notified about the 4/8/2025 fall incident first and the notification documented, instead of the family member emergency contact. On 1/21/2026 at 3:32 PM, V26 (LPN), stated, that when V26 has a resident that would be going to the hospital, V26 should notify whoever is the responsible party for that resident. V26 stated, that if resident has multiple emergency contacts on the chart, the legal guardian should be notified first and then the other emergency contacts. Facility's Document titled Fall Incident Description (4/8/2025 at 10:20 PM), showed in part R1's fall description and that family member was notified on 4/9/2025 at 07:05AM documentation by V7 (LPN). Document does not show that legal guardian was notified of R1's fall.Facility's presented document titled Letter of Instruction, Office of the [NAME] County Public Guardian (3/31/3035), showed in part that R1 has been appointed Plenary or Temporary Guardian by the Circuit court of [NAME] County and that in the event of an emergency the staff should notify the appointed guardian and that the compliance with the procedure is mandatory. The document also showed in part, that the letter should be placed in resident's chart and all personnel should be advised of the guardian role and expectations. Facility's document titled Physician-Family Notification-Change in Condition (1/1/2025) showed in part, that the purpose is to ensure that medical care problems are communicated to the attending physician or authorized designee and family in a timely, efficient, and effective manner and it is responsibility of the Licensed Nursing Personnel and Social Services. The document further showed in part, that the facility should inform the resident and notify the resident's legal representative or an interested family member when the resident is involved in accident that resulted in injury, a significant change in resident's physical status and when decision to transfer or discharge of resident was made.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement care planned, fall risk interventions for a high fall risk resident (R2); failed to provide 2 person assist during activities of daily living (ADL) care for a dependent resident in bed (R2); and failed to notify the practitioner of the nurse's assessment of a resident's pain post fall incident for one resident (R2) in the total sample of 8. These failures affected R2 who suffered a fall in the facility on 1/4/2026 from the bed to the floor sustaining a 3 centimeter left head laceration and exhibiting pain signs immediately post fall with the nurse's palpation of R2's left leg which was not communicated to the practitioner; and after increased pain signs, R2's left hip X-ray was performed on 1/6/2026 showing a proximal left femur fracture. Findings include:R2's admission Record documents, in part, diagnoses of Alzheimer's disease, dementia, chronic kidney disease, major depressive disorder, anorexia, hypotension, atherosclerotic heart disease of native coronary artery without angina pectoris, cough, hypertensive heart disease without heart failure, pressure ulcer of sacral region stage 4, gastrostomy status, simple chronic bronchitis, arthropathies, shortness of breath, hypoxemia, psychosis, insomnia, pneumonia, and displaced subtrochanteric fracture of left femur.R2's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview for Mental Status (BIMS) score of 00 which indicates that R2 has severe cognitive impairment. R2's Functional Abilities indicate that for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and personal hygiene, R2 is dependent coded as Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. For R2's bed mobility to roll left and right, sit to lying, and lying to sitting on side of the bed, R2 is coded as dependent. R2 utilizes no mobility devices per this MDS.On 1/21/2026 at 3:19 PM, V11 (Certified Nursing Assistant, CNA) stated that the V11 was assigned as R2's primary CNA on 1/4/2026 for the 2:00 pm to 10:00 pm shift. V11 stated that V11 is nonverbal, bedbound, and contracted on both arms and legs and had a floor mat next to R2's bed. V11 stated that on 1/4/2026, around 9:00 PM, V11 was making the last resident rounds. V11 stated, Whenever I (V11) want to make easier for whoever is coming behind me (night shift CNA), I was getting all of (R2's) linens made and change the bed with clean linens. (R2) kinda like drools a little bit on the bed. V11 stated that V11 had laid out the clean linens and rolled them into a linen roll. V11 stated that V11 was the only staff member rendering R2's care and moved R2's bed away from the wall, positioning V11's self in between R2's bed and the wall. V11 stated that V11 then turned R2 to the right side away from V11. V11 stated that V11 tucked the clean linen roll under R2's body as R2 is turned to the right side and realized that V11 did not have the new incontinence brief. V11 stated that V11 reached over R2's body toward the foot of the bed to retrieve the incontinence brief and in this process leaned with V11's arm on R2's low air loss mattress, which started R2 to move further away from V11's side of the bed, and R2 started to fall. V11 stated, (R2's) contracted and I grabbed (R2's) leg and it felt like it was making matters worse and I didn't want to extend it worse. I can see (R2) was in pain. V11 stated that V11 grabbed R2's leg to try to keep R2 from falling to the floor. V11 stated that as R2 was falling from the bed to the floor, R2 made no noises when R2 hit the floor, but only when I was grabbing (R2's) leg, I realized I was hurting (R2). V11 stated, I see that, the pain in (R2's) face. (R2) went from no emotion and you could see it. It was hurting. When asked if R2 fell on the bare floor or the fall mat, V11 stated, Kinda both. The mat and floor, it was both. V11 stated that R2 was laying on R2's left side, contracted arms and legs on the floor mat, and R2's head was slightly off the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	floor mat. V11 stated, I wanted to make sure (R2) was still alive. I didn't want to move (R2). I wanted to get the nurse. V11 stated that V11 left R2's room and went to the nurse's station and informed V8 (LPN) who was the nurse covering for V7 who was on break. V11 stated that V8 performed an assessment of R2 on the floor prior to the lift transfer back to the bed. V11 stated that V11 told V8 what had occurred during V11's care of R2. V11 stated that V11 provided a written statement of R2's care on 1/4/2026, and I learned to never lean on an air mattress.In V11's (CNA) signed statement for R2's witnessed fall when V11 was working on 1/4/2026 on the shift 2:00 PM to 10:00 PM, V11 documents, in part, I (V11) was entering the room to do patient care on (R2); (R2) was facing the window. As I was tucking the clean linen under the patient, I leaned on the mattress to reach for the brief. I saw (R2) begin to slide headfirst off the mattress; I attempted to keep (R2) from falling but was unsuccessful (R2) landed on the mat next to the bed. I called for help and the Nurse came in.On 1/21/2026 at 11:02 AM, V8 (LPN) stated that V8 was working on R2's floor for the 3:00 pm to 11:00 pm shift and that V8 was not assigned as R2's primary nurse during this shift. V8 stated that if a resident has a fall occurrence, V8 will perform an assessment to see if there are physical injuries or if resident is complaining of pain. When asked what the post fall assessment by a nurse entails, V8 stated that it's done prior to moving the resident, and V8 starts at the resident's head looking for bruising or discoloration. V8 moves down to the shoulders and arms, having the resident move extremities to see if there's pain or discomfort. V8 stated that V8 will perform passive range of motion for a resident that cannot actively move as baseline. When asked if a resident is contracted on the arms and legs, how will V8 assess the extremities, and V8 stated that if passive range of motion can't be done due to the contractures like R2, V8 looks at the joints to see if there is swelling or discoloration and will feel the extremity for heat, all while looking at the resident's face for grimacing or if making noises for nonverbal residents. V8 stated that R2 is total care, bedbound, and is nonverbal. V8 stated that on 1/4/2026 around 9:30 PM, V8 was covering V7's assignment while V7 was off the floor on V7's break. V8 stated that V11 (CNA) came to the nurse's station and stated, You (V8) are not going to like it but (R2) is on the floor. V8 stated that V8 immediately went into R2's room and observed R2 on R2's left side, on the floor mat with R2's head that had went on the floor but was no longer in contact with the floor. V8 stated that V8 assessed R2 for physical injuries seeing blood coming from R2's left forehead where V8 applied pressure with a gauze and did R2's remaining assessment. V8 stated that with R2's contractures to both arms and legs, V8 touched and squeezed along R2's arms and legs. V8 stated that when V8 touched with V8's hand along R2's left leg, V8 did notice that R2 grimacing, having pain on the left leg. V8 also stated that R2 made moaning noises when V8 touched R2's left leg. V8 demonstrated to this surveyor how V8 checked R2 on 1/4/2026 by V8 palpating in a slight squeezing motion with V8's hands along the left upper leg from knee up to the hip. V8 stated that V8 assisted V11 with the lift transfer of R2 to the bed and continued to clean R2's left head laceration and placed 2 adhesive tape strips over the skin opening. V8 stated that V7 was returning from V7's break, and V8 was medicating R2 with Acetaminophen for pain (already a PRN, whenever needed, order was present). When asked if V8 communicated V8's findings of new left leg pain post fall to V7, V8 stated that V8 informed V7 that R2 was in pain on R2's left side and that V11 said that R2 rolled over and slipped out of bed. V8 stated that V7 contacted V31 (Advance Practice Nurse, APN) and during this call, V8 only spoke to V31 about R2's blood thinning medication status. V8 stated that V8 did not inform V31 of R2's post fall assessment of the new left leg pain upon palpation. When asked did V11 inform V8 that as R2 was falling off the bed, V11 tried to catch R2, and V8 stated that V11 could have said that to V8. When asked did V11 tell V8 that V11 grabbed R2's leg as R2 was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	falling off the bed and that R2 moaned out in pain, V8 stated that V8 didn't recall that statement from V11.On 1/21/2026 at 9:09 AM, V7 (LPN) stated that V7 was R2's primary nurse on 1/4/2026 for the 3:00 pm to 11:00 pm shift. V7 stated that for high fall risk residents, V7 communicates to the CNAs who the high fall risk residents are and monitoring checks are performed at a minimum of every 2 hours. V7 stated that if a resident has a fall, V7 will first assess the resident for changes, then reposition the resident with another nurse or CNA, take vital signs, and will call the doctor, family and V2 (DON). V7 stated that V7 is very familiar with R2 and that R2 is nonverbal so V7 watches (R2's) body movements to get communication. V7 stated that R2's call light device is an adaptive, flat pad that V7 places near R2's jaw on the pillow for R2 to lean head on the call light. V7 stated that R2 is a 2 person assist for ADL care and that R2 is contracted both arms and legs. V7 stated that V7 returned from break on 1/4/2026 to find several staff coming from R2's room. V7 stated that R2 was back in bed at this point, where R2 had 2 adhesive tape strips on the left forehead. V7 stated that V8 informed V7 that V11 was take care of R2 when R2 fell from the bed. V7 stated that V7 took R2's vital signs and called V31 (APN). V7 stated that when V31 asked about R2's pain, V7 stated, This client is nonverbal and we do not know (R2's) degree of pain. V7 stated that V7 informed V31 that R2 had a PRN Tylenol order present and that R2 was medicated with a dose. V7 stated that V31 informed V7 to perform 72 neurological checks and to notify a practitioner with any change in R2's condition. V7 stated that V7 gave V31 the secondhand report from V8 about the witnessed fall for R2 on 1/4/2026 and that V31 relies on the information that V7 is telling V31. V7 stated that V7 questioned V11 about what occurred with R2's fall. V7 reiterated to V11 that 2 people are needed to care for R2. When asked during report at beginning of shift, did you tell V11 that R2 was a 2 person assist, No, not at the beginning of shift. I told (V11) that after the fall. (V11's) new. In R2's Fall Incident Report, dated 1/4/2026 at 9:45 PM, V7 (LPN) documents, in part, for the incident description (nursing), at approximately 9:30 AM, V11 stated that R2 was on the floor; upon entering R2's room, R2 observed lying on left side on floor mat; and per V11, ADL care was being rendered when R2 slid from bed and V11 was unable to stop R2 from sliding to the floor. For incident description (resident), R2 was unable to give any description. For the immediate action taken description, V7 (LPN) who is assigned to R2 was on lunch break and V8 (LPN, second nurse on R2's floor) went to R2's room immediately and observed R2 on the mat with skin alteration noted on R2's left forehead with a small amount of bleeding where V8 applied pressure, cleansed with normal saline and applied adhesive tape strips to R2's forehead skin laceration. In V31's (Advanced Practice Nurse, APN) Progress Note, with date of service 1/4/2026 at 10:16 PM, V31 documents, in part, that details are provided by nurse, V7, with primary chief complaint of fall with head strike. History of present illness is noted as R2 with a witnessed fall resulting in small laceration on head treated with adhesive tape strips and no active pain, bleeding or complaints. In R2's Comprehensive Pain Evaluation, dated 1/4/2026 at 11:45 PM, V7 documents, in part, that only R2's skin alteration diagnosis is the reason for R2 is experiencing pain; that pain is increased during R2's incontinence care; that R2's nonverbal indicators are facial grimaces (furrowed brow, narrowed eyes, tightened lips, dropped jaw, clenched teeth, or distorted expression); and in the category for possible workup needed/doctor ordered the following tests, the space is blank (no imaging tests ordered). On 1/15/2026 at 11:49 AM, V9 (R2's Healthcare-Power of Attorney, HC-POA) stated that on 1/4/2026 around 10:30 PM, V9 received a phone call from V7 (LPN) saying that R2 had fallen and has a head laceration. V9 stated that V9 and V10 (R2's Family Member) arrived at the facility within 15 minutes, and they see R2 in bed with blood dripping on the left side of R2's head. V9 stated that V9 and V10 questioned V7 about sending R2 out to the hospital to be examined, and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	V7 replied that R2 was stable and that V7 spoke to a practitioner who recommended to monitor R2 in the facility. V10 arrived in-person during this surveyor's interview with V9, and V10 stated on 1/4/2026 when V10 arrived with V9, V10 asked the nurse are you going to do a body examine to see if there are any broken bones, and the nurse said that they will do it. V9 stated, (R2) is nonverbal and (R2) can't speak up for (R2's) self. (R2) is contracted with (R2's) arms and legs and (R2) can't defend (R2's) self. V9 stated that on 1/6/2026, the nurse practitioner (V24) called V9 and said R2's breathing is labored, that they had R2 on Acetaminophen ordered every four hours; and were ordering an X ray of R2's hips. V9 stated that R2's resting heart rate and blood pressure were more elevated than R2's normal now. V9 stated, I was terrified of what's going on with (R2). V9 stated that the hip X-rays were done later on 1/6/2026, and I wish they had taken better care of (R2). V9 stated that on 1/6/2026 around 10:25 PM, V2 (Director of Nursing, DON) phoned V9 saying that X-ray results were back, and both of R2's hips are dislocated. V9 stated that V9 came to the facility within 15 minutes that evening on 1/6/2026, and R2 was in lots of pain, making loud noises saying ohhhhh. V9 stated that V9 and V10 went to the hospital where R2 was transported to on the night of 1/6/2026-1/7/2026, and the emergency room doctor told us that R2's left femur was broken, and we were told the doctor that V2 (DON) had told us both hips were dislocated. V10 stated that V9 and V10 were getting conflicting information from the facility. V9 stated that emergency room doctor said that the left femur was like a wish bone and due to R2's current medical status, R2 wouldn't sustain the surgery needed to repair the left femur. V9 stated, This has impacted (R2). It's not fair to (R2). (R2) has suffered lots of pain and discomfort. It's life changing. On 1/20/2026 at 10:42 AM, R2 observed in bed in room with R2's adaptive call light hanging down over the headboard of R2's bed toward the wall away from R2, and R2's bed height is visibly higher than this surveyor's observation of R2 in the lowest bed position on 1/15/2026. This surveyor called V14 (LPN) to R2's room and asked about the current height of R2's bed. V14 stated that the height of R2's bed should be lower. V14 stated, I (V14) would bring it (bed height) down more than this to prevent injury if (R2) falls. V14 used the bed control and lowered R2's bed height down to the lowest position towards the floor. When asked about the location of R2's call light, V14 retrieves the call light cord that is hanging over R2's headboard towards the wall and pins it to the pillow near R2's head saying that it is a modified call light for R2. V14 stated that R2 can't use it with her hands and they are keeping it near R2's head. On 1/20/2026 at 1:39 PM, V3 (Restorative Nurse, Licensed Practical Nurse, LPN) stated that V3 is the restorative nurse for R2's floor and sometimes works as a floor nurse on R2's floor. V3 stated that as the restorative nurse, V3 performs assessments for residents to determine what proper devices are needed for transfers and mobility, and the number of staff members needed to safely perform ADL (Activities of Daily Living) care. V3 stated that V3 also performs the fall risk assessment within the comprehensive restorative assessment to determine if a resident is a high fall risk with a score of 10 or higher. V3 stated that V3 will then care plan for interventions for the high fall risk resident and update the high fall risk resident list on the floors. V3 stated that for bedbound residents in their rooms, staff keep the bed in the lowest position and the call light within residents' reach. V3 stated that the bed is to be maintained in the lowest position, so if they do fall, they don't fall from a high plane. V3 stated that the call light is kept close to residents in bed for their safety so if they need help, they can activate the call light. V3 added that for bedbound residents, the staff must make sure to position the resident in the center of the bed, so when the resident is rolled to the side, the resident will not roll off the edge of the bed. V3 stated that when CNAs are performing 2 person assist while rendering care to a dependent resident in bed, one CNA will be on one side of the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Aliya on 87th		STREET ADDRESS, CITY, STATE, ZIP CODE 2940 West 87th Street Chicago, IL 60652	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	bed and the other CNA will be on the other side of the bed and both CNAs will log roll the resident in the center of the bed during care. V3 stated that R2 is alert to R2's name, nonverbal, receives gastrostomy tube feedings, is incontinent and depends on staff for ADL care and repositioning in bed. V3 stated that prior to R2's fall incident on 1/4/2026, R2 was at a high fall risk and was assessed as a 2 person ADL assist (dependent). V3 stated that on 1/5/2026, V3 learned of R2's fall from 1/4/2026, and V3 talked to V11 (CNA) who was rendering care for R2 during the fall incident. V3 stated that V8 responded to R2 immediately post fall. V3 stated that V3 must collect the details of R2's fall incident to be able to determine what new fall interventions to put in place in the care plan to prevent further falls. V3 stated that V3 visited R2 on 1/6/2026, and R2 was making a lot of noise and was in pain. V3 stated that V3 confirmed with the primary nurse, V14 (LPN), who had stated that V14 had given R2 the Acetaminophen. V3 stated that V9 arrived late morning on 1/6/2026, seeing R2 in pain. V3 stated that V3 informed V9 that V14 had already given R2 the pain medication (Acetaminophen), but V9 was asking for help since R2 was so uncomfortable. V3 stated that V3 would let V24 (Nurse Practitioner, NP) know. V3 stated that V3 informed V24 to come to evaluate R2, and V3 was present with V24 during V24's assessment where the left leg is more swollen than the day before. V3 stated that V24 provided STAT X-ray orders for bilateral hips and chest X-ray, since R2's respirations and heartrate were elevated. V3 stated that V3 knows R2 well, and since R2's pulse was faster than normal and that was in pain, it was a concern for V3. R2's Vitals Summary indicate R2's heart rate readings on 1/6/2026 were 102 beats per minute (bpm) at 5:39 AM and 100 bpm at 10:37 PM. On 1/21/2026 at 1:28 PM, V24 (NP) stated that V24 is familiar with R2 and routinely visits R2 in the facility. V24 stated that R2 is nonverbal, contracted muscles on all 4 extremities, normally is on 2 to 3 liters/minute of oxygen with nonlabored breathing, has eyes open but does not track, and R2 gives nonverbal cues so you can tell if something is wrong. V24 stated that on 1/5/2025, V24 did not see R2 in the facility, and on 1/6/2026, V24 ran the 72 hour report and could see that R2 had a fall incident on 1/4/2026. V24 stated that prior to seeing R2 on 1/6/2026, V3 (Restorative Nurse, LPN) came asking for V24 to assess R2 for moaning in pain during care. V24 stated that V24 did a full assessment seeing R2 breathing faster and moaning while R2 is exhaling, looked distressed. V24 stated that R2's contracted left leg normally is stationary upwards at hip joint but was leaning down and to the left side. V24 stated that when V24 touched R2's left upper leg, R2's moaning would get louder. V24 stated that V24 ordered Acetaminophen every 4 hours around the clock and STAT X-rays of hips and chest on 1/6/2026. V24 stated that the imaging results came back after V24's shift ended on 1/6/2026, and R2 was sent to the hospital later on that night with a left femur fracture. V24 stated that if the nurse had palpated R2's leg post fall, the nurse must notify the on call practitioner because R2 cannot verbally tell the nurse if there is an injury, so the nurses are trained in assessment skills for nonverbal signs of pain. V24 stated that if a fall resident is assessed with new pain immediately post fall, there is a risk of an unknown fracture. V24 stated that for R2's fall incident, V24 would have been concerned with R2 possibly developing compartment system and R2's pain. V24 stated, A nurse should recognize nonverbal cues of pain.In V24's (Nurse Practitioner) Progress Note, dated 1/6/2026 at 11:45 AM, V24 documents, in part, that R2's baseline is alert with eyes open, does not tract and oriented times zero; R2 is non-verbal and unable to make R2's needs known; and R2's past medical history includes contractures of multiple joints and functional quadriplegia. V24 documents that per nursing documentation, R2 has a witnessed fall during patient care in which R2 landed on the floor mat next to the bed sustaining a skin alteration to the forehead. V24 documents that upon assessment today (1/6/2026), R2 is moaning with exhalation and moaning when LLE (left lower extremity) was palpated. V24 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	documents that R2's LLE was noted to be slightly abducted while R2 noted to have knee bent at approximately 90 degrees with STAT X-rays ordered of bilateral hips and pelvis. V24 documents for V24's assessment of R2's extremities as the following: LLE contracted at approximately 90 degrees, unable to extend but does have some movement when abducted; RLE (right lower extremity) contracted at 90 degrees, unable to abduct, adduct or extend; RUE (right upper extremity) shoulder contracted and unable to fully abduct, arm contracted at the elbow at approximately 90 degrees and unable to extend, and fingers are contracted; and LUE (left upper extremity) shoulder contracted and unable to fully abduct, arm contracted at the elbow at approximately 90 degrees and unable to extend, and fingers are contracted. On 1/20/2026 at 2:34 pm, V14 (LPN) stated that on 1/6/2026, V14 worked the day and evening shifts as R2's primary nurse. V14 stated that V24 (NP) had ordered the X-rays for R2's STAT X-rays, and when the X-ray technician was performing the X-rays for R2, V14 said the technician could see possible bilateral hip fractures as a preliminary reading, but the radiologist must read the X-ray film to confirm this. V14 stated that V14 then phoned V2 (Director of Nursing, DON) with this information who then relayed to V14 that V34 (Physician) is ordering R2 to be sent to the hospital for further evaluation. V14 stated that R2 was grimacing a lot, and R2 was receiving the Acetaminophen every 4 hours. V14 stated that R2's heart rate would elevate to 99 bpm, then would come down to 80 after the Acetaminophen was given. Facility document titled Radiology Results Report documents, in part, with date of service 1/6/2026, R2's left hip X-ray (unilateral with pelvis, 2 to 3 views) results are fracture of the proximal left femur with overriding of the fracture fragments. R2's hospital records, dated 1/7/2026, document, in part, that R2 experienced fall at the facility on 1/4/2026 and hit head sustaining a 3 centimeter laceration that was repaired with adhesive tape strips, and R2 received X-ray in facility on 1/6/2026 showing possible bilateral hip fractures. R2 does grimace with movement of left leg. R2's hospital CT (computerized tomography) without contrast results of left hip (dated 1/7/2026) indicate comminuted displaced left intertrochanteric femur fracture with soft tissue swelling around the left hip with probable left hip joint hemarthrosis and intramuscular hematoma in the left proximal thigh. On 1/21/2026 at 1:55 PM, V2 (DON) stated that if a resident falls in the facility, V2 expects the nurses to follow this procedure: enter the area where resident is on the floor; do an assessment to see if the resident is injured; see if the resident is able to tell you what happened; assess for change in body function structures; and if there are no changes, then the nurse can assist the resident off the floor to a safe area. V2 stated that V2 expects for the nurse to follow up with practitioner, family and V2, and after making the notifications, to then document. V2 stated that the nurse must document using the risk management form (fall incident report) that allows for further information to be added in the risk management form as the fall investigation continues. V2 stated that nurses must notify V2 who will help guide the nurse on how to follow the facility's protocol post fall. V2 stated that the protocol for falls with suspected injuries is that the nurse gathers the information from the assessment. If the resident had a fall and resident complains of new pain, the nurse will report to the practitioner where the resident is having pain and recommend an X-ray. V2 stated that once there is a confirmed injury with an X-ray, the resident will be ordered by the physician to be sent to the hospital. For a resident who has fallen and is nonverbal and contracted, V2 expects that the nurse performs a full body assessment by looking and touching the resident's body while seeing if there are any facial grimacing or moaning/grunting sounds. V2 stated that nurses should not assume there is no pain if there are no facial changes, because there could be teeth grinding, jaw barring down, body shaking or resident who is trying to move. V2 stated that if the pain assessment findings are different from the resident's baseline, the nurse must inform the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	practitioner and recommend for possible X-ray if in pain. V2 stated that R2's fall incident occurred on 1/4/2026, and on 1/6/2026, V3 (Restorative Nurse, LPN) touched R2's left leg with R2 being in discomfort. V2 stated that V3 relayed this pain assessment to V24 (NP) who ordered the hip X-ray. V2 stated that V2 reported R2's left femur fracture to the State agency with a corresponding investigation. V2 stated that V11 informed V2 that V11 turned R2 to the right side in bed when rendering care by V11's self; V11 tucked the clean linen roll under R2; and as V11 moved V11's arm to reach for the incontinence brief, V11 pressed into air mattress, and R2 began to slide off the opposite edge of the bed. V2 stated that V11 informed V2 that when R2 was sliding off the bed, V11grabbed R2's left leg and got a hold of it, but it was not successful and R2 continued to slide off the bed to the floor. her and she fell down on her side. When asked was V2 informed on 1/4/2026 about R2's pain to the left leg with palpation by nurse (V8) performing post fall assessment, V2 stated no. V2 stated that the restorative nurse assesses residents to determine the number of staff needed to perform safe ADL care, and V2 expects for CNA staff to follow each the interventions from each resident's assessment.In R2's Order Summary Report for orders from 1/4/2026 to 1/6/2026 document, in part, orders as follows: monitor left forehead and report any changes or signs/symptoms of infection report to primary care physician every shift and as needed (order date 1/5/2026); Acetaminophen 500 milligrams (mg) via gastrostomy tube every morning and at bedtime for pain/elevated temperature (order date 1/5/2026); and Acetaminophen 500 mg every 4 hours for pain (order date 1/6/2026). No new orders listed on 1/4/2026.R2's Medication Administration Record (MAR) for January 2025 shows R2 was not medicated with Acetaminophen for pain prior to R2's fall incident on 1/4/2026 at 9:30 pm, and R2 received 6 doses of Acetaminophen (3 doses of 500 milligrams and 3 doses of 650 milligrams) post fall until transfer to hospital on 1/6/2026.R2's Care Plan, with created on date of 1/23/2019 and date initiated 8/23/2024, documents, in part, a focus that R2 is high risk for falls and is at risk for injury from falls related to weakness with interventions of maintain bed in the lowest position; use approved techniques for repositioning (R2); and call light within (R2's) reach when in room.On 1/15/2026, V9 and V10 presented to this surveyor photographs of R2 on 1/4/2026 with R2's left forehead laceration with 2 adhesive tape strips with blood staining noted on the strips and residual blood that has run down R2's scalp past R2's left ear and a small blood stain on R2's tile floor (with R2's oxygen tubing and gastrostomy tube pole base noted in photograph).Facility document titled (R2's Floor) High Fall Risk dated 12/24/2025 documents, in part, that R2 is a high fall risk with HF next to R2's name. V3 (Restorative Nurse, LPN) retrieved this list from R2's floor nurse's station on 1/20/2026 at 3:08 PM, and V3 stated that it's kept here for all staff to review who the high fall risk residents are.Facility Daily Assignment Sheet dated 1/4/2026 for the 2nd shift (evenings) on R2's floor, documents, in part, 2 (V7 and V8) nurses working with V7 assigned to R2's room, and V11 (CNA) assigned to R2's room. Facility policy titled Fall Prevention and Management dated July 2025 documents, in part, General: The 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 and environment as possible. All resident falls shall be reviewed, in the resident's existing plan of care shall be evaluated and modified as needed . Guidelines: Upon admission: 1. A fall risk evaluation will be completed on admission, readmission, and quarterly, significant change and after each fall. 2. Residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk. Facility Guideline following a fall incident: 1. Evaluate the resident for any injury and notify the physician and emergency contact. 2. Complete a fall incident report in the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(electronic medical record system) risk management portal. 3. A fall risk evaluation is completed by the nurse. A score of 10 or greater indicates the resident is at high risk for falls.Facility policy titled Activities of Daily Living dated 5/1/2025 documents, in part, General: A program of activities of daily living is provided to prevent disability and return or maintain residents at their maximal level of functioning based on their diagnosis. Responsible Party: All Nursing Personnel. Guideline: 1. The ability of each resident to meet the demands of daily living is determined by a Licensed Nurse. 2. A program of assistance and instructions in ADL skills is care planned and implemented.Facility policy titled Call Light Response dated 5/1/2025 documents, in part, General: To provide the staff with guidance on responding to residents' requests and needs . Protocol: . 3. Ensure the call light is always within the resident's reach. 4. When the patient or resident is in bed or confined to a bed or chair, provide the call light within easy reach of the patient or resident. Facility policy titled Pain Management dated May 2025 documents, in part, General: To facilitate and provide guidance on pain observations and management. To facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life environment. Responsible Party: Nursing, DON. Guideline: The pain management program is based on a facility wide commitment to resident comfort. Pain is defined as whatever the experiencing person says it is and exists whenever he or she says it does . Pain management is a multidisciplinary care process that includes the following: Observing the potential for pain. Effectively recognizing the presence of pain. Identifying the characteristics of pain. Addressing the underlying causes of the residents pain . Policy: 1. Pain is assesse