STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146053	A. Building B. Wing	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Palos Park	12220 South Will Cook Road Palos Park, IL 60464

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. 34069 Based on interview and record review the facility failed to implement effective fall intervention to prevent a resident from falling which resulted in resident walking by herself, falling, and sustaining a left hip fracture. This failure affected 1 resident (R2) of 3 residents reviewed for falls in a total sample of 15. Findings include: On 7-3-24 at 11:12 AM, V2 (Director of Nursing) said R2 is primarily Spanish speaking and R2 can make simple needs known. V2 said R2 has poor safety awareness due to dementia, impulsive behaviors, and gets up by herself without asking for assistance. V2 said R2 will become aggressive during redirection which could lead to falls. V2 said R2 has unsteady gait and requires 1-person assistance and assistive walking device. V2 said R2 is a fall risk. V2 said CNA cleaned, dressed, and brought R2 to common area. V2 said high fall risk residents were grouped in common area and supervised. V2 said CNA left the group to give ADL care. On 7-3-24 at 8:50 AM, V20 (Certified Nurse Aide) said R2 is alert and able to make her need known in simple terms since R2 is primarily Spanish speaking. V20 said R2 has periods of confusion, can be impulsive, and constantly tries to get up by herself. V20 said when staff redirect R2, R2 becomes combative. V20 said R2 tries to get up out of her bed and wheelchair. V20 said R2 attempts to walk to other rooms without her wheelchair and walker. R2 is a high fall risk due to unsteady gait, confusion, and impulsive behavior. V20 said all staff is aware of fall risk thus R2 is placed in common area for supervision and staff takes turn to supervise fall risk group. V20 said high risk for fall residents are kept in a group and supervised by 1 or 2 staff. V20 said she was giving R2 care when nurse discovered R2 on the floor. V20 said she cleaned and dressed R2 less than 30 minutes prior to the fall. V20 said she was supervising R2 in the common area during the night shift. V20 said she had to leave the group and give patient care for the next shift. V20 said she told the nurse she was going to do CNA rounds and nurse said OK. V20 said nurse was at nurses' station and went to pass medications. V20 said she heard R2 boom from a fall. V20 said she came out of the room and nurse was standing over R2. (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	On 7-2-24 at 2:10 PM, V21 (Registered Nurse) said R2 is alert, oriented x 1-3, and with occasional confusion and stubbornness. V21 said R2 has no safety awareness due to confusion and impulsive behaviors. V21 said R2 is a high fall risk due to unsteadiness on her feet, confusion, and poor safety awareness. V21 said R2 requires 1 person assistance with transfers. V21 said she does hourly rounding when R2 is in her room. V21 said most of the high fall risk residents are kept in common area under staff supervision. V21 said R2 does not use the call light and R2 will get up by herself. On 7-3-24 at 10:32 AM, V19 (Licensed Practical Nurse) said R2 is alert, oriented x1-2, and able to make simple needs known. V19 said R2 has occasional confusion and R2 has no safety awareness. V19 said R2 is a fall risk and believes she can do things independently but can't. V19 said R2 will try to stand up and walk, take herself to the bathroom, and gets up without telling any staff. V19 said R2 requires assistance due to fall risk and history of falls. V19 said she was ambulating around the nurses' station, V19 redirected, and R2 became aggressive. V19 said she just finished passing medications and noted R2 ambulating by herself. V19 said CNA cleaned and dressed resident prior to incident. V19 said R2 was unattended at that time. V19 said R2 requires 1:1 because she tries to do things by herself. V19 said she was passing medications and CNA did not mention R2 was placed in common area or CNA was leaving R2 unattended. R2's Admission Evaluation dated 5-23-24 documents: 1h. 19 (A score of 10 or higher indicates a High Fall Risk). Fall Risk Evaluation dated 5-24-24 documents: Score: 26 (Scoring a 10 or higher makes resident high risk for falls). State Reportable dated 5-24-24 documents: Incident Description: Resident was observed ambulating the hall, when nurse on duty attempted to redirect to seating area, she became resistant/ combative, NOD then allowed resident to ambulate and followed close behind as to not agitate resident further. While walking behind her, (R2) stumbled, falling to the floor and NOD was not able to break her fall. Upon assessment, (R2) left leg appeared to be shortened. Resident sent to ER for eval and was admitted with L hip fx. NOD made MD aware, received orders to send resident to ER for eval. EMS called; ETA of 30-60 minutes was given. Responsible party notified and agreeable with plan of care. NOD called ER and was made aware that resident was being admitted with dx of left hip fx. Investigation is ongoing. State Reportable (Final) documents: Summary of Investigation: (R2) had been awake and trying to ambulate since 1 am, when she was placed in common area for monitoring. At 0540, (R2) was observed ambulating and the nurse attempted to redirect her to the seating area, but (R2) became resistant and combative, so nurse allowed her to walk, but followed close behind her to not to agitate her to walk but followed close behind her not to agitate her further. As the resident continued to ambulate, she stumbled, falling to the floor, and the nurse was not able to break her fall. Hospital Record dated 5-24-24 documents: Admission Diagnosis: (not limited to:) Closed left hip fracture, Displaced fracture of left femoral neck. Inpatient Problem List: Displaced fracture of left femoral neck, Closed left hip fracture. Principal Problem: Closed left hip fracture. Left hip fracture traumatic on pathological secondary to osteoporosis. Chief Complaint: witnessed fall. History of Present Illness: (R2) is an 81 y.o. female history of dementia, essential hypertension, generalized anxiety disorder, presented to hospital due to weakness falls at the nursing home resulted in left hip fracture she was admitted for surgical intervention per Ortho on consult. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Progress note dated 5-24-24 documents: Resident was noted ambulating the unit. This writer came upon resident and was attempting to assist her to a chair. Resident became resistant/combative. This writer allowed resident to walk while walking behind her. Resident stumbled and fell to the floor; this writer was unable to break her fall. Resident landed into the CNA cart and ended up on her left side on the floor. Resident immediately grabbed her left leg and shouted in pain. Left leg appears shortened. This writer reached out to daughter and made her aware of situation. Orders received to send to Hospital for eval. All parties aware. Fall Prevention and Management Policy dated 1-23 documents: 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 fall, 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.