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	08/21/2025

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their hospice policy and care plan for one (R2) out of three residents reviewed for mechanical lift for transfer from chair to bed. This failure resulted in R2 sustaining a laceration on her left leg that required R2 to be sent to the emergency room for suturing. The after-emergency room summary indicates that R2 was treated for laceration repair. The facility's final summary investigation indicates that R2 returned to the facility with 17 sutures. Findings include:On 8/19/2025 at 11:37 AM, V4(Hospice CNA) said that V4 was transferring R2 to the bed, and V4 bumped R2's leg on the bed. V4 said that was when V4 saw the blood and V4 ran to get the nurse. V4 said that V4 transferred the resident from the wheelchair to the bed by herself. V4 said that R1 is a mechanical lift transfer resident. V4 said that V4 just did not use the mechanical lift and that was a mistake on V4's part. On 8/20/2025 at 1:50 PM, V4 said that V4 has been working with R2 for about 2 months. V4 said that V4 has been working as a CNA for about 17 years. V4 said that V4 received training on how to use mechanical lift from the hospice agency V4 works for. V4 said that V4 was not oriented on the facility mechanical lift. V4 said that although V4 was aware that R2 needs mechanical lift with 2 persons assist transfer, V4 said that V4 never uses the mechanical lift when transferring R2 from the chair to the bed since V4 has been caring for R2. V4 said that when V4 starts her shift, R2 has already been transferred from bed to her chair. V4's response to why V4 did not ask for assistance for transferring R2 was that everyone is busy doing their own thing, and as long as you do your job, you have no problem. V4 said they never had a situation like this since V4 has been working as a CNA, and V4 said that V4 felt bad for what happened.On 8/19/2025 at 2:01PM, V5 (LPN) said that the incident happened at the end of shift and V5 was the oncoming nurse. V5 said that V6 was the day nurse who V4 notified of the incident. V5 said that the wound care was notified of the injury and was already assessing the resident's injury when V5 went to see R2. V5 said that wound care nurse did her assessment and V5 notified the doctor and obtained an order for R2 to be sent out to the emergency room. On 8/19/2025 at 2:11 PM, V6 (LPN) said that V6 was R2 daytime nurse, and the incident happened around change of shift. V6 said that V6 was called into R2's room by V4. V6 said that V4 informed V6 that there is a cut on R2's leg. V6 said that V6 cleansed the area and applied a temporary bandage until the wound care nurse came down. V6 said that V6 notified the hospice nurse, wound care nurse, and then endorsed to V5. V6 said that no signs of pain or distress was notified. V6 said that to the best of her knowledge, it was the first time that V4 transferred R2 without the mechanical lift.On 8/19/2025 at 2:37 PM, V7 (CNA) said that R2 was assigned to her for the PM shift and V7 took care of R2 when she returned from the hospital 8/5/2025. V7 said that V7 was in room [ROOM NUMBER] performing patient care for the 2 residents in room [ROOM NUMBER]. V7 said that V7 was rounding on other residents. V7 said that she did not witness what happened. V7 said that R2 is 2 persons assist for transfer with Mechanical lift. V7 said that every time V7 takes care of R2, she always uses the mechanical lift when transferring R2.On 8/20/2025 at 12:29 PM, said V2 (ADON) said that V2 has been the facility ADON since 4/2025. V2 said that is little bit familiar with what is in the facility hospice policy but not word to word. The surveyor read out #7. protocol on the hospice policy which states, that the written contract between the facility and the hospice company must include, an agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's care and nursing needs in coordination with the hospice representative, and ensure that level of care provided is appropriate based on the individual resident's needs. V2 said that V4 should have used the mechanical lift during R2's transfer. V2 said that V2 is not aware of V4 being the CNA that cares for R2. V2 said that normally, hospice aide request assistance from the facility aide. V2 said that V4 should have requested for assistance and used the mechanical lift to transfer R2.On 8/20/2025 at 12:48 PM, V8 (Hospice Nurse) said that V8 said that V8 has been the nurse for R2 since 4/2022. V8 said that V8 received a phone call from V4 (Hospice CNA). V8 said that V4 told V8 that V4 was transferring R2 from the chair to the bed using 1 person transfer. V8 said that V4 said that when V4 laid R2 in bed, V4 noticed blood on R2's leg. V8 said that V4 said that V4 does not know how it happened. V8 said V8 used company issued Microsoft team to video chat with V4 to see R2's wound. V8 said that the wound looks to V8 as a deep skin tear. V8 said that V4 informed V8 that V6 (R2's facility RN) and wound care nurse were notified already. V8 said that V8 spoke to V6 and instructed V6 to send R2 to the ER for sutures. V8 said that V8 notified V3 (R2's son) about R2's injury and V8 recommendation for R2 to be sent out to ER for sutures. V8 said that V3 told V8 to have