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	09/04/2025

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
	146053	A. Building B. Wing	09/04/2025

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	Based on interview and record review, the facility failed to provide adequate supervision and implement effective care plan interventions for one resident (R2) who was reviewed for falls. This failure resulted in R2 experiencing a right hip fracture as a result of a fall.Findings include:R2 has multiple diagnoses including but not limited to the following: delirium, altered mental status, acute kidney failure, metabolic encephalopathy, dementia, insomnia, psychosis, cognitive communication deficit, difficulty walking, and lack of coordination. Fall Risk Evaluation dated 7/13/2025 shows R2 has a fall risk score of 22.0 indicating resident is at high risk for falls.It is to be noted that R2 was sent to the emergency room following a fall on 7/16/2025 and has not returned to the facility.Facility Reported Incident states in part but not limited to the following: On 7/16/2025 at approximately 6:28AM, V5 (Licensed Practical Nurse) was monitoring R2 in the dining area. R2 stood and attempted to walk, despite V5's attempt to redirect. R2 stumbled and fell to the floor, landing on her right hip. X-ray completed in-house revealed an impacted intertrochanteric fracture of the right femur.Progress note dated 7/16/2025 states in part but not limited to the following: While sitting at the nurses station charting, V5 looked up and noticed R2 standing up from her chair while in common area and attempting to walk. V5 jumped up and was instructing R2 to have a seat. V5 could not reach R2 in time and R2 landed on her right hip on the floor.Radiology Results Report dated 7/16/2025 shows an impacted intertrochanteric fracture of the proximal right femur with varus deformity.On 9/2/2025 at 12:50PM, V4 (Restorative Nurse) said R2 was high risk for falls. R2 was very impulsive and lacked safety awareness. R2 had a fall on 7/11/2025 where we put an intervention in place to ensure R2 was in the common area and receiving close monitoring. These residents in the common area should be closely monitored. I would expect the staff that is monitoring these residents to be within close proximity.At 1:53PM, V3 (Assistant Director of Nursing) said R2 was very impulsive and hard to redirect. She would try and get up and walk but was not safely able to.V3 said we place residents who are higher fall risk and need close monitoring in the common areas. The staff are expected to sit in the common area with them. It is not adequate supervision if a staff member is sitting at the nursing station while monitoring these residents. The staff would not have ample time to respond to a resident if they were to get up and attempt to walk.At 2:18PM, V6 (Certified Nursing Assistant) said R2 was very impulsive and needed constant redirection. R2 resided on the 2-North unit where a lot of residents with dementia reside. R2 and other high fall risk residents sit in the common area so that the staff can monitor them closely.V6 said we have a monitoring system in place where the staff is expected to rotate every 30 minutes in the common area to monitor these residents. They are expected to sit in the common area with these residents and be in close proximity. Monitoring the resident from the nurse's station would not be adequate supervision and the staff may not have enough time to respond if a resident were to get up.At 3:20PM, V5 said R2 had a lot of behaviors and would constantly try to stand up without asking for assistance. R2 was a resident that we constantly did rounds on because we knew she had these behaviors. On 7/16/2025, I witnessed R2 fall in the common area. R2 was consistently trying to stand up since had gotten up that morning. I was charting at the nurse's station and continuing to walk back and forth to redirect her and have her sit down. I had my back turned and was walking back to the nurses' station when I heard something move. As I turned around, I saw R2 attempt to walk and fall on her right hip.There were two CNA's on duty that early morning, but they were both assisting a resident out of bed that required two-person assistance. We have many residents that require two-person assistance on this unit. This unit typically has a census of 43-50 residents and most of them have dementia and behaviors. I was the one responsible to monitor the residents in the common area at the time since the two CNA's were occupied providing care. However, I do not feel as if this is adequate staffing to properly care for all these residents.R2's Fall Care Plan intervention added on 7/11/2025 shows R2 should be placed in common area while awake for close monitoring.Facility Fall Prevention and Management Policy with last review date of 2/2025 states in part but not limited to the following: The facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. Residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk.