

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER Aliya of Palos Park		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an incident to the nurse causing a delay in care for one resident (R3) out of five residents that sustained a scalp bruise and clavicle fracture. This failure resulted in R3 experiencing pain due to a fracture and bruise which was not treated until the following day. Findings include, Facility's final report to state agency documents in part: Date of incident (10/28/25 at 3:30 pm) (incident was on 10/28/25 at 3:30 am, V2 (Director of Nursing) said it was a typo, the incident happened on the night shift). R3 is alert and oriented to self. During ADL (activities of daily living) rounds, patient was noted with bruising to her left side of her head and left shoulder. She was sent to the ER (emergency room) for further eval where it was determined that she had a Comminuted fracture of the left clavicle, Mild degenerative changes to the left shoulder and a frontal lobe scalp hematoma. Final Summary of investigation: R3 is alert with a BIMS of 00 (Not cognitively intact). She has Dementia and is under Hospice care. On October 28, 2025, R3 had an incident resulting in an injury to her clavicle. Upon investigation and staff R3 was being assisted with her ADL (incontinence care) care by staff member, R3 made a jerking movement while being repositioned that caused her to accidentally Bump her head and shoulder onto the bedside dresser that is near her bed. She has a diagnosed Vit D (vitamin D) deficiency as well as her age contributed to the fracture she sustained. R3 is [AGE] years old, and her diagnosis include: Hypertensive Heart Disease With Heart Failure, Displaced Fracture Of Lateral End Of Left Clavicle, Subsequent Encounter For Fracture With Routine Healing, Contusion Of Left Eyelid And Periocular Area, Subsequent Encounter, Depressive Disorders, Dry Eye Syndrome Of Unspecified Lacrimal Gland, Chronic Pain Syndrome, Insomnia, Constipation, Macular Degeneration, Neuromuscular Dysfunction Of Bladder, Acquired Absence Of Right Breast And Nipple, Dementia, Vitamin D Deficiency, Osteo Arthritis, Anxiety Disorder, Major Depressive Disorder. On 11/22/25 at 10:43 am R3 was observed. R3 returned from church activity. R3 was observed with bruising to left side and could not recall the incident. On 11/22/25 at 9:47 am V12 CNA (Certified Nursing Assistant) said she was the night shift CNA for R3 on 10/28/25. V12 said, she went to her room around 3:30 am and patient was in bed. V12 said, she was doing rounds and R3 was in bed in the middle of it. V12 said, during the incontinence care, she was moving R3 from side to side, R3 jerked her body, and she hit her head and shoulder against the dresser/nightstand, she was in the middle of the bed. V12 said, she raised R3's bed so she can provide care, V12 was rolling R3 side to side because she wanted to provide ADL care and R3 jerked and she hit the night stand, she hit her head and the shoulder, after she hit the head and shoulder she did not have signs of pain and bruising. V12 said, she assumed R3 was ok and she made a mistake and did not tell the nurse what happened. V12 said, she didn't see any bruising, and this happened around 3:30 am. V12 said, she was suspended for not telling the nurse to what happened right away. On 11/22/25 at 10:27 am V14 LPN (Licensed Practical Nurse) said, she was staff here and is assigned to R3 as the nurse. V14 said, facility had a book with care cards at the nurses' station, and it has each resident there what kind of care they require so CNAs will know how to care for that resident. V14 said, if a resident has an incident in the room, CNA is to get her and they can even yell out and V14 will go in the room right away. V14 said, her expectation is any issues, the cna will report (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 146053	Facility ID: 146053
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to her right of way. On 11/22/25 at 10:35 am V6 (CNA) said she is assigned to R3 and is familiar with her. V6 said, R3 is a one person assist, she has never made sudden jerk movements in bed, and she never had side rails. V6 said on 10/28/25 she started her shift, and she went to R3's room to get her up and she was changing her and R3 was moaning and could not turn to the side. V6 said, she turned R3 and she saw bruising on left side of her face, and it was around 7 am in the morning. V6 said, she came and got the night and morning nurse right away. V6 said, if a resident has a fall or bumps any part of her body during care, she is to report right away to the nurse. On 11/22/25 at 10:45 am V15 (CNA) said, he is staff here and has been working here for 2 months. V15 said, if a resident would have an incident in the room, he would get the nurse, would do it right away. On 11/21/2025 at 12:54pm V4, Certified Nursing Assistant (CNA) stated, if anything happens to a resident or I see any change in a resident, I tell the nurse right away and the nurse comes to assess the resident. On 11/22/2025 at 10:54am V7, Licensed Practical Nurse stated, if a CNA sees any change in skin, bruise, scratch or skin tear the nurse lets the nurse know so we can assess. We notify the doctor. The CNA has to notify the nurse with any change in condition. The nurse will let the doctor, and they may order labs, depends on the change or we may send out to the hospital for further evaluation. If a resident says someone was rough with them, I notify V11 because she does the investigation. Any change, I will do an assessment and notify V1, the doctor and family. On 11/22/25 at 11:07 am V11 (LPN) said, he was the nurse on duty coming for morning shift on 10/28/25. V11 said, he believes he was getting report from V10 (LPN) and he was not made aware of any incident with R3 prior to V6 coming came over to him (V11) and V10 and informing them R3 had pain and bruises on the skin. V11 said, if incident happens in the room his expectation is to call the nurse immediately so he can find out what happened, assess the resident and call the doctor. On 11/22/25 at 2:14 pm V10 (LPN) said, she was the night nurse on 10/28/25 and V12 (CNA) was the CNA assigned for R3. V10 said, V12 did not come in and inform her of any incident related to R3. V10 said, she works with R3 often, normally she does not find R3 to be resistive with care, she will lay in bed, she does have Dementia and gets confused. V10 said, if providing care and resident is resistive, CNA is to attempt to redirect the resident but if not, successful they are to come and get her (V10) right away. V10 said, if she would be made aware R3 bumped her head, she would do a risk management (document the incident) and inform the doctor, but V12 said nothing to her, she would come in and assess the resident right away. V10 said, all CNAs are to tell the nurse if anything happens with the resident. On 11/22/25 at 1:31 pm V2 (Director of Nursing) regarding R3 said she was informed by V11 that V6 on 10/28/25 found R3 had bruising to the left side of her face, and had bruise on her shoulder, and she asked if R3 fell but V6 said, she found R3 in bed found like that. V2 said, she told V11 to call doctor and family and hospice, and the doctor sent her to the hospital. V2 said, she started the investigation right away, she spoke to evening and night shift, night shift nurse (V10) said nothing happened, she saw her numerous times during the night, and she checks sugar of roommate, and she was in bed all night. V2 said, she first spoke to V12 and she initially said nothing happened and she (V2) went back to V12, and she finally told her that as she (V12) changed R3 and when she turned R3, she jerked during care. V2 said, V12 said initially everything was good, all staff said nothing happened, so she went back to night shift and V12 finally said when she turned R3, she bumped her head on the dresser, she tapped the dresser, and she did not yell out. V2 said, V12 informed her after R3 bumped herself on the dresser, V12 checked and no bruising was present, she did not inform the nurse because nothing happened to her, R3 had no marks. V2 said, she told V12 that if anything happens with a resident, she was to let the nurse know right away. V2 said, V12 was suspended pending investigation, and it had to happen during her shift. V2 said, R3 is 1 person assist. V2 said, the nightstand was right next to the bed and it was moved right away. On 11/24/25 at 12:27 pm V16 (R3's Physician) said the facility staff made him aware of the incident and R3 is in hospice but he still ordered for R3 to be sent out due to hitting her head. V16 said, the CNA needed to report this incident to the nurse. V16 said, R3 ended up with clavicle fracture however at [AGE] years old she is small and weights only around 98 pounds and she has fragile (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bones. V16 said, not sure how the incident could have been avoided as the resident jerked during care and how the CNA (V12) could have known the resident would jerk during care. V16 said, he was not in the room when the incident happened, and this is what the CNA has reported. V16 said, not sure if the jerking is avoidable, we want to say all fractures are avoidable but that is not always the case. V16 said, if R3 jerked and the diagnosis of Osteoarthritis will contribute to the fracture, his bones (V16) are stronger than hers and if that would have been him, no fracture would happen. V16 said, due to R3's age and being in hospice, we are not focusing on osteoporosis, she has no padding on her body and will break her bones more easily. R3's 10/28/25 Incident Report documents in part: Upon morning rounds CNA informed nurse that resident had some discoloration to her left side of her head and her left shoulder. Upon assessment nurse noted the discoloration in those areas, the patient denied having any pain and states she is unsure of what happened. The patient is confused at baseline. (Incident happened around 3:30 am and nurse on duty was not made aware until around 7:30 am) R3's (10/28/2025 at 7:40 pm) Nursing Note: R3 returned to the facility from Hospital around 7:30 with dx of clavicle fracture and scalp bruise. The patient's vitals within her baseline, and no signs nor symptoms of pain nor distress. Facility's Certified Nurse Aide job description documents in part: 19. Observe and report any physical or emotional changes observed in the residents including any complaints or grievances made by the resident. 24. Report all hazardous conditions and equipment to the nurse immediately.		