STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003735	A. BUILDING: _____ B. WING _____	C 01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint investigations: 239O035/IL00154897 239O006/IL00154869	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to provide appropriate and sufficient supervision to prevent falls to residents who are at high risk. This deficiency resulted in R1 (who recently had a left hip surgery for a fracture) sustaining a dislocated prosthetic left hip and R3 sustaining a fractured hip requiring surgery and hospitalization. The facility also failed to implement fall prevention care plan interventions, failed to accurately complete the fall assessment and failed to use a gait belt when transferring a resident. This deficiency affects all four (R1, R3, R5 and R6) residents reviewed for fall prevention management. Findings include: 1. R1 is admitted on 10/19/22 with diagnosis	S9999		

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S9999	Continued From page 2 listed in part but not limited to Intracapsular fracture of left femur, left artificial hip joint, Type 2 Diabetes Mellitus with mild non proliferative diabetic retinopathy, Dementia, Hypertension, Generalized muscle weakness, Cognitive communication deficit, Difficulty in walking, Visual loss both eyes, Legal blindness, Long term use of anti-coagulant, History of falling, History of neoplasm of large intestine. Admission fall assessment dated 10/19/22 indicated score of 10, at risk for fall. Physician Order sheet indicated: Hip precaution and WBAT (weight bearing as tolerated to left extremity) .Physical, Occupational and Speech therapy evaluation and treatment. Surgical site: Left hip monitor daily for sign and symptoms of infection. Use Aquacel dressing to left hip and do not remove until 5-7 days. R1's unwitnessed fall incident report dated 10/20/22 indicated: CNA's rounding noted R1 on the floor in her room next to her bed at 11:20pm. R1 confused, cannot explain what happened. R1 was sent out to the hospital for evaluation due to being prescribed blood thinners. R1's family notified at 12:30am. 10/21/22 - Root cause analysis- IDT (Interdisciplinary Team) met after fall. R1 was noted with fall at bedside, unable to verbalize what happened, R1 was sent out to the hospital for further evaluation. R1's fall assessment after fall 10/20/22 indicated score of 6, at risk for fall. R1's progress notes dated 10/21/22, R1 was admitted with diagnosis of displaced hip and stroke. R1's fall care plan indicated: at risk for fall and at high risk for fall was initiated on 10/21/22 after R1 was admitted to the hospital. Surveyor unable to interview with Nurse and CNA who worked with R1 on the shift that she fell. V1	S9999		

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S9999	Continued From page 3 Administrator, V2 Assistant administrator and V3 DON are aware. V2 said that V15 LPN who worked with R1 on the night that she fell is no longer working in the facility. R1's hospital emergency room record dated 10/21/22 indicated: R1 is an 85year old female presenting with complaints of a fall. R1 recently has a left hip surgery for fracture about 8 days ago. R1 has history of dementia. R1 apparently got out of bed and fell. R1 was found by staff on her knees. R1 complained of bilateral knee pain worsen on right than on left. R1 denies nay headache or neck pain. Physical Exam: Extremities: rotated internally and shortened. Left hip and pelvis x-ray showed a dislocated prosthetic left hip. Conscious sedation and reduction of the left hip done. On 1/10/23 at 2:28pm V11 Restorative/Fall Coordinator said that they have 48 hours to do base line plan of care of the resident. V11 said that she has spoken to V13 Family member prior to fall occurrence regarding fall interventions of R1 since she is at high risk of fall such as low bed, floor mat, frequent rounding, call light within reach, etc. but she did not write in R1's care plan. Informed V11 of inconsistency in R1's fall assessment. V11 said that she will do in-services with the nurses regarding properly completing of fall assessment. The score should go up not goes down after fall. R1 is at high risk for fall. On 1/11/23 at 11:27am, V12 CNA said that she took care of R1 on morning shift of 10/20/22 prior to fall. R1 is confused and restless and moving in bed. She placed wedges on both side of the bed and bilateral floor mat. R1 was complaining of pain and not comfortable in bed. V12 reported to the nurse and endorsed to next shift. R1 needs	S9999		

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S9999	Continued From page 4 total care with ADLs due to her confusion and restlessness. R1 needed 2 persons to boost her up to bed because she is restless and keeps on moving. R1 stayed in bed during her shift. On 1/11/23 at 11:45am V14 Therapy Director said that he evaluated R1 on 10/19/22. V14 said that R1 was referred to Physical therapy (PT)due to exacerbation of decrease in strength, decrease in functional mobility, decrease in transfers, reduced balance and reduced ability to safely ambulate indicating the need for PT to increase LE (lower extremity).ROM (range of motion) and strength, increase functional activity tolerance, improve dynamic balance, facilitate with all functional mobility and increase independence with gait. R1 is on fall risk precautions, posterior hip precautions, WBAT, legally blind. After evaluation V14 discussed precautions to the floor Nurse and CNA for safety. R1 is total dependence with ADLs and transfers. On 1/11/23 at 2:28pm V11 Restorative/Fall Coordinator said that if resident is confused and restless, they should provide close supervision/monitoring for safety. 2. R3 is admitted on 12/29/22 with diagnosis listed in part but not limited to Myocardial infarction, Enterocolitis due to Clostridium Difficile, Infection and inflammation due to indwelling catheter, Urinary tract infection, Hypotension, Difficulty walking, Hypertension, Coronary artery disease, Inguinal hernia, Benign prostate hypertrophy, long term use of aspirin. Care plan indicated: Impaired ambulatory skills. ADLs self-care performance deficit. At risk for falls r/t weakness and UTI, generalized weakness secondary to ST elevation, hypotension, polyosteoarthritis and hernia. Incontinent of	S9999		

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S9999	Continued From page 5 bowel. Admission fall assessment dated 12/29/22 indicated score of 9, at risk for fall. Fall assessment after fall dated 12/30/22 indicated score of 6, at risk for fall. R3's witnessed fall incident reported to IDPH dated 12/30/22 indicated at 5:10pm, R3 was walking to the bathroom without staff assistance. R3 was witnessed coming back from bathroom and lost hi balance and fell. V16 RN assessed R3 and notified Nurse practitioner to send R3 to hospital for evaluation. R3 was admitted with closed fracture of right femur investigation completed and it was revealed through staff and resident interviews that R3 was attempting to go to the bathroom without assistance. Staff witnessed R3 walking and very unsteady, staff immediately went to R3 to attempt to assist however R3 lost his balance and fell. Safety interventions will be implemented upon return from hospital. This is the final report dated 1/4/22. R3's hospital record dated 12/30/22 indicated: an 89-year-old male presents with chief complaint of mechanical fall today. R3 was at the rehab facility after being discharged from the hospital . R3 was allowed to walk to the bathroom himself when he tripped and fell o his right side. No head injury or LOC (Loss of consciousness). R3 is complaining of pain on the right hip worse with movement, no alleviating factors with no associated symptoms. R3 had history of left hip replacement. Physical exam: Significant tenderness on the right hip, limited ROM. CT of the right lower extremity indicated: Acute intracervical fracture of right femoral neck. Hospital admission diagnosis: Closed fracture of neck of right femur. On 1/10/23 at 2:28pm, Informed V11 of inconsistency in R3's fall assessment. V11 said	S9999		

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S9999	Continued From page 6 that she will do in-services with the nurses regarding properly completing of fall assessment. The score should go up not goes down after fall. On 1/11/23 at 10:44am, V17 CNA said that she took care of R3 in the morning shift of 12/30/22 prior to his fall. V17 said that R3 is confused and restless. R3 needs total assist due to his confusion. R3 needs 2 persons assist for transfers from bed to wheelchair. V17 does not know if R3 can walk because he was just admitted a day before she took care of him. The therapist has not informed them regarding his mobility. R3 uses wheelchair for mobility. V17 said that R3 eats independently but needs supervision. V17 said that during her shift R3 attempted to get out from bed. He is restless in bed, so V18 RN and her transfer him to wheelchair and endorsed it to the next shift. On 1/11/23 at 11:05am, V18 RN said that she took care of R3 on 12/30/22 in the morning shift prior to fall. V18 said that R3 is confused and restless. She and V17 CNA transferred him to wheelchair because he is restless and keeps moving in bed. They endorsed R3 to the next shift for monitoring/supervision due to his confusion and restlessness. On 1/11/23 at 12:30pm V16 RN said that she worked with R3 on 12/30/22 on 3-11 shift. V16 said that she saw R3 walking from his bathroom going back to his bed without walker. V16 said she run to assist him walking. She did not hold to guide him, she just stands behind him when he was walking toward his bed. When he was close to his bed, he lost his balance and fell on the floor. V16 said that she could not prevent the fall. V16 said that R3 is confused. She is not aware that R3 is at risk for fall. She was not aware that	S9999		

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S9999	Continued From page 7 R3 was restless and attempted to get out from bed in the morning shift. She is not aware that she R3 needs supervision and monitoring. V16 said that there is gait in the room that is accessible, but she did not use with R3 because he is already walking when she saw him. V16 said that she should use the gait belt to assist him in ambulation back to his bed. Surveyor unable to interview CNA who worked with R3 on 12/30/22 on 3-11 shift. V1 Administrator, V2 Assistant administrator and V3 DON are aware. On 1/11/23 at 11:45am, V19 Physical Therapist (PT) said that she evaluated R3 on 12/30/22. V19 said that he was referred for PT services to evaluate need for assistive device, promote safety awareness, enhance rehab potential, increase awareness of environmental hazards, minimize falls, increase LE ROM and strength and increase functional activity tolerance in order to enhance patient quality of life by improving ability to safely return to ALF (assisted living facility), decrease level of care required from caregivers, perform steady gait and facilitate increased independent with functional mobility throughout facility. R3 needs moderate assistance with ADLs and transfers. R3's precautions: Fall risk, isolation, contact and droplet precaution due to possible COVID 19 exposures, catheter. V19 said that after her evaluation with R3 she discussed precautions to the floor nurse and CNA for safety. V19 said that she left walker at bedside for R3 to use when ambulating with staff supervision. On 1/11/23 at 2:28pm V11 Restorative/Fall Coordinator said that if resident is confused and restless, they should provide close	S9999		

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S9999	Continued From page 8 supervision/monitoring for safety. 3. R5 is admitted on 5/14/21 with diagnosis listed in part but not limited to Type 2 Diabetes Mellitus with diabetic polyneuropathy, Vascular dementia, Kidney transplant, Epilepsy, Hypertension, Anxiety disorder, End stage renal failure, Gastroesophageal reflux disease, Long term use of insulin, history of traumatic brain injury. Care plan indicated: ADLs self-care performance deficit. AT risk for fall r/t generalized weakness and decreased safety awareness secondary to history of left femur fracture after fall, epilepsy, dementia, history of traumatic brain injury, left hip ORIF (Open reduction internal fixation). Currently receiving psychotropic medications due to anxiety and depression. Noted with behavior or mood issues of restlessness, anxiousness and feeling disconnected to everything. Admission fall assessment done on 5/14/21 indicated score of 9, at risk for fall. Fall assessment after fall dated 1/21/22 indicated score of 5, at risk for fall. Fall assessment after fall dated 2/15/22 indicated score of 10, at risk for fall. Fall assessment after fall dated 4/18/22 score of 3, at risk for fall. Fall assessment after fall dated 1/1/23 score of 6, at risk for fall. R5's fall incident dated 1/1/23 reported to IDPH indicated: R5 was sitting in the TV room when staff witnessed her fall forward. The nurse assessed and notified the doctor. She was sent tot hospital for evaluation. Hospital notified staff that she was diagnosed with nasal fracture. Investigation completed and revealed that R5 was in the TV room watching TV when she fell asleep and fell forward. She returned to facility, pain management and safety intervention implemented. This is the final report dated 1/6/23. Pain management intervention was not	S9999		

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S9999	Continued From page 9 implemented. R5's fall incident dated 4/18/22 indicated: R5 found on the floor on her left side in her bedroom. R5 said that she was attempting to walk to the bathroom, tripped and fell on the floor. R5 denied hitting her head. R5 was sent out to the hospital for Right hip, sacral, thoracic and spinal x-ray. 4/18/22 Root cause analysis- IDT met after fall R5 alert and oriented x 2. R5 noted with fall in bedroom, per R5 she attempted to transfer unassisted. R5 will be encouraged to participate in activities that promote maintenance of gross motor skills. X-ray to sacral and right hip, will continue to monitor. Fall care plan interventions was not updated based on IDT recommendation. R5's fall incident dated 2/15/22 indicated: Heard R5 yelling for help at 3am. Found R5 sitting on the floor in her room. R5 said that she was trying to get out of bed and slid off of bed. R5 complained of lower back pain. R5 was sent out to the hospital for lumbar and sacral x-ray. 2/16/22-Root cause analysis- IDT met after the fall. R5 was noted with fall in her room. R5 stated that she slid from bed, intervention increase rounding at a minimum of every 2hrs and prompt or assist for change in position, toileting, offer fluids and ensure resident is warm and dry and keep in lowest position. No documentation of increased rounding/monitoring that was done. R5's fall incident dated 1/21/22 indicated: Heard R5 screaming for help. Found R5 on the floor. R5 said that she fell asleep in the wheelchair and fell on the floor and hit her head. R5 complained of left hip pain. R5 was sent out to the hospital for evaluation. 1/22/22- Root cause analysis. IDT met after fall. R5 fell due to falling asleep in her room. Intervention: Encourage participation in	S9999		

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S9999	Continued From page 10 activities to keep resident's focus on task, maintain resident in well supervised areas when up in wheelchair. On 1/11/23 at 10:10 am Observed R5 lying in bed, restless and moaning. R5 said that she is in pain and has been waiting for the nurse for pain medication. R5 has facial bruising on her check bilateral cheek bone. Her bed is in high position. She has bilateral floor mat on side of the bed. Called V20 RN and showed observation made. V20 said that the CNA probably left the bed in a high position when providing the breakfast tray to R5. V20 said that R5's bed should be in the lowest position when she is in bed for safety. R5 is at a high risk for falls. V20 put the bed in the lowest position. V20 said that she has not given R5 her pain medication. V20 said that R5 is confused and always complains of pain. V20 checked R5's e-MAR. She said that the last time R5 had her pain medication was yesterday at 4:45pm. On 1/11/23 at 12:15pm, Informed V11 Restorative/Fall Coordinator of inconsistency in R5's fall assessment. V11 said that she will do in-services with the nurses regarding properly completing fall assessments. The score should go up not go down after falls. Informed V11 of observation made with R5's bed in high position with V20 RN. V11 said that R5's bed should be in lowest position when she is in bed. Informed V11 that pain management for R5 as plan of care after the recent fall is not implemented. 4. R6 is admitted on 12/5/22 with diagnosis list ed in part but not limited to Cerebral edema, History of falling, Hemiplegia and hemiparesis following intracerebral hemorrhage affecting left non dominant side, Facial weakness following	S9999		

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S9999	Continued From page 11 cerebral infarction, Laceration with foreign body of part of head, Unsteadiness on feet, generalized muscle weakness, Dementia, age related cataract, hearing loss, chronic kidney disease, age related osteoporosis, Alzheimer's disease. Care plan indicated: ADLs self-care performance deficit. At risk for fall secondary to recent hospitalization with dx of cerebral edema is noted with increased weakness. Unsteadiness on feet. Gait/mobility abnormality. Has other co-morbidities, pulmonary fibrosis, left hemiplegia, urinary incontinence, dementia, overactive bladder and Alzheimer's disease. She has impaired cognitive function. Admission fall assessment done but not signed on 12/5/22 indicated score of 8, at risk for fall. Fall assessment after fall incident on 12/22/22 was not done. Fall assessment after fall incident on 1/5/23 indicated score of 12, at high risk for falls. Fall assessment after fall incident on 1/9/23 indicated score of 13, at high risk for falls. R6's fall incident dated 1/9/23 reported to IDPH on 1/10/23 indicated: At approximately 9:45pm, R6 was observed sitting in her wheelchair next to her bed with laceration to the back of her head. R6 said that she attempted to self-transfer and fell, hitting her head. R6 then got herself back into her wheelchair. R6 is alert and oriented to self but pleasantly confused. Nurse assessed laceration, applied pressure, cleansed, and covered with dry gauze. R6 was sent out to the hospital for evaluation. R6 returned to the facility with 3 staples to the back of the head. Pain management in place. Investigation started. Final report to follow. 1/10/23- Root cause analysis-IDT met after fall. R6 was noted with fall at bedside sent out for further evaluation, came back with laceration to left side of head. Intervention: initiate 3-day elimination record and	S9999		

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S9999	Continued From page 12	S9999		

increase rounding at a minimum of every 2 hours and prompt or assist for change in position, toileting, offer fluids and ensure R6 is warm and dry. Facility unable to provide documentation of increased rounding/monitoring of R6.

R6's fall incident dated 1/5/23 indicated: At approximately 4am, noted sitting in her chair at bedside. R6 is conscious, alert, and oriented to self but pleasantly confused and forgetful. R6's roommate uses her call light to call for help and verbalized that she saw R6 on the floor but did not see how she fell. R6 unable to give description on what happened due to confusion. R6 has an old healing laceration to the left side of head with dry scab but after she fell noted the dry scab re-opened measuring 1.5cm x 1cm with scant blood. Site cleansed with NS and kept clean and dry. R6 assisted back to bed with 2 persons assist. R6 was sent out to the hospital for CT of the head. 1/7/23-Root cause analysis- IDT met after fall. R6 was noted with fall and sent out to hospital for eval. Came back with negative findings. Intervention: dx UTI. Currently on anti-biotics, staff will increase frequent monitor. Facility unable to provide documentation of increased monitoring. V3 DON said that they did not submit report to IDPH because the scab re-opened causing open wound and not new injury related to fall.

R6's fall incident dated 12/24/22 indicated: R6 found in other resident room. R6 said that when she realized that it was not her room, she turned too fast and lost her balance and fell on the resident's bed. No injury noted 12/24/22-Root cause analysis - IDT met after fall. R6 was noted with fall due to impaired balance and was not wearing proper shoes, intervention: R6 was provided with proper footwear/nonskid socks. No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003735	A. BUILDING: _____ B. WING _____	C 01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 fall assessment done after fall incident. On 1/11/22 at 10:18am, Observed R6 lying in bed. She is alert and responsive, able to verbalize needs. She is hard of hearing. Her bed is in a high position. Her call light is on the floor on right side of the bed. She does not have floor mat. Called V21 CNA and showed observation. V21 said that R6's bed should be in the lowest position. V21 said that she raised her bed when she provided her breakfast meal and forgot to put it down. V21 picked up the call light on the floor placed it within reach. Informed V11 Restorative/Fall coordinator of observation made. On 1/11/23 at 10:51am, Observed V21 CNA transferred R6 from toilet to wheelchair without using a gait belt. V21 said that she forgot to use a gait belt. V21 said that she should use a gait belt when transfering R6. R6 is high risk for falls. On 1/11/23 at 12:15pm, Informed V11 Restorative/Fall Coordinator of R6's fall assessment after fall incident on 12/24/22 was not done. V11 said that floor nurse should complete fall assessments after each fall occurrence. Informed V11 of observation made V21 CNA transferring R6 from toilet to wheelchair without gait belt. V11 said that CNA should use a gait belt when transferring resident or ambulating for safety. On 1/11/23 at 12:31pm, V10 CNA Supervisor said that CNA should use a gait belt when transferring resident for safety. On 1/11/23 at 2:04pm V3 DON and V11 Restorative /Fall Coordinator said that they don't document their monitoring for residents' who are high risk for falls as indicated in care plan.	S9999		

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S9999	Continued From page 14 Informed both the fall care plan interventions for R5 and R6 who has recently fallen and sustained injuries- R5 sustained basal fracture and R6 sustained laceration at the back of the head both requires visit to the hospital for treatment. Both residents fall care plan intervention indicted increased rounding /monitoring. V3 and V11 said that they just informed the CNAs to do frequent or increased rounding/monitoring, but they don't have documentation of date and frequency of time residents' are being monitored. Facility's policy on Fall risk assessment indicates: Policy: Residents will be assessed for risk factors that increase their potential falls in order to identify the need to initiate additional safety measures. Procedures: 1. Residents shall be assessed upon admission, re-admission, with significant change , post fall , quarterly and annual . 2.The resident who scores 0-1 shall be considered at risk for fall 3.The resident who scores 12 or greater will have considered at high risk 4.All resident will have universal fall intervention applied 6. With each fall, the care plan interventions will be reviewed for their effectiveness and modified as appropriate to reduce hazards and risk to the residents. Facility's policy on Management of falls indicates: Policy: The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions and revised the resident 's plan of care in order to minimize the risk for fall incidents and or injuries to the resident. Facility's policy on Fall management program	S9999		

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S9999	Continued From page 15 indicates: Policy: The facility is committed to minimizing resident falls and or injury so as to maximize each resident's physical, mental and psychosocial wellbeing. While preventing all resident falls is not possible, it is the facility's policy to act in a proactive manner to identify and assess those resident at risk for falls, plan for preventive strategies and facilitates a safe environment. Facility's policy on Gait belt/Transfer belt indicates: Policy: To assist with a transfer or ambulation. A gait belt will b eused with weight bearing residents who requires hands on assistance. (A)	S9999		