STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014500	A. BUILDING: _____ B. WING _____	C 03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF NORTHMOOR	5831 NORTH NORTHWEST HIGHWAY CHICAGO, IL 60631

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S 000	Initial Comments Investigation of Facility Reported Incident of 1/29/23/IL156238	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 requirements were Not Met as evidenced by: Based upon interview and record review, the facility failed to supervise a cognitively impaired resident at risk for fall. This failure affected one resident (R2) of two residents reviewed for falls. As a result of this failure, R2 fell from the wheelchair to the floor and sustained multiple fractures to the pubic/pelvic area. Findings include: On 3/13/23 at 10:15am after the entrance conference, V1 (Administrator) presented the facility's census which shows that there were 42 residents on the fourth floor, which is the	S9999		

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S9999	Continued From page 2 Dementia Floor. The nursing staff assignment sheet for the 3-11 shift of 1/29/23 shows 2 nurses and 2 CNAs (Certified Nurse Assistants) took care of all residents on the Dementia floor for that shift. R2's face sheet shows that admission diagnoses include but are not limited to Anxiety Disorder, Overactive Bladder, Insomnia, and Dementia with Agitation. On 3/14/23, during this investigation, V2 (Director of Nursing/DON) presented the facility's incident reports of R2's fall event that was sent to the State Agency. This report states that R2 was noted by multiple staff members sitting in the wheelchair in the dining room watching TV with other residents, and later observed on the floor next to the wheelchair. On 3/16/23 at 11:30am, V19 (Licensed Practical Nurse/LPN) was interviewed about which staff was with R2 in the dining room when R2 fell. V19 stated, "It was on a 3-11 shift and (R2) was yelling and trying to get out of the wheelchair. I was busy passing medications and I put her (R2) in the dining room to watch movie with other residents, and I was watching her through the dining room window while passing medications. I saw her (R2) sliding out of the wheelchair, and by the time I got to her, she already was on the floor." The surveyor inquired from V19 if there was any staff watching R2 and the other residents in the dining room at that time; V19 responded, "I think there was a CNA assigned to watch the residents in the dining room, but I don't remember who the CNA was." On 3/16/23 at 3:34pm, V2 (DON) was asked about the staff that was watching the residents in	S9999		

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S9999	Continued From page 3 the dining room. V2 stated that she (V2) would look at the schedule to know the CNA assigned. V2 stated, V20 (Certified Nursing Assistant/CNA) was the CNA assigned. On 3/16/23 at 4:05pm, V20 (CNA) was interviewed regarding being assigned to R2 on the 3-11 shift of 1/29/23. V20 stated, she (V20) was the CNA. V20 stated, after dinner on that day, R2 was yelling and trying to get up from the wheelchair and she (V20) put R2 in the dining room with other residents to watch TV. The surveyor inquired from V20 if she (V20) was there in the dining room when R2 fell from the wheelchair. V20 responded, "I (V20) was changing another resident at that time and was not in the dining room when R2 fell." On 3/16/23 at 3:47pm, V10 (Physician) was interviewed regarding R2's supervision, fall, pelvic fracture, pelvic fracture treatment, and the eventual placement of R2 on hospice care. V10 stated, "You don't have to fix pelvic fracture, you just need proper management - No weight-bearing, and since the patient is bed-bound, that can be achieved." Inquired from V10 if R2's fall and fracture with the associated pain was the reason R2 was placed on hospice care; V10 responded, "That could be part of the equation, but not the only reason; the patient has several medical conditions." R2's records reviewed include but are not limited to the following: Hospital Records dated 1/30/23 was reviewed. Results of the CT (Computed Tomography) scan of pelvis states in part: There is an acute left pelvic sidewall hematoma, measuring approximately 6 x 4.5 cm(centimeters) in the CC,	S9999		

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S9999	Continued From page 4	S9999		

transverse dimension. In the AP dimension of this hematoma measures 7 cm. There is an impacted fracture involving the left superior pubic ramus with extension into the pubic symphysis. There is an impacted but nondisplaced fracture involving the left inferior pubic ramus on series 4 image 278. There is also a posterior inferior right pubic ramus fracture, with minimal disruption of the cortex. This is seen on series 4 image 279.

Fall Risk Assessment dated 12/20/22 and 2/6/23 both show that R2 is at risk for falls.

MDS (Minimum Data Set) section G dated 12/23/22 and MDS dated 2/8/23 both show that R2 needs extensive assistance for locomotion on unit and for transfers.

MDS section C dated 2/8/23 shows BIMS (Basic Interview for Mental Status) score of 3 out of 15 (severe cognitive impairment).

Care Plan dated 9/19/22 states R2 is at high risk for falls related to medical several medical conditions; Intervention states: Rounding frequently and prompt or assist for change in position, toileting, offer fluids, and ensure resident is warm and dry. Another intervention states to encourage appropriate use of wheelchair. Care plan dated 2/1/23 states R2 has an ADL (Activities of Daily Living) self-care performance deficit related to medical conditions; Intervention states to assist with locomotion as needed, and to assist with ADL tasks as needed.

Care Plan dated 2/1/23 states that R2 is at high risk for falls related to weakness, poor balance, unsteadiness on feet, pain, physical limitation r/t recent hospitalization with dx of fracture left superior and inferior pubic rami and right inferior

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S9999	Continued From page 5 pubic rami. POS (Physician Order Sheet) dated 2/6/2023 states: Hospice Evaluation per family request. POS dated 2/1/23 states in part: Comfort-Focused Treatment; Relieve Pain and suffering through the use of medication ... Facility's Fall Policy dated 08/2020 states in #6: Assess and monitor resident's immediate environment to ensure appropriate management of potential hazards. Facility's CNA job description (undated) states in #F: Makes rounds to assure customers are safe and comfortable. (A)	S9999		