STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016869	A. BUILDING: _____ B. WING _____	C 04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF SHOREWOOD	700 WEST BLACK ROAD SHOREWOOD, IL 60404

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S 000	Initial Comments Investigation of Facility Reported Incident of March 15, 2023/IL157982	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)3)6) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to safely transport residents using a wheelchair. The facility also failed to ensure a resident with a history of falling had footrests in place when self-propelling. This failure resulted in R1 sustaining a head laceration, requiring medical attention at the local emergency room and 15 sutures. This applies to 3 of 4 residents (R1, R2, R4) reviewed for accidents and supervision in the sample of 4.

The findings include:

1. On April 4, 2023, at 10:55 AM, R1 was sitting in his wheelchair. R1 was not able to be interviewed due to his cognitive status. R1 had a laceration on his forehead that measured about 5 inches in length and was V-shaped. R1 had 1.5 to 2 inches of the laceration scabbed over. R1 also had a foam dressing to the left hand, and steri-strips on two of his knuckles of his hands.

The EMR (Electronic Medical Record) shows R1 was admitted to the facility on December 15, 2022, with multiple diagnoses including encephalopathy, urinary tract infection, dementia, syncope, and collapse, and polyosteoarthritis.

R1's MDS (Minimum Data Set) dated March 27, 2023, shows R1 has severe cognitive impairment, and requires extensive assistance from a facility staff member for bed mobility, locomotion on and off unit, dressing, eating, toileting, and personal hygiene. R1 requires extensive assistance from two facility staff members for transferring.

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The facility's fall incident log from January 1, 2023, to present documents R1 fell on January 1, 2023, January 3, 2023, January 5, 2023, January 28, 2023, twice on March 15, 2023, and on March 26, 2023.

The facility's incident report for R1, dated March 22, 2023, shows on March 15, 2023, R1 sustained an injury following transport in wheelchair by a staff member leading to a fall requiring medical treatment at the local hospital. The incident report shows: "On March 15, 2023, resident fell and was observed with laceration to forehead. Physician gave orders to send out to [Emergency Room] for evaluation. Resident returned to facility same day with sutures to forehead. Orders received from hospital were carried out."

Hospital documentation dated March 15, 2023, shows R1 was seen in the local emergency room for a fall with a scalp laceration. R1 returned to the facility on March 15, 2023, with sutures to his laceration.

R1's initial nursing assessment dated March 20, 2023, shows R1 had 15 sutures to the forehead and 10 steri-strips applied to the back of his left hand.

On April 4, 2023, at 10:31 AM, V3 (Nurse) said on March 15, 2023, before dinner, she was pushing R1 in his wheelchair to the dining room when he put his legs on the ground, causing him to fall forward onto the floor. V3 said R1's wheelchair did not have footrests on them. V3 said R1 had increased confusion all day and was being worked up for an infection. V3 said when R1 has an infection, he becomes very confused and is unable to follow commands. V3 said on March

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15, 2023, she had told R1 to keep his feet up, but he suddenly put his feet down.

On April 4, 2023, at 10:58 AM, V4 (Activity Aide) said she was a 1:1 sitter with R1 as he was very confused and was not redirectable. V4 said on March 15, 2023, V3 came to R1's room to get him to come to the dining hall for dinner and began pushing him to the dining room. V4 said as V3 was pushing him to the dining hall, R1 suddenly put his feet down and went flying out of the wheelchair. V4 said he did not have footrests on his wheelchair.

On April 4, 2023, at 11:12 AM, V5 (CNA/Certified Nurse Assistant) said residents should have footrests on their wheelchair if staff are transporting them. V5 said if they do not have footrests, they can fall out of their chair or injure their feet. V5 also said R1 is not himself when he has an infection and requires more assistance with activities of daily living.

On April 4, 2023, at 1:05 PM, V2 (DON/Director of Nursing) said V3 (Nurse) had called him on March 15, 2023, at 4:05 PM to assist when R1 fell. V2 said R1 needed to go to the hospital because the laceration was too deep to be taken care of by the facility. V2 said earlier that day around midnight, R1 had fallen out of his bed and the facility staff called the doctor to request labs to work him up for an infection. V2 said R1 was not himself and had behaviors. V2 said on March 15, 2023, the activity aide was assigned to his room because he was experiencing agitation. V2 said V3 should have done an assessment on him to know what his mental status was prior to wheeling him to the dining hall.

On April 4, 2023, at 3:32 PM, V11 (NP/Nurse

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S9999	Continued From page 4 Practitioner) said the fall was the reason he had the laceration and went to the hospital. R1's progress note dated March 14, 2023, at 7:26 PM shows the following: "[Power of Attorney] notified staff that [R1] has hallucinated both yesterday and today in addition to an extended crying episode. Requested [urinalysis] be collected due to past histories of [urinary tract infections]." R1's progress note dated March 15, 2023, at 12:34 AM shows the following: "Resident laying on the floor. Upon entering the resident's room, writer noted resident to be laying on the floor beside his bed with his blankets." R1's progress note dated March 15, 2023, at 12:42 AM shows the following: "[Registered Nurse] notes no injury but does state over the past 3 days has been more confused than usual." 2. On April 4, 2023, at 11:42 AM, R2 was in the dining hall without footrests on her wheelchair. At 3:45 PM, R2 was in her room in her wheelchair without footrests. R2 was self-propelling in her wheelchair using her arms only, while her legs touched the ground while transporting. R2 said she does not really use her legs to transport herself and could not remember her last fall. On April 4, 2023, at 12:02 PM, V8 (CNA/Certified Nurse Assistant) said R2 should have footrests on her wheelchair, but she did not have time to put them on this morning. The facility's accident log documents R2 had a fall from her wheelchair on January 11, 2023 and sustained a skin tear to the right elbow. The EMR shows R2 was admitted to the facility on July 15, 2020, with multiple diagnoses	S9999		

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S9999	Continued From page 5 including multiple sclerosis, dementia, polyosteoarthritis, lymphedema, and peripheral vascular disease. R2's MDS dated January 20, 2023, shows R2 has severe cognitive impairment, and requires extensive assistance from one facility staff for locomoting on and off the unit, and personal hygiene. R2 requires extensive assistance from two facility staff members for bed mobility, transferring, dressing, and toileting. R2's Functional Abilities and Goals Assessment dated January 20, 2023, documents R2 requires partial/moderate assistance to travel 50 feet in her wheelchair. 3. On April 4, 2023, at 12:20 PM, R4 was being pushed in her wheelchair without footrests by V9 (CNA). V9 transported R4 from R4's room to the beauty salon to retrieve a weight, and then back from the beauty salon to the nurse's station. Surveyor noted the distance was about 150 feet in total. V9 said R4 should have had footrests on while she was pushing her because R4 could put her feet down and fall without the footrests in place. The EMR shows R4 was admitted to the facility on September 13, 2022, with multiple diagnoses including dementia, epilepsy, and a history of falling. R4's MDS dated March 12, 2023, shows R4 has moderate cognitive impairment and requires extensive assistance from one facility staff for bed mobility, transferring, locomoting on and off the unit, dressing, toileting, and personal hygiene. On April 4, 2023, at 1:38 PM, V10 (Director of Rehab) said if a resident is being transported by	S9999		

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S9999	Continued From page 6 staff, they should have their footrests on their wheelchair. V10 said not having the footrests on the wheelchair while being pushed by staff could cause the resident to fall. V10 said if R1 was confused, R1's wheelchair should have had footrests on them. V10 also said if a resident cannot use their legs to self-propel, they should have footrests on their wheelchair. "B"	S9999		