Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015101	A. BUILDING: ______ B. WING ______	C 08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (NORTHBROOK)	**3240 MILWAUKEE AVENUE NORTHBROOK, IL 60062**

(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 Investigation of Facility Reported Incident of June 8, 2024/IL174576	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.710c)3) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to supervise/monitor a resident assessed to be risk for falling while in the dining room. This failure affected one resident (R1) of three residents reviewed for fall incident. R1 had a fall	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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incident in the dining room. R1 sustained laceration on back of the head, small hematoma and was sent out to hospital for evaluation.

Findings Include:

Facility reported incident dated 6/8/24, reads in part: R1 was sitting in wheelchair in the dining room. V7 (Receptionist) was present in the house and V7 saw R1 getting up from chair. Before staff could reach R1, R1 attempted to ambulate and fell on her back hitting R1's head on the floor. Observed small hematoma with slight laceration on her occipital area with small to moderate amount of bleeding. R1 is taking anticoagulant. Transfer to Local Hospital ER via 911.

R1 has diagnoses but not limited to: Alzheimer, and Dementia.

R1 admitted in the facility and assessed to be high risk for falling on 12/2/23, with a score of 13 (Severe Risk).

R1 then again assessed status post fall dated 6/13/24 and scored 65.0 (High Risk).

On 8/8/24 at 11:55AM, V5 (Caregiver) stated V5 was watching residents in the dining room, and V6 (caregiver) was on her lunch break. One resident needed to use the toilet, and V5 was by herself in the unit at that time. So V5 made sure that R1's wheelchair was against the wall and the table pulled in front of R1 before leaving the dining room and took the other resident to use the toilet. V7 (Receptionist) reported to V5 that R1 was sitting in the wheelchair against the wall, pushed the table and V7 saw the table move. V7 witnessed R1 falling but was not able to stop R1's fall because V7 was not close enough to prevent

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R1 from falling. "Unfortunately, at the time of R1's fall incident, there was no one around to watch R1 and redirect R1".

On 8/8/24 at 11:13AM, V3 (Registered Nurse) stated there were 2 care givers working that day. V3 was not in the house (unit) and received a paged from staff regarding R1's fall and to come to the house (unit). V3 went back to the unit and noted R1 on the floor in the dining room. There were 3 to 4 other residents in the dining room at the time of V3's arrival. Assessed R1 and R1 was able to move extremities. Checked R1's head and noted small laceration, small amount of bleeding with hematoma. R1 is on anticoagulant, so 911 was called per facility policy. Caregivers were not in the dining room at the time of R1's fall. V3 stated that V7 (Receptionist) witnessed the fall. V7 went to the house (unit) to do something and witnessed R1 getting up from wheelchair and tried to walk. V7 was not able to get close to R1 to stop the fall. Facility practice is that caregivers will bring resident in the dining room for mealtime. Caregivers will leave dining room to get other residents, and when everybody is in the dining room, caregivers stay in the dining room to monitor residents. Nobody watches the resident in the dining when caregivers are getting other residents to go to the dining room for mealtimes. "R1 is alert oriented x1 (person only). R1 is not able to understand and must really be there and guide R1 to sit down when noted standing up from chair. R1 is not redirectable just by saying "sit down", someone has to physically guide R1 to sit R1 back to her chair".

On 8/8/24 at 12:53PM, V2 (Director of Nursing/DON) stated that V7 went to the unit and witnessed R1 getting up from wheelchair in the dining room. V7 saw R1 and V7 called out to say

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"R1, No". But before V7 can make it to R1, R1 fell on the floor. R1 is alert to her name only. R1is not aware of safety. She needs to be monitored and supervised.

On 8/9/24 at 9:30am, V2 (DON) also stated that high risk for falling residents need to be supervised in the dining room. R1 had impulsive behavior of getting up from wheelchair and poor safety awareness, and that someone needs to be present in the dining room with R1 and other high risk for fall residents. V2 stated that the facility has more than one high risk residents that stays in the dining room to be closely monitored at all time. Staff must be present in the dining room when high risk residents are in the dining room for resident safety.

Fall Prevention dated 6/2021 reads in part: Identify residents at risk or predisposed to falls. Evaluate the health, safety and welfare of our residents and implement measure to attempt to prevent falls and minimize the risk that serious injury will result. Fall Prevention Guidelines guide staff through a structured process to screen and identify residents for predisposing risk factors or history of falls. Whenever possible, the staff implements precautionary measure to reduce the risk of falls by individualizing resident's needs.

"B"