

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016869	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2024
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NAME OF PROVIDER OR SUPPLIER ALDEN COURTS OF SHOREWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST BLACK ROAD SHOREWOOD, IL 60404
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S 000	Initial Comments Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: ONE OF TWO 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. The REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to ensure health care worker background checks were completed prior to employees being hired. The findings include: Review of a sample of the facility's health care worker background checks found the following: V18 (Housekeeper) was hired on February 22, 2024, and her background check was dated June 17, 2024. V19 (Certified Nursing Assistant (CNA)) was hired on May 10, 2024, and her background check was dated June 14, 2024. V20 (CNA) was hired on August 15, 2024, and	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
09/20/24

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S9999	<p>Continued From page 1</p> <p>her background check was dated August 17, 2024.</p> <p>V21 (CNA) was hired on March 18, 2024, and her background check was dated June 14, 2024.</p> <p>V22 (CNA) was hired on February 23, 2024, and her background check was dated June 14, 2024.</p> <p>V23 (CNA) was hired on February 8, 2024, and her background check was dated June 14, 2024.</p> <p>V24 (Dietary Aide) was hired on July 10, 2024, and her background check was dated July 17, 2024.</p> <p>On September 11, 2024 at 9:35 AM, V16 (Admissions Director) stated that she was out of the country for two months and V17 (CNA/Scheduler) was covering for her. V16 stated did not do the background checks. V17 that background checks need to be done before an employee is hired.</p> <p>On September 11, 2024 at 10:37 AM, V16 stated that V17 was trained on how to run the background checks prior to V16 leaving, so that V17 could do the required background checks in V16's absence. However V16 stated that when she returned from her trip, she found that the required background checks had not been completed.</p> <p>(C)</p> <p>TWO OF TWO 300.610a) 300.1210a) 300.1210b)5) 300.1210d)6)</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>b) The facility shall provide the necessary</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.</p> <p>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:</p> <p>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.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to provide adequate supervision and assistance to a resident during ambulation who required moderate assistance from the staff. This failure resulted in R8 sustaining a fall, being hospitalized, and diagnosed with a fracture to her</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>pubic rami and fourth proximal phalanx of the toe. This applies to 1 of 2 residents (R8) reviewed for falls in the sample of 12.</p> <p>The findings include:</p> <p>R8 is a 83 year old female with diagnoses that include Moderate Dementia, Sacroilitis, Spondylosis of the cervical and lumbar regions, and Osteoporosis.</p> <p>R8's Admission Minimum Data Sheet (MDS) dated May 20, 2024 showed that R8 to have severe cognitive impairment. The MDS also showed that R8 requires partial/moderate assistance where the helper lifts, holds, or supports trunk or limbs, but provides less than half the effort when ambulating.</p> <p>R8's fall risk assessments dated May 13, 2024 and June 12, 2024 showed R8 was at risk for falls. R8 also has a history of a fall at the facility on June 12, 2024. R8's June 12, 2024 incident report noted that R8 has a history dementia and demonstrates impaired memory and poor safety awareness.</p> <p>R8's final incident reportable dated July 15, 2024 showed the following: "Staff were interviewed and staff stated that after dinner [R8] was coming out of the dining room and stopped to converse with the nurse and another resident. While enjoying the conversation, the resident turned her head causing her to lose her balance and began to fall towards her right side. Nurse present on the left side and assisted resident to the floor."</p> <p>The reportable futher showed R8 had a witnessed fall, resident had a sudden change in condition and was sent to the hospital via 911.</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>Per the hospital, R8 was admitted with a comminuted fracture of left medial superior pelvis and left forth toe fracture. The report also showed that the facility found that the factors contributing to the fall include a recent change in condition, distracted while ambulating, gait imbalance, cognitive impairment and poor safety awareness.</p> <p>On September 10, 2024 at 3:49 PM, V11 (Assistant Director of Nursing) stated she does the fall investigations for the facility. V11 stated that R8 had a fall in the activity room on June 12, 2024. V11 further stated that on July 7, 2024, R8 was walking to her room with V10 (Certified Nursing Assistant/CNA)). V11 stated that between the dining room and the hallway, R8 stopped to talk to nurse and then turned to talk to another resident. V11 stated that R8 then lost her balance and fell. V11 stated that V4 (LPN) wasn't able to get to resident in time to ease the fall.</p> <p>On September 10, 2024 at 4:01 PM, V10 (CNA) stated that on July 7, 2024, R8 stated she had to go to the restroom. V10 stated she then put a gait belt around R8 before she stood R8 up from the chair in the dining room. V10 stated between the dining room and the doorway R8 stopped to talk to V4 (Licensed Practical Nurse/LPN). V4 stated she was on R8's right side and holding resident with left hand and V4 was on her left side. V4 stated she left R8 with the nurse and went to answer a call light that was going off not far from the nurse's station. V10 stated on her way back from answering the call light, R8 was still talking to V4. V10 stated she then saw that R8 was starting to fall, and V10 stated she started running towards R8 and V4. V10 stated that V4 tried to grab R8 and was only able to grip her shirt and R8 landed on her right side. V10 stated she always stays close by when ambulating R8</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>because she was aware R8 was a fall risk and required one assist.</p> <p>On September 10, 2024 at 4:16 PM and 4:48 PM, V4 (LPN) stated that R8 was walking from the dining room and V4 was walking in the same direction. V4 stated R8 stopped to talk to him. V4 stated that another resident was on R8's left side and R8 turned to talk to the other resident and started falling in that direction. V4 stated he was only able to grab R8's shirt and not able to reach the gait belt that was around the R8's waist. V4 stated he held R8 by the shirt but the momentum brought her to the ground. V4 stated he did not recall where V10 was just before the fall, but no one was holding onto the resident. V10 stated they use a gait belt for assisting residents with transfers and escorting residents for safety reasons. V10 further stated that they use gait belts for all ambulatory residents who are fall risks. V10 stated that someone should have been holding R8's gait belt while she was talking to him. V10 stated he has seen before that residents get distracted, turn their heads and attention to other people, or get startled by others then can lose their balance.</p> <p>On September 11, 2024 at 12:59 PM, V2 (Director of Nursing) stated partial/moderate assistance is considered to be hands on assistance for transfers and ambulation of people who require it. If partial/moderate assistance is required then a gait belt is required to secure the resident for their safety. V2 stated R8 requires hands on assistance and staff should be holding the gait belt when ambulating, standing, and transferring the resident.</p> <p>On September 11, 2024 at 1:52 PM V14 (Rehab Director/Occupational Therapist) V14 stated they</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>use a gait belt for safety during ambulation, standing, and transfer. V14 stated that staff has to hold the gait belt if the level of assistance required is partial/moderate assist. V14 stated that a gait belt should be used for someone who requires partial/moderate assistance with ambulation for safety. V14 stated even if the resident can walk 100 feet, the gait belt should be used because the resident could fatigue, get dizzy, or their legs could buckle.</p> <p>R8's therapy notes on the morning of July 7, 2024 showed that while receiving therapy, R8 uses a rollator walker and required minimum assist to contact guard assistance. On September 11, 2024 at 2:10 PM, V14 stated that minimum assist to contact guard assist means that the resident has hands on assistance with verbal queuing due to fluctuations of ambulation performance. V14 further stated that minimum assist to contact assistance was provided to R8 for proper foot placement and gait to improve ambulation. During the same interview V14 stated that when R8 is in the nursing unit, the nursing staff should us a gait belt for R8's safety.</p> <p>On September 11, 2024 at 2:28 PM, V15 (Medical Director) stated that he expects the facility's staff to follow their policies and procedures, and the professional recommendations of the therapists.</p> <p>R8's progress note dated July 7, 2024 at 8:40 PM showed that resident had a witnessed fall at 5:00 PM and at this time being sent to the hospital via 911.</p> <p>R8's hospital emergency room report dated July 7, 2024 showed that R8's son reported the he got a call from the memory care that R8 had a fall</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>earlier today. The fall was witnessed by a staff member, R8 landed on her buttock, and was complaining of some left hip pain. Then later in the day R8 was reporting some lightheadedness/dizziness and the facility checked her oxygen and it was 93% and then dropped to 80%. The report also mentions that R8 had a confirmed fourth distal phalanx fracture of the toe.</p> <p>R8's ambulatory skills care plan dated May 17, 2024 showed the following: R8 has impaired ambulatory skills with or on: Changing directions, level surfaces, speeding up or slowing down, turning around. The related Interventions/Tasks dated May 17 2024 showed: Assist and instruct resident/caregiver with safety awareness while ambulating.</p> <p>R8's fall risk care plan dated May 13, 2024 showed the following: R8 is at risk for falls related to weakness/deconditioning, potential medication side effects, bowel and bladder incontinence, cognitive impairment/dementia, history of fall with fracture, and need for external physical assistance and use of assistive devices (wheelchair/walker).</p> <p>R8's Computed Tomography (CT) Pelvis without contrast report dated July 8, 2024 for left hip pain showed the following: Acute comminuted fractures of the left medial superior and interior pubic rami. Associated left pelvic sidewall hemorrhage and intramuscular hematoma the left obturator internus and externus muscles.</p> <p>The facility's Gait Belt/Transfer Belt policy showed the following: To assist with a transfer or ambulation. A gait belt will be used with weight bearing residents who require hands on</p>	S9999		

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