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
	IL6014500	A. BUILDING: ______ B. WING ______	C 03/18/2024

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 Facility Reported Incident of February 5, 2024/IL170320	S 000		
S9999	Final Observations State Licensure Violations: 300.1210 b)4)5 300.1210 c) 300.1210 d)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. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.	S9999		

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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.

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 regulations were not met as evidenced by:

Based on interviews, observations and records reviews, the facility failed to follow a resident's (R1) fall care plan intervention with multiple history of falls to ensure non-skid footwear was applied for 1 (R1) out of 3 residents reviewed for accidents and hazards. This failure resulted in R1 having an incident on 2/5/24. R1 was found on the bathroom floor, sustained a left elbow skin tear, and a laceration on the left forehead that was repaired with stitches in the acute hospital.

Findings Include:

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S9999	Continued From page 2 R1's clinical records show an initial admission date of 11/14/23 with listed diagnoses not limited to Chronic Obstructive Pulmonary Disease, Depression, Dementia with Mood Disturbance, Syncope and Collapse, and Primary Insomnia. R1's physician order sheet (POS) shows R1 is on antidepressant medication (Mirtazapine 7.5 mg) given at bedtime. R1's Minimum Data Set (MDS) dated 1/19/24 shows R1 is cognitively impaired with cognition and is dependent with staff on toileting and requires substantial/maximal assistance for putting on/taking off footwear. R1's "Post Occurrence Documentation" dated 2/5/24 at 8:25 PM documented by V6 (Licensed Practical Nurse) reads in part: "At approx 2025, NOD [Nurse on Duty] heard sound coming from room, call light was not initiated. [R1] observed alert and awake laying on bathroom floor, no footwear noted at time of incident. [R1] was observed sleeping in bed peacefully 10 mins prior to fall. [R1] is A&O x2 with poor safety awareness confused per baseline, able to make needs known. Neuro, LOC [Level of Consciousness], ROM [Range of Motion] and head to toe assessment done. Noted 2.5x2.0 abrasion to LT [Left] forehead/temple and skin tear to LT [Left] elbow. LT [Left] hard cast noted intact, neuromuscular assessment of the left hand done. Verbalized c/o [complains of] pain to head and LT [Left] arm. Assisted with transferring to the chair by two staff and continued to monitor. [R1] is on scheduled Eliquis daily. NP [Nurse Practitioner] order to send out to ER [Emergency Room] noted and carried out. Ar approx 1835 [R1] transported to [Acute Hospital] ER via 911. DON [Director of Nursing], ADON [Assistant Director of Nursing], Nurse managers made aware."	S9999		

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R1's progress notes dated 1/2/24 at 2:30 AM documents that at approximately 2:10 AM, R1 was noted lying n R1's right side on the floor at the end of the footboard because R1 was trying to get to R1's chair.

R1's progress notes dated 2/1/24 at 6:59 PM documents that at approximately 6:25 PM, R1 was observed lying in the bathroom floor with head against the wall and wearing no footwear.

R1's hospital records printed on 2/6/24 shows that R1's diagnoses were initial encounter for fall, initial encounter for injury of head, and initial encounter for laceration of scalp status post laceration repair. R1's progress notes dated 2/6/24 at 8:30 AM documented by V6 shows R1 came back in the facility from the acute hospital at approximately 3:00 AM with stitches on R1's left lateral forehead and wound dressing on R1's left elbow skin tear.

R1's fall risk assessment dated 2/1/24 shows R1 is high risk for fall. This fall risk assessment also shows R1 has unsteady gait, has impaired memory, had 3 or more falls in the past 3 months, and on drugs that affect the thought process. R1's fall care plan initiated on 11/15/23 shows R1 is high risk for falls due to poor cognition, poor safety awareness, weakness, activity intolerance, poor endurance, impaired balance, unsteadiness on feet, lack of coordination, pain, and incontinence with one fall intervention initiated on 2/1/24 that reads: "Use proper fitting, non-skid footwear." R1's progress notes on 2/5/24 does not document R1 refused to wear non-skid socks.

On 3/17/24 at 8:49 AM, R1 was noted alert and verbally responsive with some forgetfulness and confusion. When Surveyor asked R1 about the

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incident on 2/5/24, R1 stated, "The fall happened years ago. I got off from the toilet I slipped and fell over."

On 3/17/24 at 10:18 AM, V5 (Restorative Nurse/Fall Coordinator) stated that fall interventions in the resident's care plan are implemented based on the root cause of the resident's previous falls and based on the needs of the resident. V5 stated that R1 had multiple falls on 1/2/24, 2/1/24, and 2/5/24. V5 stated that R1 is confused, tries to get up on his own without calling for help at times, and is high risk for falls. V5 stated that based on R1's fall that happened on 2/1/24, one fall intervention that was added in the care plan is for R1 to use proper fitting non-skid footwear. V5 stated that a non-skid footwear could be a non-skid socks or non-skid shoes. V5 stated that R1 is confused and has very unsteady gait. V5 stated that V5 expects the staff to apply R1's non-skid socks and R1 needs to wear the non-skid socks at all times even when sleeping just in case R1 tries to get up on his own and needs to go to the bathroom in the middle of the night. V5 stated that according to the progress notes, when R1 fell on 2/1/24 and 2/5/24, R1 was not wearing proper footwear.

On 3/17/24 at 11:08 AM, V8 (Registered Nurse) stated that R1 is confused and needs one person assist with activities of daily living (ADL). V8 stated that R1 needs assistance to go to the toilet and that R1 forgets to use the call light to call for help when needed. V8 stated that R1 is high risk for falls.

On 3/17/24 at 11:23 AM, a phone interview conducted with V9 (Certified Nursing Assistant). V9 stated that on 2/5/24 at around 7:00 PM, V9 put R1 to bed and after 10 minutes, V6 (Licensed

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S9999	Continued From page 5 Practical Nurse) told V9 that R1 was on the floor. V9 stated that when V9 put R1 in bed, V9 did not put R1's non-skid socks on. V9 stated that R1 did not refuse to wear it, but V9 just did not put it on because V9 thought R1 was going to sleep. V9 stated, "I thought [R1] was going to sleep. I put [R1] to bed and I put [R1's] blanket on." V9 stated that V9 does not know why R1 got up. V9 stated that R1 is confused. V9 stated that when V9 and V6 went back to R1's room, R1 was lying down on the floor on R1's left side in the bathroom. V9 stated that R1 said R1 hit R1's head and V9 saw blood around R1's head. V9 stated that R1 could not state what happen. V9 stated that R1 would get up without calling for help. V9 stated that R1 side rails were not up. On 3/17/24 at 12:06 PM, V10 (Resident Care Coordinator) stated that care plans should be individualized. V10 stated that the purpose of the fall care plan is for the resident to avoid more falls in the future and for the staff to know what to do for the resident. V10 further stated that all interventions in the care plan should be implemented and followed by the staff on the floor working with the resident. On 3/17/24 at 2:52 PM, a phone interview conducted with V6 (Licensed Practical Nurse). V6 stated that V6 was the nurse in-charge of R1 on 2/5/24. V6 stated that 10 minutes before R1's incident, R1 was resting in bed with bilateral half side rails up. V6 stated that around after 8:00 PM, V6 heard a sound in R1's room and when V6 went to R1's room, and V6 found R1 on the bathroom floor. V6 stated that it looks like R1 went to the bathroom finished up and tried to go back to bed, and the way R1 was leaning, R1's head was close to the bathroom entrance door, leaning on R1's left side facing the outside door.	S9999		

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V6 stated that R1 did not have any footwear at that time, no pants, no shoes, and no non-skid socks. V6 stated that the call light was not initiated. V6 stated that R1 knows how to use the call light but does not remember all the time to use it. V6 stated that R1 tries to be independent and tries to do things on his own. V6 stated that V6 assessed R1 and noted a bump and bleeding on R1's head. V6 stated that R1 pointed to R1's head that it was hurting. V6 stated that R1 was unable to state what happen. V6 stated that R1 was sent to the hospital via emergency paramedics.

On 3/17/24 at 12:50 PM, V2 (Director of Nursing) stated that R1 came back from the hospital the morning of 2/6/24. V2 stated that R1 sustained a laceration on the forehead and was treated in the emergency room with stitches.

The facility's policy titled; "MANAGEMENT OF FALLS" dated 8/2020 reads in part:
POLICY:
The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risks for fall incidents and/or injuries to the resident.
PROCEDURE:
3. Develop a plan of care to include goals and interventions which address resident's risk factors.

(B)