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
	IL6014922	A. BUILDING: ______ B. WING ______	C 08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF ORLAND PARK	**16450 SOUTH 97TH AVENUE ORLAND PARK, IL 60462**

(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
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210c) 300.3240a) 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 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.	S9999	Attachment A Statement of Licensure Violations	

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c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on observation, interview and record review, the facility failed to monitor and prevent an avoidable fall incident for 1 of 3 residents R1 all reviewed for falls and failed to follow their fall prevention policy and develop effective fall prevention interventions for 3 residents (R1, R2, R3) out of 3 residents reviewed for falls. This failure resulted in R1 falling in the bathroom on 6/30/15 and hospitalization on 6/30/15 for a subdural hemorrhage and pelvic fracture as a result of the fall.

Findings include:

R1 was admitted to the facility on 6/24/15 with the following diagnoses: Dementia, hypertension, spinal stenosis unspecified region other than cervical, esophageal reflux,anxiety state, difficulty walking, generalized muscle weakness, hypothyroidism, hyperlipidemia, depressive disorder, sepsis and urinary tract infection. R1's admission fall risk assessment score on 6/25/15 was 18 (High Risk). The range for the fall risk assessment scores is 12 or above means the resident is high risk for falling. On 7/29/15 at 10:30am E2 (Director of Nursing) stated that

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residents who are assessed as high risk for falling are in the falling star program as a prevention measure for falls. R1 was in the falling star program since R1 was high risk for falling. E2 stated that R1 had a star on her door and on her wheelchair so that facility staff would know that R1 was high risk for falling.

R1's incident report dated 6/30/15 at 22:27 reads " Witness statement of what happened written by E4 (Certified Nursing Assistant) entered by E3 (Registered Nurse) - Stated I was at the door post waiting for R1 to finish having bowel movement when suddenly alarm sound and I rush inside and found R1 on the floor, then I immediately call the nurse." On 7/29/15 at 10am, E4 stated that she helped R1 get on the toilet on 6/30/15 at approximately 7pm. E4 stated that after she helped R1 get on the the toilet, she went into R1's bedroom by the TV because R1 wanted privacy. E4 stated that she checked on R1in the bathroom because she was quiet and observed R1 standing. E4 stated that R1 then fell on her left side and hit her head on the floor. E4 stated that she immediately called the nurse." On 8/4/15 at 2:55pm, E4 stated that she did not know that R1 was high risk for falling. E4 stated that she did not know that R1 was on the falling star program. E4 stated that most residents on the dementia floor are high risk for falling. On 8/4/15 at 3:15pm, E2 (Director of Nursing) stated that E4 did know that R1 was high risk for falling because the high risk status is displayed on the electronic charting system.

On 7/30/15 at 10:15am, E3 (Registered Nurse) stated that he was not sure if E4 was present when R1 fell on 6/30/15. E3 stated that he would

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have to refer to his paperwork. E3 stated that he observed R1 on the bathroom floor with bleeding noted to the left side of her head. E3 stated that he applied an ice pack to her head and sent R1 to the hospital emergency room. E3's paperwork dated 6/30/15 at 22:18 reads "E4 stood by door post for privacy. Suddenly R1 stood up alarm sounding and E4 went in and saw R1 on the left side of the floor with laceration/hematoma on the left side of R1's head. R1 went to the hospital emergency room."

R1's emergency room notes dated 6/30/15 at 22:20 reads "R1 is an 81 year old female with dementia who presents to the emergency room after experiencing a fall off the toilet tonight. R1 appears to have had an unwitnessed fall while she was in the bathroom, suffering an injury to the back of her head. R1 was also complaining of left hip pain." CT scan dated 6/30/15 reads "CT scan did reveal a 3.2 cm by 8 mm in depth subdural hematoma in the occipital left aspect of the brain. R1's posterior scalp had a 2 and half centimeter lacerations of the left occipital aspect of the scalp. 7 staples were placed. X-ray of the left hip did reveal a superior rami fracture of the pelvis nondisplaced."

On 7/30/15 at 2:30pm, E6 (Physical Therapist) stated that R1 was moderate assistance to rise from sit to stand. E6 stated that R1 needed physical assistance to lift from sitting to standing position.

On 7/30/15 at 3:05pm, Z1 (Attending Physician) stated that the report he received regarding R1's fall on 6/30/15 was that E4 was standing outside the door when R1 fell.

On 7/31/15 at 1:45pm, E5 (Restorative Nurse)

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stated "I wouldn't think we would leave a resident in the bathroom by themselves if they have dementia and is high risk for falling." R1's face sheet lists dementia as one of her admitting diagnoses on 6/25/15.

On 8/4/15 at 2:45pm, E3 stated that residents who are high risk for falling should not be left unattended. E3 stated "We cannot leave them alone in the bathroom if they are confused." R1's admission fall risk assessment was 18 (High Risk) for falling.

On 8/5/15 at 10:10am, E10 (Certified Nursing Assistant) stated that she cared for R1. E10 stated that one time when she toileted R1, R1 asked her to leave. E10 stated that she stood by the door but could see R1 at all times. E10 stated R1 attempted to stand up but E10 explained to R1 that she has to stay on the toilet and wait for E10. E10 stated that she never left R1 alone in the bathroom. E10 stated that R1 was confused and even though R1 wanted privacy, it was impossible to give her privacy because she was at risk for falling. E10 stated "In situations like this, you have to be there because R1 was high risk for falling."

R1's physical therapy evaluation dated 6/25/15 reads "R1 referred to physical therapy due to exacerbation of pain, decrease in strength, decrease in functional mobility, reduced ability to safely ambulate, decreased neuromotor control, reduced balance, reduced functional activity tolerance, cognitive deficits and increased need for assistance from others.

R1's MDS (Minimum Data Set) dated 6/30/15

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reads under Functional Status "Moving on and off toilet & moving from seated to standing position - not steady, only able to stabilize with staff assistance." R1's brief interview for mental status score dated 6/30/15 was 7 out of 15.

R1's care plan dated 6/25/15 reads "R1 has an ADL (activity of daily living) self care performance deficit related to activity intolerance, limited mobility, fatigue, impaired balance, recent hospitalization, weakness." R1's intervention includes "Assist with toileting needs as necessary."

R2 is an 88 year old female with dementia. R2 has had 8 unwitnessed falls since 10/1/14. R2 fell on 10/1/14, 10/7/14, 11/10/14, 12/30/14, 1/4/15, 1/30/15, 7/1/15 and 7/10/15. R2's fall risk assessment score on 7/10/15 was 17 (high risk) for falling.R2's clinical notes on 7/1/15 read "Continue to monitor R2 at all times." On 7/29/15 at 11am, R2 was observed being transferred to the bathroom via mechanical lift by E8 (Certified Nursing Assistant). R2's clinical notes dated 7/27/15 read "Needs 2 person assist with adls of transfer and hygiene." E8 left R2 in the bathroom unattended and went into R2's bedroom to get a pad from R2's cabinet. E8 then returned to the bathroom where R2 was on the toilet. R2's MDS dated 7/20/15 under functional status reads "Toilet use - 2 person assist." R2's care plan dated 1/19/12 reads "R2 is at high risk for falls related to: history of falls, use of assistive devices, poor safety awareness related to diagnosis: dementia with poor awareness of abilities, and limitations."

R3 is an 87 year resident with dementia. R3 was admitted to the facility of 3/18/15 with diagnoses

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S9999	Continued From page 6 that include: Subdural hemorrhage, muscle weakness, personal history of fall, syncope and collapse and difficulty walking. R3 has had 3 unwitnessed falls on 5/10/15, 5/21/15 and 7/15/15. R3's fall risk assessment score on 5/22/15 was 22 (high risk) for falling. R3's occurrence report dated 5/21/15 reads "Certified Nursing Assistant heard R3 yelling for help from R3's bathroom floor and summoned help to the scene." The conclusion of the incident reads "R3 requires assistance from staff with her ADLs (activities of daily living), toileting and transfer needs. It was found that R3 was placed on the toilet by E12 (Certified Nursing Assistant), E12 provided privacy and within a few minutes while E12 quickly attempted to provide care to another resident in the hallway, E12 responded to R3 calling out for help." R3's brief interview for mental status score was 2 out of 15 on 5/25/15. R3's care plan reads "at High Risk for falls secondary to history of falls, unsteady gait and cognitive deficits." Interventions include "Accompany and stay with R3 during toileting for frequent monitoring and encourage R2 is placed in a high visible area while she is waiting for assistance. R2's clinical notes dated 7/15/15 read "Continue to monitor R3 at all times." On 7/29/15 at 11:10am, R2 was observed propelling herself in the hallway without any staff supervision. On 8/5/15 at 1:50pm, E9 (Registered Nurse) stated that on 5/21/15 at 9:30am, R3 wheeled herself into the bathroom and had an unwitnessed fall on the bathroom floor. E9 stated that there were no injuries. E9 stated that R3 was yelling for help from the bathroom floor. E9 stated that R3 likes to wheel herself into the bathroom and staff need to keep an eye on R3. On 8/5/15 at 2:05pm, E10 (Certified Nursing Assistant) stated that another nursing assistant (E12) put R3 on the toilet on	S9999		

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5/21/15 and then left R3 alone in the bathroom. E10 stated the next thing she knew, R3 was on the bathroom floor yelling for help. On 8/5/15 at 2:30pm, E12 (Certified Nursing Assistant) stated that she does not remember putting R3 on the toilet on 5/21/15 and does not remember R3 on the bathroom floor yelling for help. E12 stated at she does not remember the incident on 5/21/15 regarding R3.

The facility's fall risk assessment policy dated 3/12 reads "Residents will be assessed for risk factors that increase their potential for falls in order to identify the need to initiate additional safety measures. The resident who scores 12 or greater will have individual High Risk interventions implemented, including Falling Star Program."

The facility's prevention of falls policy dated 6/13 reads "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." The policy reads "Initiate falling star program for residents who are at high risk for falls (refer to falling star program policy).

The facility's falling star program policy dated 11/10 reads "To minimize the chance that a fall will occur, residents who are assessed at high risk for falls, or who have a history of falls within the last 180 days, will be included in the falling star program." The falling star program procedure reads "1)Place a falling star icon outside the resident's room next to the resident's name. 2) Attach a falling star icon to the resident's mode of transportation, (i.e.

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S9999	Continued From page 8 wheelchair, walker, cane) if applicable. 3) Initiate/update fall risk care plan and 4) Educate the resident and/or family on the falling star program and the resident's individualized high risk interventions." (B)	S9999		