

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/11/2022
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NAME OF PROVIDER OR SUPPLIER ALDEN GARDEN CTS OF DES PLAINES	STREET ADDRESS, CITY, STATE, ZIP CODE 1227 GOLF ROAD DES PLAINES, IL 60016
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(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 Facility Reported Incident Investigation of 02-11-2022/IL144427	S 000		
S9999	Final Observations Statement of Licensure Violation: 330.710c)3) 330.7103)A)B)C) Section 330.710 Resident Care Policies 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. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling. C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>This requirement was NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to follow its transfer policy by not transferring 1 of 3 (R1) safely. This failure resulted in R1 having a fall sustaining a traumatic neck injury: strained neck muscles, 4-centimeter face laceration and a closed fracture of the right maxilla (jaw).</p> <p>Findings include:</p> <p>R1 has the diagnoses of Alzheimer's disease, atrial fibrillation and orthostatic hypotension. Resident service plan dated 12/01/21 documented: Mobility/transfers: R1's level of assistance - one person. Reportable event dated 2/11/22 documents: R1 was walking to the bathroom with her walker with CNA (Certified Nursing Assistant) alongside R1 when, R1 fell suddenly to the floor, hitting head. R1 was alert and oriented to time one (self) and ambulated independently with slow steady gait.</p> <p>On 3/10/22 at 12:29pm, V3 (nurse) stated, R1 was being assisted to the bathroom. R1 fell quick. I don't recall seeing a gait belt. R1 was supposed to transfer with a gait belt for safety. R1's family reported, R1 was having falls before being admitted.</p> <p>On 3/10/22 at 12:35pm, V2 (caregiver) stated, when transferring a resident, staff should walk behind the resident with the gait belt around the resident's waist. The gait belt should be used to prevent falls and in every transfer. R1 uses a gait belt now.</p> <p>On 3/10/22 at 12:54pm, V1 (executive director)</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>stated, R1 had a habit of going limp. It just so happen that R1 went limp while standing up. R1's family reported, R1 had a history of just going limp.</p> <p>On 3/10/22 at 1:01pm, V4 (CNA) stated, I was walking R1 to the bathroom. As we entered R1's room, R1 led the way because we both could not fit in R1's doorway. I was not using a gait belt. I was not physically touching R1. R1 was independent. R1 was ahead of me. R1 started to fall. I could not catch R1. R1's face hit the carpet. R1 sustained a cut on right eyebrow.</p> <p>On 3/10/22 at 2:21pm, V1 stated, the (CNA) will determine the level of assistance for residents. Ask the (CNA) what one person assist means. I don't feel comfortable answering that question.</p> <p>On 3/10/22 at 2:45pm, V5 (CNA) stated, one person assist is when the staff physically help a resident with transfers using a gait belt. Staff cannot stand back; the resident must be physically touched/assisted.</p> <p>Hospital paperwork dated 2/7/22 documents: EMT arrived at the facility for an unwitnessed fall. R1 was found awake on the ground. R1 had a 4 cm laceration above the right eyebrow requiring suture repair. CT Cervical spine documents: traumatic neck injury. Emergency Department diagnoses documents: Strain of neck muscles, injury of head and closed fracture of the right side of maxilla (jaw).</p> <p>Transfer techniques dated 6/19 documents: purpose to safely transfer the resident.</p> <p style="text-align: center;">(B)</p>	S9999		

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