STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003735	A. BUILDING: _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF BARRINGTON	1420 SOUTH BARRINGTON ROAD BARRINGTON, IL 60010

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S 000	Initial Comments Complaint Investigation: 2396495/IL162859 Facility Reported Incident date 4/17/23/IL160790-	S 000		
S9999	Final Observations Statement of Licensure Violations: 1/2 300.1210b) 300.1210d)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. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 interview and record review, the facility failed to prevent a resident from sustaining an injury during care for one (R272) of three residents reviewed for injury in a sample of 25. The deficient practice resulted in R272 sustaining a linear incomplete oblique fracture of the mid and proximal shaft of the right humerus. Findings Include: Initial State Reportable dated 7/12/23 documents: R272 is a long-term resident at facility. R272 has the following diagnosis anxiety, BPH, protein calorie malnutrition, epilepsy, type 2diabetes and muscle spasms. On 7/11/23 an x-ray was performed on R272's right arm due to swelling and resulted in an incomplete right humerus fracture. Investigation started immediately. Final report to follow. Final State Reported dated 7/17/23 documents: Investigation completed, it was noted through staff and resident interview that no trauma or fall occurred. Resident is severely contracted which most likely contributed to the facture. Resident has returned to the facility. Pain management in place, care plan has been updated. NP Progress note dated 7/12/23 documents that R272 was seen for follow-up and increased right arm swelling noted. On 7/11/23 an x-ray was done and it was reported that it showed a linear incomplete oblique fracture of the mid and proximal shaft of the right humerus. R272 with no	S9999		

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S9999	Continued From page 2 reported fall or trauma. R272 sent to ER for further evaluation. R272 underwent an x-ray which showed a right humerus minimally displaced spiral fracture of the right proximal and mid right humoral shaft. NP Progress note dated 7/17/23. R272 was seen by orthopedic in ER and it was recommended that R272 is non-weightbearing to right upper extremity. The Incident Report dated 7/11/23 an x-ray was performed on R272's right arm due to swelling reported by the CNA and resulted in an incomplete right humerus fracture. R272 was sent out for further evaluation and returned to the facility the next day but is no longer in the facility (sic). On 8/16/23 at 2:12pm V20 (Primary Physician) stated that, due to R272 being contracted, he was always in a contracted position to his right side and difficult to move from that position. V20 stated that R272 was at high risk for fracture because of his comorbidity, low calorie intake, low muscle mass, and non-weight bearing and thinner bone. V20 stated that, she believes the facture was accidental and can happen from twisting the arm. V20 stated "I don't think this was avoidable even with all precaution taken." On 8/16/23 at 2:37 pm, V19 (Nurse Practitioner) stated that she last saw the resident on 7/3/23 and did not see any swelling on the resident's arm. V19 stated that R272 was seen and sent out on 7/12/23 for further evaluation. V19 stated that residents are seen once a month, but R272 was seen more often or as needed due to his high comorbidity. V19 stated that she is not aware how the swelling happened.	S9999		

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S9999	Continued From page 3 On 8/17/23 at 10:00am, V18 (RN) stated that she took care of R272 on 7/10/23 and did not notice any swelling. V18 stated that she was informed by V17 on 7/11/23 that R272's arm was swollen. V18 stated that she notified V19 (NP) who ordered an x-ray. V18 stated that the night nurse got the results, and the resident was sent out to the Emergency room (ER) for further evaluation. V18 stated "I know he is contracted; spiral fractures happen from sudden movement." V18 stated that R272 returned to the facility the same day with a splint. On 8/17/23 at 10:15 am, V17 (CNA) stated that she reported the swelling to the nurse after returning from a day off (7/10). V17 stated "I saw the arm was different and asked the mom who was at the bedside if she noticed any difference with the arm. I reported it to the nurse." On 8/17/23 at 10:45am, V15 (Restorative Nurse) stated that R272 was in a restorative, splint and PRM program 5-6 times provide by restorative aid. V15 stated she did not receive any information about R272 having a swollen arm. We found out when the nursing assistant reported it to the nurse. V15 stated that Therapy orders the brace and restorative follow their recommendations. On 8/17/23 at 11:am, V1(Administrator) stated that R272 was in a vegetative state, V1 stated "the fracture could have happened when he was being turned or when they were trying to put a gown on him. I do not think it was intentional and the staff that cares for the resident on a regular basis was not able to tell me what happened and how it happened."	S9999		

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S9999	Continued From page 4 On 7/17/23 at 11:40am V22 (RN) stated that she worked the night shift on 7/12/23 and did not notice any swelling to R272's arms. V22 stated that R272 was normal with no pain and the arm did not look swollen. V22 stated that she got the results that morning and notified the NP. On 7/17/23 at 1:50 V28(Director of Nursing) stated that he saw R272 daily and did not notice any swelling to his arms as he always had his gown on. Care plan reads; "assist and instruct family and staff in proper splinting and positioning to manage existing/improved/prevent contractures of the bilateral upper extremities while in bed". Bed Mobility ... Be sure your physical contact is gentle do not grab right upper extremity, monitor for presence of pain/intolerance, total assist with bed mobility. Radiology report dated 7/11/23 reads; Procedure: X-ray exam of humerus. Reason, Pain and swelling. Impression: Linear incomplete oblique fracture of the mid and proximal shaft of the right humerus. R272's Hospital discharge record dated 7/12/23 document: what causes a humerus Fracture? A humerus facture is most often the result of trauma. This may be from fall, blow, accident or sport injury. Facility unable to provide ADLs (Activity of Daily Care) policy. (B) 2/2 300.610a)	S9999		

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S9999	Continued From page 5 300.1210b) 300.1210d)6) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999		

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S9999	Continued From page 6 that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidenced by: Based on interview and record review the facility failed to supervise a resident that was a high fall risk and presented with impulsive behaviors for 1 of 3 residents (R176) in a total sample of 25. This failure resulted in R176 having an unwitnessed fall sustaining a laceration to her head and requiring 14 staples. Findings include: On 8-16-23 at 12:13 PM, V1 (Administrator) said R176 is alert and oriented to self and able to make simple needs known. R176 does not use the call light. R176 has impulsive behaviors and will get up by herself without asking for help. R176 requires 1 person assist with transfers. V1 thinks R176 would be high risk for falls. R176 has history of falls prior to facility. V1 said R176 was last seen in the dining room and must have left the dining room on her own and was later found by CNA in her room. R176 was noted with active bleeding from the head and was on anticoagulants. R176 was sent out 911, treated, received 14 sutures to her head and returned the same day. On 8-17-223 at 11:15 AM, V2 (DON) said R176 is alert, oriented x1, unable to carry meaningful conversation. R176 is confused and forgetful and has Alzheimer's. R176 has poor safety awareness due to forgetfulness and impulsivity. R176 will get up from bed and chair without asking for helping. requires 1 person assistance	S9999		

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S9999	Continued From page 7 for transfers. R176 has history of fall at facility and high risk for falls. On 8-17-23 at 9:36 AM, V15 (Restorative Nurse) said is alert to self, confused and forgetful. R176 is able to make simple needs known. R176 is forgetful and forgets to use the call light. R176 has poor safety awareness due to impulsivity and forgetting to ask for assistance. R176 requires 1 person physical assistance for transfer and ambulation. R176 is a high fall risk. R176 has a history of falls at facility and at home. This was unwitnessed fall. Staff was aware of fall risk, frequent rounding, keep items in reach, low bed, call light in reach, encourage activity, by nursing station for supervision. Around 7:30 AM, R176 had unwitnessed fall in room, nurse saw R176 in wheelchair, nurse saw blood and R176 said she lost balance when walking in the room and did not ask for help. This was unwitnessed fall. On 8-16-23 at 12:04 PM, V10 (RN) said R176 is alert to self and confused at night. R176 is able to make her needs known. R176 does use the call light and will get up by herself. R176 is a fall risk due to impulsivity and needs assistance with transferring. R176 thinks she can do more than she can and has impaired safety awareness. R176 requires supervision every 15 minutes in her room or kept in common area with staff supervision. On 8-16-23 at 12;29 PM V11 (CNA) said R176 is alert and sometimes able to make her needs known. R176 seldom uses the call light. R176 is impulsive, gets up by herself, R176 requires 1 person assistance with transfers and getting up. R176 is high fall risk because she is impulsive. R176 has dementia and thinks she is more independent than she actually is and therefore	S9999		

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S9999	Continued From page 8 has poor safety awareness. V11 said R176 was kept at the nurse station under staff supervision. R176 prefers to be in the room however it not safe to let R176 stay in the room because she will get up by herself. R176 needs frequent checks when she is in her room for safety. On 8-16-23 at 12:44 PM, V12 (LPN) said is alert and oriented x1. R176 is confused forgetful and impulsive. R176 would get up by herself without calling for help. R176 require 1 person assistance with transfers. R176 is a fall risk due impulsiveness, confusion, unsteady gate, and poor safety awareness. LPN is aware of R176 having history of falls and has seen R176 attempt to get up without using her call light. Staff was doing frequent checks, kept in the common area (by nursing station or activities) for supervision. LPN said she noted R176 in her wheelchair with bleeding to her head. Progress not said R176 told LPN she must have fallen. R176 was sent out via 911. R176's Fall Risk Assessments (dated 1-23-23, 3-5-23, and 4-17-23) document R176 as a High Fall Risk. MDS (ARD 6-6-23) documents: 1 Person Physical Assistance for Support Transfers, Moving from seated to standing position: not steady, Walking: not steady. Final State Reportable (dated 4-18-23) documents: R176 is 83 year old female resident at facility. She admitted to facility after CVA with left side hemiparesis and fall with scalp hematoma. R176 developed hydrocephalus during her hospitalization requiring a shunt. She has diagnosis Cerebral Edema, muscle weakness, unsteadiness on feet, abnormalities of gait/mobility. Pulmonary fibrosis, left hemiplegia, unspecified urinary incontinence, dementia,	S9999		

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S9999	Continued From page 9	S9999		

overactive bladder and Alzheimer's disease and osteoporosis. On 4-17-23, R176 was observed in her wheelchair with small amount of blood on her left arm and posterior left occipital area. Resident reports having an unwitnessed fall and did not alert staff at the time of the incident. Initial assessment by the nurse revealed small laceration to head, therefore she was sent to the ER for evaluation per MD order. Resident required 14 staples to laceration site. The facility conducted an investigation it was note through interviews that the resident was assisted by assigned CNA with morning care and dressing and then assisted to the dining room for breakfast. Resident wheeled herself back to the room, got out of wheelchair to ambulate around her room. She lost her balance resulting in a fall.

R176's Hospital Record (dated 4-17-23) documents: HPI: Patient is a 83 year old female with extensive past medical history presents to the emergency department via EMS from facility after unwitnessed fall. Patient has history of dementia and is an unreliable historian. Patient had a fall hit the back of her head sustaining a minor laceration. Patient states she falls a lot. Comments: 2 inch laceration left side posterior occipital scalp. Procedure Note: Laceration repair: the 2 inch laceration was irrigated with normal saline under normal pressure and anesthetized locally with 1% lidocaine. 14 staples were placed in simple interrupted fashion. Hemorrhage controlled.

Fall Policy (dated 8-20) documents: The facility is committed to minimizing resident falls and/or injury so as to maximize each resident's physical, mental, and psychosocial wellbeing. While preventing all resident falls is not possible, it is the facility policy to act in a proactive manner to

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S9999	Continued From page 10 identify and assess those residents at risk for falls, plan for preventive strategies and facilitate a safe environment. (B)	S9999		