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
	IL6007165	A. BUILDING: ______ B. WING ______	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN PARK STRATHMOOR	**5668 STRATHMOOR DRIVE ROCKFORD, IL 61107**

(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 Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 c) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide assistance at meals or implement interventions for a resident with significant weight loss for 1 of 5 residents (R48) reviewed for nutrition in the sample of 31. This failure resulted in R48 having a 10.22% weight loss in one month. The findings include:	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/19/24

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S9999	Continued From page 1	S9999		

R48's face sheet showed a 93 year old female with diagnosis of Alzheimer's Disease, cerebrovascular disease, dementia, osteoarthritis, and chronic kidney disease. A diagnosis of failure to thrive was added 3/14/24.

R48's weights showed a 2/1/24 weight of 107.6 pounds, and a 3/4/24 weight of 96.6 pounds.

R48's 3/16/24 nutrition note showed R48's weight of 96.6 pounds was a 5% weight change in one month. This note showed a failure to thrive diagnosis was added, and the weight loss was contributed to a recent illness. No new interventions were added or recommended.

R48's care plan showed she was at risk for dehydration and weight loss due to variable intake, history of dementia, and history of dehydration. This plan of care showed to monitor and encourage fluid intake, offer substitutes as needed and provide assistance or cueing for meals as needed.

R48's physician order sheet (POS) showed a a 5/20/20 order for fortified potatoes, a 5/21/20 order for fortified cereal, a 2/7/22 order for a nutritional supplement twice daily, and a 12/5/23 order for fortified pudding.

R48's 2/16/24 Nutrition Quarterly Assessment showed she required supervision with meals.

On 04/02/24 at 12:36 PM, R48 was in a wheelchair at a table in the dining room. R48's food was in front of her. Staff were present in the room assisting other residents. R48 was not assisted, cued to eat, or prompted by staff.

At 12:45 PM, R48 repeatedly moved away from

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S9999	Continued From page 2	S9999		

the dining table by self propelling and moving the wheelchair away from the table. Staff would push her wheelchair back into place at the table . No attempts to assist or encourage R48 to eat were done.

At 12:56 PM, R18, who was seated to R48's right at the dining table, pulled R48's plate of food away from R48 and toward herself. R18 ate some of R48's food with her fingers. R48 showed indifference at her food being taken.

At 12:58 PM, V4, Memory Care Director, moved R48 in her wheelchair back to the dining table without noticing there was no food plate in front of her. R48 continued to attempt to move away from the table.

At 1:01 PM, V4 pushed R48 in her wheelchair from the dining room and down the hall to her room.

On 04/03/24 at 08:44 AM, R48 was in a wheelchair at the dining table. Minimal food was gone from her plate. There was no staff assisting R48. There was no cueing, supervision, or prompting her to eat.

On 4/4/24 at 9:15 AM, V14, Dietician, said she was familiar with R48, and R48 is to be supervised during meals. "I would expect the staff to be watching the residents, assisting them as needed, and to intervene if another resident is removing food from her tray. Due to her diagnosis of dementia, some days she eats well on her own, and other days she just stares off and needs staff assistance to eat. It's variable. I expect the staff to ensure they are meeting her needs each day. Cueing is an important aspect of meal supervision. Her PO (oral) intake is variable

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S9999	Continued From page 3 between 50-100%." On 4/4/24 at 10:42 AM, V2, Director of Nursing (DON), said R48 was diagnosed with shingles on 2/12/24, and was isolated in her room. V2 said, "That's the reason for her weight loss." (B)	S9999		