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	IL6014922	A. BUILDING: _____ B. WING _____	C 05/24/2024

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ALDEN ESTATES OF ORLAND PARK	16450 SOUTH 97TH AVENUE ORLAND PARK, IL 60467

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S 000	Initial Comments Complaint Investigation Survey: 2473893/IL173302	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999		

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meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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 requirements were not met as evidenced by:

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Based on interview and record review, the facility failed to provide stand-by assistance to a resident who required assistance to ambulate. This failure led to R1 falling and fracturing her nasal bone.

This applies to 1 of 3 residents (R1) reviewed for accidents and supervision in a sample of 7.

Findings include:

R1's Hospital Records showed "Clinical Summary: 94-year-old female had a fall easily agitated and restless developed sundowning [she] had epistaxis from her right nare that was repaired. Patient had cauterization as well as a rhino rocket since patient is on Eliquis and thus contributed to her bleeding." The Record also showed on May 13, 2024 at 07:04 PM, a CT (Computed Tomography) of the maxillofacial bones, orbits, and paranasal sinuses without contrast was taken with results showing "Bilateral comminuted nasal bone fractures are visualized."

R1's Incident Report dated May 13, 2024 at 12:42 PM showed a statement written by V3, which showed the following: "Writer heard a loud noise went into the dining area, noted resident on the floor lying on her left side of the face. Resident was trying to get up. Writer noticed blood on the floor. Resident was bleeding from her nose. [Abdominal] pads applied to stop bleeding. Vital signs taken and 911 called. Family informed as well as NP (Nurse Practitioner) [Name] informed as well. Paramedic came and transfer resident to [Hospital]." The Incident Report also showed a statement by V2, which showed the following: "On 5/13/24 at approximately 12 noon resident was ambulating in dining room with her rolling walker and was witnessed to have tripped either on her

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foot or the wheel of the walker and fell on her left side striking her nose on the floor per witness statements. Discoloration noted to bridge of nose with swelling along with copious amount of bleeding from nares. First aid rendered with ice packs to nose. Complete body check done no other injuries observed, 911 called. MD (Medical Doctor) and family aware of occurrence. Resident taken to [Hospital] for further evaluation. Resident stated that she fell. Resident stated that no one caused her to fall when asked. Based on staff statements any occurrence of abuse was ruled out due to residents seating prior to fall and the fact that no other residents were around or nearby [R1] at time of fall. Report called to ER (Emergency Room)."

The EMR (Electronic Medical Record) shows diagnoses including hypertension, Alzheimer's disease, atrial fibrillation, type 1 diabetes mellitus, chronic obstructive pulmonary disease, and fall from chair. R1's discharge MDS (Minimum Data Set) dated May 13, 2024 showed R1 had modified independence with daily decision making. R1 required set up assistance for eating, oral hygiene, toileting hygiene, shower/bathing, upper body dressing, putting on/taking off footwear, and personal hygiene. R1 required supervision for lower body dressing. R1 required supervision or touching assistance to ambulate 10 feet, 50 feet, and 150 feet. R1's care plan initiated on May 9, 2024 had a focus which showed R1 was at risk for falls. R1's admitting interventions included "Monitor for changes in ability to navigate the environment. Promote placement of call light within reach. Provide an environment clear of clutter. Provide proper, well-maintained footwear." On May 11, 2024, the following interventions were included after R1 fell: "Encourage appropriate use of wheelchair... Walk

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along side of resident when walking."

On May 21, 2024 at 8 AM, V13 (Family Member) said R1 had fallen but she had heard multiple stories about what happened. V13 said she was told her mother had been walking and fell; another story was she had fallen and hit her head on the table; and lastly R1 told her she had been pushed. V13 said she was trying to figure out what had happened, and the facility did not have cameras to confirm. V13 said R1 broke her nose, had two black eyes, and at first could not even open her eyes. V13 said R1 used a rollator to walk. V13 said R1 had fallen first on May 11, 2024. V13 said she was told R1 tripped and fell to her knees. V13 said the second fall was on May 13, 2024 and she had received a call about it from V3 (LPN) at 11:54 AM.

On May 21, 2024 at 1:20 PM, V4 (CNA/Certified Nurse Assistant) said he had seen R1 ambulating around the unit using a walker by herself. On May 22, 2024 at 2:20 PM, V4 said V6 had said someone needed to walk behind R1 but R1 usually walked by herself from her room to the dining room and back. V4 said R1 was independent with walking.

On May 21, 2024 at 1:25 PM, V17 (Memory Care Aide) said the residents were in the dining room because they had finished the morning group activities. V17 said she told the residents who could ambulate by themselves to find their seats for lunch, which included R1. V17 said she saw R1 stumble and fall forward to the ground. V17 said she was not sure if R1 tripped on her shoes or the walker. V17 said V16 (Memory Care Aide) was the first person to get to her. V17 said there were no residents behind her and the closest resident to her was farther up in front of her. V17

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said R1 had a bloody nose and a bump on her forward in between her eyebrows and was sent out to the hospital. On May 22, 2024 at 02:05 PM, V17 said she was not notified R1 needed assistance to walk and had asked V18 (Memory Care Aide) if R1 had any changes, and V18 said R1 was able to ambulate on her own.

On May 21, 2024 at 1:43 PM, V3 (LPN) said according to the activity aides, they had told R1 to sit somewhere else. V3 said he did not see R1 fall but heard her fall and went to assess her. V3 said R1 fell onto her face and was bleeding uncontrollably. V3 said he brought the treatment cart as well as the crash carts, put abdominal pads on R1's face and applied pressure to get the bleeding to stop. On May 23, 2024 at 9:43 AM, V3 said he was aware R1 had fallen in the facility prior to her fall on May 13, 2024, but he was not clear on what had happened. V3 said he thought it had something to do with the walker, but he was aware R1 was a fall risk. V3 said during the stand up meeting held every morning, he was told to closely monitor R1, keep her bed low, make sure she was using her walker correctly, and fall mats when she was in bed. V3 said no one had notified him that R1 required stand by assistance to ambulate. V3 said he had not notified the staff about it either but said everyone knew she was a fall risk.

On May 22, 2024 at 3:10 PM, V20 (Medical Doctor) said R1 had a history of falls. V20 said he was notified R1 had fallen on May 11, 2024 and he said he would expect the staff to follow their interventions. V20 said if R1 required assistance for transporting, the staff should be walking with her because she would be at a higher risk of falling. V20 said R1 did fall, which caused her to fall on her face, requiring her to go

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to the hospital.

On May 22, 2024 at 9:22 AM, V16 (Memory Care Aide) said she was working on May 13, 2024 when R1 fell. V16 said they had just finished their regular morning group and needed to rearrange the residents back into their regular seats for lunchtime. V16 said the residents were sitting in a circle with the tables behind them. V16 said there were some residents that were able to ambulate by themselves, and R1 was someone who walked by herself. V16 said V17 asked R1 to go back to her table for lunch. V16 said she and V17 were moving the residents who needed assistance to their tables when they heard another resident yell and saw that R1 had fallen. V16 said she did not see R1 fall but she was the first person to get to her when she fell. V16 said R1 was face down on the side and when she got to her, and R1 was "freaking out." V16 said there were no other residents near her close enough to touch her or push her. V16 said R1 was known to stumble a bit. V16 said prior to her fall on May 13, 2024, she had notified V5 (LPN) how R1 stumbled when she walked and had told R1's daughter her shoes seemed too heavy for her to walk with. V16 said the staff often had to tell R1 to slow down because she walked fast. On May 23, 2024 at 09:06 AM, V16 said she was walking alongside R1 on May 11, 2024 when she stumbled. V16 said she tried to grab R1 from falling and they both fell down, with R1 falling onto her knees. V16 said she had another CNA (Certified Nurse Assistant) help get R1 back up and she notified the nurse. V16 said none of the staff notified her after her fall on May 11, 2024 that R1 needed to be in a wheelchair or needing stand-by assistance to ambulate. V16 said R1 had also walked to the dining hall by herself on May 13, 2024.

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On May 22, 2024 at 2:15 PM, V18 said she was working on May 13, 2024, but did not witness R1 falling as she was in the TV room. V18 said she was never given any instructions about R1 needing someone to walk with her. V18 said she went to the stand-up meeting that morning, and she did not remember hearing them instruct on that.

On May 22, 2024 at 1:24 PM, V5 (LPN) said she did not witness R1's fall on May 11, 2024, but an activity aide had. V5 said it sounded like R1 had tripped on her shoes and went down on her knees but did not get hurt. V5 said R1 used the walker pretty well. V5 said there were no changes to R1's care after her fall because she was fine, so no changes were made. At 1:40 PM, V5 came to the Surveyor to clarify R1's care had changed, and she needed someone to walk with her to assist her. V5 said she had just asked V6 (Restorative Nurse) and V6 told her the intervention was to standby assist R1 during ambulation.

On May 22, 2024 at 1:52 PM, V6 (Restorative Nurse) said she assessed R1 when R1 was admitted, and again when she tripped on May 11, 2024. V6 said she had told the staff they needed to walk by her side at all times but was still safe to walk using the rollator. V6 said she mentioned it to the nurse taking care of R1, as well as during the stand-up meeting, so the staff were made aware of the changes. V6 said the staff should be assisting her from one seat to another seat.

On May 22, 2024 at 3:52 PM, V21 (Physical Therapy Aide) said when a resident requires stand-by assistance, it means whoever is assisting the resident did not need to touch the

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resident but had to walk with the resident. V21 said if a resident needed stand-by assist, it meant there was a risk the resident could fall.

On May 23, 2024 at 9:25 AM, V22 (CNA) said R1 was independent, and she was not notified R1 needed stand by assistance to walk.

On May 23, 2024 at 12:03 PM, V7 (Patient Care Coordinator) said if a resident needed stand by assistance, any time they were up, the staff needed to stand by them to ambulate with them just in case they lost their balance. V7 said if the resident needing stand by assistance was not given assistance, they could possibly fall.

The facility's Management of Falls policy dated August 2020 showed "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. Develop a plan of care to include goals and interventions which address resident's risk factors. Risk factors may include but are not limited to the following ...history of fall incidents ...assistance required with ADL's (Activities of Daily Living), gait/transfer/balance issues, behaviors, and/or cognitive status. Review and/or modify the resident's plan of care at least quarterly and as needed in order to minimize risk for fall incidents and/or injury.

(B)