| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0042192 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 09/11/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **ALDEN ESTATES OF ORLAND PARK** | **16450 SOUTH 97TH AVENUE , ORLAND PARK, Illinois, 60467** |

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| S0000 | Initial Comments<br><br>Complaint Investigations<br><br>2578268/2605935<br><br>2578243/2602699 | S0000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations 1 of 2<br><br>300.1210b)<br><br>300.1210c)<br><br>300.1210d)6)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>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.<br><br>These requirements were not met as evidenced by: | S9999 | | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br><br>Based on interview and record review, the facility failed to ensure effective supervision and monitoring of residents in the dining room to prevent accidents. Specifically, staff failed to maintain visual supervision of a resident assessed to be at risk for falls. This affected one of three residents (R1) reviewed for falls. This failure resulted in R1 sustaining an unwitnessed fall in the dining room and being sent to the local hospital where R1 was treated for a hip fracture.<br><br>Findings include:<br><br>R1's face sheet shows diagnoses including chronic hepatic failure hepatic encephalopathy anemia Alzheimer's type 2 diabetes COPD depression anxiety hypertension and dementia. MDS dated 5/29/25 section C shows Brief Interview for Mental Status (BIMS) score of 4 (cognitive impairment).<br><br>The facility final report to the State department dated 8/22/25 denotes in-part R1 is a 79-year-old female resident who was admitted to the facility to 2/19/25 with diagnosis that include but not limited to chronic hepatic failure hepatic encephalopathy anemia Alzheimer's type 2 diabetes COPD depression anxiety hypertension and dementia. Resident is alert and oriented times one to two spheres and requires partial to moderate assist with ADL's (activities of daily living). BIMS 4/15. Resident was observed lying on the floor in the dining room with reports of pain resident alert and oriented times one to two per baseline. Hospice notified with orders to send to ER (emergency room) for further evaluation. POA (Power of Attorney) also notify of occurrence. Resident was transported to (hospital name) then subsequently transferred to (hospital name) where she was admitted with a right femoral neck fracture. It is probable residence led to floor based on proximity of wheelchair to table. Table mates were unable to provide detail regarding incident the nurse interview reveal the resident was seated at the table properly positioned with proper footwear a few minutes prior to the incident. During this investigation abuse was not found to be a factor based on staff/ resident interviews.<br><br>On 9/3/25 at 2:05pm V5, Licensed Practical Nurse (LPN) said she was covering for R1’s nurse because she was on break. V5 said she walked pass the dining room where she observed R1 sitting in her wheelchair at the second table to the left (front facing when walking through the doors of the dining room) R1's back was to the door. V5 said she did not see any food trays in the | S9999 | | |

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| S9999 | Continued from page 2<br>dining room, lunch was over. V5 said she went and sat down at the nurse station, across from the dining room. V5 said she could not see R1 from her position. V5 said she was monitoring the dining room from the Nurse station. V5 said a couple minutes later two staff members approached her an informed her that R1 was on the floor in the dining room, V5 said this was around 1:20pm, she looked at the clock. V5 said she did not see R1 fall. She did not see what R1 was doing just before she fell. V5 said she was not aware that R1 was at risk for falls, V5 said the Nurse did not give her a report before she took her break. V5 said she assessed R1, she observed R1 laying on the floor on her right side, she was laying in between two tables, her head was toward the wall and her feet was out. V5 said she palpated R1's body and when she touched R1 back, R1 winced and complained of pain. V5 said R1 did not have pain when she palpated R1's hip. V5 said R1 was not moved from the floor, and 911 was summoned, physician notified, and R1 daughter was notified. V5 said 911 took R1 to the hospital for further evaluation. V5 said there's no solid rule that someone must be in the dining room to monitor the residents, they can be monitored from the Nurse station. V5 said she did not see R1 fall, while she was monitoring the dining room.<br><br>On 9/3/25 at 2:25pm V6 (Director of Nursing) said R1 had an unwitnessed fall. V6 said the root cause of R1 fall was maybe R1 was trying to take herself back to her room after lunch as she often did. V6 said V5 was monitoring the dining room when R1 fell. V6 said if the residents are in dining room staff should be there to monitor the residents. V6 said the staff should be able to see all the residents when monitoring the dining room. V6 said if she had to do things different, she would have the staff bring the residents out of the dining room after lunch. V6 said the residents can sit near the Nurse station for observation by staff.<br><br>On 9/3/25 V2 (LPN) said R1 had to often be redirected and asked to sit down in her wheelchair because she could fall.<br><br>9/3/25,12:46pm V4, Certified Nursing Assistant (CNA) said R1 had to often be redirected and asked to sit down in her wheelchair because she could fall.<br><br>9/4/25 at 1:32pm V7 (CNA) said he was picking up lunch trays from the resident's rooms, as he headed to the dining room R1 was observed on the floor on her back. V7 said there were no other residents in there with R1. There were no staff in there with R1. V7 said he summoned the Assistant Director of Nursing and V5 (LPN). V7 said R1 was trying to get up a few times but | S9999 | | |

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| S9999 | Continued from page 3<br>she couldn't, V7 said he even went downstairs to get a lift pad just incase they was going to get R1 up. V7 said R1 often stood up from her chair and sat back down, and if the wheels were not locked the chair would roll backwards. V7 said he believes that what happened. V7 said V5 did assess R1, 911 was called and R1 was sent to the hospital for further evaluation.<br><br>R1's care plan with initiated date of 2/19/25 denotes in-part R1 is at risk for falls related to weakness impaired mobility use of narcotic cognitive impairment diagnosis hepatic encephalopathy and Alzheimer's disease use of assistive device, use of medications that affects GI (gastrointestinal) motility, use of psychotropics overactive bladder continent of bowel and bladder. Goal: will remain free of falls through next review. Interventions: assure resident is wearing eyeglasses. Encourage appropriate use of Walker. Encourage appropriate use of wheelchair. Ensure that the bed is inappropriate lowest position for the patient and the bed is locked as appropriate. Fall risk assessment quarterly and as needed. Monitor for changes in ability to navigate the environment. Offer resident assistance to bathroom as needed throughout the night early morning when making rounds. Orientate resident to surroundings frequently including location of bathroom dining room bedroom and activity locations. Place resident in bed if returning her to her room period do not leave in room in wheelchair without supervision/monitoring. Promote placement of call light within reach. Provide an environment clear of clutter. Provide proper well-maintained footwear. Remove resident from common areas after completion of her meal.<br><br>R1 fall risk assessment dated 6/26/25 denotes in-part post fall assessment, unsteady gait and or use of ambulatory device, confused, 1-2 falls in the last 3 months, taking medications that have a diuretic effect, drugs that affects thought process, and drugs that effect hypotensive effect, regularly incontinent: needs assist to et to the toilet. Score is 8, at risk for falls.<br><br>R1 hospital record dated 8/15/25 denotes in-part Xray, hip, there is sclerosis the femoral neck, there is suspicious for an impacted nondisplaced right femoral neck fracture. Impression, probable nondisplaced femoral neck fracture.<br><br>Facility policy titled Fall management program dated 8/2020 denotes in-part the facility is committed to minimizing resident falls and or injury so as to maximize each resident physical mental cycle social | S9999 | | |

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| S9999 | Continued from page 4<br>well-being. While preventing all resident falls is not possible it is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls plan for preventive strategies and facilitate a safe environment.<br><br>Prior to the survey date of 9/11/2025, the facility had taken the following action to correct the noncompliance:<br><br>1. On 8/18/2025 the facility reviewed all residents that were a fall risk in the past 3 months and care plans were reviewed and interventions put in place.<br><br>2. On 8/22/2025 thru 8/29/2025 the facility in-serviced all nursing staff on fall management program, fall prevention, and management of falls. Staff in-service on resident supervision while dining and after dining.<br><br>3. On 8/18/2025 QA audit tool for dining room supervision developed and monitoring of resident started and continues to be done (8/18/2025 to 9/4/2025) audits reviewed.<br><br>4. 8/29/2025 and emergency QA meeting was held by the Administrator with the interdisciplinary team and Medical Director and the team approved the past noncompliance plan.<br><br>(A)<br><br>Statement of Licensure Violations 2 of 2<br><br>300.697d)<br><br>300.697e)<br><br>Section 300.697 Infection Preventionists<br><br>A facility shall designate a person or persons as Infection Preventionists (IP) to develop and implement policies governing control of infections and communicable diseases. The IPs shall be qualified through education, training, experience, or certification or a combination of such qualifications. The IP's qualifications shall be documented and shall be made available for inspection by the Department. (Section 2-213(d) of the Act). The facility ' s infection prevention and control program as required by Section 300.696(e) shall be under the management of an IP. | S9999 | | |

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| S9999 | Continued from page 5<br>d) Facilities with more than 100 licensed beds or facilities that offer high-acuity services, including but not limited to on-site dialysis, infusion therapy, or ventilator care shall have at least one IP on-site for a minimum of 40 hours per week to develop and implement policies governing control of infectious diseases. For the purposes of this subsection (d), "infusion therapy" refers to parenteral, infusion, or intravenous therapies that require ongoing monitoring and maintenance of the infusion site (e.g. central, percutaneously inserted central catheter, epidural, and venous access devices).<br><br>e) A facility ' s IP shall coordinate with the facility group listed in Section 300.696(c) to ensure compliance with Section 300.696.<br><br>(Source: Added at 46 Ill. Reg. 6033, effective April 1, 2022)<br><br>These requirements were not met as evidenced by:<br><br>Based on interview and record review, the facility failed to have an infection preventionist on-site for a minimum of 40 hours per week developing and implementing policies governing control of infectious diseases. This failure has the potential to affect all 174 residents that reside within the facility.<br><br>Findings include:<br><br>On 9/09/25 at 12:06pm, V16 (Assistant Administrator) affirmed that the facility has over 100 residents and also offer higher acuity services. V16 confirmed that V15 (Assistant Director of Nursing/ADON & Infection Preventionist) is currently fulfilling both roles. V16 further acknowledged that V15 does not dedicate a full 40 hours per week exclusively to Infection Preventionist responsibilities, as V15 is concurrently performing duties associated with the Assistant Director of Nursing position.<br><br>On 9/09/25, V3 (Administrator) confirmed that V15 (Assistant Director of Nursing/ADON & Infection Preventionist) currently serves in a dual capacity as both the Assistant Director of Nursing and the facility's designated Infection Preventionist. V3 stated that she was not aware of the requirement for the Infection Preventionist role to be a full-time position (minimum of 40 hours per week) and indicated she would need to consult with corporate leadership for further clarification and guidance on this matter.<br><br>Facility job description titled, "Infection | S9999 | | |

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| S9999 | Continued from page 6<br>Preventionist Nurse," dated 7/2024, documents, in part, "The Infection Prevention Nurse is responsible for overseeing the Infection Control Program. The Infection Prevention Nurse systematically collects and assesses data in collaboration with the team to provide therapeutic, evidenced based care. The Infection Control Nurse works collaboratively with the team to develop plans of care and documents progress toward achieving defined outcomes. This includes assessing the effectiveness and the needs of the program, development and planning of services, organizing and coordinating the implementation of services, monitoring and evaluating the effectiveness and efficiency of the programs and services. The position requires the knowledge of epidemiology and application of public health practices in the facility, with the goal of implementing effective and efficient procedures and policies to combat disease transmission among residents and staff. The Infection Preventionist Nurse is accountable for maintaining compliance with current federal, state and local standards, guidelines and regulations, facility policies… Daily observation on facility infection control process in all departments…"<br><br>Pamphlet titled, "Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities," revised date 11/18, documents, in part, "Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike…"<br><br>Facility census, dated 9/08/2025, documents 174 residents residing at the facility.<br><br>(C) | S9999 | | |