STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046524	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

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

(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) COMPLETION DATE
S0000	Initial Comments Investigation of Facility Reported Incident of 12/07/2025/252690787 Complaint Investigation 25912209/2691679	S0000		01/09/2026
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210c) 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. 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: Based on interview and record review, the facility	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 failed to ensure a safe environment and provide adequate supervision and assistance to prevent falls for two residents (R1 and R2) by failing to implement appropriate fall prevention interventions and ensure adequate assistance during high-risk care. This failure affects one ventilator-dependent, quadriplegic resident (R1), and one cognitively impaired resident (R2). These failures resulted in R1 falling during incontinence care by staff iand R1 sustaining fractures to the left tibia and fibula, requiring surgical intervention and R2 falling immediately following an activity, while not being supervised by staff resulting in three sutures to the left eyebrow. Findings include: 1. R1 is admitted to the facility on 5/21/2025 2025 on ventilator support with the diagnoses including morbid obesity, subarachnoid hemorrhage due to cerebral aneurysm, hydrocephalus, epilepsy, quadriplegia, chronic kidney disease, pulmonary embolus, and left lower extremity Deep vein thrombosis, diastolic heart failure, atrial fibrillation. R1 is incontinent of bowel and bladder and has a urinary catheter and receives enteral nutrition. Facility reported incident documents that on 12/6/25, the nurse on duty was called to R1's room and R1 was found on the floor in a supine position. R1 remained on the floor with staff present while 911 was called and was then transferred to local hospital for emergency services. Minimum Data Set (MDS) assessment of 10/18/2025 documents the following: Section C 1000(Cognitive skills for daily decision making) score is 3 (indicating severe impaired decision making) Section GG: R1 is dependent for toileting hygiene, roll left and right, shower, oral care, dressing, and lying to sitting. The helper does all the effort. The resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. 12/13/25 at 12:17 PM V3 RN said, R1 is a total care resident on a ventilator under hospice care. I was the nurse caring for him when he fell. I was passing medications when I heard someone calling for help. When I went to the R1's room, R1 was on the floor and I called 911. The emergency team came fast and picked him and sent him to the hospital. I assessed R1, checked	S9999		

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S9999	Continued from page 2 vital signs, oxygen saturation, and started an intravenous line, and 911 came and took over. I saw blood on the left leg below the knee and I did not clean or do anything because 911 was already there and took over. R1 was cared for by one person instead of two during his care. When asked, V3 said, "I think he was one assist with his care." V4 (Certified Nursing Assistant) was caring for R1 the day of the fall and V4 did not ask for my assistance. 12/13/25 at 12:50 PM, V4 (Certified Nursing Assistant) said, I was doing my last rounds around 5:00 AM when I pulled R1's covers. I noticed that R1 had a bowel movement and I started to change him. First, I cleaned his front and I turned him on his side. I pulled the sheets towards me and started to clean his back. R1 was still having a bowel movement. I reached out to grab more wipes to clean R1 when he kicked out with his left leg and started to fall. I held him and called for help. But when the nurse came into the room, R1 was already on the floor. Initially, I did not see any blood on his left leg because he had foam boots on. Then, after we removed the boots, I saw blood just before 911 came in. The nurses and everyone came to help but I could not stop the fall. The resident is a total assist and technically I was supposed to use two (person) assist but I was caring for him by myself. R1 had a low air loss mattress. 12/13/25 at 2:37 PM, V7 (Restorative Nurse/Fall coordinator) said, R1 had a fall from the bed and was sent out to the hospital. R1 was a total assist and required one assist. V7 did not provide any additional details regarding the fall. On review of the hospital record, R1 had a comminuted fracture of the left distal tibia. Dorsal displacement and angulation of distal fracture fragments. Fracture distal fibula with dorsal displacement major fracture fragment. V8 (Orthopedic Surgeon) notes indicated that operative versus nonoperative management was discussed with R1’s brother and POA (power of attorney) wanted to proceed with surgery after risks and benefits were discussed, which included death, stroke, and myocardial infarction, to name a few risks mentioned by the surgeon. V9 (Critical Care Physician) notes indicated that R1 was taken to surgery and suffered a cardiac arrest upon induction. R1’s code status was DNR (Do not Resuscitate) and in accordance with R1’s wishes, no ACLS (Advanced Cardiovascular Life Support) was initiated and R1 expired at 12/6/2025 11:45 AM in a local hospital. 12/13/25 at 2:49 PM, V2 (Director of Nursing) said, R1	S9999		

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S9999	Continued from page 3 had a bariatric air loss mattress and weighed 269 pounds, under hospice care, and was in and out of the facility, going back and forth to the hospital for being hypodermic or hypotensive. The interdisciplinary team met with the family and decided to go with hospice. During the fall, R1 was being cared for by one nurse assistant. R1 was having a bowel movement. R1 was not able to help or provide directions. R1 was not able to follow commands. The nursing assistant would call for help if they need assistance. V2 continued to say that a total/dependent resident with a ventilator, air loss mattress, who is incontinent only requires one person assist for care and that is what they always used for R1. Despite surveyor asking during interviews and review of documentation, there is no documentation supporting one-person assist during turning/incontinence care for R1. 2. R2 admitted to the facility on 05/20/2023 with the diagnoses including, Anxiety, heart failure, anemia, depression, hypertension, and dementia. Facility reportable documents that R2 was found lying on the floor on her back in the activity room on 12/7/2025. Minimum Data Set (MDS) assessment of 12/9/2025, Section C documents R2's BIMS (Brief Interview for Mental Status) score as 6/15, indicating severe cognitive impairment. MDS of 09/15/2025, Section GG documents that R2 requires supervision or touching assistance. Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as the resident completes the activity. Assistance may be provided throughout the activity or intermittently. 12/13/2025 at 11:20 AM, R2 said, I fell in the past but the last fall was bad. I was in the activity room and we had just finished making decorations for Christmas. I had my walker near me and just got up and started to walk when I saw a small box on the floor and I thought I could walk and tripped over it. The small box was on the floor because we were wrapping up and putting it away. I was by the Christmas tree. When I fell, I stayed there until 911 came to pick me up. I was taken to the hospital because I hurt my left eyebrow. I can walk around the facility and the staff will help me. R2 said that she did not call for assistance or wait to get assistance after the activities. 12/13/25 at 1:42 PM, V6 (Activities Aide) said, I was not present when R2 fell. I was bringing the other	S9999		

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S9999	Continued from page 4 residents to their rooms after the end of the activities. The activity that the residents were doing that day was a craft and we were making a Christmas tree with felt. The Christmas bins with supplies were behind us and we were seated by the window; R2 was sitting next to me. R2 was with us for about 1-4 hours and there was no box on the floor near R2. On the other side, there was a Christmas tree with a small nativity under the tree and I did not see any box on the floor. The activity ended around 4:00 PM. 12/13/25 at 2:15 PM, V11 (Certified Nursing Assistant) said, I was not there when R2 fell. I was passing by and I heard R2 had fallen and was already on the floor. Someone was already there with a paper over her forehead. I think the person was a visitor or a family member. I asked R2 how she was and R2 said she was okay. R2 was in the middle near the Christmas tree and there were little boxes of gifts as decorations under the tree. R2 walks around the facility with supervision. 12/13/25 2:49 PM, V2 (Director of Nursing) said, there should always be someone supervising residents during activities and when residents are going back to their rooms. I don't think we have an activity room policy/monitoring during and after activities. 12/13/25 2:57 PM, V10 (Assistant Director of Nursing) said, R2 stood up without her walker and R2 said she kicked a small ornament, a square box, and lost her balance and fell. R2 had an unwitnessed fall just after finishing the activity. We had an activity aide in the kitchen and another was bringing residents to their rooms. When questioned about any activity room policy and monitoring during and after activities, V10 said that she didn't think there was any facility policy regarding activity room observation and monitoring. 12/14/25 at 12:24 PM V5 (Activity Aide) said, I was washing dishes in the activity kitchen next to the activity room after the activities and getting ready for dinner and my co-worker V6 (Activity Aide) stepped away from the activity when I heard a commotion and R2 was on the floor. R2 was sitting on her bottom near the Christmas tree and I did not see any box next to the tree and R2's walker was next to her. R2 can ambulate around the facility. Review of R2's hospital emergency room records and discharge notes document that R2 required three sutures to the forehead. Throughout the course of this survey, the facility was	S9999		

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S9999	Continued from page 5 unable to provide a policy, procedure, or staff guidance regarding the supervision of residents in the activity room during or after activities for residents who are at high risk of falls. Facility Policy titled, Fall Management Program (revised on 08/2020), which reads: The facility is committed to minimizing residents' falls and or injury so as to maximize each resident's physical a psychosocial wellbeing. While preventing all residents' falls is not possible, it's the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls and plan for preventive strategies and facility a safe environment...4. Plan care reviewed and updated at the time of occurrence, quarterly, and as needed in order to minimize risks for fall incidents. Facility Policy titled Activity Calendar (revised on 11/16) reads: ...4. The Activity Director or Designee will determine level of functioning through the assessment process and care plan this level per resident. The following information will be utilized to determine level of functioning: information from assessments, clinical observations, and the BIMS score from the MDS 3.0: 13-15: Cognitively intact, High Functioning, 8-12: Moderately impaired, Moderate Functioning, 0-7: Severely impaired, Low Functioning...10. Adaptations for residents will be determined based off the Comprehensive Activity/Memory Care Assessments and will be made on-going based off of the residents' needs. "A"	S9999		