

Illinois State Department of Health

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 04/04/2026	
NAME OF PROVIDER OR SUPPLIER ALDEN ESTATES OF ORLAND PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 16450 SOUTH 97TH AVENUE , ORLAND PARK, Illinois, 60467			
(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	S0000					
	Complaint Investigation 2693824/2969655						
S9999	Final Observations	S9999					
	STATEMENT OF LICENSURE VIOLATIONS:						
	300.610a)						
	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.						
	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						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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 EVIDENCED BY: Based on interviews and record reviews, the facility failed to provide adequate supervision and fall prevention measures for one resident (R11) with advanced dementia, resulting in a preventable accident. This affected one of three residents (R11) reviewed for supervision, monitoring and avoidable accidents. This failure resulted in R11 propelling to an emergency door exit door opening the door and falling down a flight of stairs sustaining a right femur fracture and left humerus fracture. On 4/3/26 at 10:48 AM, V11 (nurse) stated that V12 CNA (certified nurse aide) got R11 up at 5:00 AM on 3/23/26. V11 stated that V12 brought R11 to the nurses' station. V11 stated that he was rounding on residents at that time. V11 stated that R11 self-propelled wheelchair down the middle hallway and exited the unit by the emergency exit. V11 stated that he heard the door alarm sound, and he went searching for where alarm coming from. V11 stated that R11 was found at the bottom of stairs with wheelchair. V11 stated that R11 needs constant re-direction when in wheelchair. V11 stated that there weren't any fall precautions in place for R11. V11 stated that the residents of this nursing unit have dementia and Alzheimer's disease. On 4/3/26 at 11:43 AM, V12 CNA stated that R11 was trying to get out of bed without assistance on 3/23. V12 stated that R11 is a fall risk so she got R11 dressed, transferred to wheelchair, and brought R11 to the nurses' station. V12 stated that everybody was rounding so no one was at nurses' station monitoring residents. V12 stated that when she heard the alarm, she checked the stairwell and found R11 at bottom of stairs with wheelchair. R11's hospital record, dated 3/23/26, notes R11 presented to the emergency room after unwitnessed fall down flight of stairs. R11 unable to tolerate left arm being moved. R11 with diffuse bruising. X-ray of right femur shows comminuted fracture of the distal femur extending to the joint space. X-ray of left humerus shows comminuted humeral head and neck fracture with mild displacement of the distal fragment anteriorly. R11 underwent surgical repair of right femur fracture.		S9999				

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S9999	Continued from page 2 R11's falls report, dated 3/23/26, notes R11 was observed in supine position with wheelchair over lower extremities in the emergency stairwell. Upon assessment, R11 noted to be grimacing and guarding extremities. R11's orientation is x 1 with memory impairment, consistent with baseline cognition. R11 has predisposing factors including but not limited to impaired memory, poor safety awareness, and weakness. R11's falls care plan, dated 3/10/26, notes R11 is at risk for falls, history of fall, weakness, impaired cognition, use of assistive device, use of narcotic medication, and use of psychotropic medication. R11's cognitive care plans note R11 with impaired cognitive functioning related to advanced vascular dementia and history of stroke resulting in significant cognitive decline. R11 exhibits unpredictable behaviors and actions. R11 has deficits in short term/long term memory and ability to make decisions. R11 has difficulties in effectively communicating her needs and at times does not reflect signs of comprehension or understanding during simple communications. (A)			S9999			