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
	IL6014500	A. BUILDING: ______ B. WING ______	C 04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF NORTHMOOR	5831 NORTH NORTHWEST HIGHWAY CHICAGO, IL 60631

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S 000 Initial Comments — S 000

Complaint investigation survey:
1982646/IL111241
1982655/IL111251

S9999 Final Observations — S9999

Statement of Licensure Violations:

300.610a)
300.1210a)
300.1210b)5)
300.1210d)3)6)
300.3240a)

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

Attachment A
Statement of Licensure Violations

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comprehensive care plan for each resident that includes measurable objectives and timetables to 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. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and

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determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These Regulations were not followed as evidence by:

Based on interview and record review the facility failed to monitor and provide supervision while in the dining room, failed to follow the facility fall management program and failed to appropriatly care plan for 1 of 3 residents R1 reviewed for fall prevention and supervision. This failure resulted in R1 being left in the dining room and falling from the wheel chair and being sent to the local hospital and was admitted with a diagnosis left orbital wall fracture, left zygomatic arch and closed fractures of distal end of left radius and ulna.

Findings Include:

R1 admitted to facility on 2/17/19 with diagnosis dementia with behavioral disturbances and displaced intertrochanteric fracture of left femur.

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R1's Brief interview for mental status dated 2/28/19 documents a score of 3. A BIMS score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment.

On 4/23/19 at 11: 50 AM, V2 (DON) said R1 requires supervision and required redirection. Upon admission R1 would attempt to stand from wheelchair and ambulate. Staff would try to use distraction, activities or place near nursing station.

On 4/23/19 at 2: 53 Pm V18 (physician) said R1 was confused and needed redirection every 5 minutes. R1 required close supervision.

On 4/23/19 at 1:38 Pm, V16 (Restorative nurse) said R1 had behavior from admission of trying to get up from R1's wheelchair and attempting to ambulate. R1 was unsteady and would fall if R1 got up unassisted. R1 needed constant redirection and required supervision. Interventions for this behaviors including contacted family to calm resident or give R1 a specific time of when family would be coming to visit. These interventions are not documented in R1 's care plan.

On 4/23/19 at 10:09 AM, V13 (Physical therapy Director) said R1 was not safe to use or be in her wheelchair by herself. R 1 was not cognitively aware of how to use wheelchair or safety concerns. R1 required very close supervision at all times.

On 4/19/19 at 3:44 PM, V11 (nurse) said R1 would stand up from wheelchair and require cueing to sit back down. R1 required low bed and

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frequent monitoring at least every 15 minutes.

On 4/19/19 at 3:13 PM, V10 (nurse) said R1 required supervision when in wheelchair because R1 would stand up from wheelchair and try to ambulate. R1 was fall risk and needed constant redirection.

On 4/19/19 at 1: 39 PM, V6 (CNA) said R1 required supervision and R1 was usually by nursing station or common dining room. R1 would stand up from wheelchair and try to walk unassisted since admission. On 4/9/19, I assisted R1 in her wheelchair to common room. I locked R1's wheelchair and turned around to assist another resident with feeding. I heard a noise and R1 had fallen out of her wheelchair.

R1's incident report dated 4/9/19 documents R1 alert to person. Under notes documents R1 has habit of getting up from wheelchair and likes to attempt to walk. She requires constant re-directing from staff to remain seated in her wheelchair to prevent injuries from fall.

Local hospital records dated 4/9/19 document an admitting diagnosis of left orbital wall fracture, left zygomatic arch and closed fractures of distal end of left radius and ulna.

On 4/19/19 at 4:00 Pm, V12 (CNA) said R1 required one to one due to confusion. R1 will stand up as soon as you turn your back. She needed to be by the nurses.

R1 's Physical Therapy evaluation and plan of treatment dated 2/18/19 to 5/18/19 under functional assessment section titles gait analysis documents; Gait pattern: slow, unsteady, needs physical assistance to prevent falling. Fall

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predictors: Reduced insight for unsafe situations, reduced recognition of unsafe situations, poor negotiation of obstacles, inadequate postural control and discontinuity of steps.

R1's Incident report dated 3/6/19 documents R1 sitting on floor next to wheelchair in dining room/ TV area at 15:30. Fall unwitnessed. Under mental status documents disoriented and oriented to person. Under notes documents R1's falls are triggered due to need of extensive assist from staff.

R1's care plan with date initiated 4/9/19 document R1 is high risk of falls due to recent fall, weakness, unsteady gait, poor safety awareness and cognitive impairment. She utilizes a wheelchair as a primary mode of transportation and requires assistance from staff with mobility. R1 is observed to have habit of standing up and attempting to walk, and doing things on her own. Staff need to constantly redirect R1. Intervention documented on 2/17/19; provide proper well maintained footwear; environment free of clutter; call light within reach. Interventions documented on 3/7/19 include: Dycem to wheelchair; Educate resident on the importance of complying with safety measures. Document resident understanding of education and instances of noncompliance; encourage appropriate use of wheelchair; encourage resident to call don't fall; encourage to report fall; notify family and md of any new fall. Interventions on 4/9/18 include provide activities that R1 may enjoy to keep her focused on task.

Facility policy titled comprehensive care plans dated 11/2017 documents an individualized, person centered comprehensive care plan, including measurable objectives with timetables

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S9999	Continued From page 6 to meet residents physical, psychosocial and functional needs, is developed and implemented for each resident. Facility fall management program dated 2/2019 documents it is in 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. R 1's resident/education sheet dated 3/6/19 documents R 1 "noncompliant of staff redirection. Getting up on her wheelchair without assistance which may lead to fall incident. " Under readiness to learn documents no interest. Under outcomes documents needs practice and reinforcement. R 1's resident/education sheet dated 3/16/19 documents R1 does not understand basic information and under readiness to learn documents no interest. Barriers to learning document R1 confused and under outcomes unsuccessful. (A)	S9999		