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January 17, 2019

Mary Chelotti - Smith, Registered Agent
Alden Courts of Shorewood, Inc.
4200 West Peterson Avenue, STE 140
Chicago, Illinois 60646

RE: Complaint #: IL00107309
Survey Date: November 19, 2018
Docket #: 18-C0538
Violation Type: B Level

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Alden Courts of Shorewood.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure

cc: Administrator

File

Alden Courts of Shorewood/November 19, 2018//RegAgent/S.Geer

PROTECTING HEALTH, IMPROVING LIVES

Nationally Accredited by PHAB

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS,
Complainant,

v.

ALDEN COURTS OF SHOREWOOD, INC.,
D/B/A, ALDEN COURTS OF SHOREWOOD,
Respondent.

) Docket No. NH18-C0538
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NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED;
NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF
VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.)
(hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint IL00107309 Investigation conducted by the Department on November 19, 2018, at Alden Courts of Shorewood, 700 West Black Road, Shorewood, Illinois 60404. On January 16, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

- 1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
- 2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.

- 3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of \$ 2,200.00, as follows:

Type B violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b)4)5), 300.1210c), 300.1210d)2)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

- (A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.
- (B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or
- (C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

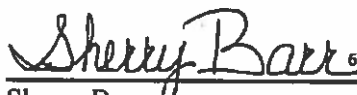
Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POChearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.



Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulation

Dated this 17th day of January, 2019.

THE DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

ALDEN COURTS OF SHOREWOOD, INC.,
D/B/A, ALDEN COURTS OF SHOREWOOD,
Respondent.

BF300/18-C0538/Alden Courts of Shorewood/November 19, 2018/S.Geer

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016869	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/19/2018
NAME OF PROVIDER OR SUPPLIER ALDEN COURTS OF SHOREWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST BLACK ROAD SHOREWOOD, IL 60404		
(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) COMPLETE DATE
S 000	Initial Comments Investigation of Complaint 1877430/IL107309 Statement of Licensure violations	S 000			
S9999	Final Observations 300.610a) 300.1210b) 4)5) 300.1210c) 300.1210d)2)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 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	S9999			

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/10/18

Illinois Department of Public Health

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S9999	Continued From page 1 shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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.	S9999			

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S9999	Continued From page 2 These requirements were not met as evidenced by: Based on interview and record review, the facility failed to follow the physician's orders for the use of a slide board during resident transfer from the bed to wheelchair. This failure resulted in R1 sustaining a right tibia and fibula fracture. This applies to 1 of 3 residents (R1) reviewed for falls with injury in the sample of 3. The findings include: On October 13, 2018, V3 (RN-Registered Nurse) documented: "Caregiver and writer attempted to transfer [R1] from the bed to wheelchair using gait belt and lateral transfer at approximately 11:10 AM. First [R1] was positioned on the side of the bed for proper balance. While transferring patient from the side of the bed into the wheelchair, patient became unsteady and stumbled over her feet. Writer and caregiver then eased [R1] down to the floor due to weakness and inability to bear full weight on legs. Knees started buckling and [R1] missed the wheelchair seat." V8's (Physician) documentation dated October 14, 2018 shows R1 sustained a right lower extremity non-displaced acute tibia/fibula fracture. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on October 1, 2018 with multiple diagnoses including muscle weakness, difficulty walking, lack of coordination, pressure ulcer of sacral region Stage 2,	S9999			

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S9999	Continued From page 3 pneumonia, depressive episodes, anemia, history of TIA (Transient Ischemic Attack), spinal stenosis, repeated falls, anxiety, and dementia. The EMR shows R1 discharged to the local hospital on October 13, 2018 following her fall, and returned to the facility on October 21, 2018. R1 was discharged from the facility on November 2, 2018 to a different facility. R1's MDS (Minimum Data Set) dated October 8, 2018 shows R1 had severe cognitive impairment, required extensive to total assistance with all ADLs (Activities of Daily Living), and was always incontinent of bowel and bladder. The MDS showed R1 had a functional deficit in range of motion of the bilateral upper and lower extremities. The EMR showed the following order dated October 2, 2018: "Two person slide board transfer from bed/wheelchair." On November 15, 2018 at 12:12 PM, V4 (Caregiver) said, "[R1] required the assistance of two people for transfers because she was non-weight bearing. She cannot stand, she cannot walk. [V3] (RN) came into the room to help me. I applied a gait belt to the resident, and we attempted to do a stand and pivot transfer of the resident. I assumed the nurse knew the patient, but it didn't seem like the nurse knew the resident couldn't stand. As soon as we started the transfer, I could tell we weren't going to be able to transfer the resident. The gait belt was too high, and the resident couldn't help us. I told the nurse we had to put her back down on the bed, but the nurse insisted we continue with the transfer. We had to lower her to the floor because we couldn't hold her up, and she ended up on the floor on her knees. [V3] said to me that	S9999			

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S9999	Continued From page 4 she didn't know the resident couldn't stand. I am not her usual caregiver. I had never transferred the resident before that day. The nurse told me she had never transferred the resident prior to that day. We did not use the slide board for the transfer the day of the fall." On November 15, 2018 at 1:51 PM, V3 (RN) said, "On October 13, the caregiver pressed the call light and asked for help to transfer [R1] from the bed to the wheelchair. We attempted to transfer the resident from the bed to the wheelchair with the gait belt. Both of us were holding the gait belt. The resident became weak, so I decided to lower her down to the floor. Her knee was bent when we lowered her. I asked the caregiver prior to the transfer, and she said the resident could not bear weight on her legs at all. I float a lot at the facility, so I haven't taken care of this resident often. I looked at the nurse-to-nurse report and it showed to use a slide board for transfers for this resident. I did not see the slide board in the room. I know she had a physician order to use the slide board and two people for transfers." On November 19, 2018 at 11:35 AM, V7 (RCC-Resident Care Coordinator) said, "The way facility staff find out how to transfer a resident is to look at the physician orders. Transfer orders are put on the POS (Physician Order Sheet). Staff should follow the transfer orders on the POS." On November 19, 2018 at 12:00 PM, V8 (Physician) said, "It would be my expectation that facility staff followed my orders and should have used a slide board for [R1's] transfer. They should not have transferred her using a gait belt. This failure resulted in the resident's right leg fracture. Even if the resident had a pressure sore	S9999			

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S9999	Continued From page 5 on her coccyx, they should have used the slide board for transferring the resident. They should have followed my order." The facility's Transfer Techniques Policy dated December 2015 shows: "Purpose: To safely transfer the resident from bed to chair or from one location to another. Equipment: 1. Appropriate type and size of wheelchair. 2. Mechanical lift, if necessary. 3. Physical devices to assist with transfer (i.e. sliding boards, belts, spin disc, etc.)." (B)	S9999			

COMPLAINT DETERMINATION FORM

FAC. NAME: ALDEN COURTS OF SHOREWOOD

COMPLAINT #: 0107309

LIC. ID #: 0052530

DATE COMPLAINT RECEIVED: 11/14/18 15:18:00

IDPH Code	Allegation Summary	Determination
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131	RESIDENT INJURY	<u>1</u>

X The facility has committed violations as indicated in the attached*
 No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

- 1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.
- 2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.
- 3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.