STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014765	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN NORTH SHORE REHAB & HCC	5050 WEST TOUHY AVENUE SKOKIE, IL 60077

(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 Facility Reported Incidents of: December 4, 2023 IL167571 October 30, 2023 IL167258 November 13, 2023 IL167266	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1220 b)3) 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014765	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN NORTH SHORE REHAB & HCC	5050 WEST TOUHY AVENUE SKOKIE, IL 60077

(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
S9999	Continued From page 1	S9999		

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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements are not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014765	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN NORTH SHORE REHAB & HCC	5050 WEST TOUHY AVENUE SKOKIE, IL 60077

(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
S9999	Continued From page 2	S9999		

Based on observation, interview, and record review, the facility failed to have resident-specific and effective interventions in place for a resident with multiple falls while in the facility; failed to ensure care plan interventions are being carried out per the resident's plan of care; and failed to have a fall care plan in place for a resident who was assessed to be at risk of falls. These failures applied to two (R2 and R3) of three residents reviewed for falls, and resulted in R2 sustaining multiple rib fractures after a fall, and R3 sustaining a pelvic fracture as a result of a fall.

Findings include:

1. R2 is a 93-year-old resident, originally admitted to the facility on 2/26/21. R2 has medical diagnoses that include but are not limited to: Parkinson's Disease without dyskinesia, dementia, history of falling, mild cognitive impairment, and longtime use of Aspirin.

R2's MDS (Minimum Data Set) assessment, dated 6/21/23, documents R2 requires limited assistance of one person for toilet use and is occasionally incontinent of urine.

Review of R2's fall risk assessments from 08/12/23 to current, all document R2 is at risk for falls.

Nursing Progress Note, dated 8/27/23, documents R2 is one person assist with ADL's (activities of daily living).

Nursing Progress Note, dated 9/13/23, documents R2 is incontinent of bowel & bladder and requires one person assist with ADL's.

There are several nursing progress notes that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014765	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN NORTH SHORE REHAB & HCC	5050 WEST TOUHY AVENUE SKOKIE, IL 60077

(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
S9999	Continued From page 3	S9999		

document ,R2 does not use a bed/chair alarm, and R2 forgets to use the call light (these are dated throughout October 2023)

Review of R2's medical record shows R2 had the following falls while at the facility:
8/12/23 - fell out of wheelchair in room (no injury)
9/13/23 - fell from bed (no injury)
10/25/23 - fell in room near bedside table (no injury)
11/13/23 - fall on bed, resulting in rib fracture
1/5/24 - fell in room (no injury)

R2 had a significant change MDS, completed on 10/17/23, which documents R2 had a BIMS (Brief Interview for Mental Status) score of 5, which indicates severe cognitive impairment and that R2 is frequently incontinent of bowel and bladder.

Facility submitted incident report, documenting on 11/13/23, R2 was transferred to local hospital at approximately 12am due to chest pain and per report from, he had fallen onto his bed.

Hospital record from 11/13/23 admission, documents R2 sustained displaced fractures of left 7-11 ribs due to a fall.

Review of R2's care plan for falls includes interventions for falls, however, R2 was still having falls in the facility.

On 01/19/2024 at 2:35pm, V11 (Licensed Practical Nurse/LPN) stated, "I sent (R2) to the hospital after a fall back in November because he had rib pain, increased respirations, blood pressure, and chest pain. 911 was called and then the hospital confirmed he had multiple rib fractures. The fall was unwitnessed, and he was in his room. (R2's) normal baseline is alert and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014765	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN NORTH SHORE REHAB & HCC	5050 WEST TOUHY AVENUE SKOKIE, IL 60077

(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
S9999	Continued From page 4	S9999		

oriented x 1. Before the fall, he ambulated better. but now he uses the wheelchair. We watch him all the time. He is always one person assist."

On 1/19/24 at 2:12pm, V25 (Certified Nursing Assistant/CNA) stated, "(R2) is confused, and he needs help." V25 continued to state that she was not on duty when R2 fell back in November, but she heard he fell a couple weeks ago. V25 stated, "I always watch (R2) because I know that he is confused, and he doesn't use the call light." At this time, R2 was found to be lying in bed, and it was noted R2's wheelchair was pulled up next to R2's bed (in between the bed and the wall), and there was no bed alarm in place for R2; bed alarm was on the wheelchair. V25 said, "The alarm is not supposed to be here, and the wheelchair is not locked. I'm sorry, I don't know who put him in bed; I just got in and haven't gotten a chance to do my rounds."

On 1/21/24 at 3:59pm, V2 (Director of Nursing) stated, "We are constantly assisting (R2) and taking him into consideration. He's in the room close to the nurses' station and we encourage him to stay in areas where he can be seen. We weren't sure how to label it (11/13/23 fall), because he didn't have a change of plane. He wouldn't have been able to get himself off the floor. We think that he attempted to self-transfer from the bed and maybe he hit himself with the side rail of the bed. It may have had to do with his ability to self-transfer." V2 stated she was not sure why that intervention (bed alarms) was not added sooner. It is noted bed and chair alarm interventions were added to the care plan after the fall on 01/05/24.

2. R3 is a 91-year-old resident, admitted to the facility on 12/4/17. R3 has medical diagnoses that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014765	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN NORTH SHORE REHAB & HCC	5050 WEST TOUHY AVENUE SKOKIE, IL 60077

(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
S9999	Continued From page 5	S9999		

include but are not limited to: history of falling, dementia, fracture of right pubis, fracture of right ischium, and unsteadiness on feet.

Facility submitted incident report, documenting R3 had an unwitnessed fall on 12/3/23 at approximately 4:20pm on the bathroom floor. R3 was subsequently transferred to the local hospital and per hospital records, was found to have an acute fracture of the right inferior pubic ramus and a mildly comminuted, acute fracture of the right ischial tuberosity. Hospital record also documents R3's son was contacted and stated R3 has frequent falls and worsening weakness recently, has baseline dementia, walks with assistance, but doesn't regularly use walker.

Based on facility documentation of investigation, multiple staff reported resident ambulates on his own to the bathroom, without assistance.

R3's most recent fall risk assessment prior to falling on 12/3/23 was completed on 9/25/23, and was scored at a "3 - At Risk."

The fall risk assessment completed on 9/25/23 documents R3 is alert & oriented x 3 (mentation) and R3 is regularly continent (no assist to get to the toilet); both of these categories are conflicting with the information documented on the resident's MDS (Minimum Data Set) assessment of approximately the same timeframe.

R3's most recent MDS assessment prior to falling on 12/3/23 was completed on 9/28/23, and documents the following:
(BIMS) Brief Interview for Mental Status score is 7, which indicates severe cognitive impairment;
ADL (Activities of Daily Living) needs include limited assistance, one person assist with bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014765	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN NORTH SHORE REHAB & HCC	5050 WEST TOUHY AVENUE SKOKIE, IL 60077

(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
S9999	Continued From page 6	S9999		

mobility, transfers, walking in room, and toilet use; R3 is occasionally incontinent of bowel.

Review of R3's medical record includes psychiatry note dated 9/26/23, which documents:
Chief Complaint/Nature of Presenting Problem: dementia
History of Present Illness: F/U with 91-year-old patient who has a history of dementia. Patient found in his room, with baseline level of confusion ...

Facility was asked to provided fall risk care plans for R3, and it is noted the fall care plan provided was not initiated until 12/6/23. Although the care plan has interventions initiated in 2019, there were no recent care plan interventions for all of 2023, prior to R3's fall on 12/3/23.

On 01/19/24 at 2:24PM, V10 (Registered Nurse) stated, "(R3) used to be independent, but now he needs help of one person assistance. (R3) had another fall on 01/04/24 while I was on duty; he went into the bathroom in the hall. When I heard a loud sound coming from the bathroom, I went to check and found (R3) on the floor. He did not have any injuries with this fall."

On 1/21/24 at 3:59pm, V2 (Director of Nursing) stated, "(R3) had a hospital stay and then came right back and the care plan was initiated when he came back. Surveyor asked why the fall care plan was not updated all of the prior year, and V2 stated t if he hadn't had a fall prior to that, then his care plan wouldn't have been updated. "We don't change the dates of the interventions if they are still applicable." Surveyor asked if the care plan should be updated since the resident has declined or had a change in condition since he first arrived in the facility several years ago, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014765	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN NORTH SHORE REHAB & HCC	5050 WEST TOUHY AVENUE SKOKIE, IL 60077

(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
S9999	Continued From page 7	S9999		

V2 stated that she does not know, because she was not working here then. "The MDS (Minimum Data Set) coordinators update the care plans quarterly. It (fall on 12/3/23) was an unwitnessed fall. He was attending activities in the lower level and then went to the bathroom; he went to the bathroom without asking for assistance. Sometimes he's not compliant with asking for help; he thinks that he is more independent than he is. The discrepancy in the MDS and assessment could be two different people are completing them. Assuming that they are looking at the same information, I would expect them to be the same. We do have trainings and in-services to ensure that staff are on the same page to confirm what they are describing and seeing accurately. Assessments need to be completed correctly so that everyone can be aware of the residents current functioning and need level."

Facility provided policy titled, COMPREHENSIVE CARE PLANS, dated 11.2017, reads:
Policy Statement
An individualized, person-centered comprehensive care plan, including measurable objectives with timetables to meet Resident's physical, psychosocial and functional needs, is developed and implemented for each Resident.
PROCEDURE:
1.) In coordination with the Resident and Resident representative, as applicable, the Interdisciplinary team will develop and implement a person centered, comprehensive plan of care. Care plans are comprised of Focus statements, Goals and Interventions.
2.) The Interdisciplinary team includes, but is not limited to:
a. The Attending Physician
b. A nurse and nurse's aide that have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014765	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN NORTH SHORE REHAB & HCC	5050 WEST TOUHY AVENUE SKOKIE, IL 60077

(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
S9999	Continued From page 8	S9999		

responsibility for the Resident;
c. A member of the food and nutrition services staff
d. The Resident and Resident representative, if applicable;
e. Other appropriate staff or professionals determined by the Resident's needs, preferences, or requests.
3.) The Resident's comprehensive, person-centered care plan will be kept consistent with the Resident's rights to participate in the development and implementation of his or her plan of care, including the right to:
a. Participate in the care planning process;
b. Identify individuals or departments to be included;
c. Request meetings;
d. Request revisions to the plan of care;
e. Provide input into the expected goals and desired outcomes of care;
f. Receive the care and services as outlined in the plan of care;
g. View the care plan after significant changes are made.
4) Care plan interventions are initiated based on an analysis of information collected throughout the comprehensive assessment process.
5.) The medical record will show evidence of an explanation if the Resident or Resident representative's participation in the development of the plan of care is determined to not be practicable.
6.) The comprehensive person-centered care plan will:
a. Reflect treatment goals, timetables and objectives in measurable outcomes;
b. Describe the services that are to be provided to attain or maintain the highest practical physical, mental and psychosocial well-being;
c. Describe services that would be provided to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014765	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN NORTH SHORE REHAB & HCC	5050 WEST TOUHY AVENUE SKOKIE, IL 60077

(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
S9999	Continued From page 9 attain the above, but the Resident refuses; d. Describe specialized services to be provided based on PASARR recommendations; e. Include the Resident's goals for progress, reflect the Resident's expressed wishes regarding care and treatment goals, including discharge planning; f. Identify the professional services that are responsible for interventions; 7.) The comprehensive, person-centered plan of care is developed within 7 days of the completion of the required comprehensive MDS. 8.) Assessment of the Resident is ongoing and care plans are revised based on the Resident condition, preferences, treatments and goals change. 9.) After the initial comprehensive, person-centered plan of care is developed, formal care plan reviews will be held in conjunction with the MDS schedule and shall be no longer than 92 days apart. (A)	S9999		