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 |
|---|---|---|---|
| | IL6016950 | A. BUILDING: ____ B. WING ____ | 04/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ALDEN ESTATES CTS OF HUNTLEY | 12140 REGENCY PARKWAY HUNTLEY, IL 60142 |

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| S 000 | Initial Comments<br><br>Annual Health Survey | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210a)<br>300.1210b)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental | S9999 | | |

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| S9999 | Continued From page 1 | S9999 | | |

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.

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 failed to ensure a resident was safely positioned in a wheeled recliner for one of 28 residents

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| S9999 | Continued From page 2 | S9999 | | |

(R82) reviewed for safety in the sample of 28. This failure contributed to R82 falling out of the wheeled recliner and obtaining a subdural hematoma.

The findings include:

R82's Admission Record shows she was admitted to the facility on November 28, 2023 with diagnoses including traumatic subdural hemorrhage, dementia, major depressive disorder, and generalized anxiety disorder.

R82's Fall Risk Assessment dated April 2, 2024 shows R82 is at risk for falling.

R82's Care Plan initiated November 29, 2023 shows she is at risk for falls. Interventions include audio monitoring to prevent unassisted transfers, provide an environment clear of clutter.

R82's Psychiatry Note dated April 16, 2024 at 9:16 AM, shows staff reporting increased agitation and behaviors. R82 was seen in her wheelchair after eating lunch and is unfocused and very restless.

The facility's Occurrence Report dated April 16, 2024 shows R82 was observed on the floor next to the nurses station. R82 stated she did not know what happened and upon assessment swelling was noted to the back of R82's head. R82 complained of pain. 911 was called and R82 was taken to the local hospital.

R82's Progress Notes dated April 16, 2024 at 5:55 PM written by V20 LPN (Licensed Practical Nurse) shows, R82 was place in a (high back reclining) wheeled chair. R82 tipped backwards out of the chair and hit her head. R82 had a lump

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| S9999 | Continued From page 3 | S9999 | | |

on the back of her head and a hematoma was forming. R82 was sent out to the local hospital via 911. R82's Progress Note dated April 16, 2024 at 9:28 PM shows R82 was admitted to the local hospital with a subdural hematoma.

R82's Hospital Records dated April 17, 2024 shows R82 presented to the emergency department with a chief complaint of a fall. It shows R82 to be leaning too far back in her recliner causing her to fall. R82 struck the back of her head. R82's CT Scan results show that R82 had a right sided subdural hematoma and a moderate soft tissue hematoma to the back right of R82's head. R82's Assessment shows neurosurgery was consulted and recommended intensive care unit admission for neuro checks every hour and aggressive blood pressure control. R82 was a do not resuscitate code status and after talking with R82's power of attorney, and R82's daughter, the family decided they were not going to pursue any aggressive interventions including operative plans.

On April 24, 2024 at 10:59 AM, V20 LPN said R82's fall was a "frustrating one for me. It has bothered me since it happened." V20 said it was around dinner time and V20 was in the dining room helping residents. V20 said that V21 CNA (Certified Nursing Assistant) was assisting R82 and another resident to eat. V20 said she did not realize that V21 placed R82 in the high back wheeled recliner and near the nurses' station. V20 said next thing she knew, R82 was flipped backwards. V20 said R82's high back wheeled recliner was flipped backwards, and the back rest was laying on the floor. V20 said she did not see it happen. V20 said that V21 must have walked away. V20 said that she ran to R82 and R82's head was on the ground. V20 said she asked

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| S9999 | Continued From page 4 | S9999 | | |

R82 if anything hurt and R82 pointed to her head. V20 said she could see a bump on the back of R82's head. V20 said she asked V21 what she did and V21 told V20 that V21 reclined R82 in her high back wheeled recliner and placed a wheelchair under R82's feet rest. V20 said she told V21 that she couldn't do that because it was a restraint. V20 said that she always tries to keep a close eye on R82 because R82 constantly tries to get up. R82 is restless and anxious. Someone has to be around R82 to watch her.

On April 24, 2024 at 11:39 AM, V5 said that she performed the investigation in regards to R82's fall. V5 said V21 was with R82 at the nurses' station and then walked away to assist another resident. V5 said based on her investigation, they believe R82 was moving around in the chair, and it was tipped. V5 said she did not know if the chair was tipped backwards or sideways. V5 said that V21 no longer works at the facility. V5 said that V21 has had issues with tardiness. V5 said she did not get reports that a wheelchair was used as well, but V5 said there was a wheelchair nearby R82.

On April 24, 2024 at 12:00 PM, V2 DON (Director of Nursing) said he was not sure if her recliner got tipped. V2 said that R82 must have gotten herself out of the recliner. V2 said he did not get any reports of a wheelchair being used as well. V2 said that V21 no longer works at the facility due to attendance issues. V2 said that V21's late date of employment with the facility was April 16, 2024 which was also the same date of R82's fall.

On April 24, 2024 at 12:30 PM, V21 said R82 was trying to climb out of her chair. V21 said she did not witness R82's fall. "I think she just climbed."

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| S9999 | Continued From page 5<br><br>The facility's Fall Management Program dated August 2020 shows, "The facility is committed to minimizing resident falls and/or injury. While preventing all resident fall is not possible, it is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies and facilitate a safe environment."<br><br>(B) | S9999 | | |