STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145557	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Barrington	1420 South Barrington Road Barrington, IL 60010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a safe environment and provide adequate supervision and assistance to prevent falls for two residents (R1 and R2) by failing to implement appropriate fall prevention interventions and ensure adequate assistance during high-risk care. This failure affects one ventilator-dependent, quadriplegic resident (R1), and one cognitively impaired resident (R2). These failures resulted in R1 falling during incontinence care by staff iand R1 sustaining fractures to the left tibia and fibula, requiring surgical intervention and R2 falling immediately following an activity, while not being supervised by staff resulting in three sutures to the left eyebrow. Findings include:1. R1 is admitted to the facility on [DATE] 2025 on ventilator support with the diagnoses including morbid obesity, subarachnoid hemorrhage due to cerebral aneurysm, hydrocephalus, epilepsy, quadriplegia, chronic kidney disease, pulmonary embolus, and left lower extremity Deep vein thrombosis, diastolic heart failure, atrial fibrillation. R1 is incontinent of bowel and bladder and has a urinary catheter and receives enteral nutrition.Facility reported incident documents that on [DATE], the nurse on duty was called to R1's room and R1 was found on the floor in a supine position. R1 remained on the floor with staff present while 911 was called and was then transferred to local hospital for emergency services. Minimum Data Set (MDS) assessment of [DATE] documents the following:Section C 1000(Cognitive skills for daily decision making) score is 3 (indicating severe impaired decision making)Section GG: R1 is dependent for toileting hygiene, roll left and right, shower, oral care, dressing, and lying to sitting. The helper does all the effort. The resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activityXXX[DATE] at 12:17 PM V3 RN said, R1 is a total care resident on a ventilator under hospice care. I was the nurse caring for him when he fell. I was passing medications when I heard someone calling for help. When I went to the R1's room, R1 was on the floor and I called 911. The emergency team came fast and picked him and sent him to the hospital. I assessed R1, checked vital signs, oxygen saturation, and started an intravenous line, and 911 came and took over. I saw blood on the left leg below the knee and I did not clean or do anything because 911 was already there and took over. R1 was cared for by one person instead of two during his care. When asked, V3 said, I think he was one assist with his care. V4 (Certified Nursing Assistant) was caring for R1 the day of the fall and V4 did not ask for my assistanceXXX[DATE] at 12:50 PM, V4 (Certified Nursing Assistant) said, I was doing my last rounds around 5:00 AM when I pulled R1's covers. I noticed that R1 had a bowel movement and I started to change him. First, I cleaned his front and I turned him on his side. I pulled the sheets towards me and started to clean his back. R1 was still having a bowel movement. I reached out to grab more wipes to clean R1 when he kicked out with his left leg and started to fall. I held him and called for help. But when the nurse came into the room, R1 was already on the floor. Initially, I did not see any blood on his left leg because he had foam boots on. Then, after we removed the boots, I saw blood just before 911 came in. The nurses and everyone came to help but I could not stop the fall. The resident is a total assist and technically I was supposed to use two (person) assist but I was caring for him by myself. R1 had a low air loss mattressXXX[DATE] at 2:37 PM, V7 (Restorative Nurse/Fall coordinator) said, R1 had a fall from the bed and was sent out to the hospital. R1 was a total assist and required one assist. V7 did not provide any additional details regarding the fall. On review of the hospital record, R1 had a comminuted fracture of the left distal tibia. Dorsal displacement and angulation of distal fracture fragments. Fracture distal fibula with dorsal displacement major fracture fragment. V8 (Orthopedic Surgeon) notes indicated that operative versus nonoperative management was discussed with R1's brother and POA (power of attorney) wanted to proceed with surgery after risks and benefits were discussed, which included death, stroke, and myocardial infarction, to name a few risks mentioned by the surgeon. V9 (Critical Care Physician) notes indicated that R1 was taken to surgery and suffered a cardiac arrest upon induction. R1's code status was DNR (Do not Resuscitate) and in accordance with R1's wishes, no ACLS (Advanced Cardiovascular Life Support) was initiated and R1 expired at [DATE] 11:45 AM in a local hospitalXXX[DATE] at 2:49 PM, V2 (Director of Nursing) said, R1 had a bariatric air loss mattress and weighed 269 pounds, under hospice care, and was in and out of the facility, going back and forth to the hospital for being hypodermic or hypotensive. The interdisciplinary team met with the family and decided to go with hospice. During the fall, R1 was being cared for by one nurse assistant. R1 was having a bowel movement. R1 was not able to help or provide directions. R1 was not able to follow commands. The nursing assistant would call