STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145963	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Orland Park	16450 South 97th Avenue Orland Park, IL 60467

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34490 Based on interview and record review the facility failed to timely notify a resident's family after a fall that required transportation to a local hospital for evaluation for 1 of 3 residents (R2) review for notification of change in the sample of 6. This past non-compliance occurred from 1/9/25 to 1/14/25. The findings include: R2's Fall Investigation Report shows that on 1/9/25 at 9:30 PM, R2 had a fall from his wheelchair resulting in a bruise to the right side of his head, an abrasion to his face and blood on his lips/mouth area due to biting his lip when he fell . R2 was transported to the hospital for evaluation. The report shows that V14 (R2's Mother) was notified on 1/10/25 at 4:40 AM. R2's Nursing Notes from 1/10/25 at 3:59 AM shows, The resident was returned to the facility from [Local Hospital] at 3:30 AM .The resident had been sent out as a result of a fall at 9:30 PM on 1/9 . On 1/17/25 at 12:25 PM, V14 said that she was notified at 6:56 AM on 1/10/25 that R2 had fallen, was sent to the emergency room and had returned to the facility and was fine. V14 said that the facility never called her when he fell or notified her that he was being sent out to the hospital. On 1/17/25 at 2:49 PM, V2 (Director of Nursing) said that family should be notified immediately after a resident falls. V2 said that family should be notified if a resident is being sent out to the hospital for a change in condition. V2 said that V14 approached her on 1/10/25 and said that she was not notified that R2 had a fall and was sent to the hospital. V2 said that she spoke with V17 (Licensed Practical Nurse) and he said that he notified V14 when R2 returned from the hospital but did not notify her when he fell and was sent out to the hospital. The facility's Change of Condition (Resident) policy dated 9/20 shows, The .responsible party will be notified with changes in a resident's condition. Prior to the survey date of 1/17/25, the facility had taken the following action to correct the noncompliance: 1. On January 10, 2025- January 13, 2025 all facility nurses were educated on notification of family after a change in condition. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145963	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Orland Park	16450 South 97th Avenue Orland Park, IL 60467

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On January 14, 2025 the facility Compliance Assurance Committee developed a plan of correction regarding notification of family after a change in condition. 3. Subsequent changes in condition from 1/10/25 to 1/17/25 were determined by the Quality Assurance Tool to have been completed timely.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 34490 Based on observation, interview, and record review the facility failed to ensure a resident was assessed and monitored after a fall and failed to document that the fall occurred for 1 of 3 residents (R2) reviewed for quality of care in the sample of 6. The findings include: On 1/17/25 at 12:25 PM, V14 (R2's Mother) showed a video of R2 falling out of bed on 12/18/24. The video showed that on 12/18/24 at 10:20 AM, R2 was sitting on the floor in his room with his back up against the right side of his bed. Two staff members entered the room (identified by V14 as V15 (Wound Certified Nursing Assistant-CNA) and an unknown CNA) and picked R2 up from the floor and placed him in bed. On 1/17/25 at 4:11 PM, V15 said that on an unknown date, she was walking past R2's room and saw him on the floor. V15 said that she called for someone to help her get him back to bed. V15 said that she does not recall who helped her get him back to bed or how they got him back to bed but it was probably another aide. V15 said that she did notify the nurse but she does not recall what nurse. On 1/17/25 at 10:40 AM, V6 (Registered Nurse) said that after a resident falls, the staff should immediately notify the nurse before moving the resident so the nurse can do an assessment. V6 said that the assessment should include doing vital signs, checking for bruising, bleeding or injuries and checking the resident's range of motion and pain. V6 said that if everything appears ok, the resident is moved back into bed. V6 said that the physician should be notified along with the family and any new orders carried out. V6 said that the assessment should be documented in the resident's clinical records. On 1/17/25 at 2:49 PM, V2 (Director of Nursing) said that all falls should be documented in the medical record. V2 said that if a resident falls, the staff should not touch the resident until after the nurse does a full body assessment. V2 said that the physician, family, and herself should be notified of the fall. V2 said that new fall interventions should be immediately implemented and their care plan updated to try and prevent future falls. R2's clinical records from 12/18/24 does not document any falls or assessments from the fall that happened at 10:20 AM. On 1/17/25 at 4:30 PM, V1 (Administrator) said that the facility does not have a policy or procedure for the staff to follow after a resident falls. The facility's Fall Risk Assessment Policy dated 8/2020 shows, If a resident fall, the nurse will complete an Occurrence Report and Initiated Post-Occurrence documentation.