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	09/11/2025

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 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 effective supervision and monitoring of residents in the dining room to prevent accidents. Specifically, staff failed to maintain visual supervision of a resident assessed to be at risk for falls. This affected one of three residents (R1) reviewed for falls. This failure resulted in R1 sustaining an unwitnessed fall in the dining room and being sent to the local hospital where R1 was treated for a hip fracture. This past non-compliance occurred from 8-15-2025 to 8-29-2025. Findings include:R1's face sheet shows diagnoses including chronic hepatic failure hepatic encephalopathy anemia Alzheimer's type 2 diabetes COPD depression anxiety hypertension and dementia. MDS dated [DATE] section C shows Brief Interview for Mental Status (BIMS) score of 4 (cognitive impairment).The facility final report to the State department dated 8/22/25 denotes in-part R1 is a [AGE] year-old female resident who was admitted to the facility to 2/19/25 with diagnosis that include but not limited to chronic hepatic failure hepatic encephalopathy anemia Alzheimer's type 2 diabetes COPD depression anxiety hypertension and dementia. Resident is alert and oriented times one to two spheres and requires partial to moderate assist with ADL's (activities of daily living). BIMS 4/15. Resident was observed lying on the floor in the dining room with reports of pain resident alert and oriented times one to two per baseline. Hospice notified with orders to send to ER (emergency room) for further evaluation. POA (Power of Attorney) also notify of occurrence. Resident was transported to (hospital name) then subsequently transferred to (hospital name) where she was admitted with a right femoral neck fracture. It is probable residence led to floor based on proximity of wheelchair to table. Table mates were unable to provide detail regarding incident the nurse interview reveal the resident was seated at the table properly positioned with proper footwear a few minutes prior to the incident. During this investigation abuse was not found to be a factor based on staff/ resident interviews.On 9/3/25 at 2:05pm V5, Licensed Practical Nurse (LPN) said she was covering for R1's nurse because she was on break. V5 said she walked pass the dining room where she observed R1 sitting in her wheelchair at the second table to the left (front facing when walking through the doors of the dining room) R1's back was to the door. V5 said she did not see any food trays in the dining room, lunch was over. V5 said she went and sat down at the nurse station, across from the dining room. V5 said she could not see R1 from her position. V5 said she was monitoring the dining room from the Nurse station. V5 said a couple minutes later two staff members approached her an informed her that R1 was on the floor in the dining room, V5 said this was around 1:20pm, she looked at the clock. V5 said she did not see R1 fall. She did not see what R1 was doing just before she fell. V5 said she was not aware that R1 was at risk for falls, V5 said the Nurse did not give her a report before she took her break. V5 said she assessed R1, she observed R1 laying on the floor on her right side, she was laying in between two tables, her head was toward the wall and her feet was out. V5 said she palpated R1's body and when she touched R1 back, R1 winced and complained of pain. V5 said R1 did not have pain when she palpated R1's hip. V5 said R1 was not moved from the floor, and 911 was summoned, physician notified, and R1 daughter was notified. V5 said 911 took R1 to the hospital for further evaluation. V5 said there's no solid rule that someone must be in the dining room to monitor the residents, they can be monitored from the Nurse station. V5 said she did not see R1 fall, while she was monitoring the dining room. On 9/3/25 at 2:25pm V6 (Director of Nursing) said R1 had an unwitnessed fall. V6 said the root cause of R1 fall was maybe R1 was trying to take herself back to her room after lunch as she often did. V6 said V5 was monitoring the dining room when R1 fell. V6 said if the residents are in dining room staff should be there to monitor the residents. V6 said the staff should be able to see all the residents when monitoring the dining room. V6 said if she had to do things different, she would have the staff bring the residents out of the dining room after lunch. V6 said the residents can sit near the Nurse station for observation by staff.On 9/3/25 V2 (LPN) said R1 had to often be redirected and asked to sit down in her wheelchair because she could fall. 9/3/25,12:46pm V4, Certified Nursing Assistant (CNA) said R1 had to often be redirected and asked to sit down in her wheelchair because she could fall.9/4/25 at 1:32pm V7 (CNA) said he was picking up lunch trays from the resident's rooms, as he headed to the dining room R1 was observed on the floor on her back. V7 said there were no other residents in there with R1. There were no staff in there with R1. V7 said he summoned the Assistant Director of Nursing and V5 (LPN). V7 said R1 was trying to get up a few times but she couldn't, V7 said he even went downstairs to get a lift pad just incase they was going to get R1 up. V7 said R1 often stood up from her chair and sat back down, and if the wheels were not locked the chair would

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure that the Infection Preventionist participated in the facility's QAA/QAPI programming. This failure has the potential to affect all 174 residents that reside within the facility. Findings include:On 9/09/25 at 1:49pm, V16 (Assistant Administrator) affirmed that V15 (Assistant Director of Nursing/ADON & Infection Preventionist) Became IP (Infection Preventionist) in February 2025.On 9/09/25 at 12:06pm, upon review of the Facility's Quality Assurance and Assessment (QAA) Committee meeting sign-in sheets dated 3/11/25, 4/08/25, 7/08/25, and 8/12/25 with V16 (Assistant Administrator), there was no documented signature from V15 (Assistant Director of Nursing and designated Infection Preventionist) to confirm her attendance. V16 (Assistant Administrator) confirmed that the facility's designated Infection Preventionist did not attend the Quality Assurance and Assessment (QAA) Committee meetings. V16 further acknowledged that, the Infection Preventionist is required to participate in QAA Committee meetings as a standing member. V16 confirmed that the intent of QAPI is to ensure that residents consistently receive safe, effective, and high-quality care that is subject to ongoing evaluation and continuous quality improvement.Facilities policy titled, QAPI Plan, revised date October 2019, documents, in part, . Leadership of our facility shall be ultimately responsible for the QAPI Program. The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements.Facility job description titled, Infection Preventionist Nurse, dated 7/2024, documents, in part, . Participate in staff meetings, QA meetings.Pamphlet titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, revised date 11/18, documents, in part, Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike.Facility census, dated 9/08/2025, documents 174 residents residing at the facility.