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	02/20/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision and monitoring, including maintaining visual oversight, for residents assessed to be at risk for falls in accordance with their care plans and assessed needs. This affected two of four residents (R#3 and R4) reviewed for accidents and fall prevention in a sample of 44 residents. This failure resulted in R3 accessing the staff nurses' closet without supervision and sustained a fall resulting in a head laceration requiring two staples. R3 also sustained a subsequent fall in the dining room while in the presence of staff, resulting in a femur fracture. R4, who had a history of forgetfulness and dementia, sustained an unwitnessed fall after being left unsupervised in her room, resulting in a left hip laceration, scalp contusion, and arm fracture.Findings Include: R3 R3 was admitted to the facility on [DATE] with a diagnosis of dementia with psychotic disturbances, history of falling, orthostatic hypotension, syncope and collapse. R3 memory care initial assessments dated 10/22/25 documents fast scale of stage 5 moderate dementia. In this stage of dementia, the person needs more help to survive, she does not assistance with toileting or eating but does need help choosing proper clothing to wear fo the day. The person displays increased difficulty with serial subtraction. The person may not know the date and year or where she lives. However, she does know who she is and names of family. R3 Minimum Data Set, dated [DATE] document under cognitive patterns R3 has memory problems under short term memory; under cognitive skills for daily decision-making documents a 3 which indicates severely impaired never /rarely makes decisions. R3 toilet transfer documents a score of three which indicate partial /moderate assistance. R3's fall risk assessment dated [DATE] documents at risk for falls. R3 was located on a locked dementia unit. The area where R3's fall took place on 10/25/25 was in a room labeled nurse's closet. The door to the nurses closet has a pad lock on the door and you need a code to enter the room. Upon entering the room there is a small space for staff personal items and a small chair. There is a second door leading to a staff bathroom. R3's incident report dated 10/25/25 documents: The resident was found on the floor in the common bathroom, where she had apparently attempted to use the bathroom. No staff witnessed the fall. The resident was lying on her left side with bleeding noted to the back of the head toward the left side. Under notes dated 10/30/25; Facility has investigated the occurrence, and the details as followed. R3 sent to local hospital for an opening to left occipital area due to fall. two staples were placed (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: 145963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Alden Estates of Orland Park		STREET ADDRESS, CITY, STATE, ZIP CODE 16450 South 97th Avenue Orland Park, IL 60467	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and to be removed within 7- 10 days. Based on interviews with staff, resident had been in her wheelchair at the nurse's station prior to the fall. A staff member observed resident in staff bathroom on the floor with wheelchair next to her. Resident fully clothes with pants on and nonskid socks. It is probable the resident wheeled herself to the bathroom and when she arose lost her balance and fell. Root cause analysis is resident lost her balance when she stood up from the wheelchair to use the commode and fell. R3's progress note dated 10/25/25 documents: The resident was found on the floor in the common bathroom, where she had apparently attempted to use the bathroom. No staff witnessed the fall. The resident was lying on her left side with bleeding noted to the back of the head toward the left side.Bleeding area cleansed and controlled. Full body assessment completed. No swelling, deformity, or pain noted in upper or lower extremities during assessment. VS obtained and WNL. 911 called; resident transported to Hospital for further evaluation. R3's ambulance run report dated 10/25/25 documents: R3 found sitting on bathroom floor and leaning against the wall in nursing home. Staff on scene holding towel on the back of the head. Staff state they heard R3 fall and found in current position. R3 presents with an approximate one-inch laceration on the back of her head. R3 said she slipped in the bathroom and hit her head on the door. R3's hospital records dated 10/25/25 documents: discharge diagnosis laceration of the scalp: unwitnessed fall. orientation assessment: not oriented to place or time, identifies self and situation. Under complaint: R3 in ER for unwitnessed fall. Per Emergency medical staff (EMS) R3 found in the bathroom after staff heard fall. laceration to back of the head. Laceration repair length 0.5 centimeters. Skin closure two staples. R3's progress note dated 10/26/25 documents: Received the resident back from hospital. Full body assessment completed. Two staples noted on the back of the head, covered with clean dry gauze. On 2/11/26 at 5:01PM, V8(Certified nursing aide, CNA) said the nursing closet door is usually closed for security, so residents do not go in there. On 2/13/26 at 11:44AM, V17(nurse) said the nursing closet is usually closed unless staff is in the room On 2/11/26 at 3:47pm, V7(Nurse) said she was working with R3 on day of incident on October 25. R3's floor is a locked dementia unit, residents wander, and some rooms have codes to enter. V7 said R3 gait was unsteady and had behavior of trying to get up and walk. V7 said last saw R3 at the nursing station during change of shift around 7:45PM with no concerns. V7 said staff informed her of fall while she was passing medications on the hallway. V7 said she observed R3 on the floor in the staff bathroom, wheelchair at the door on her back. Blood on the back of her head and V7 called 911 to assist R3. V7 said someone must have left the door open. V7 said the door to the room R3 was found is usually closed and requires a code to enter. R3's progress note dated 11/6/25 at 11:00AM created date of 11/7/25 documents: Resident restless yelling at staff to leave her alone and screaming get away from me while redirecting her to have a sit. Resident standing and trying to walk unassisted. Resident covering her mouth refusing oral medication from nurse and screaming at nurse. Interventions Implemented: Resident was ambulated with device and staff assistance around the unit 3x's. Did Intervention(s) work? no. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's progress note dated 11/6/25 at 12:25PM documents: Resident seen standing attempting to ambulate near nurses station. Writer attempted to redirect resident to sit safely. Resident stated she didn't want to sit writer educated resident on safety of asking for assistance with standing resident said ok and sat down resident redirected to activities. R3's progress note dated 11/6/25 at 3:34pm with a created date of 11/7/25 documents: Describe Behavior: Crying, yelling, screaming at staff, attempting to ambulate unsafely (without staff assistance- staff assisted with walking x2 prior in the day). Stating so leave her alone, get away from her. Interventions Implemented: offered word searches, coloring books, assisted therapy with walking [NAME] around the unit, playing calming music, moving to a quiet area, offering to use the phone to call her family (refused-stating she didn't want to talk to them) Did Intervention(s) work? No R3's point of care behaviors charting for November 2025 documents under interventions: Symptoms if R3 is crying interventions: 1. offer to play music, 2. Offer coloring books, 3. Offer word search, 4. Assist with calling her family, 5. All interventions utilized. On 11/6/25 documents at 1:07 no behaviors; at 1:59 behaviors yes, interventions 4 and 5 utilized with behavior decreased. At 9:59PM, yes behaviors intervention 5 with behaviors continuing. Under interventions if R3 is anxious and restless 1. Offer coloring book, 2 sit with R3 and talk about family, 3. Ofer to take R3 on walk around unit. 4. Play calming music, 5. All interventions utilized. On 11/6/25 documents at 1:07 no behaviors; at 1:59 behaviors yes, intervention 3 with behavior decreased. At 9:59PM, yes behaviors intervention 5 with behaviors continuing. R3's incident report dated 11/6/25 documents: Resident brought to the dining area for dinner. Shortly after another resident reported that R3 stood up from her wheelchair. CNA observed the R3 walk around the table before she fell. CNA was assisting another resident and unable to reach the resident in time to prevent the fall. was this incident witnessed documents no. Under notes documents, R3 requires moderate to maximal assist with activities of daily living. Staff observed R3 ambulating without staff assistance around the table she was seated at. Root cause analysis: R3's fall attributed to gait imbalance, not utilizing staff assistance with ambulation and impaired safety awareness R3's progress note dated 11/6/25 at 6:15pm documents: Writer notified of assistance needed in dining room. writer observed resident in dining room Near table lying on back pillow applied under head while being assessed. Writer and 1 staff assessed R3 visible swelling to left leg. Nonverbal pain scale resident pain at 8/10. 911 called for transport related to pain and swelling to left leg for further evaluation. R3's post fall occurrence note dated 11/6/25 at 6:15pm documents Description of occurrence : (If initial) Resident was brought to the dining area for dinner. Shortly after, another resident reported that the resident stood up from her wheelchair. CNA observed the resident walked around her table before she fell. CNA was assisting another resident and unable to assist at the moment of the fall. R3's facility final report dated 11/12/25 documents: staff observed R3 ambulating without staff assistance around the table she had been seated at. Staff attempted to assist R3 but were unable to get the resident before falling, staff report R3 seemed more confused and restless earlier in the day. New order for urinalysis and culture. Staff report spending a lot of time redirecting R3 and state R3 is spontaneous. R3's fall attributed to gait imbalance, not utilizing staff assistance with ambulation and impaired safety awareness. Investigation statements document: V10(nurse) statement said she did not see the fall. V10 statement documents staff were in the dining room attending to other residents the time of fall. no one actually saw R3 fall. V17(nurse) statement documents: Several staff (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	were in the dining room but nobody saw R3 actual fall. R3 is impulsive and restless. V17 notified by staff that R3 fell. R3 was on the floor two spots over from where she was seated. V15 (CNA) statement documents she did not see the fall and her back was to R3. V32(CNA) said she was in the dining room but could not see R3 table from where she was seated. V11 statement documents: V11 said she just picked up a tray from the service counter and turned to walk towards a resident. V11 said she heard another resident say hey sit down and looked in that direction and saw R3 attempting to ambulate. V11 said she immediately turned her back to place the tray back at the service encounter to assist R3 and by the time V11 turned back around, R3 had already fallen. V11 said she was a few seats away from where she was originally seated and it looked as though she was attempting to walk around the table. On 2/13/26 at 2:21Pm, V11(Certified nursing aide, CNA) said she was in the dining room at time of R2 fall on 11/6/25. V11 said she recalls seeing R3 standing up by her table and V11 said she turned around to put a tray down at a table and R3 fell. Unable to recall any other details related to fall. V11 was showed typed statement and confirmed that was what she saw a time of incident On 2/20/26 at 3:19Pm V31 (Certified nursing aide, CNA) said she does not recall seeing R3 fall in the dining room on 11/6/25. V31 thinks she was feeding another resident at the time of the fall. On 2/11/26 at 5:01PM, V8(Certified nursing aide, CNA) who was assigned to R3 the evening of 11/6/25, said he does not recall R3 having any behaviors that day. V8 said he brought R3 in the dining room in her wheelchair to the table and locked the wheelchair. V8 said he did not see R3 fall because he was assisting other residents into the dining room. V8 said R3 has behaviors of trying to get up unassisted and we redirect her to sit down. On 2/13/26 at 11:44AM, V17(nurse) said R3 would need one to one monitoring if she was trying to get up and ambulate. On day of the incident, R3 was at the nursing station prior to dinner and V17 said she assisted bringing R3 into the dining room and locked her wheelchair at the table. V17 said she did not see R3 fall. V17 said a resident called out that R3 fell. V17 said she was near the dining room exit door when she heard the resident. V17 was found on the floor a few feet from her wheelchair. Wheelchair was still locked. V17 said R3 went around the wheelchair to stand up and was holding onto the table as she walked around before falling per staff interview. Ambulance run report dated 11/6/25 documents: timeline: 11/6/25 5:38PM- symptom onset; 5:46PM, unit notified by dispatched. Upon arrival R3 was located in her room with staff. Staff stated R3 began to walk where she fell injuring her left leg. R3 hospital records dated 11/6/25 documents witnessed fall at nursing home with left leg deformity. R3 presents to emergency room for witnessed fall that occurred at nursing home. R3 had gone from seated to standing position in dining room and fell. Xray of left femur documents midshaft left femur fraction with anterior angulation. On 2/19/26 at 3:21PM, V29 (NP) said she was familiar with R3. R3 has behaviors of being agitated, crying, and trying to stand up. V29 said she not familiar with the falls but would expect staff to be monitoring R3. V29 said If R3 was exhibiting behaviors she would expect staff to intervene and provide supervision. V29 said supervision and monitoring would include being within close distance to the resident and with staff visual fields. On 2/17/26 at 3:41PM, V28 (memory care coordinator) said in the dining room, staff are monitoring (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	residents needs and having there eyes on the residents. Staff are spot checking residents and passing out trays during mealtimes. V28 said there is not a designated staff monitoring the room when staff are passing out meal trays. R3's care plan dated 10/16/25 documents R3 is at risk for falls related to history of falls, weakness, impaired balance and mobility, use of assistive device, impaired cognition, wanders on the unit, hypotension. Interventions: encourage appropriate use of wheelchair dated 10/16/25; ensure bed is in the appropriate lowest position for the patient and ensure bed is locked. Initiated 10/27/25; fall risk assessment quarterly and as needed 10/27/25; monitor resident for attempting to get out of chair or not using assistive device to ambulate. Cue resident to accordingly if this is noted dated 10/25/25; offer resident assistance with toileting dated 10/27/25; promote placement of call light within reach dated 10/27/25; provide environment free of clutter dated 10/27/25; provide proper well-maintained footwear dated 10/27/25; Redirect Resident and offer toileting opportunities when resident appears to be wandering dated 10/31/25. Facility Fall Management Program policy dated 8/2020 documents: The facility is committing to minimizing resident falls and/or injury so as to maximize each resident's physical, mental, psychosocial wellbeing. While preventing all resident's falls is not possible, it is the facility's policy to act in a proactive manner to identity and assess those residents at risk for falls, plan for preventative strategies and facilitate a safe environment. Facility Management of Falls policy dated 8/2020 documents: The facility will assess hazards and risks, develop a plan pf care to address hazards and risks, implement appropriate resident interventions and revise the residents plan of care in order to minimize the risks for the fall incidents and/or injuries to the resident. Assess and monitor resident's immediate environment to ensure appropriate management of potential hazards. (R4) R4 care plan dated 5/18/2018 documents: R4 is at risk for fall secondary to unsteady gait, use of A.D (walker, rollator), hypertension medication, anti-depressant medication use, history of seizures, occasional incontinence, COPD/SOB with exertion and pain, history of fall. (10/31/24) R4 has Dementia. R4 has difficulties with short- and long-term memory acquisition and confusion. Section GG (functional abilities) dated 7/25/25 documents: R4 needs supervision or touching assistance (helper provides verbal cures and/or touching/steading and /or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently with sit to stand: the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Fall Risk assessment dated [DATE] document a score of seven which indicates at risk. Mobility: Unsteady gait and/or use of ambulatory device. Mentation: Impaired memory. Drugs that have a diuretic effect or increase GI motility. Drugs that affect the though process (i.e., sedative, hypnotics, narcotic, analgesics). Dugs that create a hypotensive effect (new ordered or dosage adjustment.) Elimination status Regularly continent, needs assist to get to the toilet. On 2/17/26 at 2:47pm, V6 (nurse), said, R4 has a history of Dementia. R4 is alert but forgetful. V6 said, R4 required monitoring every fifteen minutes. V6 said, R4 should never be left in her room unless she is sleep. V6 said, R4 must be encouraged to use her rollator because she is forgetful. V6 said, R4 can ambulate by herself when she is in her room but need staff assistance when ambulation in the hallway/from the nursing station back to her room to use the bathroom due to an unsteady gait. V6 said, when she works, she keeps R4 at the nursing station for monitoring. V6 said, she walked (continued on next page)

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