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	05/22/2026

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 - Minimal harm or potential for 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 prevent fall incidents and failed to provide safe transfer using a mechanical lift equipment. This deficient practice affects R2 of three residents reviewed for fall incidents.Findings Include:R2 is a [AGE] year-old female resident with diagnoses but not limited to: Morbid Severe Obesity, Vascular Dementia, Depression, Anxiety and Hypertension. BIMS (Bried Interview for Mental Status) of 9/15 (Moderate Cognitive Impairment). R2's fall incident on 4/23/26 at 2015PM, reads in part: Nurse walked into the room and saw R2 laying on the floor on her left side with a pillow under her head sling pads underneath R2. extremities were laid on her left side. Did not notice any injuries but R2 complaining of her back and head hurting. Nurse contacted doctor and left a voicemail. Nurse also tried to perform range of motion but R2 was laid on her left side. Nurse called Director of Nursing right away and was told to send the R2 to hospital.On 5/20/26 at 12:10PM, V7 (Assigned Nurse to R2 on 4/23/26) stated that V7 heard noise coming from R2's room, when V7 entered in R2's room, R2 had already fallen and was on the floor. 2 CNAs was with R2. V7 stated she called 911 and stayed with R2 until paramedics arrived in the facility.On 5/21/26 at 10:35AM, V17 (CNA) stated we tried to calm down R2, R2 would calm down for a little bit and start screaming and moving again. We put the sling on the mechanical lift, V14 stood on one side of the bed. V17 operated the mechanical lift. Stated that R2 is a heavy resident and hard to position, so the other CNA (V14) was guiding R2 during the transfer. R2 was calm for a little bit, for about a minute and when we lifted off from chair and onto trying to position R2 in the middle of the bed, R2 started trying to reach for the top of the mechanical lift (the area where the sling connects). When placing and moving towards the middle of the bed, R2 was already holding on the top part of the mechanical lift (where the sling connects). R2 was still hanging as we tried placing the sling and R2 in the middle of the bed, so when we lower the mechanical lift down, R2 could be in the middle. We tried to calm R2 down, R2 continued to scream for help. We reminded R2 we are almost done and that we just need to lower R2. R2 continued with the behavior, sling was swinging in mid-air. R2 was moving a lot and the whole body was swinging in mid-air.The mechanical lift moved and started tilting and V17 tried to hold the mechanical lift, but the lift continued to tilt on the side. R2 fell on the bed and mechanical lift fell in the corner of the bed. Mechanical lift started sliding down and it pulled R2 along with mattress. Mechanical lift was tilted but stayed on the bed frame. V14 and V17 were able to hold the bed, and we were about to call the nurse, and the nurse already heard the incident and came to the room.R2 and mechanical lift sling were still connected to the machine when it fell. On 5/21/26 at 1:00PM, V2 (DON) stated V1 (Administrator) did thorough investigation of the incident, and what V2 knows is that the staff were transferring R2 and the lift appropriately positioned under the bed and R2 was at the time above the bed and became agitated and started moving around. R2 is heavy set, the weight of her movement started the mechanical lift from tipping. Machine's legs were under the bed frame and as R2 moved around, the mechanical lift started tilting and lifting the bed frame off the floor and R2 landed on the mattress then slid to the floor with the mattress. For what I know she was not agitated enough for the transfer not to happen. If we waited for her, she would not have been transferred (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 - Minimal harm or potential for actual harm Residents Affected - Few	because she screamed a lot.On 5/21/26 at 1:30PM, V1 (Administrator) stated R2 was in her chair and got attached to the lift. They lifted out of the chair and R2 was position over the bed. Mechanical legs were positioned under the bed, and the R2 was directly on top of the bed. V17 (CNA) was in control of the mechanical lift and V14 (CNA) had walked around on the other side of the bed to spot R2. Just as V14 started walking to go on the other side. R2 started thrusting around and throwing her arms and legs, flailing her arms and legs, yelling I want water. V17 stated the mechanical lift begin to tip and V17 tried to grab the mechanical lift to keep it upright but R2's weight carried R2 towards the foot of the bed. Back leg of the mechanical lift machine lifted the head of the bed. R2 landed on the foot of the bed, landed on the bed mattress first. The mattress broke R2's fall. The pressure of R2's falling on the bed and the mechanical lift leg lifting the head of the bed, R2 seesawed the bed upright and R2 rolled over from the foot of the bed to the floor.R2's has a care plan for At Risk for Falls due to cognitive deficits and functional deficits (date Initiated 10/25/22) with interventions of Assess resident for anxiety and agitation prior to transfer (Date Initiated: 4/24/26).Hospital record dated 4/23/26, reads in part: R2 to Emergency Department from facility after falling out of mechanical lift. R2 states fell on the right side and hit her head. Complaint of right sided head and back pain. Denied loss of consciousness. Per EMS, R2 received Ativan prior to being put in to Mechanical Lift.Management of Falls policy dated 8/2020 reads in part: The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risk for fall incidents and/or injuries to resident.Develop plan of care to include goals and interventions which address resident risk factors. Risk factors may include but are not limited to the following: Contributing diagnoses/disorders/disease processes/active infections/other comorbidities, history of fall incidents, Incontinence, Medications (Narcotics, Antihypertensive, etc.) assistance required with ADL's gait/transfer/balance issues, behaviors and/or cognitive status.Provide assistive devices for mobility, hearing and vision as appropriate for the residents.Fall Management Program dated 8/2020 reads in part: The facility is committed to minimizing resident falls and/or injury so as to maximize each resident's physical, mental and psychosocial well-being. While preventing all residents fall is not possible, it is the facilities policy to act in a proactive manner to identify and assess those residents at risk for fall, plan for preventive strategies and facilitate a safe environment.