STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145998	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Des Plaines Rehab & Hc	1221 East Golf Road Des Plaines, IL 60016

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** 44570 Based on interview and record review, the facility failed to ensure that fall interventions were in place for a resident with a history of falls. This failure affected one (R4) of four residents reviewed for falls and resulted in R4 experiencing an unwitnessed fall which resulted in a nasal fracture. Findings include: R4 was admitted to the facility on [DATE] with diagnoses that included: Left humerus fracture (status post fall), dementia, weakness, and lack of coordination. On admission, Minimum Data Set assessment dated [DATE] documents that R4 has severe cognitive impairment and according to notes, was non-verbal, and hard of hearing. Fall incident reports were reviewed relating to R4 experiencing three unwitnessed falls in the facility on 8/26/24, 9/9/24, and 10/10/24. 8/26/24 incident report notes at 12:40 pm a nurse on duty heard a noise and rushed to the dining room. R4 was found on the floor in the dining room laying on R4's back and left side. The nurse notes that just five minutes prior, R4 was assisted with eating lunch. R4 was sent to the hospital for evaluation related to the incident. Interventions updated in the care plan after the fall included Will prevent fall by adding the use of bed alarm and wheelchair alarm to resident fall prevention plan. R4 was admitted to the hospital for evaluation and treated for a urinary tract infection. R4 returned to the facility 9/2/24. The Order Summary Report included an order written 9/3/24: Bed alarm and wheelchair alarm for fall risk patient. On 10/23/24 at 12:26 PM, V7 ADON (Assistant Director of Nursing) said that when a resident is at a risk, or has had multiple falls, the interdisciplinary team meets and discusses the root cause of the fall and updates the care plan right away. The interventions are implemented as soon as the care plan is updated. Once the intervention is implemented, it should either auto-populate or can be added to the CNA (Certified Nursing Assistant) tasks. This ensures proper monitoring and ensuring the chair and bed alarms are functioning and being used appropriately. (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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(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	Fall incident of 9/9/24 occurred at 7:30 pm and was described as follows: (R4) was seated at the nursing station in wheelchair prior to fall. (R4) was observed on the floor, smiling upon the writer's arrival. (R4) unable to give description. Interventions after this fall included evaluating seating system for modifications as needed and evaluate multiple falls to determine commonalities or patterns. Fall incident of 9/10/24 occurred at 2:15 am and Nursing Description includes: 'at 2:15am R4 noted at the door in front of room face down, nosebleed noted. R4 was conscious but confused.' Nursing progress notes relating to this incident, note that R4 was sent to the hospital via 911 and was diagnosed with a nasal fracture. R4 returned to the facility after evaluation in the afternoon on the same day. On 10/23/24 at 10:23 AM, V8 Registered Nurse (Agency) said after arriving to the facility, V8 did rounds at about 1:00AM and saw R4 in the bed. V8 remembers specifically viewing R4, because V8 received in report that R4 had fallen earlier in the day. V8 said there were chairs near R4's room, however V8 did not see any nursing assistants on the unit, and furthermore V8 was answering call lights due to no nursing assistants being available. Shortly after 2:00am, V8 described sitting at the nurse's station on the computer and seeing a flash from the corner of the eye. V8 got up to investigate and found that R4 appeared to have gotten up from the bed and ambulated several feet across the hall before falling in the doorway. V8 called out for help and staff came to assist. V8 said there was no unusual sounds or alarms heard at the time. On 10/22/24 at 3:06 pm, V9 CNA (Certified Nursing Assistant) said they were working the overnight shift at the time R4 fell however, V9 was on break at the time. V9 said R4 was in bed prior to leaving for break, and informed another CNA of leaving the unit, however V9 said that they did not inform the nurse. V9 said another CNA (V10) came to assist after hearing V8 call out, and V10 texted V9 to return to the floor. V9 could not remember if R4 had a bed alarm activated, or on the bed when rounds were performed prior to leaving the unit. R4's care plan was updated 9/4/24 to duplicate the use of pressure alarms while in chair and bed, however after reviewing the Point of Care documentation (CNA tasks), staff did not begin documenting use of pressure alarms until the morning (7am-3pm) shift 9/10/24. Facility Policy Management of Falls revised 8/20 states in part; Policy: 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 risks for fall incidents and/or injuries to the resident.