

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/12/2024
NAME OF PROVIDER OR SUPPLIER  Alden Courts of Shorewood		STREET ADDRESS, CITY, STATE, ZIP CODE  700 West Black Road Shorewood, IL 60404	

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	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43389</p> <p>Based on interview and record review the facility failed to provide adequate supervision and assistance to a resident during ambulation who required moderate assistance from the staff. This failure resulted in R8 sustaining a fall, being hospitalized, and diagnosed with a fracture to her pubic rami and fourth proximal phalanx of the toe. This applies to 1 of 2 residents (R8) reviewed for falls in the sample of 12.</p> <p>The findings include:</p> <p>R8 is a [AGE] year old female with diagnoses that include Moderate Dementia, Sacroilitis, Spondylosis of the cervical and lumbar regions, and Osteoporosis.</p> <p>R8's Admission Minimum Data Sheet (MDS) dated [DATE] showed that R8 to have severe cognitive impairment. The MDS also showed that R8 requires partial/moderate assistance where the helper lifts, holds, or supports trunk or limbs, but provides less than half the effort when ambulating.</p> <p>R8's fall risk assessments dated May 13, 2024 and June 12, 2024 showed R8 was at risk for falls. R8 also has a history of a fall at the facility on June 12, 2024. R8's June 12, 2024 incident report noted that R8 has a history dementia and demonstrates impaired memory and poor safety awareness.</p> <p>R8's final incident reportable dated July 15, 2024 showed the following: Staff were interviewed and staff stated that after dinner [R8] was coming out of the dining room and stopped to converse with the nurse and another resident. While enjoying the conversation, the resident turned her head causing her to lose her balance and began to fall towards her right side. Nurse present on the left side and assisted resident to the floor.</p> <p>The reportable further showed R8 had a witnessed fall, resident had a sudden change in condition and was sent to the hospital via 911. Per the hospital, R8 was admitted with a comminuted fracture of left medial superior pelvis and left forth toe fracture. The report also showed that the facility found that the factors contributing to the fall include a recent change in condition, distracted while ambulating, gait imbalance, cognitive impairment and poor safety awareness.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On September 10, 2024 at 3:49 PM, V11 (Assistant Director of Nursing) stated she does the fall investigations for the facility. V11 stated that R8 had a fall in the activity room on June 12, 2024. V11 further stated that on July 7, 2024, R8 was walking to her room with V10 (Certified Nursing Assistant/CNA)). V11 stated that between the dining room and the hallway, R8 stopped to talk to nurse and then turned to talk to another resident. V11 stated that R8 then lost her balance and fell . V11 stated that V4 (LPN) wasn't able to get to resident in time to ease the fall.</p> <p>On September 10, 2024 at 4:01 PM, V10 (CNA) stated that on July 7, 2024, R8 stated she had to go to the restroom. V10 stated she then put a gait belt around R8 before she stood R8 up from the chair in the dining room. V10 stated between the dining room and the doorway R8 stopped to talk to V4 (Licensed Practical Nurse/LPN). V4 stated she was on R8's right side and holding resident with left hand and V4 was on her left side. V4 stated she left R8 with the nurse and went to answer a call light that was going off not far from the nurse's station. V10 stated on her way back from answering the call light, R8 was still talking to V4. V10 stated she then saw that R8 was starting to fall, and V10 stated she started running towards R8 and V4. V10 stated that V4 tried to grab R8 and was only able to grip her shirt and R8 landed on her right side. V10 stated she always stays close by when ambulating R8 because she was aware R8 was a fall risk and required one assist.</p> <p>On September 10, 2024 at 4:16 PM and 4:48 PM, V4 (LPN) stated that R8 was walking from the dining room and V4 was walking in the same direction. V4 stated R8 stopped to talk to him. V4 stated that another resident was on R8's left side and R8 turned to talk to the other resident and started falling in that direction. V4 stated he was only able to grab R8's shirt and not able to reach the gait belt that was around the R8's waist. V4 stated he held R8 by the shirt but the momentum brought her to the ground. V4 stated he did not recall where V10 was just before the fall, but no one was holding onto the resident. V10 stated they use a gait belt for assisting residents with transfers and escorting residents for safety reasons. V10 further stated that they use gait belts for all ambulatory residents who are fall risks. V10 stated that someone should have been holding R8's gait belt while she was talking to him. V10 stated he has seen before that residents get distracted, turn their heads and attention to other people, or get startled by others then can lose their balance.</p> <p>On September 11, 2024 at 12:59 PM, V2 (Director of Nursing) stated partial/moderate assistance is considered to be hands on assistance for transfers and ambulation of people who require it. If partial/moderate assistance is required then a gait belt is required to secure the resident for their safety. V2 stated R8 requires hands on assistance and staff should be holding the gait belt when ambulating, standing, and transferring the resident.</p> <p>On September 11, 2024 at 1:52 PM V14 (Rehab Director/Occupational Therapist) V14 stated they use a gait belt for safety during ambulation, standing, and transfer. V14 stated that staff has to hold the gait belt if the level of assistance required is partial/moderate assist. V14 stated that a gait belt should be used for someone who requires partial/moderate assistance with ambulation for safety. V14 stated even if the resident can walk 100 feet, the gait belt should be used because the resident could fatigue, get dizzy, or their legs could buckle.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R8's therapy notes on the morning of July 7, 2024 showed that while receiving therapy, R8 uses a rollator walker and required minimum assist to contact guard assistance. On September 11, 2024 at 2:10 PM, V14 stated that minimum assist to contact guard assist means that the resident has hands on assistance with verbal queuing due to fluctuations of ambulation performance. V14 further stated that minimum assist to contact assistance was provided to R8 for proper foot placement and gait to improve ambulation. During the same interview V14 stated that when R8 is in the nursing unit, the nursing staff should us a gait belt for R8's safety.</p> <p>On September 11, 2024 at 2:28 PM, V15 (Medical Director) stated that he expects the facility's staff to follow their policies and procedures, and the professional recommendations of the therapists.</p> <p>R8's progress note dated July 7, 2024 at 8:40 PM showed that resident had a witnessed fall at 5:00 PM and at this time being sent to the hospital via 911.</p> <p>R8's hospital emergency room report dated July 7, 2024 showed that R8's son reported the he got a call from the memory care that R8 had a fall earlier today. The fall was witnessed by a staff member, R8 landed on her buttock, and was complaining of some left hip pain. Then later in the day R8 was reporting some lightheadedness/dizziness and the facility checked her oxygen and it was 93% and then dropped to 80%. The report also mentions that R8 had a confirmed fourth distal phalanx fracture of the toe.</p> <p>R8's ambulatory skills care plan dated May 17, 2024 showed the following: R8 has impaired ambulatory skills with or on: Changing directions, level surfaces, speeding up or slowing down, turning around. The related Interventions/Tasks dated May 17 2024 showed: Assist and instruct resident/caregiver with safety awareness while ambulating.</p> <p>R8's fall risk care plan dated May 13, 2024 showed the following: R8 is at risk for falls related to weakness/deconditioning, potential medication side effects, bowel and bladder incontinence, cognitive impairment/dementia, history of fall with fracture, and need for external physical assistance and use of assistive devices (wheelchair/walker).</p> <p>R8's Computed Tomography (CT) Pelvis without contrast report dated July 8, 2024 for left hip pain showed the following: Acute comminuted fractures of the left medial superior and interior pubic rami. Associated left pelvic sidewall hemorrhage and intramuscular hematoma the left obturator internus and externus muscles.</p> <p>The facility's Gait Belt/Transfer Belt policy showed the following: To assist with a transfer or ambulation. A gait belt will be used with weight bearing residents who require hands on assistance.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 16746</p> <p>Based on observation, interview and record review the facility failed to ensure that the oxygen was administered to the residents as ordered by the physician.</p> <p>This applies to 2 of 2 residents (R2 and R95) reviewed for oxygen use in the sample of 12.</p> <p>The findings include:</p> <p>1. R2 had multiple diagnoses including dementia without behavioral disturbance and senile degeneration of the brain, based on the face sheet. R2's significant change in status MDS (minimum data set) dated July 26, 2024 showed that the resident was moderately impaired with cognition and required total assistance from the staff with her ADLs (activities of daily living).</p> <p>On September 10, 2024 at 10:45 AM, R2 was in bed, alert and verbally responsive. R2's oxygen concentrator was running to deliver oxygen via nasal cannula to the resident. R2's nasal cannula was on her mouth and the oxygen gauge was set to deliver oxygen below 2 liters per minute which was confirmed by V4 (Licensed Practical Nurse). V4 reapplied R2's nasal cannula to the resident's nostrils and checked the resident's oxygen saturation which registered between 96% and 97%. R2 had no shortness of breath and the resident did not complain of respiratory distress.</p> <p>R2's active order summary report showed an order dated July 20, 2024 for, Oxygen per nasal cannula at 2 liters per minute continuous every night shift for hypoxia, on at HS (bed time).</p> <p>On September 10, 2024 at 11:03 AM, V4 (LPN) checked R2's active orders for oxygen and stated that based on the physician's order, R2 should receive 2 liters per minute of oxygen via nasal cannula only at night, to be applied before bed time and continuously while R2 is asleep.</p> <p>2. R95 was admitted to the facility on [DATE] with multiple diagnoses including acute respiratory failure with hypoxia, pneumonia, dementia with behavioral disturbance and adult failure to thrive, based on the face sheet.</p> <p>R95's admission MDS dated [DATE] showed that the resident was severely impaired with cognition and required moderate to maximum assistance from the staff with most of her ADLs.</p> <p>On September 9, 2024 at 11:02 AM, R95 was sitting in her wheelchair inside her room. R95 was alert, verbally responsive with hard of hearing and was confused. R95 had an ongoing oxygen at 3 liters per minute using an oxygen concentrator.</p> <p>On September 10, 2024 at 10:26 AM, R95 was sitting in her wheelchair inside her room. R95 was alert, verbally responsive but confused. R95 had an ongoing oxygen at 3 liters per minute using an oxygen concentration which was confirmed by V4. R95 had no shortness of breath and the resident did not complain of respiratory distress.</p> <p>R95's active order summary report showed an order dated August 23, 2024 for, oxygen via nasal cannula at 2 liters per minute as needed for respiratory symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R95's active oxygen therapy care plan initiated on September 5, 2024 showed multiple interventions including administration of oxygen as ordered by the physician.</p> <p>On September 10, 2024 at 11:00 PM, V4 checked R95's active orders for oxygen and stated that based on the physician's order, R95 should only receive 2 liters per minute, as needed.</p> <p>On September 11, 2024 at 9:32 AM, V2 (Director of Nursing) stated that oxygen should be delivered as ordered by the physician because oxygen therapy is considered as medication since it is prescribed by the physician. V2 stated that for R2, it was specifically ordered to be given only at night/at bedtime because the resident would complain of shortness of breath at night and based on the physician's order it should not be administered during the day, especially since R2 had not complained of shortness of breath and her oxygen saturation was stable and within normal limits, when it was checked by V4. V2 added that for R95, the order was to deliver 2 liters per minute as needed for shortness of breath.</p> <p>The facility's policy regarding oxygen concentrator dated September 2020 showed in-part, Residents will be administered oxygen via oxygen concentrator upon Physician's orders by an RN (Registered Nurse), LPN (Licensed Practical Nurse) or RT (Respiratory Therapist).</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36567</p> <p>Based on observation, interview and record review, the facility failed to ensure that the dishes were sanitized during high temperature dishwashing procedure.</p> <p>This applies to 42 residents that receive foods prepared and served from the facility kitchen.</p> <p>The findings include:</p> <p>The facility provided information that on September 09, 2024 the facility census was 43 residents with 1 resident on NPO (nothing by mouth) status.</p> <p>On September 09, 2024 at 01:49 PM, the high temperature dish machine was monitored in the presence of V6 (Executive Chef), V7 (Dietary Aide) and V8 (Dietary Aide) were at the dish machine washing dishes, one employee each on the dirty and clean side respectively. During the dishwashing procedure, the 'Wash' temperature fluctuated between 158-167 degrees Fahrenheit, the 'Rinse' temperature fluctuated between 157-171 degrees Fahrenheit, and the 'Final Rinse' temperature fluctuated between 144-163 Fahrenheit. When a test strip that was adhered to a washed dish was sent through the dish machine, it remained white color. V6 stated that they had tested the dish machine with a test strip that morning and it had turned black color. A 'Dish Machine Temperature Log' was seen posted on the wall and the same log showed 186 degrees Fahrenheit logged on September 09, 2024 for breakfast. The test strip was sent through the dish machine two more times after waiting several minutes between each test and the test strips remained white color and light gray respectively with the Final Rinse temperature setting continuing to fluctuate between 152-166 Fahrenheit. After another couple minutes, another test strip was sent again through the dish machine and this time it turned black and it was noted that the Final Rinse showed 188 degrees Fahrenheit for a second or two at that time. The Final Rinse temperatures continued to fluctuate at temperatures below 180 degrees Fahrenheit thereafter during the dish washing process and V8 was seen placing the just washed dishes away on the clean rack ready for service. V6 (Executive Chef) was notified that the Final Rinse should show 180 degrees Fahrenheit on a consistent basis for the dishes to be sanitized and the dishes that were just washed and put away on the clean rack when the Final Rinse was not 180 degrees Fahrenheit, will have to be rewashed.</p> <p>Test strips labeled '1-Temp Thermolabel' included as follows: 1. Remove label from sheet. 2. Adhere to clean, dry dish using clean hands 3. Run through wash and final rinse cycles. 4. The gray/white temperature sensitive element will turn black if the dish has reached the rated temperature .</p> <p>On September 10, 2024 at 1:03 PM, when the the high temperature dish machine was revisited again V6 (Executive Chef) stated that he notified the company that services the dish machine on September 9, 2024 and they came in that morning (on September 10, 2024) and checked the dish machine and told the maintenance that they need to boost up the water temperature.</p> <p>Customer Service Report from the Dish machine servicing company dated September 10, 2024 showed as follows: 'When arrived, the Final Rinse would go as low as 152 temperature. Incoming water too low, incoming should be at 140 [degrees Fahrenheit]. Told maintenance man, he adjusted some valves. Now machine is hitting 187-180 degrees after 4 racks.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On September 11, 2024 at 01:02 PM, V12 (Dish Machine Company Service Personnel) verified that he was the one who serviced the dish machine on September 10, 2024. V12 stated that when checked, the temperature of the incoming water was at around 100 degrees Fahrenheit, and it should be best at 140 degrees Fahrenheit in order to maintain the booster at 180 degrees Fahrenheit at the Final Rinse setting. V12 stated that V13 (Maintenance Director) adjusted the value at a different site at the facility in order to raise the water temperature up.</p> <p>On September 10, 2024 at 04:24 PM, V5 (Dietary Supervisor, Registered Dietitian) stated that the Final Rinse should be at 180 degrees Fahrenheit in order for the dishes to be sanitized.</p> <p>Facility Policy and Procedure Mechanical Washing Sanitation Testing (revised June, 2024) included as follows:</p> <p>Policy: Dish machine test strips will be used to verify the dish machine sanitation system is working correctly.</p> <p>Purpose: To reduce the risk of food borne illness.</p> <p>Procedure:</p> <p>2. For high temperature sanitizing machine: Attach a 160-degree Fahrenheit test strip to clean, dry, cool dish; weave a 180-degree Fahrenheit test strip per manufacture's direction or run through the wash/rinse cycle with a maximum reading thermometer to determine if the sanitizing water reaches 180-degree Fahrenheit.</p> <p>4. If the test strip does not turn the correct color, the above procedure should be repeated. If the test strip does not the appropriate color after multiple attempts, the dish machine should be evaluated for proper functioning before the dishes are washed.</p>		