STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146186	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates Cts of Huntley	12140 Regency Parkway Huntley, IL 60142

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37232 Based on observation, interview, and record review the facility failed to maintain a resident's dignity by not assisting the resident to the bathroom prior to the resident becoming incontinent of stool for 1 of 28 residents (R287) reviewed for dignity in the sample of 28. The findings include: R287's progress notes dated 4/22/24 described R287 as being alert, oriented, understood and followed commands. The same notes indicated R287 had a fall at home resulting in a fractured hip. On 04/22/24 at 9:20 AM, when entering R287's room there was a noticeable smell of stool. R287 was sitting in bed. R287 said this morning (4/22/24) she put her call light on at 8:15 AM because she needed help from staff to go to the bathroom. R287 said she had to have a bowel movement. R287 said she did not get help to go to the bathroom until 8:50 AM. R287 said by the time staff helped her to the bathroom it was too late and she had an accident of stool. R287 said it was .embarrassing . R287 said she normally was continent of stool but wears an adult incontinence brief for occasional urinary incontinence. R287 said she was incontinent of stool one other time on 4/20/24 because staff were too slow assisting her to the bathroom. R287 added that after the first incontinent event on 4/20/24 she makes sure she does not wait until the last minute to ask for help going to the bathroom. R287 said she came to the facility for therapy after falling at home and fracturing her hip. On 4/22/24 at 10:04 AM, V8 (Certified Nursing Assistant- CNA) said R287 is alert and aware of what was going on. V8 said when R287 needs to have a bowel movement she puts her call light on and is continent of bowel movements. V8 said R287 had an accident of stool on the morning of 4/22/24. R287's bowel continence task documentation going back to R287's admitted (4/16/24) showed R287 was continent of stool and was incontinent of stool one time on 4/20/24 (the date R287 said she was incontinent because staff were slow on assisting her to the bathroom). On 4/24/24 at 10:23 AM, V16 (CNA) said a resident that is continent of stool should receive help going to the bathroom before they become incontinent. On 4/23/24 at 12:40 PM, V2 (Director of Nursing) said staff should respond to call lights within 3-8 minutes. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/24 at 9:57 AM, V1 (Administrator) said the facility is unable to track when a call light was turned on or off. The State of Illinois Department on Aging Residents' Rights for People in Long-term Care Facilities booklet given to residents on admission showed, Your facility must provide services to keep your physical and mental health, and sense of satisfaction.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37232 Based on observation, interview, and record review the facility failed to accommodate a resident's need for an alternative call light for 1 of 28 residents (R285) reviewed for accommodation of needs in the sample of 28. The findings include: R285's face sheet showed R285 admitted to the facility on [DATE]. The face sheet indicated R285 was a [AGE] year old female with the diagnoses of osteoarthritis and chronic gout. R285's Functional Abilities and Goals Admission assessment done on 4/22/24 showed R285 had range of motion impairments to her upper extremities because of discomfort. The assessment also showed R285 had a contracture to her left hand. R285's progress notes dated 4/20/24 showed R285 was alert and oriented. On 4/22/24 at 9:40 AM, R285 was in bed. R285 had a regular call light lying in bed next to her. There was no alternative call light. R286 (R285's roommate) was sitting in a wheelchair next to R285's bed. R285 said she struggles to push the button for her call light because of her hand strength. R285 said she has arthritis and gout. R285 said at times she could not physically push the call light button and would ask R286 to push the call light. R286 said she has to push the call light button .all the time . for R285. R285 said on the first few days she arrived at the facility, she informed staff she was having issues pushing the call light button. On 4/22/24 at 9:46 AM, the call light outside of R285's room was on. V7 (Certified Nursing Assistant) responded to the call light. R285 informed V7 that she was uncomfortable. V7 repositioned R285. On 4/22/24 at 9:53 AM, R286 said she pushed R285's call light button at R285's request because R285 was uncomfortable. On 4/22/24 at 9:57 AM, V7 said earlier in her shift R286 had pushed the call light button for R285. V7 added that R285 could not push the call light button because of her hands. V7 confirmed R285 had a history of not being able to use the call light. On 04/23/24 at 12:40 PM, V2 (Director of Nursing) said if a resident had difficulties pushing the call light button an alterative call light such as a soft touch call light should be provided. V2 added that a soft touch call light can be provided by maintenance. R285's care plan for activities of daily living list as an intervention to, Encourage the use of call light for assistance when needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on interview and record review the facility failed to obtain daily weights on residents with orders for daily weights with congestive heart failure (CHF) for two of 28 residents (R93, R59) reviewed for quality of care. The finding include: 1. R93's Admission Record shows he was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, lymphedema, Parkinson's disease, dementia, and acute on chronic diastolic congestive heart failure. R93's Care Plan initiated October 12, 2023 shows weigh monthly and as otherwise ordered by physician. V22's Nurse Practitioner Progress Note date April 4, 2024 shows, Follow up cardiology. Nursing tells me he was hospitalized for acute hypoxemia respiratory failure from March 9, 2024-March 12, 2024, at which time he also has a new diagnosis of CHF. Daily weights ordered, trending down. Late entry: BLE (Bilateral lower extremity edema) daily weights ordered X 4 weeks (total), trending down. V17's MD (Medical Doctor) note dated April 5, 2024 shows, Assessment and plan: HF hospitalized (at local hospital) for acute exacerbation 3/9-3/12. Dose of furosemide recently reduced to 20 mg twice a day. Cardio on board. Daily weight. R93's Hospital Records dated March 12, 2024 shows, Daily weights. Tracking your weight will be done one time every day. R93's Weights and Vitals Summary shows R93 was not weighed from April 9, 2024-April 17, 2024. R93's weight on April 9, 2024 was 208.4 and his weight on April 17, 2024 was 210.6. On April 24, 2024 at 9:58 AM, V23 RN (Registered Nurse) said R93's original daily weight order was for four weeks and that why the order disappeared. V23 said V17 came to see R93 and saw that daily weight was not ordered and so V17 re-ordered daily weights for R93. V23 said it is important to obtain daily weights for residents with congestive heart failure because weight gain is a sign of pulmonary edema or congestive heart failure exacerbation. 45540 2. On 4/23/2024 at 1:58 PM, V2, Director of Nursing (DON) said residents with congestive heart failure (CHF) get daily weights. V2 said weights are completed for CHF patients daily to monitor fluid shifts, gains or losses. V2 said if the weights are ordered daily for a resident they should be obtained daily by staff. R59's Admission Record shows a diagnosis of chronic diastolic (congestive) heart failure entered on 3/8/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R59's Order Summary Report active orders as of 4/23/2024 show an order for daily weight every day shift starting on 3/9/2024. R59's Weights and Vitals Summary dated 3/24/2024 to 4/23/2024 shows no weight entered on 4/15/2024, 4/12/2024, and 3/25/2024. The facility provided Weights policy dated 9/2020 shows, Residents will be weighed to establish baseline weights and identify trends of weight loss or weight gain.

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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** 34506 Based on interview and record review, the facility failed to ensure a resident was safely positioned in a wheeled recliner for one of 28 residents (R82) reviewed for safety in the sample of 28. This failure contributed to R82 falling out of the wheeled recliner and obtaining a subdural hematoma. The findings include: R82's Admission Record shows she was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage, dementia, major depressive disorder, and generalized anxiety disorder. R82's Fall Risk assessment dated [DATE] shows R82 is at risk for falling. R82's Care Plan initiated November 29, 2023 shows she is at risk for falls. Interventions include audio monitoring to prevent unassisted transfers, provide an environment clear of clutter. R82's Psychiatry Note dated April 16, 2024 at 9:16 AM, shows staff reporting increased agitation and behaviors. R82 was seen in her wheelchair after eating lunch and is unfocused and very restless. The facility's Occurrence Report dated April 16, 2024 shows R82 was observed on the floor next to the nurses station. R82 stated she did not know what happened and upon assessment swelling was noted to the back of R82's head. R82 complained of pain. 911 was called and R82 was taken to the local hospital. R82's Progress Notes dated April 16, 2024 at 5:55 PM written by V20 LPN (Licensed Practical Nurse) shows, R82 was place in a (high back reclining) wheeled chair. R82 tipped backwards out of the chair and hit her head. R82 had a lump on the back of her head and a hematoma was forming. R82 was sent out to the local hospital via 911. R82's Progress Note dated April 16, 2024 at 9:28 PM shows R82 was admitted to the local hospital with a subdural hematoma. R82's Hospital Records dated April 17, 2024 shows R82 presented to the emergency department with a chief complaint of a fall. It shows R82 to be leaning too far back in her recliner causing her to fall. R82 struck the back of her head. R82's CT Scan results show that R82 had a right sided subdural hematoma and a moderate soft tissue hematoma to the back right of R82's head. R82's Assessment shows neurosurgery was consulted and recommended intensive care unit admission for neuro checks every hour and aggressive blood pressure control. R82 was a do not resuscitate code status and after talking with R82's power of attorney, and R82's daughter, the family decided they were not going to pursue any aggressive interventions including operative plans. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On April 24, 2024 at 10:59 AM, V20 LPN said R82's fall was a frustrating one for me. It has bothered me since it happened. V20 said it was around dinner time and V20 was in the dining room helping residents. V20 said that V21 CNA (Certified Nursing Assistant) was assisting R82 and another resident to eat. V20 said she did not realize that V21 placed R82 in the high back wheeled recliner and near the nurses' station. V20 said next thing she knew, R82 was flipped backwards. V20 said R82's high back wheeled recliner was flipped backwards, and the back rest was laying on the floor. V20 said she did not see it happen. V20 said that V21 must have walked away. V20 said that she ran to R82 and R82's head was on the ground. V20 said she asked R82 if anything hurt and R82 pointed to her head. V20 said she could see a bump on the back of R82's head. V20 said she asked V21 what she did and V21 told V20 that V21 reclined R82 in her high back wheeled recliner and placed a wheelchair under R82's feet rest. V20 said she told V21 that she couldn't do that because it was a restraint. V20 said that she always tries to keep a close eye on R82 because R82 constantly tries to get up. R82 is restless and anxious. Someone has to be around R82 to watch her. On April 24, 2024 at 11:39 AM, V5 said that she performed the investigation in regards to R82's fall. V5 said V21 was with R82 at the nurses' station and then walked away to assist another resident. V5 said based on her investigation, they believe R82 was moving around in the chair, and it was tipped. V5 said she did not know if the chair was tipped backwards or sideways. V5 said that V21 no longer works at the facility. V5 said that V21 has had issues with tardiness. V5 said she did not get reports that a wheelchair was used as well, but V5 said there was a wheelchair nearby R82. On April 24, 2024 at 12:00 PM, V2 DON (Director of Nursing) said he was not sure if her recliner got tipped. V2 said that R82 must have gotten herself out of the recliner. V2 said he did not get any reports of a wheelchair being used as well. V2 said that V21 no longer works at the facility due to attendance issues. V2 said that V21's late date of employment with the facility was April 16, 2024 which was also the same date of R82's fall. On April 24, 2024 at 12:30 PM, V21 said R82 was trying to climb out of her chair. V21 said she did not witness R82's fall. I think she just climbed. The facility's Fall Management Program dated August 2020 shows, The facility is committed to minimizing resident falls and/or injury. While preventing all resident fall is not possible, it is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies and facilitate a safe environment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview and record review the facility failed to ensure a resident's medication was administered as ordered an not left at the bedside for 1 of 28 residents (R189) reviewed for medications in the sample of 28. The findings include: On 4/22/24 at 10:14 AM, R189 had a medication cup sitting on his bedside table with medication in the cup. R189 said that he did not know what the medication was or how long it had been on his bedside table. On 4/22/24 at 10:14 AM, V18 (Registered Nurse) said that the medication looked like R189's Carbidopa-Levodopa. V18 said that she is not sure when they medication was supposed to be administered because she gave him his morning medications in the dining room. On 4/24/24 at 8:36 AM, V19 (Licensed Practical Nurse) said that medications should never be left at the bedside. V19 said that if they are left at the bedside, you can not ensure that the resident took them. V19 said that they could get lost, dropped or not taken. R189's April Medication Administration Record shows that he receives: Carbidopa-Levodopa ER ,d+[DATE] mg-three tablets by mouth three times a day for Parkinson's disease at 8:00 AM, 2:00 PM and 8:00 PM. R189's Electronic Medical Record does not document that R189 is allowed to self-administer his medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34506 Based on observation, interview, and record review the facility failed to change gloves and perform hand hygiene in a manner to prevent cross contamination for two of 28 residents (R3, R109) reviewed for infection control in the sample of 28. The findings include: 1. R3's Care Plan initiated November 23, 2020 shows R3 experiences functional bowel and bladder incontinence. On April 22, 2024 at 10:13 AM, V3 CNA (Certified Nursing Assistant) provided incontinence care to R3. V3 wiped R3's front peri area. There was stool noted to the wet wipe when V3 wiped R3's front peri area. V3 helped R3 to turn onto her side and touched R3's body and gown. V3 then wiped R3's buttocks area. V3 did not change her gloves or perform hand hygiene when going from dirty to clean surfaces. 2. R109 's Care Plan shows R109 is incontinent of both bowel and bladder. On April 23, 2024 at 11:29 AM, V3 and V4 CNAs (Certified Nursing Assistants) provided incontinence care to R109. There was urine noted in R109's incontinence brief. V3 wiped R109's front peri area, touched R109's body to help her turn and placed a new incontinence brief without changing her gloves or performing hand hygiene. On April 24, 2024 at 10:02 AM, V24 said gloves should be changed and hand hygiene should be perform after soiled items are touched and prior to touching clean items. The facility's Hand Washing and Hand Hygiene policy dated June 5, 2020 shows, Appropriate hand hygiene is essential in preventing the spread of infectious organisms in healthcare settings. Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items.