DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145582	A. BUILDING ______ B. WING ______	C 11/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF NAPERVILLE	1525 SOUTH OXFORD LANE NAPERVILLE, IL 60565

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Investigation of Complaint 1173240 - IL54991.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to: - develop and implement individualized and specific interventions including use of bed and chair alarm; - monitor supervise a resident (R1) to prevent from falling. As a result: R1 who has history of multiple falls, had fallen on 10/09/11 and fractured her left hip. This is for one of four residents (R1) in the sample. Findings include: On 11/3/11 at 11:45 am E4, Certified Nurse Aide (CNA) transferred R1 from her bed to her wheel chair. After E4 was done transferring R1 to her chair, there was no bed alarm on her mattress. R1's wheel chair alarm sounded intermittently	F 323		12/5/11

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

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.

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F 323	Continued From page 1 without even being in use. E4 stated R1 has no bed alarm. R1's chair alarm needs batteries. R1 on 11/3/11 at 2:30 pm who was able to recall the incident of her falling on 10/9/11. R1 was alert and oriented to time, place and person and able to carry on conversation. R1 stated she has Vertigo. On the night of 10/9/11 R1 indicated she could not wait to go to bath room, she needed to go quickly, other wise bath room accidents happen. R1 indicated she goes to bath room at least two to three times at night. R1 stated on the night of 10/9/11 the accident happened shortly after the midnight. R1 also stated it took a while for the girls to come when she called for help, so she got up herself from her bed, and turned her head quickly after she got up from bed and she felt dizzy from Vertigo and fell. R1 answered there was no bed alarm on the bed and she does not like it any, because it sounds, no one comes, and she looses her sleep. The facility documented six incidents (3/16, 4/14, 4/24, 4/30, 7/26, and 10/9/11). After R1's falling the facility recommendations included: On 3/16/11 and 4/14/11 educate R1 on the call light and asking for assistance. It is unclear as to how the facility will ensure that R1 will follow to call for help. On 4/24/11 it was recommended to place bed alarm as a reminder for resident to ask for assistance during transfer. On 4/30/11 move R1 closer to nurses station; in the details it was there was no alarm. The facility did not evaluate why R1 has no alarm on her bed. On 7/26/11 incident details noted the alarm was not sounding and one of the recommendations	F 323		

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ensure bed alarm in place and functioning. Again the facility did not evaluate why the alarm was not sounding.
On 10/9/11 incident details noted there was no alarm, the recommendations included to ensure chair alarm in place to help remind resident of need for assistance. Once again the facility failed to ensure the staff did not implement the intervention to have alarm on R1's bed.
R1's 10/9/11 incident report noted the staff found her on the floor by her bed, alert and verbally responsive. The facility final incident investigation indicated she sustained left hip fracture after her falling on 10/9/11.

R1's 7/6/11 Minimum Data Set (MDS) noted she is alert and oriented, needs one staff assistance from sitting to standing, transferring surface to surface, ambulate, turning, moving on off toilet, and ambulation.

The facility conducted a fall risk assessment indicating numerical value for each contributing factor. These assessment scores (1/5, 3/16, 4/14, 4/24, 4/30, 6/29, 7/26, 10/9 and 10/16/11) indicated that R1 was at high risk for falling. The facility did not evaluate these risk factors to indicate if the risk factors could be modified.

R1's unsteady gait care plan, dated 1/7/11 which was revised on 3/16, 4/5, 4/14 and 7/11/11, interventions added to 'place bed pad alarm.'

On 11/3/11 at 12:30 pm Z1 (R1's physician) stated R1 is clumsy, independent (mentally), she wants to do what ever she wants to do, but she is unsteady and needs assistance. If there is any thing wrong R1 jumps and wants it right away. R1

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needs close supervision, that is the only way her falling can be prevented.

On 11/3/11 E7, day shift Nurse stated in the presence of E3 (the Clinical Support Nurse) that R1 needed limited assistance of one staff prior to her falling 10/9/11 to take her to bath room, but some times R1 takes herself to bath room without calling for help. E7 indicated the staff has to watch R1, she has to have bed alarm and chair alarm. The staff should hear the alarm and respond immediately.

It is clear from the observations on 11/3/11 and the facility incident investigation reports, and staff interview the facility did not follow the recommendations to use bed alarm and have a functional chair alarm. R1's fall on 10/9/11 was preventable.

F9999 FINAL OBSERVATIONS — F9999

Licensure Violations:

300.610a)
300.1210b)6)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance

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with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Sction 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

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These regulations were not met as evidenced by:

Based on observation, record review and interview the facility failed to:
- develop and implement individualized and specific interventions including use of bed and chair alarm;
- monitor supervise a resident (R1) to prevent from falling.

As a result:
R1 who has history of multiple falls, had fallen on 10/09/11 and fractured her left hip.

Findings include:

On 11/3/11 at 11:45 am E4, Certified Nurse Aide (CNA) transferred R1 from her bed to her wheel chair. After E4 was done transferring R1 to her chair, there was no bed alarm on her mattress. R1's wheel chair alarm sounded intermittently without even being in use. E4 stated R1 has no bed alarm. R1's chair alarm needs batteries.

R1 on 11/3/11 at 2:30 pm who was able to recall the incident of her falling on 10/9/11. R1 was alert and oriented to time, place and person and able to carry on conversation. R1 stated she has Vertigo. On the night of 10/9/11 R1 indicated she could not wait to go to bath room, she needed to go quickly, other wise bath room accidents happen. R1 indicated she goes to bath room at least two to three times at night. R1 stated on the night of 10/9/11 the accident happened shortly after the midnight. R1 also stated it took a while for the girls to come when she called for help, so she got up herself from her bed, and turned her

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F9999	Continued From page 6 head quickly after she got up from bed and she felt dizzy from Vertigo and fell. R1 answered there was no bed alarm on the bed and she does not like it any way, because it sounds, no one comes, and she loses her sleep. The facility documented six incidents (3/16, 4/14, 4/24, 4/30, 7/26, and 10/9/11). After R1's falling the facility recommendations included: On 3/16/11 and 4/14/11 educate R1 on the call light and asking for assistance. It is unclear as to how the facility will ensure that R1 will follow to call for help. On 4/24/11 it was recommended to place bed alarm as a reminder for resident to ask for assistance during transfer. On 4/30/11 move R1 closer to nurses station; in the details it was there was no alarm. The facility did not evaluate why R1 has no alarm on her bed. On 7/26/11 incident details noted the alarm was not sounding and one of the recommendations ensure bed alarm in place and functioning. Again the facility did not evaluate why the alarm was not sounding. On 10/9/11 incident details noted there was no alarm, the recommendations included to ensure chair alarm was in place to help remind resident of need for assistance. Once again, the facility failed to ensure the staff implemented the intervention to have alarm on R1's bed. R1's 10/9/11 incident report noted the staff found her on the floor by her bed, alert and verbally responsive. The facility final incident investigation indicated she sustained left hip fracture after her falling on 10/9/11. R1's 7/6/11 Minimum Data Set (MDS) noted she	F9999		

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is alert and oriented, needs one staff assistance from sitting to standing, transferring surface to surface, ambulate, turning, moving on off toilet, and ambulation.

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F9999	Continued From page 8 recommendations to use bed alarm and have a functional chair alarm. R1's fall on 10/9/11 was preventable. (B)	F9999		