STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146008	A. BUILDING _____ B. WING _____	05/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN OF WATERFORD	2021 RANDI DRIVE AURORA, IL 60505

(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 498	Continued From page 18 E5's personal file includes an 8/31/12 written counseling for failure to follow transfer precautions as listed in the plan of care when weighing a resident (R12). E5 wrote a response on the counseling form, to include ; E5 was unaware of the splint and did not see it. E5's file also documents date of hire 4/24/12. E5's skills evaluation checklist is dated 6/26/12. On 8/31/12 E5 was inserviced on use of splints. During 5/09/13 9AM interview, R12 stated she will never forget the 8/30/12 fall incident and how painful it was. R12 said a "little nurse aide was trying to get me on the scale, without using a gait belt, she could not hold me up and dropped me." R12 also said "I told her (E5), my knee had to lock before I could stand and that it hadn't." I was so scared and in so much pain. I broke two bones in my knee from that fall. I also developed foot drop in my right foot since the fall from bedrest and the long casts I had to have. It has taken a long time to heal and I would have been out of here a long time ago if it hadn't been for that fall." R12 also said E5 was fired by facility related to her dropping her on 8/30/12. E5's personal file included an "Employee Separation Report" dated 10/11/12 that includes last date worked was 9/08/12. Reason documented for E5 being terminated, was E5 did not work when scheduled and did not respond to facility phone calls.	F 498		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 19 300.610a) 300.1210b) 300.1210c) 300.1210d)6)	F9999		

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents'

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F9999	Continued From page 20 respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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. THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on observation, interview and record review facility failed to provide a safe transfer according to the residents plan of care. This failure resulted in a fall incident that caused two right lower extremity fractures, development of right foot drop and heel cord contractures and have also resulted in long term decline in physical functioning. This failure applies 1 of 8 residents (R12), reviewed for falls in a sample of 15. R12 was admitted to facility 6/10/12 for therapy services after having a right hip surgery. R12 is also diagnosed with recurrent septic infections in the right hip. R12's 6/17/12 Minimum Data Set Assessment (MDS), documents rarely in pain, decreased range of motion (ROM), to one lower extremity, requires extensive assistance with transfers,	F9999		

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F9999	Continued From page 21	F9999		

ambulation, hygiene, toileting and dressing, not steady standing without physical assistance and continent of bladder. This MDS also documents fully intact cognitive status on the BIMS (Brief Interview for Mental Status), scoring 15 out of 15.

R12 was hospitalized after admission due to right hip surgical infection and was readmitted to facility 7/08/12.

R12's 7/08/12 hospital discharge summary includes; admitting diagnosis chronically infected right total hip arthroplast and had surgical intervention on 6/26/12 to irrigate and debried the hip. On 7/08/12 R12 was observed to have some quadriceps weakness distally. The discharge activity section documents "can be weight bearing as tolerated on right lower extremity assuming her quad function returns."

R12's 7/12/12 Physical therapy (PT), plan includes; unable to ambulate at this time, transfer with knee immobilizer and 2 person assist.

R12's 7/16 - 7/23/12 PT note includes; "Must wear knee Immobilizer."

R12's 8/20 - 8/27/12 PT notes include; Poor standing balance and pain with activity.

R12's 7/25/12 physician order include right knee splint to be worn for all transfers.

R12's 8/30/12 fall incident report includes;
On 8/30/12 at 2PM in the shower room, R12's right knee buckled while standing on a scale. R12 was being weighted by E5 (certified nurse aide), without a right knee immobilizer in place and R12

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F9999	Continued From page 22	F9999		

told E5 that her right knee was not locking in place, prior to falling. R12 immediately complained of severe right knee pain, sent to the hospital and diagnosed with displaced transverse fractures of right tibia and fibula.

R12's incident report included Z2 (physiatrist / medical director), spoken to about this fall incident and Z2 indicated the lack of immobilizer use does cause harm and can put R12 at a risk for falls.

E5's personal file includes an 8/31/12 written counseling for failure to follow transfer precautions as listed in the plan of care when weighing a resident (R12). E5 wrote a response on the counseling form, to include ; E5 was unaware of the splint and did not see it.

During 5/09/13 9AM interview, R12 stated she will never forget the 8/30/12 fall incident and how painful it was. R12 said a "little nurse aide was trying to get me on the scale, without using a gait belt, she could not hold me up and dropped me." R12 also said "I told her (E5), my knee had to lock before I could stand and it hadn't." I was so scared and in so much pain. I broke two bones in my knee from that fall. I also developed foot drop in my right foot since the fall from bedrest and the long casts I had to have. It has taken a long time to heal and I would have been out of here a long time ago if it hadn't been for that fall." R12 also said that E5 was fired by facility related to her dropping her on 8/30/12.

E5's personal file included an "Employee Separation Report" dated 10/11/12 includes last date worked was 9/08/12. The reason

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F9999	Continued From page 23 documented for E5 being terminated, was E5 did not work when scheduled and did not respond to facility phone calls. During 5/09/13 3:15PM interview, E9 (therapy manager), said prior to R12's 8/30/12 fall, R12 was assessed to have 3 out of 5 (fair strength in right knee and ankle) and no right heel cord contractures or foot drop. On 7/08/12 readmission, R12's right knee was a 0 / 5 (no strength), so we obtained an order from the doctor for a right knee immobilizer. R12 was to use the right knee immobilizer whenever out of bed. E9 said that R12's right ankle was always tight but she did not have right foot / ankle contractures or foot drop prior to the 8/30/12 fall incident, which she now has. On 5/09/13 at 9AM, R12 observed in bed, alert and oriented to time, place and person. R12 was in good spirits and said that she frequently has a lot of pain in her right knee and foot / ankle. R12's right foot was observed to be in constant extension and with presence of foot drop. R12's care plan on 8/30/12 did not include use of right knee immobilizer, as ordered or two assist as noted by PT. R12's care plan did include use of a gait belt during transfers and assistance as needed. (B)	F9999		