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 _____	04/16/2007

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 496	Continued From page 105 The examples include: During the record review of the facilities Health Care Worker Background Checks on 4/6/07 at 10:30 am. Ten CNA's files were reviewed for registry verification. One employees file reviewed did not have a CNA registry verification. Registry verification report found in E 7's file documented "No records on the Nurses Aide Registry found for E 7." During the review of the 10 Health Care Worker Background Checks on 4/6/07 with E 6 (Personal Director) at 10:30 am, E 6 said E 7 (CNA) was hired on 8/21/06. I did check the Nurses Aide Registry at that time but it was not on the registry. E 7 brought in a verification at a later date stating she had passed the exam but I did not copy it because I trusted her. I forgot to recheck the registry after that.	F 496		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)6) 300.1220b)2) 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with	F9999		

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F9999	Continued From page 106 each resident's comprehensive assessment and plan of care. 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determing care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.	F9999		

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F9999	Continued From page 107 These requirements are not met as evidenced by: Based on interview and record review the facility failed to: 1. Supervise and monitor residents to prevent falls. 2. Analyze circumstances and/or reasons for falls. 3. Implement interventions to prevent further occurrences of falls. This is for 2 residents in a sample of 15 (R23 and R19) and 1 resident outside of the sample (R100). These failures resulted in R23 sustaining multiple fractures and a head injury and R100 sustaining skin tears and fracture of the hip. Findings include: 1) Review of admitting Minimum Data Set (MDS) dated 7/6/06 shows that R23 is 79 years old and was admitted to facility on 6/24/06 with diagnosis including diabetes, hypertension, osteoporosis and emphysema/COPD. This MDS shows that R23 is alert and orientated and requires extensive assistance for transfers and for the use of the toilet including one person physical assist. The MDS also notes that R23 has unsteady gait. R23 is 61 inches tall and weighs 84 lbs, per MDS, and has fallen in the past 30 days. The Resident Assessment Protocol (RAP) dated 7/6/06 shows that the RAP assessment documentation in the area of falls can be found in the nurses note dated 6/25/06. This nurses note is not an assessment summary but rather the	F9999		

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F9999	Continued From page 108 nursing entry for R23's first fall. The following is a list of falls R23 sustained between 6/25/06 and 7/29/06 as documented in R23's nurses notes: 6/25/06 8:00pm found beside the bed 7/6/06 4:00am found lying on the floor by the bedside 7/8/06 3:40pm found on bathroom floor 7/14/06 7:45am found in sitting position on floor. Housekeeping staff reported R23 was using the wheelchair as a walking device. R23 stated she was trying to get to washroom. 7/14/06 4:00pm found on floor beside bed. R23 stated she needed to go to the bathroom. Skin tear on arm. 7/15/06 12:00am found lying on bathroom floor around 11:30pm. R23 states has pain in lower back right on the pelvic bone. R23 sent to hospital. Nurses note dated 7/16/06 states R23 sustained compression fracture to T12 and L5 in addition to a head injury as a result of the fall on 7/15/06. R23 was readmitted to facility on 7/16/06 at 4:30am. Upon return R23 was noted to have bruises to the left lower leg and ankle and right upper thigh. R23 was hospitalized 7/19/06 to 7/28/06 for pneumonia, readmitted to facility on 7/28/06. 7/29/06 8:30pm R23 was seen by sitter on the floor inside R23's bathroom. Sent to hospital. R23 sustained an impacted fracture involving the right distal radius as a result of the fall on 7/29/06. Nurses note dated 7/30/06 at 12:00am (midnight) state R23 was readmitted back to facility and now is also complaining of hip pain. There is no further assessment of this complaint	F9999		

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F9999	Continued From page 109 of hip pain nor specific mention of it throughout 7/30 and into 7/31 when, at 10:00am, the nurses note states a call was placed for an x-ray to the right hip. During this time frame there is no documentation in the medical record referring to R23's mobility, if she remained in bed, how she responded to bed mobility, i.e., turning or repositioning or how R23's toileting issues were met. The x-ray was obtained at 3:00pm on 7/31/06 per nurses note which goes on to document that the physician and family member were notified on 8/1/06 at 11:00am of the x-ray results. Review of facility incident/accident notification dated 8/31/06 states that this report is an addendum to the incident faxed to IDPH on 7/29/06 in which R23 sustained a right wrist fracture. R23 now has an incomplete intertrochanteric fracture of the right hip and multiple end plate compression fracture of the lumbar spine which was sustained on 7/29/06, x-rayed on 7/31/06 and the results not obtained until 8/1/06. R23 was discharged to the hospital on 8/1/06 and did not return to facility. Review of admitting care plan dated 6/24/06 in the area of falls states R23 is at risk for falling due to unsteady gait/poor safety awareness/history of falls. The goal is for R23 to remain free of injury through 9/24/06. There are multiple approaches listed on the care plan such as verbal reminders not to ambulate without assistance, observe frequently and place in supervised area when out of bed, call light within reach, equip with device that monitors rising, low bed, falling star program, move bed closer to door. There is no indication in record that these approaches were monitored for their effectiveness after any of the multiple falls R23 sustained, nor was there an analysis of the	F9999		

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F9999	Continued From page 110 circumstances surrounding R23's falls to assist staff in developing individualized interventions in an attempt to prevent R23's falls. Interviews with E1, E2, and E3 during the course of the survey stated that, as with other residents in facility who sustained falls, the circumstances surrounding the falls have not been analyzed to determine if there are any trends to the falls such as residents trying to toilet themselves. Incidents/falls in the facility have not been tracked and/or trended in order to assist staff in developing individualized approaches to plans of care for residents at risk of falling. 2) R100's closed record review showed that R100 was admitted to the facility on 7/30/06 with diagnoses including Cellulitis, Hypertension, and Hip Replacement. Incident report review showed that R100 had a fall on 10/20/06 with resultant skin tears to the head, right shoulder, left hand, and a bruise to the bridge of his nose. Another incident report dated 1/29/07 showed that R100 was found on the floor with skin tears to bilateral hands, hematomas to the right lower leg and left knee, and a left hip fracture. R100's medical record showed no documentation that R100's fall were analyzed to see why R100 was falling. R100's Falls RAP summary was brief and inconclusive. It did not address R100's history of falls or the circumstances/reasons relating to the history of falls. R100's fall assessment dated 1/02/07 was blank. A nurses note on the fall assessment form did not mention falls or fall risks. Review of R100's plan of care for falls showed no added, updated, or changed interventions to prevent further falls.	F9999		

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F9999	Continued From page 111 3) Review of R19's plan of care, fall assessment, and resident assessment protocol dated 3/17/07, showed the facility failed to develop an individual plan of care, fall assessment, or comprehensively assess R19 for falls or nutrition. R19's plan of care documents for falls to have a chair and bed alarm on at all times, push the bed up against the bookshelf. On 4/4/07, 4/5/07, and 4/6/07 at various times of the survey, R19's bed/chair alarm was not connected. R19's fall assesment scores him as 15 which indicates he is a high for falls, he has a history of falls. During an interview on 4/5/07 with R19's family members, they stated the facility told them to hire a sitter at night so he won't fall. We did hire a sitter for 12 hours every night because before we hired the sitter he almost fell climbing out bed to go to the bathroom. The facility brought him to the nurses station and he sat up awake all night because they don't have enough staff to monitor him. The facility then pushed the bed against the bookshelf to prevent him from from being able to climb out both sides and then yesterday (4/407) E2 (Asst. Administrator) and E4 (ADON) told us that the state will not allow his bed to be pushed up against the bookshelf or put restraints on him, the state would rather see him fall, but they have been pushing his bed against the bookshelf until now. It is because you are in the building and we have never seen so many staff members come into the room to check on him. Review of R19's fall assessment which scores: 10 or greater= high risk, R19 is scored a 15- high risk. The facility has not had a care plan meeting with the family to discuss this situation, attempted to develop any other interventions to prevent falls. My husband has a history of falls, one hip is frozen and the other hip has had a fracture, I	F9999		