STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510115	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARENDALE OF MOKENA	21536 SOUTH WOLF ROAD MOKENA, IL 60448

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A 000	Initial Comment Annual Licensure Survey --295.3000 a) h) 3) Personnel Requirements, Qualifications and Training --295.4010 a) d) e) Service Plan Complaint # 190441 Unsubstantiated-No violation	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: General Violation Section 295.3000 a) h) 3) Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) h) The establishment shall have sufficient personnel to provide the following for its current resident population: 3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis. This requirement is not met as evidenced by:	A3000		

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A3000	Continued From page 1 Based on record review and interview the facility failed to Adequately assess residents for falls, failed to provide sufficient and adequately trained staff to monitor residents and prevent falls, and failed to follow up on residents with change in condition. These failures affected 3 residents (R1, R2 and R4) in the sample of 7 reviewed for falls and care needs and has the potential to affect all residents in the facility. Findings include: 1). R1, a resident in Memory Care (MC) was admitted with diagnoses that included "History of Falls". R1's 1/19/25 and 2/26/25 Health and Service Evaluation assessed the resident as having "very mild cognitive decline", requires extensive assistance with transfers. Both assessments indicated R1 was a high fall risk had who experienced several falls in the 90 days prior to the two assessments and had a shuffling, unsteady gait. Review of incident reports and progress notes showed the resident fell 18 times from 1/8/25 through 5/27/25. Incident Reports showed the resident fell 9 times on the night shift and 6 times on the day shift. Progress Notes documented 3 falls not identified on the incident reports. R1's service plan wasn't revised with new interventions developed and implemented to address the multiple falls. On 6/9/25 at 1:45PM E2 (Resident Care Director) stated R1 had begun to decline while living in Assisted Living (AL) and was ultimately transitioned to Memory Care (MC) where he received physical therapy and had a sitter supplied by R1's family. When R1 continued to fall even with the sitter, ED and facility informed	A3000		

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A3000	Continued From page 2	A3000		

his family the resident needed a higher level of care. E2 denied the resident having had serious injuries from his falls. R1 was later discharged from MC to another facility.

On 6/11/25 at 3:40PM E2 (Resident Care Director) stated R1's mattress had been changed, staff uses a Broda Chair, pillows under his legs and staff lays him down twice daily after he's gotten up in the morning.

2). R2 was admitted with diagnoses including Parkinson's Disease, Dementia, Restlessness and Agitation.

R2's 4/1/25 Health and Service Evaluation indicated the resident had a current or history of poor judgement, had a moderate cognitive decline had fallen within 90 days prior to this evaluation and was a high risk for falls.
Review of incident reports and progress notes showed R2 fell 12 times from 1/29/25 through 5/20/25. Incident Reports documented the resident fell once on the night shift and 7 times on the day shift. Progress Notes documented R2 fell 4 times that weren't addressed on incident reports.

Progress notes show R2 fell on 3/17/25 at 9:00AM, hit her head, received a small puncture to the top of her head with bleeding, was transferred to an area hospital for evaluation and returned with 9 staples in her head.

Staff failed to address/assess R2's head wounds and staples after her return to the facility until3/26/25 when Z1 (Nurse Practitioner/NP) stated R2's scalp appeared tender, and she would remove the staples 3/28/25. This entry is the only mention of the resident's scalp or

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A3000	Continued From page 3	A3000		

staples, nor is there any assessment of the resident's scalp wound or staple removal by the facility's nurses.

R2's service plan wasn't revised with new interventions implemented to address the multiple falls.

On 6/11/25 at 3:40 PM E2 (Resident Care Director) identified interventions used for residents who are high risk for falls which included making sure the resident wears appropriate shoes, medications are assessed, physical therapy is initiated, encouragement to use their walker or wheelchair, to use their call pendent for help before trying to get up on his or her own.
When asked for a copy of the facility's fall prevention policy E1 (Executive Director) and E2 presented a Fall Management policy which addressed care and treatment to be used after a resident falls. E2 stated the facility doesn't have a Fall Prevention policy.

On 6/11/25 at 4:30PM this surveyor observed R5 and R6 in the dining room eating dinner. Both were alert and non-interviewable.

On 6/11/25 at 4:45PM E5 (nurse) stated R1 was confused, not interviewable , not ambulatory and needs a wheelchair to transfer to the toilet with assistance. R1 wouldn't be able to remember instructions including calling for help.

E5 continued on to say most of R1's falls occurred in his room. R1 uses a Hoyer lift and tries to get out of bed on his own. R1will sometimes crawl to the bathroom now has a scoop mattress. He doesn't know how the use the call pendent. To prevent him continuing to fall

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A3000	Continued From page 4	A3000		

staff checks him more often, get him up first in the mornings, now has a fall mat. R1 had skin tears due to wheeling himself and scraping his arms on the door frames, parts of his wheelchair. R1 is now sitting in a Broda chair.

On 6/11/25 E12 (QLS/Quality of Life Specialist) stated R5 is alert but doesn't talk. He likes to slide down in his chair onto the floor and even though he's now using a recliner he still tries to slide to the floor. To try to prevent more falls staff keep him active, use pillows when he's in bed. R5 believes he can use his call pendent.

On 6/10/25 at 11:30 AM E3 (Director of Memory Care) stated the facility uses 12 hour shifts: 7:00AM-& 7:30PM and 7:00PM-7:30AM. On the 7:00AM-7:30PM shift there are 2 caregivers and 1 "float" and on the 7:00PM-7:30AM shift there are caregivers. There is 1 nurse each shift with the 7:00PM-7:30AM nurse also covering the Assisted Living (AL) and Memory Care (MC).

3). R4 was admitted to the facility with diagnoses including Osteoarthritis, Low back pain, History of falls and Pacemaker.

Review of R4's progress notes showed the facility's failure to address the presence of his pacemaker, care and monitoring of the pacemaker.

Progress note of 5/7/25 documented R4 became lethargic and had 2+ bilateral leg edema and had a blood pressure of 81/41mg/hg. R4 refused to go to a hospital for evaluation. There was no further assessment /mention of the resident's lethargy, leg edema nor his low blood pressure.

Progress note of 6/11/25 documented R4's

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A3000	Continued From page 5 inability to stand, transfer himself and documented the resident's pain. As stated by R4 he'd had an "outpatient spinal injection" on 6/10/25 that affected his ability to stand. Staff failed to address the resident's pain and inability to walk after the entry on 6/11/25.	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation 295.4010 a) d) e) Service Plan a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). This requirement is not met as evidenced by:	A4010		

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A4010	Continued From page 6 Based on record review and interviews the facility failed to revise, develop and implement individual service plans for residents who fall. These failures affected 2 residents (R1 and R2) in the sample of 7 reviewed for falls and has the potential to affect all residents assessed as at high risk for falls. Findings include: 1). R1 was admitted with diagnoses that included "History of Falls". Review of incident reports and progress notes showed the resident fell 18 times from 1/8/25 through 5/27/25. While the service plan currently in use identified the resident as having a potential or actual risk for falls the facility failed to revise, develop and implement additional individual interventions when it became obvious those interventions in place at the times of the falls were not effective. 2). R2 was admitted with diagnoses including Parkinson's Disease, Dementia, Restlessness and Agitation. Review of incident reports and progress notes showed R2 fell 12 times from 1/29/25 through 5/20/25. Progress notes show R2 fell on 3/17/25 at 9:00AM, hit her head, received a small puncture to the top of her head with bleeding, was transferred to an area hospital for evaluation and returned with 9 staples in her head. Review of R2's current service plan showed the service plan currently in use identified the	A4010		

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A4010	Continued From page 7 resident as having a potential or actual risk for falls, but the facility failed to revise, develop and implement additional individual interventions when it became obvious those interventions in place at the times of the falls were not effective.	A4010		