STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

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S 000	Initial Comments Statement of Licensure Violations Complaint Investigations 1894251/IL103813 1894525/IL104099	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 Licensure Violations 300.1010h) 300.1210b)c) 300.1210d)3) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 1	S9999		

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' respective resident care plan.

Section 300.1210 General Requirements for Nursing and Personal Care

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining 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.

These regulations were not met as evidenced by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 2	S9999		

Based on interview and record review, the facility failed to follow the plan of care and monitor the side effects of constipation a opioid pain medication and failed to monitor the effectiveness for use of a laxative to reduce the risk of constipation for 1 of 4 residents reviewed for opiod use and constipation. This failure resulted in R2 being sent to the local hospital and assessed and treated for Dehydration and Abdominal pain with Constipation / Opioid-Induced Constipation.

Findings include:

On 7/9/18, review of R2's medical record showed that R2 was admitted to the facility on 5/18/18 with diagnosis that includes and not limited to Lack of coordination, Bacteremia HIV (Human Immunodeficiency Virus) Disease, Anemia, Nausea, abnormal Gait and mobility, use of Anticoagulants, Long Term use of Antibiotics and Obstruction of Bile Duct. R2 was discharged to a local hospital on 6/15/18.

Review of R2's hospital record shows that R2 was admitted with diagnoses that includes but not limited to Acute Kidney Injury, Dehydration and Abdominal Pain with constipation/Opioid-induced Constipation.

Review of R2's medical record MAR and Physician Orders showed that R2 was on pain medications that has the potential side effect of causing constipation. R2 was also on medication to enhance bowel movement to treat the constipation. R2's complaints of constipation was not properly followed up or communicated to the hospice care nurse or the physician. R2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(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) COMPLETE DATE
S9999	Continued From page 3	S9999		

complained of stomach pain and pain medication was recorded given with no documentation of assessment for constipation.

Review of MAR dated 5/1/2018 - 5/31/2018 showed that Senna tablet 8.6mg two tablets was ordered 5/18/18 to be given every 24 hours as needed. And in June 2018, Bisacodyl suppository 10mg was ordered 6/13/18 to insert one suppository rectally every 12 hours as needed for bowel movement. The MAR did not show that Bisacodyl suppository was administered before R2 was discharged to the hospital.

Review of MAR dated 5/1/2018 - 5/31/2018 showed that Senna tablet was only given once on 5/25/18 at 2250 (10:50pm) and documented that it was effective. In June it was recorded given on 6/8/18 and 6/12/18 with effectiveness recorded as unknown.

Review of R2's medical record Progress note did not show any documentation that showed that R2 was assessed by the floor licensed nurses assigned to R2 for complaints of constipation or any encouragement to increase fluid intake.
On 7/9/18, the facility was unable to provide any communication book for continuity of care for R2. V4 ADON (Assistant Director of Nurses) stated I looked for it and was unable to find it now will continue to search for it. V10 (Restorative/Clinical Support Supervisor) stated the hospice communication book is supposed to be at the nurses station for the nurses. After searching, V10 then stated I will have to let V4 know about it.

On 7/10/18 at approximately 3:02pm, during interview with V9 LPN (Licensed Practical Nurse) who was assigned to R2 at the time of transfer to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(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) COMPLETE DATE
S9999	Continued From page 4	S9999		

the local hospital. V9 stated (R2) attributed the care rendered to R2 to R2 signing for hospice care stating the family wanted a lot more to be done for (R2). V9 acknowledged that V9 did not check for R2's last BM (Bowel Movement). V9 explained that (V9) was not trained on hospice care.

Review of R2's medical record progress note dated 6/15/18 timed 19:29 (7:29pm) V9 documented that R2 complained that R2 did not have any bowel movement for one week.

On 7/11/18 at approximately 3:43pm, V34 (Physician) stated that on 6/6/18 (V34) followed up on R2 for admission assessment because (V34) was notified that R2 will be discharged. V34 stated I had to see R2 that day. V34 stated R2 is very ill with end stage cancer and it will not be advisable to have R2 live alone or with V28 (Family) who will be gone most of the time. V34 stated I made a suggestion to R2 to consider Hospice care because they have good resources to care for R2's needs. V34 explained that R2's family (V28) were notified of this and R2 was evaluated for hospice care and was admitted. When V34 was asked about the responsibility of the facility in taking care of R2's symptoms of side effects of medications that includes but not limited to dehydration and constipation despite being on hospice care. V34 stated the facility should still take care of every concern verbalized or noted, V34 stated R2's hospital record was reviewed and medications were continued. V34 explained that for constipation, medications and offer fluids for dehydration. V34 explained that oftentimes no invasive procedure is recommended.

On 7/10/18 and 7/11/18, the facility was still

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(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) COMPLETE DATE
S9999	Continued From page 5	S9999		

unable to provide hospice communication book, V3 DON (Director of Nurses) stated the contracted Local hospice services agent did not leave their books (referring to communication form) with us but I will try and get it.

On 7/16/18 at approximately 11:15am, both V1 and V3 stated they have being trying to get the Hospice communication book. Both V1 and V3 stated the resident has the right to change his or her mind after signing for a treatment or care. V3 stated the nurses are responsible for assessing for symptoms and proper nursing care concerning any complaint of illnesses.

Review of R2's plan of care under Focus documented that R2 has potential for constipation initiated 5/30/18 and under Goal pointed out goals that includes but not limited to R2 will show no sign and symptoms of constipation and will have regular bowel movement. And interventions / tasks pointed out to administer meds (medication) for constipation per Medical Director Order, to monitor for signs of constipation that includes but not limited to decrease bowel sounds abdominal pain, distension, decrease in appetite and fever. This plan of care was not followed.

(B)

2 of 2 Licensure Violations

300.610a)
300.1210b)
300.1210d)6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

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S9999	Continued From page 6	S9999		

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. Restorative measures shall include, at a minimum, the following procedures:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

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S9999	Continued From page 7	S9999		

Section 300.1210 General Requirements for Nursing and Personal Care

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 regulations were not met as evidenced by:

Based on interview and record review the facility failed to monitor kitchen utensils from being utilized as tool to unscrew window saftey screws and failed to monitor the stock piling of linen to use as an escape device to leave through the window on the third floor nursing unit for 1 of 3 residents reviewed for safety and monitoring. This failure resulted in R7 leaving through a window on the third floor falling to the ground and being pronounced dead at the local hospital. The facility also failed to follow the manufacture recommendation and plan of care of utilizing (2) person assist for transfers utilizing the mechanical lift during a transfer for 1 of 4 residents (R4) reviewed for safe tranfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(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) COMPLETE DATE
S9999	Continued From page 8	S9999		

Findings include:

On 7/11/18, review of R7's medical record admission record indicated that R7 was admitted to the facility on 11/22/17 with diagnosis that includes but not limited to Cirrhosis of Liver, Ascites, essential Hypertension, Atherosclerotic Heart Disease, Angina Pectoris, Ischemic Cardiomyopathy, Type 2 Diabetes Mellitus, Congestive Heart Failure and Dementia with behavioral Disturbances. Per facility report R7 was found outside adjacent to the building with sheets tied together from the 3rd floor window to the ground. R7 was transferred to a local hospital where R7 was pronounced dead.

Review of R7's medical record documented that R7 is a high functioning, alert and oriented to time place and persons. R7 has a behavior of taking things that belong to other residents. R7 was a full code, attempt CPR (Cardio Pulmonary Resuscitation).

During this investigation, V16, V17, V18, V20, V21, V22 CNA (Certified Nurse's Aides), V19 and V23 LPN (Licensed Practical Nurse) were interviewed concerning any behavior, signs that can indicate that R7 is planning to escape. They all described R7 as pleasant, very helpful, and compliant with care regimen. V16, V17, V18, and V19 stated on the day of incident R7 did not show any sign of depression or being sad. V18 and V23 stated R7 went about the day in the regular way through-out the night there was no abnormal behavior that will make them suspect that R7 is sad or depressed or planning to escape. V18 assigned to R7 explained that she worked a double shift from 3:00pm 7/10/18 to 7:00am 7/1/18. V18 stated I did not suspect that R7 was going to escape. V18 stated that R7 was last

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

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S9999	Continued From page 9	S9999		

seen at around 10:00pm on 7/10/18 when R7 was going to bed and was asleep till around 4:00am when R7 woke up and went in the TV (Television) room watching TV. V18 stated that she asked R7 about the program R7 was watching and R7 responded that there no other program to watch. V18 explained that she then started assisting other residents.

V18 stated around 5:00am or 5 something (unsure of the exact time), V18 heard V23 screaming and calling V18 and V23 informed V18 that R7 had fallen out of the window. When asked about what V18 saw in R7's room, V18 stated the window to R7's room was opened and sheet (Linen) was tied to the bed and out of the window. V18 stated I saw R7 laying on the grass.

V18 further explained that she did not see R7 picked up linens and did not know where R7 got all the linens from.
On 7/11/18 at approximately 7:25pm, V20, V21, and V22 (CNA)'s stated the rounds are supposed to be made every one to two hours to make sure the residents are accounted for with incontinent care done at the same rounds. They all stated the linens are kept in the linen cart in the hallways on all the floors, and the residents are not allowed to get into the carts by themselves to get linens.

On 7/12/18, V16, V17, V18, V19 and V23 stated they did not hear any noise to indicate that R7 was trying to escape through the window.

Random observation on 7/11/18 and 7/12/18 showed linen carts in the hallways unattended to. Interview with V15, V17, V18, V19, V20, V21, and V22 (CNA), they all acknowledged that the linens are kept in the linen carts in the hallway. They all stated that the residents are not supposed to go

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(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) COMPLETE DATE
S9999	Continued From page 10	S9999		

in the linen cart without supervision.
Review of R7's medical record did not show any record for risk of elopement assessment until after the incident on 7/11/18.

On 7/11/18, V14 (Memory Care Director) presented R7 behavior Assessment sheet dated 7/11/18. V23 stated that the only behavior assessment done was done 7/11/18 after (R7) went out of the window. V14 stated R7 expressed wanting to go and visit friends.

Review of the facility surveillance video cameras shows that the cameras were centered only at the nurse's station not in the hallways. V1 (Administrator stated) this was designed to monitor the staff to make sure the rounds are being made. The back door camera did not show who is leaving or coming in through the back door.
Review of R7's plan of care initiated 11/25/17 with target date of 8/29/18 documented under goals that R7's goal includes but not limited to being able to get home to visit with his friends, this goal was not individualized in care plan for desire to go home and how R7 will achieve this.

R7's plan of care for discharge initiated 12/01/2017 for returning to community where R7 lives with friends, this was marked D/C (discontinue) with remarks that pointed out that this is not feasible due to the assistance R7 needs and for safety reasons manifested by Dementia.

On 7/11/18, V14 (Memory Care Director) presented R7 behavior Assessment sheet dated 7/11/18. V23 stated that the only behavior assessment done was done 7/11/18 after (R7) went out of the window. V14 stated R7 expressed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(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) COMPLETE DATE
S9999	Continued From page 11	S9999		

wanting to go and visit friends was not addressed as a problem because R7 did not exhibit any behavior previous to this incident to indicate any suspicion of elopement.

On 7/11/18, observation of R7 room with V1 (Administrator), V1 stated the room has been cleaned with all furniture put back into place after the local law enforcement department inspected the room. V1 stated that R7 attached (tied) the linen sheet to the bed and open the window, bursting out the window and went out of the window. V1 stated no one knows how R7 got the linens tied together in going out of the window. V1 explained that R7 must have somehow opened the locking system by sliding it, V1 was able to open the window easily. During this observation new screw-able nails were noted on the panel of metal used in holding the window together to the wall then V1 stated we have just repaired it, you (referring to Surveyor) can see the nails are new. When asked about how the facility monitors the safety features on the window V1 stated the staff monitors it daily.

On 7/12/18 at approximately 3:07pm, V1 informed the surveyor that the local law enforcement department wanted the facility to look for screws or any window brackets in R7's room and to notify the department when found. V1 then explained that a butter knife was found in R7's night stand and window locks were noted in the AC (Air-condition) unit. V1 stated we don't know how (R7) got the knife, but it seems (R7) used the knife to unlock the screws. V1 then added we have to start counting the utensils now. V1 further explained that R7's roommate stated R7 brought out the linens from under R7 bed so the linens will now be locked up on the 3rd floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(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) COMPLETE DATE
S9999	Continued From page 12	S9999		

V1 stated the staff did not know how R7 got the knife to un-screw the window nails. V1 stated we will now have to count the cutleries from down stairs (Referring to the kitchen) and when they are returned. V1 stated the linens will now be locked away and not placed in the hall way because R8 (Roommate) said R7 brought out the linens from under (R7)'s mattress.

On 7/12/18, V16, V17, V18 (CNA) and V19 (LPN) were interviewed concerning whether a code for elopement was called. They all stated it was not called that V23 (LPN) was just screaming.
On the 7/19/18 , V33 (Maintenance Director) and V2 (Assistant Administrator) stated that the linens are kept in the cart on all the floors but after the incident the carts are placed in locked coded room on the 3rd floor.

On 7/19/18 at approximately 11:27am, when V1 was asked about what the QA (Quality Assurance) are working on based on the incident with the securing of the window concerning the type of screw used to secure down the window. V1 Replied we are waiting on the decision from the cooperate office.

On 7/19/18 at approximately 12:23pm, the surveyor asked V26 how R7's need for wanting to visit friends was addressed, V26 stated R7 did not have any interventions for this.

The facility presented the Local Police Department's On Scene Investigation report dated 7/11/18 at 0800hrs (8:00am) that pointed out that R/D (Responding Detective) observed the following at the scene that includes but not limited to, a number of sheets tied together from the corner of (R7) bed frame extending out of window which was closed atop of sheets. Missing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(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) COMPLETE DATE
S9999	Continued From page 13	S9999		

metal clamps from the side of the window allowing full extension. The R/D was unable to locate any window brackets or screws.

According to the facility Final Investigation report presented, the facility concluded by pointing out that per police department (R7) appeared to have being planning his escape and had hidden his sheets tied together under (R7)'s mattress. The facility located butter knife in (R7)'s nightstand and the window safety locks stuffed down inside the heating/ cooling unit in (R7)'s room. No opportunities had been presented for the facility staff to have reasonably anticipated that this event.

On 7/9/10 at approximately 11:10am, V5 CNA (Certify Nurses' Aide) was observed in the room assisting R4 to transfer from bed into the wheelchair using a transfer mechanical lift device by herself.

At approximately 12:49pm, V5 was asked about use of Mechanical lift devices, V5 replied I'm supposed to use (have) two people (referring to staff) when using the mechanical lift device. V5 explained that the facility is short of staff on the floor and was waiting for V6 LPN (Licensed Practical Nurse) assigned with her to come because other CNA's were assisting with shower so she just did what she could by using the mechanical lift by herself before V6 came.

At approximately 12:58pm, V6 stated with use of mechanical lift device, two persons are needed. V6 acknowledged that R4 needs two person assist for transfer. V6 explained that when (V6) walked into the room V5 was transferring R4 by herself.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(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) COMPLETE DATE
S9999	Continued From page 14 Review of R4's MDS (Minimum Data Set) section G dated April 17, 2018 showed that R4 was coded 4/3 for transfer, pointing out that R4 is totally dependent on full staff performance every time and with two plus physical assistance. And under G0400 for functional limitation in range of motion was coded 2 for both upper and lower extremity which placed R4 as a risk for injury. Review of R4's plan of care with initiated date of 1/22/ 17 and target date of 4/30/18 pointed out that R4 requires use of mechanical lift with 2 assist for transfer. And under interventions/ task it indicated to provide 2 staff assistance for transferring. This plan of care was not followed putting R4 at risk for injury. On 7/10/18 at approximately 2:16pm, V10 (Restorative / Clinical Support Supervisor) stated that at least two staff are needed to prevent fall and injury. The facility policy on Total Mechanical Lift dated 5/16 pointed out under equipment that 2 (two) caregivers are required to operate the mechanical lift. This guideline was not followed. (A)	S9999		