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 01/15/2021

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 Complaint Investigation: #2190076/IL129955 #2098764/IL128410	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210d)3) 300.1210d)6) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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.
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 requirments are not meet as evidenced by:

Based on interview and record review the facility failed to have specific and effective interventions in place for a resident who was cognitively impaired and at high risk for falls; the facility also failed to assess the resident after a witnessed fall. This failure resulted in one resident (R1) being sent to local hospital six days after a fall and was diagnosed with a left hip fracture.

Findings include:

R1 is an 85 year old female originally admitted on 12-8-2019 with medical diagnosis that include and are not limited to: Dementia, Alzheimer's disease, transient ischemic attack (TIA) and Cerebral infarction, R1 was sent to the hospital on 9-14-2020 and on 9-16-2020 had a left hip hemiarthroplasty.

1-12-2021 at 2:45pm V1 (Administrator) said, I did not conduct the investigation for R1 because that is a nursing responsibility since it was a fracture. I was informed that R1 had a fracture but I do not remember the reason for the fracture.

1-12-2021 at 3:20pm V2 (Director of Nursing)

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S9999	Continued From page 2	S9999		

said, I do remember (R1) a patient from the third floor, confused, ambulatory without any devices. I did not investigate R1's fracture, the prior Director of Nursing is here and she is the restorative nurse now; she was the one that investigated the fracture and I was not privy of the findings.

1-12-2021 at 3:50pm V3 (Former Director of Nursing/ Current Restorative Nurse) said, I did the investigation for R1's left hip fracture, we do not know what happened. R1 was demented, unable to follow any directions. R1 was very active walking independently without any assistive devices, no walker, in the hallway and going into other patient's rooms. On 9-8-2020 R1 was observed by V11 (Licensed Practical Nurse) and V19 (Certified Nursing Assistant) to ease herself down to the floor on her knee, it was not a fall. R1 was assisted to standing position by the two staff members, V11 failed to document in the progress notes what had happened with R1, I do not have any documentation in the progress notes until 9-14-2020 that R1 was guarding her leg, we did a x-ray with abnormal results, R1 was sent out to the hospital and was admitted with left hip fracture. V3 reviewed R1's reportable investigation and said, I sent the reportable to IDPH; the initial and final. After V3 reviewed the investigation, pulled some documents out and said, these are my working documents it should not be here, these are the recommendations from the company's attorney for me to make some changes. V3 read the conclusion that indicated: R1 and her emergency contact POA informed that a complete body assessment revealed no other skin impairments. R1 and POA notified of the x-ray results, pain medication, plan of care and primary care physician findings. The facility determined the cause of R1's fracture was

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S9999	Continued From page 3 potentially related to an unwitnessed fall. 1-13-2021 at 9:30am V19 (Certified Nursing Assistant) said, I do remember R1, she was a third floor patient, demented, confused, wanderer. I saw R1 on the floor and V11 (Licensed practical Nurse) and I picked R1 from the floor. 1-13-2021 at 1:15pm V11 (Licensed Practical Nurse) said, I remember R1. On 9-8-2020 it was around lunch time, I was leaving another patients room when I saw that R1 was in the hallway holding to the hand rails and lowering herself to the floor, it was not a fall because she lowered herself to the floor. I called R1's name and asked her in Spanish if she was okay. R1 did not respond. At that time V19 came and assisted me to get R1 into a standing position and we walked back to the dining room. R1 was able to walk holding on to my arm with no visible discomfort. I did not make any documentation or any report to the supervisor because I forgot, it was a hectic day. One week later I was interviewed by V3 (Former Director of Nursing/ Current Restorative Nurse) and V10 (Assistant Administrator), they asked me if R1 had any falls and I told them no. Per record review, MDS (Minimum Data Set) assessment dated: July 8-2020 reads: walking; not steady, but able to stabilize without staff assistance with mobility devices: walker. BIMS (Brief Interview for Mental Status) reads 1/15 showing a severe cognitive impact. Care plan dated 12-9-2020 reads: (R1) is a high risk for falls related to poor safety awareness, unsteady gait and balance. Interventions include: 4-5-2020: notify family and Medical doctor of any new falls. Fall risk assessment dated: 7-2-2020 reads that R1 is at risk for falls with score of 6.	S9999		

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S9999	Continued From page 4 Facility policy- "Fall Management program" (dated: 8-2020) reads: the facility is committed to minimizing resident fall and/or injury so as to maximize each resident's physical, mental and psychosocial wellbeing, complete a fall risk assessment post fall. (B)	S9999		