Illinois Department of Public Health

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 ______	02/14/2024

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
S 000	Initial Comments	S 000		

Annual Licensure and Certification Survey

Complaint Investigations:
23910445/IL167816
2490255/IL168590

Facility Reported Incident Investigation of 9/5/23 - IL166186
Facility Reported Incident Investigation of 9/17/23 - IL166184
Facility Reported Incident Investigation of 10/22/23 - IL166187
Facility Reported Incident Investigation of 11/01/23 - IL167260
Facility Reported Incident Investigation of 11/19/23 - IL167271
Facility Reported Incident Investigation of 12/4/23 - IL168460

S9999	Final Observations	S9999		

Statement of Licensure Violations 1 of 3

300.3210a)
300.3210t)

Section 300.3210 General

a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of a facility. (Section 2-101 of the Act)
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

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S9999	Continued From page 1	S9999		

These regulations were not met as evidenced by:

Based on interview and record review facility failed to protect a resident from sexual abuse from another resident with a known history of sexually inappropriate behavior. This failure applied to two (R136, R585) of six residents reviewed for abuse and resulted in R136 being sexually abused by R585.

Findings include:
R136 is a 82-year-old female admitted to the facility on 4/20/2022 with diagnosis including but not limited to Alzheimer's Disease, Essential Hypertension, Dementia, and Cerebral Cyst.

According to R136's MDS (Minimum Data Set) assessment dated 09/22/2023 under section C, R136 has BIMS (Brief Interview of Mental Status) score of 2 indicating severely impaired cognition. According to R136's MDS (Minimum Data Set) assessment dated 09/22/2023 under section G, R136 required Total Dependence, Two+ person physical assist with bed mobility transfers. R136's care plan dated 01/18/2023 reads in part, "(R136) is at risk for abuse; Interventions: Check and assure physical comfort."

R136's Abuse Risk Assessment dated 09/22/2023 reads in part, "(R136) is at risk for abuse due to dx (diagnosis) of dementia."

R585 is a 87-year old male admitted to the facility 1/13/2023 with diagnosis including but not limited to Alzheimer's Disease, Dementia, Major Depressive Disorder, Hypertensive Chronic Kidney Disease, and Type 2 Diabetes.

According to R585's MDS (Minimum Data Set)

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S9999		S9999		

Continued From page 2

assessment dated 09/21/2023 under section C, R585 has BIMS (Brief Interview of Mental Status) score of 14 indicating intact cognition.

According to R585's MDS (Minimum Data Set) assessment dated 09/21/2023 under section G, R585 required Limited Assistance, One person physical assist with transfers.

R585's care plan dated 01/18/2023 reads in part, "(R585) is sexually inappropriate with staff; Interventions: Compliment resident for appropriate social interactions." No intervention pertaining to monitoring R585 noticed in the care plan.

R585's Abuse Risk Assessment dated 10/12/2023 reads in part, "Is there a history of/current socially inappropriate behavior? Yes."

R585's Psychiatric Progress Note date 09/26/2023 reads in part, "(R585) Previously hospitalized d/t (due to) auditory hallucinations, increase confusion, combative behavior, displays inappropriate sexual behavior."

On 02/06/24 at 12:59 PM Surveyor observed R136 in the dining room. Surveyor attempted to interview R136, R136 able to say "yes', and "no", and speaks only Spanish. Surveyor attempted to utilize Spanish translator; however, R136 did not answer when asked about the incident.

On 02/06/24 at 02:04 PM Surveyor interviewed V14 (Memory Care Director) who related the following in summary: I was notified of the incident on the morning of 10/23/2023. The incident happened over night from 10/21/2023 to 10/22/2023, and as a result, R585 was transferred out of the facility on 10/23/2023 to

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S9999	Continued From page 3	S9999		

provide safety to other residents. On the early morning of 10/22/2023, staff found R585 in R136's room. From what I was told, R136 was calling for help and when staff came into the room, R585 was seen pulling down R136's briefs but was fully clothed. R136 and R585 resided in two different hallways in the dementia unit. They had no know relationship. R585 had history of sexually inappropriate behavior, but only towards staff. R136 was assessed by the nurse on duty and there were no apparent injuries, so she was not sent out to the hospital. The doctor was made aware and assessed her on 10/27/2023.

On 02/06/24 at 04:23 PM Surveyor interviewed V1 (Administrator) who related the following in summary: There is no police report or hospital record pertaining to the incident involving R136 and R585 on 10/22/2023. We called V17 (R136's family) and gave details of the incident, we asked if they wanted police to be involved or if they wanted R136 go to the hospital, but V17 refused. V17 was mostly concerned about R585 being removed from the facility, which he was on 10/23/2023."

On 02/07/24 at 10:02 AM Surveyor interviewed V15 (Certified Nursing Assistant) who related the following in summary: I was working night shift on 10/21/2023 (11:00 PM to 7:00 AM). When Iwas rounding at the beginning of my shift, R585 was sitting in the wheelchair outside of his room. It was unlike him, so I encouraged him to go back to his room. I asked him why he's not asleep, R585 said, he was awake all day and doesn't feel sleepy, but went back into his room. I moved on and continued my rounds. At about 1:20 AM, I was sitting on my hall (highest numbers of 300 of the dementia unit). R585's room was in the

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S9999	Continued From page 4 adjacent hallway to where R136's room was located; I was assigned to the hallway where R136 was residing at the time. The first time, R585 attempted to come through the shower room. The shower room connects two hallways. One of those hallways was where R136' room was located. R585 made an echo when he was propelling through the shower room, so that's how I realized he was trying to get to R136's hallway. I said to R585, "I thought you were going to sleep? Are you ready to go back to your room?" R585 said "Yes". I pushed him back to his room. I closed the shower room doors, on both ends, and returned to my hallway. Around 2:30 AM, R585 propelled down his hallway, around the nursing station and down to R136's hallway. I didn't hear him this time; I just heard R136 saying, "No, no, stop, help!". R136 is quiet, she doesn't really talk, so when I heard her calling for help, it was different. R136 was clearly calling for help, that's what made me think something was wrong and I jumped and ran into her room. When I came in, I saw R585 in the bed, on top of R136. R585 had no pants, but his brief and t-shirt were on. R136's brief was off her and folded neatly underneath. I don't believe R585's private parts were out, but his hands were on his diaper, like he was trying to take it off. I separated them, said to R585 "stop it" and told him to get off R136. I helped R585 to his wheelchair. After that, I reported it to the nurse who met me in the hallway when I got him out of R136's room and pushing back to his room. I reported it to the unit manager and called V1 (Administrator) as well. The incident itself occurred around 2:30-3:00 AM, I called my immediate supervisor right away and V1 around 4:00 AM. V1 talked to me the following morning and I gave her my statement. There were four CNAs and two nurses on the unit that night. One nurse was in the nursing station and the other	S9999		

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S9999	Continued From page 5	S9999		

one was in another resident's room at the time of the incident. Not sure where were other CNAs. Nobody else responded but me.

On 02/07/2024 at 10:32 AM Surveyor interviewed V16 (Agency Registered Nurse) who related the following in summary: On 10/22/2023, I was working 11:00 PM-7:00 AM shift. V15 (CNA) was doing her round and came to let me know that R585 was on the top of another resident (R136) in her room. There was no roommate in R136's room at the time. V15 (CNA) said that R585 could not remove himself and that she needs help removing him off R136. R585 was clothed when I came into R136's room. R585 had his t-shirt, diaper, and shorts on. R136's brief was down, and she had her gown on. We placed R585 in his wheelchair and V15 (CNA) took him back to his room. I assessed R136; I performed head-to-toe assessment. I looked at R136 head, looked for any scratches or lacerations. I looked into her mouth, at her neck and shoulders. I looked at her abdomen and legs. Her brief was already pulled down, so I looked at her pubic area, as it was already exposed, but I didn't look between her legs. I moved down her legs, ankles, and feet. R136 doesn't speak but moans when in distress, she didn't display any sort of distress at the time of assessment. I documented it in the electronic medical record. Both residents were monitored for the remaining of the shift. The incident happened between 2:00 AM - 3:00 AM. I notified V21 (Clinical Leader) around 3:30 AM - 4:00 AM, I believe I left her a voicemail and texted her too. I didn't notify anyone else. I did not hear back from her or anybody else. This is the first time I'm giving statement about this incident. The facility never presented abuse policy to me, I'm not familiar with it. My agency provides abuse in-services, I did one in August 2023. We were

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S9999	Continued From page 6	S9999		

told to contact elderly services in case of knowledge of any adult abuse, but I did not contact them after this incident.

On 02/07/24 at 10:41 AM Surveyor interviewed V17 (R136's family) who related the following in summary: We visit R136 once or twice a week. R136 is not able to talk or have a conversation, she can only say "yes" and "no". The facility notified me, at the end of last year (2023), maybe in November, that somebody was trying to touch or hurt R136. They didn't tell me who was the perpetrator but told me that they were separating men to one side and women to the other side of the unit, and they were getting rid of the perpetrator. The facility never asked me if they can call police or send R136 to the hospital at the time of the incident.

On 02/07/24 at 11:03 AM Surveyor interviewed V18 (Medical Director) who related the following in summary: The facility notified me that R585 pulled brief off R136 and was on top of her, not sure the exact date, but I remember they called me in the morning. Staff talked to V17 (R136's family) and they refused to send her out to the hospital. They sent R585 to the hospital due to aggressive behavior. R136 was assessed by V16 (Agency Registered Nurse) and she appeared to be ok, had no injuries. I didn't feel like R136 should have been sent out to the hospital for further assessment. I see R136 every Friday, so I also assessed R136 on the following Friday (10/27/2023). R136 is demented, so she is not a good historian, and she is on hospice care. When residents are on hospice care, it is not recommended to send them to the hospital. I would recommend rape kit, if there were abrasions, or obvious signs of distress. In this case, R136 couldn't give us a statement and we

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S9999	Continued From page 7	S9999		

didn't see any signs of rape, so we didn't send her out for further evaluation.

On 02/07/2023 at 1:28 PM Surveyor interviewed V19 (Licensed Practical Nurse) who related the following in summary: The incident occurred in October of 2023. Upon beginning of my shift (7:00 AM), I was told by V16 (Agency Registered Nurse) that R585 went into R136's room and tried to get into bed with her. I sent R585 out to the hospital for inappropriate behavior from previous night at around noon on 10/22/2023. R585 was able to transfer out of the bed and into the wheelchair independently. R136's all needs were met with full assist from staff. R136 didn't really speak. When I assessed her on the morning of 10/22/2023, I looked for grimacing because that's how she displayed distress. I didn't talk to R136 about the incident.

On 02/07/2024 at 2:34 PM Surveyor interviewed V1 (Administrator) who related the following in summary: The incident occurred on the early morning of 10/22/2023. V15 (Certified Nursing Assistant) called me in the morning of 10/22/2023, not sure about exact time, it was early though. She said, she was doing rounds and heard R136 saying "stop" and went into her room. V15 saw R585 laying on R136 with her briefs down. I instructed V15 (CNA) to have R585 on 1:1 monitoring. I also called V16 (Agency Registered Nurse) and told her to do full body assessment. I arrived in the facility around 7:00 AM. I spoke to V19 (Licensed Practical Nurse), she said R585 was on 1:1 monitoring, and she was working on sending him out for change in behavior. I don't remember when V18 (Medical Director) was notified, but it was per her order, to send R585 to the hospital. After that, I started in-servicing staff on abuse. I also notified V14

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S9999	Continued From page 8	S9999		

(Memory Care Director) about the issue and called V17 (R136's family) to give them details. I asked if they want police to be involved or send R136 to the hospital, but they refused. I took a statement form V15 (CNA) and V16 (Agency RN) who were witnesses and additional staff who worked R585 and R136. General investigation for sexual abuse consists of removing perpetrator and initiation of investigation. I also report it to IDPH. The date and time of the fax confirmation is not accurate, it says I reported this incident the day before the incident occurred, it's inaccurate. There is no way to confirm the date and time of when this incident was reported. I called the facility to send a report before I arrived at the facility on the morning of 10/22/2024. I had no indication that rape, or penetration occurred in case of R136 and R585 based on staff's statements and assessment. Surveyor clarified if there was anyone in the room at the time of the incident to witness whether rape actually occurred, V1 stated that V15 (CNA) went in there right after she heard R136 screaming, and she didn't see R585 penetrating R136. V1 continued stating that V16 (Agency RN) is an appropriate person to conduct post sexual abuse assessment. Normally, we send sexual abuse victims to the hospital and involve local police, but in this case, R136 didn't have any injuries, so there was no necessity to send her out. I'm not sure when the rape kit should be done.

On 02/07/2024 at 5:20 PM Surveyor interviewed V27 (Assistant Director of Nursing) who related the following in summary: R585 was sexually inappropriate towards staff, flash his penis. We thought R585 knew what he was doing, he had dementia but was one of the higher functioning residents, that's why we were looking for placement for him. When R585 was sent out for

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S9999	Continued From page 9	S9999		

assessment after the sexual abuse incident involving R136 and himself, we refused to take him back because he already had a placement in a different facility."

4. Progress note dated 10/27/2023 written by V18 (Medical Director) reads in part, "Chief Complaint: follow up for Deconditioning, Dementia, Pacemaker, Unable to take care of herself. (R136) seen and evaluated today for follow up on Alzheimer's disease, hypertension, deconditioning, high risk for falls." No indication of assessment pertaining sexual abuse noticed.

Progress note dated 10/22/2024 at 11:36 AM reads in part, "(R585) sent out to (the local) hospital. Ambulance left at approximately 12:29 PM." R585 was transferred out of the facility approximately 10 hours after the incident occurred.
According to record review, no progress note nor assessment documented by V16 (Agency Registered Nurse) pertaining to R136's post incident assessment noticed in the electronic medical record.

V1 (Administrator) did not provided V16's (Agency RN) Sexual Assault Nurse Examiner certificate per surveyor's request.

V1 (Administrator) did not provide R585's 1:1 monitoring documentation per surveyor's request.

Abuse policy dated 09/2020 reads in part, "The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents. Sexual Abuse is non-consensual sexual contact of any type with a resident. This includes, but not limited to, sexual harassment,

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S9999	Continued From page 10	S9999		

Continued From page 10

sexual coercion, or sexual assault. Prevention: As part of social service assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on regular basis. Protection of Residents."

(A)

Licensure Violations 2 of 3
300.610a)
300.1210b)
300.1210c)
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

b) The facility shall provide the necessary care and services to attain or maintain the highest

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S9999		S9999		

Continued From page 11

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.

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, the facility failed to follow their policy and procedures for fall prevention by failing to implement personalized fall prevention interventions and failing to supervise a dependent resident with impulsive behaviors. These failures applied to three of 15 residents (R17, R73, R109, R535) reviewed for accidents/supervision and resulted in R17 sustaining a left femur fracture and R73 sustaining a subarachnoid hemorrhage.

Findings include:

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S9999	Continued From page 12	S9999		

R73 is a 73-year-old, male, admitted in the facility on 04/07/2017 with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side; Aphasia Following Cerebral Infarction; and History of Falling. Per MDS (Minimum Data Set) dated 09/08/23, R73 has BIMS (Brief Interview for Mental Status) score of 11, which means moderate impairment in cognition. According to incident report dated 11/19/23, V6 (Registered Nurse, RN) was notified that R73 had a fall in the smoking patio. V6 went to see R73 and was observed lying on the ground with his head pointed towards the left side of his motorized wheelchair. V7 (Activity Director) who was present at the time of incident stated that he started to tilt to the left and she (V7) tried to brace his fall but could not. Progress notes dated 11/19/23 indicated that he (R73) was not strapped in at the time of fall.

On 02/06/24 at 11:05 AM, R73 was observed smoking on the outside patio. R73 is alert, oriented, with right hand contracture. He had right above knee amputation. He is unable to talk and carry a full conversation but able to say yes or no, nods head, moves left hand and left leg and can communicate with gestures. He (R73) is using a motorized wheelchair and had the safety belt fastened and secured. R73 was asked regarding fall incident last 11/19/23. R73 communicated via gestures, that he was at the smoking patio, in his motorized wheelchair. He was repositioning himself in the wheelchair and slid. He also communicated that there were staff on the patio, and he tried to ask for help by raising his left hand, but staff did not respond.

On 02/06/24 12:05 PM, V7 (Activity Director) was interviewed regarding R73's fall last 11/19/23. V7 replied, "That incident with R73, it was the 11 AM

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 ______	02/14/2024

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		

smoke. I was the designated staff to supervise. I was lighting cigarettes of other residents. I was on the other side of the table where he (R73) was sitting. I noticed that he was actively tilting. I went there and not able to catch him on time. He fell. He didn't call my attention. He is non-verbal but he can raise his right hand for assistance."

Progress notes dated 11/19/23 documented that R73 was assessed and was transferred out to the emergency room for further evaluation and management.

R73's Hospital records under Trauma Progress Notes dated 11/24/23 recorded: Diagnosis: Acute right subarachnoid hemorrhage.
On 02/06/24 at 1:43 PM, V2 (Director of Nursing) was asked regarding R73. V2 stated, "They called me when that incident happened. V7 was with them. She (V7) was distributing the smoking materials like bib, cigarettes when he (R73) was tilting from the wheelchair. She (V7) was about to stop the fall but was too late. When I investigated, the seatbelt was loose when he was smoking outside. The order was to release it during activities. Smoking is an activity, so she (V7) kept it loose. R73 has a safety belt in his wheelchair. He slid from the wheelchair on his left side. He has poor trunk control related to hemiplegia on his right dominant side." A follow-up interview with V2 was conducted on 02/08/24 at 1:12 PM. V2 was again asked if R73's seat belt was loose at the time of incident. V2 stated, "His safety belt was totally released. It was totally not secured, it was released, it was not put on. V7 should be monitoring if his (R73) safety belt is on or secured and if he has a problem with repositioning. Designated staff during smoking should be closely monitoring residents, and should be in close contact to all the residents during activities

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 ______	02/14/2024

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	S9999		

or during smoking."

R73's POS (Physician Order Sheet) dated 02/22/22 documented: Self release safety belt while up in wheelchair, check and release every two hours and PRN (when needed), during activities and during meals.

V13 (Physician) was asked on 02/07/24 at 11:22 AM regarding R73. V13 verbalized, "He uses an electric wheelchair. During smoking, his safety belt should still be secured, not off, not loose. The expectation is that the belt helps him from falling out of the wheelchair. It should be secured/fastened during smoking since he is up in his wheelchair."

Care plan regarding at risk for falls dated 04/08/2017 documented interventions: R73 to be escorted to the patio and monitored while on the patio smoking.

R73 has a care plan formulated related to the use of self-release safety belt for medical reasons while up in the electric wheelchair related to poor trunk control.

2. R17 is a 66-year-old female with a diagnoses history of Fracture of Left Femur, Partial Paralysis due to Cerebrovascular Disease Affecting Left Non-Dominant Side, History of Falling, Generalized Anxiety Disorder, and Nicotine Dependence who was admitted to the facility 05/13/2019.

On 02/06/24 at 11:25 AM R17 stated she fell 2 to 3 months ago but has no memory of the fall. R17 stated she was on blood thinners, and her head filled up with fluid, so she was afraid touch it. R17 stated she also fell 6 months ago because she

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 ______	02/14/2024

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 15	S9999		

couldn't get any help when she needed it. R17 stated she broke her femur during the last fall.

R17 stated she had a metal rod in her leg and broke it because she fell so hard. R17 stated the doctors told her they had never seen anything like that. R17 stated she's a sleepwalker and wonders if she was trying to walk when she fell and broke her leg. R17 stated last night they put something on the right side of her bed so she couldn't move because she keeps leaning towards that side. R17 stated she's been in a lot of pain since her fall.

R17's current care plan initiated 05/23/2019 documents she has an ADL (Activities of Daily Living) Self Care Performance Deficit secondary to weakness, history of CVA (Coronary Vascular Accident) with left hemiplegia/limitation in range of motion, wheelchair being primary mode of locomotion, COPD/shortness of breath (continues to smoke), impaired balance, history of falls, occasionally incontinent, chronic pain and anxiety; has behaviors of not asking for help although she requires it, and often refuses help; her ADL's tend to fluctuate related to this behavior with interventions including: Encourage palm protector to left hand; Allow enough time for completion of ADL tasks. Do not rush the resident; Assist with ADL tasks as needed; Assist with personal hygiene as needed; Assist with toileting needs as necessary; Encourage resident to participate as able in ADL's, Encourage to participate to the fullest extent possible with each interaction; Nurse encourage use of call light for assistance when needed; Monitor for any signs and symptoms of pain/discomfort during ADLs; Offer as needed analgesics prior to ADL activities and/or rehab if indicated; Palm protector to left hand, encourage resident daily to allow staff 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 ______	02/14/2024

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 16	S9999		

apply; Provide needed level of assistance and support to complete Activities of Daily; Physical/Occupational Therapy evaluation and treatment as per physician orders. R17's current care plan initiated 05/23/2019 documents she is at risk for falls secondary to history of falls, incontinence, left partial paralysis, anxiety, pain, use of opiates, use of psychotropic medication and hypertension., R17 is impulsive, does not always wait for assistance for transfers, noted with impulsive behaviors, continued poor safety awareness and judgement with interventions including: Add "Call Don't fall" Posters in several areas of room for reminders to ask for assist; Encourage appropriate use of wheelchair; Encourage R17 to ask for assist with all transfers including toileting; Encourage resident to Call, don't fall; encourage resident to report falls as they happen; Encourage R17 to be aware of her surroundings; Encourage the use of a reacher for hard to reach places; Encourage/Remind R17 to wait for assist and if she feels it's taking a bit longer than she expects, call reception to let them know you are waiting for assist rather than doing on her own; Ensure resident is positioned in middle of bed; Evaluate multiple falls to determine commonalities or patterns; Promote placement of call light within reach; Provide 1:1 supportive counseling, reiterating the importance of becoming/remaining treatment plan compliant, especially as it relates to R17's safety; Provide an environment clear of clutter; Provide proper, well maintained footwear; Staff to ensure resident removes her shoes before bed and place in wheelchair for her; Supply a clock resident can see during night time hours; Will review care plan on return from Hospital (Date Initiated: 09/05/2023).

R17's physician progress note dated 9/1/2023 at

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 ______	02/14/2024

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 17	S9999		

09:42 AM documents Pain assessment interview was conducted for R17 today; she states frequent Left Hip and neck pain in the last 5 days. R17 describes the pain as stabbing and crushing that make it hard to sleep at night.

Incident Report dated 09/02/2023 states at approximately 10 AM R17 self-reported a fall, no visible signs of injury noted, when she was interviewed, she was not really able to state how fall occurred. R17 complained of pain in right hip area, and x ray was ordered, and results were negative for a fracture. However, she continued to complain of pain in left lower extremity on 09/04/2023, an x-ray was ordered and results were positive for a fracture of left femur. Physician was notified with orders received to send her to the emergency room for further evaluation. R17 uses a low bed and floor mats and was not able to state exactly what happened. Per staff R17 was last observed in her bed at 10PM. Predisposing factors include gait imbalance, poor safety awareness, and weakness.

R17's X Ray results dated 09/04/2023 documents a positive result for fracture of left distal femur.

R17's progress note dated 9/5/2023 2:14 PM documents: This writer was made aware the resident has a fracture on her left distal femur and received order from physician to send her to the emergency room for further evaluation and treatment. R17 verbalized pain to her left hip and had been administered an opioid at 6 AM. R17 refuses to go to hospital because she has not been able to smoke. The restorative RN spoke to R17. R17 was transferred from the first floor to the emergency room and left the facility at approximately 09:30 AM.

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 ______	02/14/2024

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 18	S9999		

The incident investigation paperwork provided by the facility did not include documentation of a thorough investigation. This paperwork includes two undated witness statements from V41 (Morning Shift Certified Nursing Assistant) stating R17 could not remember exactly when she fell but she remembered landing on her matt. She has a habit of forgetting to use the call light for assistance; and from V21 (Restorative Nurse) stating R17 can't recall exactly what day and time she fell but remembered landing on her floor mats. R17 forgot to call for assistance and just got herself up to bed.

R17's Post Occurrence Documentation progress note dated 1/13/2024 04:40 PM documents: Resident was observed on the floor by her bedside in a right side lying position, R17 was transferred back to bed by two nursing staff.

On 02/08/24 at 01:21 PM V5 (Restorative Nurse/LPN/Fall Coordinator) stated R17 refuses assistance and won't wait for assistance especially if trying to go out and smoke. V5 sated R17 might have been half asleep when she fell 09/02/2023. V5 stated R17 often falls asleep in her chair. V5 stated she has had many conversations with R17 about safety awareness and she will listen but will not always correct her behaviors. V5 stated sometimes R17 will be receptive to redirection and sometimes she will continue to do as she pleases. V5 stated normally R17 has a fall when transferring herself when going to smoke. V5 stated we've tried to have someone go out with R17 when she wants to smoke to accommodate her smoking times but often she won't wait for assistance. V5 stated in January it seems R17 missed the chair when getting ready to go smoke. V5 stated R17 likes 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 ______	02/14/2024

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 19	S9999		

smoke before she eats. V5 stated revising R17's care plan interventions for falls may not be received well from R17. V5 stated R17's current fall interventions are sometimes effective in preventing her from falling. V5 stated besides assisting R17 when going to smoke she could not provide any additional personalized interventions to prevent her from falling. V5 stated educating R17 and constant monitoring when she wants to smoke are some possible interventions for preventing her from falling.

3. R109 is a 63-year-old female with a diagnoses history of Partial Paralysis due to Brain Hemorrhage, Epilepsy, and History of Falling who was admitted to the facility 10/21/2023.

On 02/05/24 at 11:34 AM Observed R109 sitting on the edge of a geriatric chair leaning forward in the 2nd floor dining area unsupervised by staff for several minutes. V42 (Certified Nursing Assistant) stated R109 is not a fall risk.
On 02/06/24 at 11:09 AM Observed R109 seemed uncomfortable & didn't look well. R109 reported she had a fall yesterday and a couple of days ago. R109 stated she has some pain on her right upper arm and the right side of her head.

R109's current care plan initiated 11/20/2023 documents she is at risk for falls, she has an ADL (Activities of Daily Living) Functional, Performance Deficit; she is a confused 63-year-old female readmitting to the facility after being stabilized at hospital post a suspected internal hemorrhage; she experiences weakness and gait abnormality with the Diagnosis of: End Stage Renal Disease, partial paralysis following a brain hemorrhage, COPD, Diabetes Mellitus 2, Hypertension, bacteremia, epilepsy, GERD (Gastro Intestinal Reflux Disease, Non

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 ____	02/14/2024

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 20 Rheumatic valve stenosis, anemia in chronic kidney disease, cataracts, dependence on renal dialysis, hyperlipidemia, and hypothyroidism; she requires substantial max assistance with most ADLs and is incontinent of both bowel and bladder; and she has a documented history of falls within the last 6 months with interventions including: assist with ADL tasks as needed., Cue resident to grasp side rail and pull herself upto a sitting position or to the side of bed, Monitor/document/report to Nurse any as needed changes in ADL ability, any potential for improvement, reasons for inability to perform ADLs, Provide needed level of assistance and support to complete Activities of Daily Living; Assure resident is wearing eyeglasses; Encourage appropriate use of walker; Promote placement of call light within reach; Provide an environment clear of clutter; Provide proper, well maintained footwear; psych consult for anxiety medication. R17's current care plan initiated 12/12/2023 documents she has potential for injury related to seizure disorder with interventions including: Keep call light within reach. R109's current care plan initiated 12/04/2023 documents she has anxiety symptoms, as evidenced by constantly putting herself on the floor next to her bed, delusions such as stating that a person she knows is present but not there, and false accusations with interventions including: Assure bilateral mats are next to bed. Incident Report/Post Occurrence Documentation 11/20/2023 at 10:30 AM documents at approximately 10:30 A.M. CNA (Certified Nursing Assistant) reported that resident was on the floor in her room. Nurse immediately went to resident's room and observed her on the floor on the left side of her bed lying on the floor mat with her	S9999		

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 ___	02/14/2024

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 21	S9999		

upper body under the bed facing the window. Nurse and staff pulled her out from under the bed. Resident was wearing gown, clean and dry brief and one sock on her right foot. Both quarter side rails were up and in a locked position. Lighting was adequate and floor was dry. Resident was very restless. Resident was observed by nurse approximately 20 minutes prior to incident and was very restless and grabbing at left side rail. Resident was redirected and calmed. Predisposing factors include confusion, gait imbalance, poor safety awareness, recent change in medications, recent illness, weakness, and improper footwear. Fall was unwitnessed.

Incident Report dated 01/27/2024 at 5:21 PM documents R109 reported she fell yesterday but didn't tell anyone. Fall was unwitnessed. Predisposing factors include recent change in cognition. R109 was last observed prior to incident by nurse at 3:45 PM.
R109's Progress note dated 1/28/2024 at 06:58 AM documents local hospital was called, nurse stated resident admitted into hospital due to fall.

R109's hospital report dated 01/28/2024 documents she was placed on high fall risk interventions while in the emergency room; she presented from nursing facility with chief complaint of shortness of breath, she also fell.

Incident Report/Post Occurrence Documentation dated 2/3/2024 11:52 PM documents R109 was observed in a sitting position with wheelchair behind her in her room outside the washroom door. R109 stated she was trying to get up from her wheelchair to use the washroom and slid down to a sitting position on the floor. Assisted back to bed with another nursing staff. Was

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 ____	02/14/2024

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 22 encouraged and educated on use of call light and waiting for assistance from staff, was educated as well on locking wheelchair, resident demonstrated proper locking of wheelchair and use of call light. Predisposing factors include noise, and poor safety awareness. R109 was last observed prior to incident at 10:15 PM. Fall was unwitnessed. R109's Progress note dated 2/4/2024 10:45 AM documents reminded patient to call for assistance. Do not get up without assistance. Patient did not follow instructions. Patient got into wheelchair minutes after I reinforced to use call light, which is close to her. She insisted to go bathroom and not wait. R109's Progress note dated 2/6/2024 10:53 PM documents Notified by CNA (Certified Nursing Assistant) that resident had unwitnessed fall last night and hit her head 1st then right shoulder on bed and slid to the floor. Some discomfort to right shoulder with range of motion. On 02/08/24 at 01:21 PM V5 (Restorative Nurse/LPN/Fall Coordinator) stated she understands R109's urgency in going to the bathroom because she is diabetic. V5 stated in addition to R109's medical acuity, many times she says she needs to use the bathroom and tries to transfer herself. V5 stated R109 is impulsive and has anxiety and requires constant education on safety awareness and using call light to let CNA's (Certified Nursing Assistants) know she needs assistance. V5 stated re-education has not prevented R109 from falling. V5 stated additional fall interventions for R109 may include educating the staff on anticipating her needs, and possibly having her moved closer to the nurses station with the family's approval.	S9999		

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 ___	02/14/2024

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 23 V5 stated R109 is one of the facility's falling stars residents. V5 stated falling stars are residents considered high fall risks and they are constantly being monitored by staff. V5 stated every morning during the standup meeting residents who are high fall risk and residents who require frequent monitoring are discussed. V5 stated when R109 is out of her room she should be in the presence of staff. V5 stated if residents are high fall risks and are up and, in their wheelchairs, they should be kept engaged in activities and out of their room. V5 stated most of R109's falls are unwitnessed, and she seems to have a pattern of falling in the evenings which is when she seems to be more active. V5 stated during those times R109 should possibly be monitored more frequently. V5 stated these interventions would be more personalized for R109. 4. R535's medical records indicated resident admitted to the facility on 05/07/2021 and discharged on 01/19/2024. Resident had a past medical history not limited to: hypertension, tremors, anemia, syncope and collapse, psychotic disorder with delusions, vascular dementia, insomnia, palliative care, and Parkinson's disease. R535's care plan with closed date of 01/25/2024 reads in part: had an actual fall with minor injury of small laceration to left eyebrow due to unsteady gait, poor safety awareness and poor endurance and trunk control (11/12/2023) with interventions to continue interventions on the at-risk plan (11/13/2023), monitor/document/report as needed x 72 hours to physician for signs/symptoms of pain, bruises, change in mental status, or new onset of confusion, sleepiness, inability to maintain posture, agitation (11/13/2023); resident will be	S9999		

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 ______	02/14/2024

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 24	S9999		

monitored and placed on high traffic areas for close monitoring and frequent monitoring (11/13/2023).

Care plan also indicated that R535 was a high risk for falls secondary to altered elimination pattern, cardiovascular disease, cognitive deficits, history of fall(s), medications that could affect functional level, level of consciousness, gait, visual acuity or cognitive ability, muscle weakness, poor safety awareness, use of assistive devices, use of psychotropic medication and Parkinson's with tremors; notify family and physician of any new fall (04/29/2022). Care plan also indicated R535 had a potential for alteration in skin integrity due to history of laceration to the right eyebrow and multiple medical diagnoses.

R535's Fall Risk Assessment dated 12/13/2023 indicated resident fall risk score at 11. Scoring guidelines per assessment indicated, "for scores 0-11 at risk-implement general safety interventions".

Facility presented fall incident list dated 02/05/2024 for date range of 09/05/2023 to 02/05/2024 that indicated R535 had fall incidents on 11/11/2023 at 08:30 PM and 11/23/2023 at 11:30 AM.

Facility presented final report investigation completed by V2 (Director of Nursing) dated 11/17/2023 that indicated on 11/11/2023, R535 was observed with active bleeding to his left eyebrow, and was sent out emergently to a local hospital for further evaluation. R535 returned to facility with laceration to left forehead that was closed with skin glue. R535's Nurses Note dated 11/11/2023 20:55 indicated the same. Reviewed hospital after visit summary dated 11/11/2023 that

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 ______	02/14/2024

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 25	S9999		

Continued From page 25

indicated R535 was seen for a laceration that was repaired with skin glue.

Facility investigation report indicated R535 was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4, and fall incident was unwitnessed yet concluded that R535 reported slipping and sliding while ambulating from bathroom, fell and then crawled to his bed where he had hit his forehead on the bedframe while pulling himself back into bed. Resident was discharged from facility during investigation and was not available for interview.

On 02/07/2024, upon further record review, noted Hospice Note dated 11/12/2023 11:19 that indicated R535 had been increasingly weaker and had two falls with injury within 24 hours. Nurses Note dated 11/23/2023 11:12 indicated writer was informed by housekeeping that resident was on the floor, in another patient's room laying on the floor when found by the writer; patient will be transferred to local emergency department for further observations. Hospice Note dated 11/27/2023 22:37 indicated R535 had an unwitnessed fall in his room and was found between his roommate's bed and the wall and sustained a 2.5 centimeter (cm) x 0.3cm laceration to the right brow with active bleeding.

First aid was provided and fall protocol was initiated.

On 02/07/2024, requested complete fall incident investigations for the following fall incidents: second fall "within 24 hours" indicated in 11/12/2023 hospice note, and for fall incidents on 11/11/2023, 11/23/2023, and 11/27/2023. V1 (Administrator) only provided a typed, undated and unsigned statement by the "nurse on duty" at

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 ______	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 26	S9999		

time of incident related to R535's 11/11/2023 fall incident.

On 02/08/2024, facility presented hospice certification of terminal illness statement dated 01/03/2024 that indicated R535 had "multiple falls over the last few moths and difficulty maintaining trunk strength" signed by V28 (Medical Director). No other investigation reports were provided by facility for R535.

Facility provided document titled, Management of Falls policy dated 08/2020 reads in part:
Policy: The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident ' s plan of care in order to minimize the risks for fall incidents and/or injuries to the resident.
Procedure:
1. Complete a Fall Risk Assessment upon admission, re-admission, with significant change, post-fall, quarterly, and annually.
2. Orient resident to room, call light, unit and location of the nurse ' s station upon admission to the facility.
3. Develop a plan of care to include goals and interventions which address resident ' s risk factors. Risk factors may include but are not limited to the following: Contributing diagnoses/disorders/disease processes / active infections/other comorbidities, history of fall incidents, Incontinence, Medications (Narcotics, Anti-hypertensives, etc.), assistance required with ADL ' s, gait/transfer/balance issues, Behaviors, and/or cognitive status.
4. Provide assistive devices for mobility, hearing and vision as appropriate for the resident.
5. Assess appropriateness for resident to participate in skilled therapy or restorative

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 ____	02/14/2024

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 27	S9999		

programming in order to maintain or improve physical function of resident.
6. Assess and monitor resident ' s immediate environment to ensure appropriate management of potential hazards.
7. Monitor for changes in medical condition and notify physician as necessary to manage changes in status of the resident.
8. Conduct Care Plan Meetings with Resident, Responsible Party, and Facility Interdisciplinary Team quarterly and as needed.
9. Review and/or modify the resident ' s plan of care at least quarterly and as needed in order to minimize risk for fall incidents and/or injury.

Facility provided document titled, Incident/Accident Reports policy dated 09/2020 reads in part:
Policy: The Incident/Accident Report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors or other, and resident-to-resident altercations.
Procedure: An accident refers to any unexpected or unintentional incident, which may result in injury or illness to resident. This does not include adverse outcomes that are a direct consequence or treatment or care that is provided in accordance with current standards of practice (e.g., drug side effects or reaction).
1. All serious accidents or incidents of residents
2. All injuries of staff, families, and visitors
3. All unusual occurrences
4. All situations requiring the emergency services
of a hospital, the police, fire department, or coroner
5. Any type of resident abuse
6. Resident to resident altercation
7. Suicide or attempted suicide

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 ______	02/14/2024

NAME OF PROVIDER OR SUPPLIER: **ALDEN TOWN MANOR REHAB & HCC**

STREET ADDRESS, CITY, STATE, ZIP CODE: **6120 WEST OGDEN CICERO, IL 60804**

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S9999	Continued From page 28	S9999		

8. Any condition resulting from an incident requiring first aid, physician visit, or transfer to another health care facility
9. An incident/accident report is to be completed and shall complete and shall include:
a. date and time of incident/accident
b. description and possible cause of incident, physical assessment, injuries noted, vital signs, treatment rendered, and notification of appropriate parties.
10. The facility shall maintain a file of each incident and accident affecting a resident that is not expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's note of that resident.
12. The Director of Nursing, Assistant Director of Nursing or Nursing Supervisor must notify:
a. The Illinois Department of Public Health (IDPH) of any serious incident or accident, "Serious" means any incident or accident that causes physical harm or injury to a resident.
b. The facility shall, by fax or phone, notify the regional office within 24 hours after each reportable incident or accident.
c. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven (7) days after the occurrence.
13. e. A minimum of seventy-two (72) hours of documentation by all three shifts on resident status after the incident or accident, vital signs, mental and physical state, follow-up, tests, procedures, and findings are to be determined.
14. All incident/accident reports are reviewed, signed, and investigated by:
a. the administrator; and
b. the director of nursing or the assistant director of nursing

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 ______	02/14/2024

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ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

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S9999	Continued From page 29	S9999		

15. Facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.
Facility policy: Smoking Policy, dated 8.2023:
Policy: The facility will assess hazards and risk factors associated with smoking, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care to minimize the risks of incidents/accidents associated with smoking.
The facility's policy for Management of Falls reviewed 02/08/2024 states:
"The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risks for fall incidents and/or injuries to the resident." "Develop a plan of care to include interventions which address resident's risk factors."
"Review and/or modify the resident's care plan as needed in order to minimize the risk for fall incidents and/or injury."

(A)

Statement of Licensure Violations 3 of 3
300.610a)
300.610c)2)
300.1010h)
300.1210a)
300.1210b)
300.1210d)3)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the

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 ______	02/14/2024

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 30	S9999		

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.

c) The written policies shall include, at a minimum the following provisions:

2) Resident care services, including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic services (including laboratory and x-ray);

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

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 ____	02/14/2024

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ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

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S9999	Continued From page 31	S9999		

Continued From page 31

Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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

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 ______	02/14/2024

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 32	S9999		

made by nursing staff and recorded in the resident's medical record.

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow their policy of obtaining resident weights, failed to document meal intake, and failed to update an individualized care plan for one of two residents who were reviewed for nutrition. This failure applied to one of one (R166) resident reviewed for weight loss and resulted in R166 demonstrating an unintended weight loss of 29% during the first two months of admission.

Findings include:

R166 was admitted to the facility 10/4/23 with diagnoses that included hypertension, pressure ulcers and dysphagia. During this survey R166 was observed to receive lunch meals in bed, and on 2/6/24 observed to eat 0% of the meal provided. When R166 was interviewed at 1:00PM and observed siting up in bed alert and conversive. R166's arms and face appeared thin, and R166 refused further assessment due to room temperature. R166 mentioned that R166 was not very hungry and didn't want the meal. According to hospital transfer records and the facility's electronic health record, R166 was admitted at a weight of 146 lbs (pounds). During the second week of admission, R166 recorded weight was 145 lbs and the next recorded weight thereafter was recorded to be 103.4 lbs for a total weight loss of 29.18%.

On 2/8/24 at 12:00PM V2 DON (Director of Nursing) was interviewed regarding the weight

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 ______	02/14/2024

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S9999	Continued From page 33	S9999		

loss of R166. V2 said that it was the policy of the facility that residents who were newly admitted to the facility should have be weighed at least once weekly for four weeks to establish a baseline and pattern for meal habits and intake. After the baseline is established, the resident should have weights recorded at least monthly or daily as appropriate to condition or diagnosis. V2 said this is especially important for residents with wounds because nutritional status greatly affects wound healing. V2 reviewed the recorded weights with the surveyor and noted that the "Weight Report" for R166 was missing weight results for the third and fourth week of October, and no weight was recorded for November. V2 said that although some nutritional supplements were ordered and in place for R166, it was expected that when the weight loss was identified, that the care plan for nutrition would be revised to provide a more individualized plan. While referring to the Weight Report, V2 said that since the weight loss was identified in December, it remains stable and has even increased with weights reported on 1/5/24 at 107.8 lbs and 2/1/24 106 lbs.

R166's Care Plan initiated 10/5/23 states in part; "{R166} requires nutritional support {related to} {diagnosis} of dysphagia and presence of pressure wounds; receiving general pureed, {protein supplement} and fortified cereal. Scored malnourished on mini nutrition assessment due to moderate decrease in food intake, bed bound, and BMI (Body Metabolic Index) above 23." Interventions of the care plan were also initiated 10/5/23 and did not indicate any revisions had taken place. Interventions included "Monitor labs and wight for signs of effective disease management and Weekly weights".

Facility policy titled "Weights" revised 9/2020

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 ______	02/14/2024

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S9999	Continued From page 34 states in part; "Policy: Residents will be weighed to establish baseline weights and identify trends of weight loss or weight gain. Procedure: 1. A baseline weight will be established upon admission. The resident will be weighed weekly for 4 weeks after admission and monthly thereafter." (B)	S9999		