STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145736	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Town Manor Rehab & Hcc	6120 West Ogden Cicero, IL 60804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41758 Based on observation, interview and record review, the facility failed to provide timely incontinence care for one of three residents (R3) reviewed for incontinence care on the sample list of 18. Findings Include: R3's diagnoses include Dementia. R3's Minimum Data Set (MDS) section H (bowel and bladder) dated 2/8/24 documents: Urinary continence: always incontinent. R3's care plan initiated 8/4/23 documents: activities of daily living (ADL) self care performance deficit related to weakness and assist with toileting needs as necessary. On 05/02/24 at 2:20pm, R3 was sitting on the side of the bed, with her gown pulled up exposing her incontinence brief. (Initials) 6:20AM was written on R3's brief with a black marker. R3 was alert and oriented to person, place and time and said she needed to be cleaned. R3 said, she has not been provided incontinence care today. R3 was saturated with urine. R3 also had a wet incontinence pad with a strong smell of urine. V10 (cna) said, she has not provided any care to R3. R3 was her last resident. V10 said, R3 was wet, the bed pad was wet and there is an odor of urine. On 05/03/24 at 12:24pm, V9 (Assistant Administrator), said she over sees R3's unit. V9 said residents should not be in the same incontinence brief for over two hours. Resident's should be checked and changed throughout the day. Staff should be rounding all day.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to supervise one of three residents (R4) reviewed for risk for falls. This failure resulted in R4 falling from her wheelchair and having to be transferred to local hospital with a contusion to the bridge of her nose. Findings include: R4 was admitted to the facility 6/6/23 with a diagnosis end stage renal disease, type II diabetes, major depression, Alzheimer's disease, anxiety disorder, dementia and hypertension. R4's Minimum Data Set, dated dated dated [DATE] documents R4's brief interview for mental status score 4/15 which indicates severe cognitive impairment. R4's fall risk assessment dated [DATE] documents resident is at risk for falls. Under mobility unsteady gait; under mentation: confused. R4's progress note dated 5/1/24 documents: Writer down the hall doing rounds and assessing patients that were in their rooms when staff hollered out to me and informed me that resident was on floor while in dining room with other residents. Assessed patient and noted bruising and swelling to bridge of nose and area superior to right eye. Contacted MD (Medical Doctor) who requested that R4 be transferred to local hospital for computed tomography (CT) scan and evaluation. R4's incident report dated 5/1/24 at 7:48AM documents under incident description was informed by certified nursing aide that resident was observed on the floor face down in the dining room. Resident unable to give description. Under witnesses: no witness found. Interview dated 5/1/24 from V22 (Housekeeping) documents: V22 saw R4 in the dining room yelling out. V22 said she approached the resident and informed her that someone would be attending to her in a few minutes. R4 responded okay. V22 said she turned her back for two minutes, and R4 was no longer in her chair. V22 yelled for assistance and explained R4 had fallen, another resident told me that R4 did not fall that she threw herself on the floor. Interview form dated 5/1/24 documents: R4 said she felt desperate and she threw herself on the floor. R4 mentioned she will not do that anymore and that she will wait for staff to assist her moving. R4's plan of care dated 4/24 documents: When R4 shows behaviors such as picking her face, stating that she will throw herself on the floor, crying out, staff provide one to one session. On 5/2/24 at 1:27PM, R4 was observed in reclining wheeled chair with deep purple bruising observed around bilateral eyes and nose. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/3/24 at 10:47AM, V22 (Housekeeping) said she starts her shift at 7:00AM and works on the third floor. V22 said around 730AM, she will tidy up the dining room. V22 said she was cleaning up a table in the dining room and there were about eight residents including R4. V22 said R4 was at a table in the dining room in her reclining wheeled chair yelling for help. V22 said there were no other staff in the dining room. V22 said she went to R4 to let her know someone would there to help. V22 said she turned around back to her cart and did not see R4. R4 was on the floor on her side under the table. On 5/3/24 at 12:44PM, V7 (Restorative Nurse) said R4 was in the dining room asking for help and then she fell . V7 said a staff should be present in common areas when residents are in them. If R4 was yelling out or having behaviors staff should have stayed with the resident. Staff should monitor common areas to monitor fall risk residents to prevent falls. R4's hospital record dated 5/1/24 documents R4's diagnoses including fall, contusion of scalp, face and neck. Patient arrived form nursing home for unwitnessed fall from wheelchair. Patient has bruise to her face. After calling nursing home, nurse states that patient like to throw herself, patient was in the kitchen awaiting to eat, was found on the ground. Contusion to bridge of nose. Under CT: Soft tissue edema overlying bridge of nose and left frontal bone suggesting contusion.