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No. 0938-0391

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	10/18/2024

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 39340 Based on interview and record review, the facility failed to notify the physician of one resident's change in condition which included new onset of pain, changes in mobility, skin changes to lower left extremities and refusal of doppler study for over 6 days. This affected one of one (R1) residents reviewed for notification of change. This failure resulted in R1 being found to have an acute displaced fracture of distal tibia from an unknown origin, osteomyelitis and skin necrosis that requiring a left through the knee amputation of the lower extremity. Findings include: R1 had the diagnosis of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominate side, peripheral vascular disease, personal history of (healed) traumatic fracture and history of falls. Minimal data set section C (cognitive pattern) brief interview for mental status (BIMS) dated 8/28/24 documents a score of fourteen which indicated cognitively intact. Section GG (functional abilities and goals) documents: impairment on one side for upper/lower extremity (shoulder, elbow, wrist, hand, hip, knee, ankle, foot). R1 required substantial/maximal assistance- help does more than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort for roll left to right, sit to lying, lying to sitting on side of bed. Sit to stand not attempted due to medical condition or safety concerns. On 10/17/24 at 4:12PM, V27 (Medical doctor) is unable to recall if she was notified of the refusal of the doppler on 9/26/24. If she was notified of the refusal, she would of ordered another treatment or x-ray. V27 said facility staff and/or her nurse practitioner did not notify her of any changes in pain or condition for R1. R1's progress notes dated 9/26/24 by V9(Nurse): X-ray company came to do doppler on R1 , she refused. Tried to convince her, she was upset and said no. Facility Witness interviews dated 10/3/24 documents: V9(Nurse) received report that R1 was scheduled for a doppler, but she refused. I did not assess her leg. When I asked her to assess her and she refused. I did not notify per primary care provider she refused the doppler study on 9/26/24. The last time R1 was due for a refill of her pain medication, V27(MD) stated there would need to be a review of her pain management because she is using pain medication too often. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	On 10/17/24 at 9:39am, V17 (CNA) said, R1 started complaining of pain at the end of August to her left contracted leg. R1 always complained of pain. R1 reported she fell while attempting to self-transfer. R1 complained of pain being worse, most severe than her normal pain level after her self-reported transfer/fall. V17 said, R1 was dependent with transfers. R1 was able to stand and pivot on her non-contracted leg with one-person physical assistance. V17 said, she reported the incident to the nurse, agency nurse and all the nurse managers every day during stand-up report. V17 said, stand-up report is where the nurse and managers get reports about resident from the cnas. V17 (CNA) witness statement undated documents: When was the last time you provide care for R1? Not sure, sometimes this week, V17 was not her c.n.a but V17 did assist V24 (CNA). How was R1 transferred? With a mechanical lift. Did she complain about pain? Yes, she did. Who did you notify? V17 notified V9 (nurse) and agency nurse and during stand up. R1 has been complaining for about a month. Two weeks ago, V17 was providing showers and when V17 asked her to take a shower R1 stated no because her leg was hurting. Did you notice anything wrong with her leg? V17 did not notice anything wrong with R1 leg due to R1's leg being contracted. R1 stated that, she was in pain more than usual. V17 notify the nurse about her refusal of shower and leg pain. Did she tell you she was in pain that day? Yes, V17 informed the nurse and stand up. Anything else you would like to add? V17 know they came to so x-ray twice and R1 refused once. On 10/17/24 at 10:08am, V24 (CNA) said, R1 always transferred with a one-person physical assist while she stood and pivoted. V24 said, R1 reported she could not take the pain of standing up to transfer anymore. R1 started to use the mechanical lift for transfers. V24 said, she reported the nurses and nurse managers in stand-up about R1's complaint of pain, change in transfer status and the appearance of R1's leg for about a week to a week in the half prior to R1 being sent to the hospital on 10/2/24. V24 said, she reported R1's change in condition every day. V24 said, R1's left lower leg was redden at first and she reported that. Next R1's leg started to swell and she reported that. Then R1's leg turned dark purple in color and she reported that in stand-up because it did not look right. V24 said, towards the end before R1 went to the hospital, when she was putting on R1's shoes, R1's leg felt broken. V24 said, R1 leg was loose near the ankle. R1's leg was dangling. On 10/17/24 at 10:17am, V23 (CNA) said, she started working for the facility on 9/9/24. R1 was a pivot with transfers. V23 said, R1 always had a bandage on her left ankle and foot. V23 said, R1 used to ask her to wrap her left leg up in the blanket in-order to apply pressure. V23 said, R1 complained of pain when she was rolled from right to left during care. During stand-up report, the question was asked if there was any change in resident's condition. V23 said, she did not report anything because all the nurse managers were aware of R1's condition. On 10/16/24 at 1:20pm, V16 (CNA) said, R1 had a darken discoloration area on the left ankle the size of palm. V16 said, the discoloration looked like gangrene which she had seen before on another resident in the past. V16 said, she reported to V4 (unit manager). V16's witness statement dated 10/2/24 documents: On the 25th, V16 saw R1 and she had dark color by her ankle. R1 was in pain. V16 reported to V4. V16 had not seen this dark color on R1 in days prior. V16 asked R1 what happen, she said she didn't know. We transferred R1 with a mechanical lift because we didn't want R1 to stand. V16 asked the nurse what was going on with her foot and she said they were doing an x-ray. V16 texted on 9/25 at 9:17am about the dark ankle. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 10/18/24 at 9:51AM, V3(ADON) said all clinical management participates in stand-up meeting to include herself, V2(DON), unit managers, nurses and CNA's. Clinical management staff would be responsible for following up with any medical concerns that are brought up during stand-up meeting. V3 said V2(DON) was responsible for concerns related to R1 and unable to recall any further details related to R1. V3 said if a resident is experiencing a change in condition, nurses should report to clinical management, report to the physician and documents any orders. All this information should be documented in the progress notes. R1's Clinical and Order alert listing report dated 9/25/24 documents: Pain-new or worsening; Participate less in activities. R1's medical record does not document any notifications to the physician or nurse practitioner of R1 reports of increased pain, changes to skin and changes in mobility/transfer status. Radiology Results examination dated 10/01/24 at 20:45 (8:45pm) reported at 00:30 (12:30am) document: X-ray exam of lower leg. Findings: acute displaced fracture of distal tibia noted. On 10/16/24 at 6:39pm, V18 (hospital staff nurse) said, R1 presented to the emergency department with edema to the left lower extremity and no pedal pulse. The hospital did a work up and found a left tibia fracture. R1 had osteomyelitis and skin necrosis. R1's left limb was not salvageable. R1 had a through the knee amputation of left lower extremity on 10/16/24. Facility medication and treatment refusal policy dated 9/2020 documents: Patient refusal of mediation and or treatment must be recorded in the resident medical record. Under procedure: The date and time the physician was notified as well as the physician response. Facility change of condition policy dated 9/20 documents: To ensure that the resident's physician/physician on call/Nurse practitioner and responsible party is kept informed regarding the residents change in condition.

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

41758

Based on interview and record review, the facility neglected to assess R1 who was observed with a change in condition, new onset of worsening pain, redness, swollen, dark purple bruised discoloration to the left lower extremity for over four weeks . This affected one of three residents (R1) reviewed for nursing assessments and change of conditon. This failure resulted in R1 be found to have an acute displaced fracture of distal tibia from an unknown origin, osteomyelitis and skin necrosis that requiring a left through the knee amputation of the lower extremity.

Findings include:

R1 had the diagnosis of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominate side, peripheral vascular disease, personal history of (healed) traumatic fracture and history of falls. Minimal data set section C (cognitive pattern) brief interview for mental status (BIMS) dated 8/28/24 documents a score of fourteen which indicated cognitively intact. Section GG (functional abilities and goals) documents: impairment on one side for upper/lower extremity (shoulder, elbow, wrist, hand, hip, knee, ankle, foot). R1 required substantial/maximal assistance- help does more than half the effort. Helper lifts or hold trunk or limbs and provides more than half the effort for roll left to right, sit to lying, lying to sitting on side of bed. Sit to stand not attempted due to medical condition or safety concerns.

On 10/15/24 at 12:24pm, R1 who was assessed to be alert and oriented to person, place and time, said the facility reported she was trying to get in bed by herself. R1 said, that was a lie. R1 said, she had a stroke with left side numbness. R1 said, her left side was dead and she does not have any feeling or control on her left side. R1 said, she uses a motorized wheelchair and can't stand or walk. R1 said, her electric wheelchair has a metal plate foot rest that she can't lift in order to self-transfer. R1 said, she wanted to go to bed, two black female staff members assisted her out of her motorized wheelchair to the bed and dropped her. R1 said, the mechanical lift was broken. R1 did not recall the staff's names or the exact date she was dropped. R1 said, the incident happen about three weeks prior to her being hospitalized . R1 said, she requested to go the hospital and was denied. R1 said, was in pain for three weeks. R1 said, she has to have her leg cut off because it leg got infected due to the bone sticking through the skin. R1 said, she had to have her leg cut off or die.

On 10/15/24 at 2:05pm, V9 (nurse) said, during stand-up report she was alerted that R1 had hip pain. R1 had an ultra sound schedule. The tech came to do the ultra sound and said, he could not do the ultra sound because R1's leg looked fractured. V9 said, she assessed R1 left lower leg at that time. R1's leg had a black area with dry skin. V9 said, she did not see a break/opening in R1's skin. V9 said, she was informed R1 had a history of a fracture. V9 said, V2 (don) ordered a stat x-ray.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	V19 (x-ray tech) incident report dated 10/01/2024 at 4:01pm documents: `When V19 arrived at the facility, the patient (R1) was not in the room, so V19 asked the nurse to inquire with the aide and have R1 placed in bed. When the patient arrived, two CNAs helped R1 into bed using a machine. Once R1 was settled, V19 entered the room and noticed that R1 appeared upset about lying down. V19 explained the procedure and assured R1 that V19 would do it as quickly as possible. Upon examining R1's leg, V19 noticed that R1's foot and lower leg were misaligned, it look's displaced and foot dangling. It was swollen and discolored around the distal lower leg. V19 asked R1 if she had received an X-ray of her left leg or ankle, but she could not remember. Concerned about moving her leg, V19 asked the nurse if an X-ray had been ordered, but she said none had been ordered but wanted to be sure, so she called the Director of Nursing (DON) and the Administrator. The Nurse and DON checked the leg and informed me that the patient had suffered a fracture a long time ago. They advised me to proceed with the Doppler procedure and assured me that an X-ray would be ordered. They even asked V19 to perform the X-ray, but V19 explained that we have different techs and machine for that purpose. V19 suggested they call the office. Radiology Results examination dated 10/01/24 at 17:12 (5:12pm) reported at 19:36 (7:36pm) documents: Bilateral lower extremity arterial Doppler ultrasound Left ABI was not attempted due to possible fracture. Wound in left lower distal leg. Discoloration in left foot. On 10/16/24 at 12:36PM, V1 (administrator) said, she was informed by the team that R1 had some pain, tenderness and refused to have an ultra sound on 9/25/24. V1 said, she was informed, prior to that R1 was trying to self-transfer. R1 use to stand and pivot but R1 had to be transferred with the mechanical lift. V1 said, V10 (treatment nurse) said, R1 had a history vascular diseases so she ordered a Doppler. V1 said, she is not aware of who completed a pain assessment or body assessment for R1 on 9/25/24 when she was informed about R1 pain and tenderness. V1 said, she was not a nurse. V1 said, she went to speak to R1 by herself after stand-up. R1 reported no one harm her. R1 denied attempting to get up. R1 was alert and oriented times three. We found out that R1 had a fracture on 10/1/24. On 10/16/24 at 1:20pm, V16 (cna) said, R1 had a darken discoloration area on the left ankle the size of palm. V16 said, the discoloration looked like gangrene which she had seen before on another resident in the past. V16 said, she reported to V4 (unit manager). V16's witness statement dated 10/2/24 documents: on the 25th, V16 saw R1 and she had dark color by her ankle. R1 was in pain. V16 reported to V4. V16 had not seen this dark color on R1 in days prior. V16 asked R1 what happen, she said she didn't know. We transferred R1 with a mechanical lift because we didn't want R1 to stand. V16 asked the nurse what was going on with her foot and she said they were doing an x-ray. V16 texted on 9/25 at 9:17am about the dark ankle. On 10/16/24 at 1:30PM, V10 (treatment nurse) said, she was informed that R1 had a bruise on her lower leg. V10 said, based on R1's history of Peripheral Vascular Disease she notified the doctor, got an order for a Doppler. V10 said, she did not conduct any type of body assessment. V10 said, the body assessment should have been done by the nurse. V10 said, she does not treat bruises. On 10/16/24 at 6:00pm, V20 (complainant) said, R1 came to the emergency room with thick wool socks and heavy shoes on. R1 complained of pain at an eleven out of ten (11/10). R1's lower left leg wound did not have a dressing in place. The nurse reported, R1 had a fracture and a part of R1's leg bone was showing. R1 reported, she was transferred by staff and dropped. R1 reported, she complained of pain but the facility didn't do anything. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 10/16/24 at 6:39pm, V18 (hospital staff nurse) said, R1 presented to the emergency department with edema to the left lower extremity and no pedal pulse. The hospital did a work up and found a left tibia fracture. R1 had osteomyelitis and skin necrosis. R1's left limb was not salvageable. R1 had a through the knee amputation of left lower extremity on 10/16/24. On 10/17/24 at 9:39am, V17 (cna) said, R1 started complaining of pain at the end of August to her left contracted leg. R1 always complained of pain. R1 reported she fell while attempting to self-transfer. R1 complained of pain being worst, most severe than her normal pain level after her self-reported transfer/fall. V17 said, R1 was able to get herself up off the floor and back into the wheelchair. V17 said she did not witness R1's fall or the self-transfer. V17 said, R1 was dependent with transfers. R1 was able to stand and pivot on her non-contracted leg with one person physical assistance. V17 said, she reported the incident to the nurse, agency nurse and all the nurse managers every day during stand up report. V17 said, stand-up report is where the nurse and managers get reports about resident from the cnas. V17 (cna) witness statement undated documents: When was the last time you provide care for R1? Not sure, sometimes this week, V17 was not her c.n.a but V17 did assist V24 (cna). How was R1 transferred? With a mechanical lift. Did she complain about pain? Yes, she did. Who did you notify? V17 notified V9 (nurse) and agency nurse and during stand up. R1 has been complaining for about a month. Two weeks ago, V17 was providing showers and when V17 asked her to take a shower R1 stated no because her leg was hurting. Did you notice anything wrong with her leg? V17 did not notice anything wrong with R1 leg due to R1's leg being contracted. R1 stated that, she was in pain more than usual. V17 notify the nurse about her refusal of shower and leg pain. Did she mentioned to you at any time that someone dropped her or injured her? She mentioned that night cna dropped her and couldn't tell me who, but V17 don't remember when. Who did you notify? The nurse (not sure who) and at stand up. About a month ago R1 was on her wheelchair and when asked how she got on the chair she told V17 she transferred herself and fell so she can go smoke. Did she tell you she was in pain that day? Yes, V17 informed the nurse and stand up. Anything else you would like to add? V17 know they came to so x-ray twice and R1 refused once. On 10/17/24 at 10:08am, V24 (cna) said, R1 always transferred with a one person physical assist while she stood and pivoted. V24 said, R1 reported she could not take the pain of standing up to transfer anymore. R1 started to use the mechanical lift for transfers. V24 said, she reported the nurses and nurse managers in stand-up about R1's complaint of pain, change in transfer status and the appearance of R1's leg for about a week to a week in the half prior to R1 being sent to the hospital on 10/2/24. V24 said, she reported R1's change in condition every day. V24 said, R1's left lower leg was redden at first and she reported that. Next R1's leg started to swell and she reported that. Then R1's leg turned dark purple in color and she reported that in stand-up because it did not look right. V24 said, she asked R1 what happen. R1 reported two variations of what happened. R1 said, she attempted to self- transfer and fell . V24 said, she asked R1 as her leg got worst what happen again. R1 replied, she was dropped by agency cnas. V24 said, the facility did not use agency cnas. V24 said, towards the end before R1 went to the hospital, when she was putting on R1's shoes, R1's leg felt broken. V24 said, R1 leg was loose near the ankle. R1's leg was dangling. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 10/17/24 at 10:17am, V23 (cna) said, she started working for the facility on 9/9/24. R1 was a pivot with transfers. V23 said, R1 always had a bandage on her left ankle and foot. V23 said, R1 used to ask her to wrap her left leg up in the blanket in-order to apply pressure. V23 said, R1 complained of pain when she was rolled from right to left during care. During stand-up report, the question was asked if there was any change in resident's condition. V23 said, she did not report anything because all the nurse managers were aware of R1's condition. On 10/17/24 at 2:32pm, V25 (nurse practitioner) said, if a resident is having a new onset of pain she would expect the nurse to completed a body assessment to determine the location of the pain. On 10/17/24 at 2:59pm, V27 (medial doctor) said, she was aware of R1 having chronic PVD.R1 had a history of refusing care. R1 was alert and responsible for herself. V27 said, she would expect the nurse to complete an body assessment for any new or worsening pain. V27 said, a distal tibia fracture can result from a fall, trauma of the c.n.a putting too much pressure on a resident's limb, V23 (cna) witness statement undated documents on the 27th or 28th, R1 pivots with my assistance. R1 complained about the leg with a bandage on it. R1's Clinical and Order alert listing report dated 9/25/24 documents: Pain-new or worsening; Participate less in activities. Radiology Results examination dated 10/01/24 at 20:45 (8:45pm) reported at 00:30 (12:30am) document: X-ray exam of lower leg. Findings: acute displaced fracture of distal tibia noted. Nursing Note dated 10/2/2024 document: Observed R1 at 7:30 am, she was roaming around in her wheel chair getting ready for breakfast. Looked over R1's X-ray results of the leg and it was reported she had a fracture. Nurse asked R1 could she perform a full body assessment R1 declined. Communicated results to doctor who stated to send R1 out to the hospital. Nurse went to R1 and told R1 we would be sending her to the hospital because she has a fracture. R1 was very upset and didn't want to go the hospital because she didn't want to miss her smoke breaks. Offered R1 pain medication and she declined because wanted her oxycodone but nurse informed R1 it was too early because it had not been 6 hours since the last time she received it. R1 refused any other pain medication. V12 (cna) witness statement dated 10/3/24 documents: V12 stated a few weeks ago on a Saturday, she noticed R1 transferred herself to the chair, she stated R1 told the nurse that she was in pain. She stated nurse instructed the c.n.a's to left R1 out to go smoke. V12 stated, she notified V2 (don) in regards to R1 complaining of pain, V12 stated that R1 has always been a time one person assist in transfers until just recently on 9/25/24. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	V22 (R1's nurse on 9/25/24) witness statement dated 10/3/24 documents: What type of care does the resident require? I/(V22) am not certain of the type of care she (R1) required. V22 did not have access to the computer system because there was a delay in getting her login information and V22 was not familiar with the computer system. 9/25/24 was the first time V22 took care of R1. V22 was at the facility from 7:30AM-10:30AM then sent home. V22 was not aware of any occurrence that may have occurred with R1. R1 was screaming in pain wanting her oxycodone. R1 was not scheduled to get her oxycodone until 11:50AM but R1 would stop screaming if she could get it at 11AM.What actions, if any did you take in response to the allegation? None because V22 was not aware of any allegations of abuse. If you're familiar with the alleged victim, have you noticed any change in alleged victim's behavior because of the alleged abuse? V22 was not familiar with R1's normal behavior. Facility abuse policy dated 9/20: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of property, corporal punishment and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents and has attempted to establish a resident sensitive and resident secure environment. 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. Neglect is the failure of the facility, its employees or service providers to provide goods and services necessary to avoid physical harm, pain mental anguish or emotional distress.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41758 Based on interview and record review, the facility failed to follow their abuse policy by not reporting an injury of unknown origin to include bruising and acute displaced fracture of distal tibia to the State regulatory agency. This affected one of three residents (R1) reviewed for reporting injury of unknown origin. Findings Include: R1 had the diagnosis of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominate side and peripheral vascular disease. On 10/15/24 at 12:37PM, V21 (Illinois department of public health regional office staff) reported that there was no facility report incident or reportable incident for R1. On 10/16/24 at 10:50AM, V5 (regional consultant) said, she does not have and could not find a facsimile or email conformation that R1's reportable incident was sent to Illinois Department of Public Health. On 10/16/24 at 12:24PM, V3 (adon) said, injuries of unknown origins should be reported to Illinois Department of Public Health. On 10/16/24 at 12:36PM, V1 (admin) said, injuries of unknown origins should be reported to Illinois Department of Public Health. On 10/16/24 at 1:20pm, V16 (cna) said, she saw R1 who had a darken discoloration the size of hand palm on R1's ankle. V16 said, the discoloration looked like gangrene which she had seen before on another resident in the past. V16 said, she reported to V4 (unit manager). On 10/16/24 at 1:30PM, V10 (treatment nurse) said, she was informed that R1 had a bruise on her lower leg. V10 said, based on R1's history of Peripheral Vascular Disease she notified the doctor, got an order for a Doppler. V10 said, she did not conduct any type of body assessment. V10 said, the body assessment should have been done by the nurse. V10 said, she does not treat bruises. On 10/16/24 at 2:27PM, V5 said, anything in the abuse policy should be reported no later than two hours after being informed. V16's witness statement dated 10/2/24 documents: on the 25th, V16 saw R1 and she had dark color by her ankle. R1 was in pain. V16 reported to V4. V16 had not seen this dark color on R1 in days prior. V16 asked R1 what happen, she said she didn't know. We transferred R1 with a mechanical lift because we didn't want R1 to stand. V16 asked the nurse what was going on with her foot and she said they were doing an x-ray. V16 texted on 9/25 at 9:17am about the dark ankle. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145736	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Clinical and Order alert listing report dated 9/25/24 documents: Pain-new or worsening; Participate less in activities. (9/26/24) Venous and Arterial Doppler with ABI of bilateral lower extremities (BLE). Radiology Results examination dated 10/01/24 at 17:12 (5:12pm) reported at 19:36 (7:36pm) documents: Bilateral lower extremity arterial Doppler ultrasound Left ABI was not attempted due to possible fracture. Wound in left lower distal leg. Discoloration in left foot. Radiology Results examination dated 10/01/24 at 20:45 (8:45pm) reported at 00:30 (12:30am) document: X-ray exam of lower leg. Findings: acute displaced fracture of distal tibia noted. Facility final report dated 10/7/24 documents: To: Illinois Department of Public Health (DPH.[NAME]. LTC@illinois.gov) Resident: R1 is alert and orient to self, place and time with a BIMS score 14. R1 utilizes a motorized wheelchair for ambulation. On 10/1/2024, R1 reported pain in her left lower leg. Full head-to-toe assessment completed which revealed discoloration to lower left extremity. X-ray result results revealed an acute displace fracture distal tibia. Abuse Policy dated 9/20 documents: Identification: the nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruising or unknown origin, lacerations or other abnormalities as they occur. Upon report Reporting: Initial reporting of allegation shall be completed immediately upon notification of an allegation. The written report shall be sent to Department of Public Health. Incident/Accident Reports (for Illinois Facilities) dated 9/2020 documents: The facility shall, by fax or phone, notify the regional office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, the facility shall notify the Department's toll-free complaint registry hotline. Any injuries of unknown source are reported immediately (no later than 2 hours) reported to state survey agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145736	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on observation, interview and records review, the facility failed to follow physician's orders for Oxygen for one (R4) of three residents reviewed for Oxygen use. Findings include: R4 was admitted to the facility on [DATE] with diagnosis of nephrotic syndrome, hypertensive heart disease with heart failure, heart failure, and kidney disease. On 10/15/24 at 1:55PM, R4 was observed in bed with nasal cannula attached to a green Oxygen tank. V9(nurse) said R4's oxygen was set to one liter. V9 confirmed R4's oxygen tank was empty and needed to be replaced. R4's physician order dated 2/1/24 documents Oxygen per nasal cannula at two liters per minute continuous every shift. On 10/16/24 at 12:14PM, V3 Assistant Director of Nursing (ADON) said all residents with Oxygen should have Oxygen applied according to the physician orders. The Oxygen tanks should never be empty. R4's Oxygen care plan dated 2/21/24 documents: administer Oxygen per physician orders; elevate the head of the bed while napping or sleeping to avoid shortness of breath while lying flat; monitor for changes in respiratory status; monitor for any signs or symptoms of respiratory distress and report to the medical doctor as needed; obtain Oxygen saturations per doctor orders. Facility Oxygen gas policy dated 9/2020 documents: Oxygen will be provided via compressed gas to the resident per the physician's orders by a nurse. Under procedure: adjust the liter flow control knob on the regulator to the prescribed flow.