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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>145736 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                             | (X3) DATE SURVEY COMPLETED<br><br>09/04/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Alden Town Manor Rehab & Hcc |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6120 West Ogden<br>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.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>(continued on next page)</p>  |

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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| <p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure laboratory services were completed as ordered and in a timely manner for 1 (R1) of 5 residents reviewed for laboratory services in the sample of 5. Findings include: R1 is an [AGE] year-old female admitted to the facility on [DATE] with diagnosis including but not limited to Chronic Systolic (Congestive) Heart Failure; Hypertensive Heart Disease with Heart Failure; Chronic Obstructive Pulmonary Disease; Type 2 Diabetes Mellitus Without Complications; Arthritis Due To Other Bacteria, Left Knee; Adjustment Disorder With Depressed Mood; and History of Falling. On 08/26/2025 at 01:08 PM Surveyor verified that R1 remains hospitalized at this time and is not available for observations nor interview. On 08/27/2025 at 01:48 PM V3 (Director of Nursing) said, I was not aware that R1 had weekly labs that were ordered post R1's last hospitalization and readmission on [DATE]. Nurses receive hand off report from the discharge facility, the receptionist gets medical records, uploads them into the electronic medical chart and then they bring it to the nurses. Any order that comes from the hospital, should be verified by nurses with attending physician to make sure they are appropriate for the resident. The attending physician may or may not agree with the discharge orders. The nurses should then transcribe all discharge orders into electronic medical chart. Laboratory service orders have to be also transcribed on to the hard copy and placed in the binder for laboratory staff to pick them up each morning when they come to collect residents' specimens. On 08/28/2025 at 10:00 AM V6 (Licensed Practical Nurse) said, I vaguely remember readmitting R1 on 7/17/2025; it's been a month. I don't remember if R1 returned with any new orders for labs. When a resident gets readmitted with new lab orders, I put them in the system (electronic medical chart). R1 was readmitted on Friday (07/18/2025), her labs were going to be drawn on Monday, and the results were supposed to be faxed to infectious disease doctor. They were standing labs, meaning, they are automatically scheduled to be done on a regular, weekly basis. I believe I placed R1's labs in the system as a standing order. Additionally, we place lab orders on a hard copy and place them in the bin for phlebotomist to pick it up and be able to determine which resident needs which labs to be drawn. On 08/28/2025 at 10:25 AM V3 (Director of Nursing) said, I think what happened was, R1 had a standing order for laboratory services; however, upon readmission, V6 (LPN) placed lab order to be done on Monday (07/21/2025) and repeated a week after (07/28/2025) instead of routine, weekly laboratory service. The most recent order should have been placed as routine, weekly laboratory service order. I am unable to produce the original order from 07/18/2025 at this time, it disappeared from the system. There were no further labs drawn after 07/21/2025 and 07/28/2025 until infectious disease clinic called and said they are missing R1's weekly labs. We then placed an order on 08/15/2025 for labs to be restarted on 8/18/2025 (Monday) and continued weekly every Monday. Additionally, nurses placed a one-time order for labs to be drawn on 08/16/2025. R1's labs were drawn after that on 08/25/2025 as per schedule and R1 was hospitalized later in a day on 08/25/2025 for chest pain. All together, we missed labs on 08/04/2025 and 08/11/2025 due to V6's (LPN) mistake while placing lab order. On 08/28/2025 at 12:03 PM V15 (Assistant Director of Nursing) said, I was called by infectious disease clinic to be made aware of R1's missing labs. The clinic staff appeared to be upset and was demanding R1's labs be drawn and sent to the clinic weekly. I explained that I wasn't aware of the order, but I will try to resolve it as soon as I can. The clinic staff proceeded to hang up on me. I gathered all available lab results and sent it to the clinic, I gave them a call; however, I didn't get a response. I tried again and I was able to speak to the clinic staff and confirmed that the clinic received available blood work results; however, did not get further directions. Per record review, R1's discharge order dated 07/18/2025 reads in part, Please draw weekly labs: CBC w DIFF, BUN, Creatinine, and LFT's, Fax results weekly to xxx-xxx-xxxx. Per record review, R1's laboratory service reports show collection dates on 07/21/2025, 07/28/2025, 08/16/2025, and 08/25/2025. Per R1's hospital readmission order dated 07/18/2025, laboratory services should have been provided on weekly basis and were not done on 08/04/2025, 08/11/2025, and 08/18/2025. The facility Job Description: Staff Nurse (Registered Nurse/License Practical Nurse) reads in part, Arrange for diagnostic and therapeutic services, as ordered by the physician; obtain sputum, urine, and other lab tests as ordered.</p> |  |  |