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	05/31/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure toiletries were secured inside the residents' rooms on the Memory Care unit in violation of the facility's policy. This failure affected 4 of 9 (R1, R2, R5, and R6) residents reviewed for hazards in the sample of 9.The Findings include:The (05/30/2026) email correspondence with V12 (Restorative Director/Registered Nurse) documented that there were 21 residents on the Memory Care Unit who can ambulate without staff assistance. On 05/29/2026 at 10:55am with V5 (Licensed Practice Nurse) there was a basin with a tube of Vitamin A and D cream and bottles of perineal wash cleanser on top of a side table inside R5's and R6's room. This was pointed out to V5, and she stated those are bottles of peri wash cleanser and barrier cream the CNAs use for incontinence care. V5 picked the basin up and put it inside R5 and R6 toilet room and stated the floor is a dementia unit and they have a lot of confused residents ambulating.On 05/30/2026 at 12:05pm with V10 (Restorative Aide/Certified Nursing Assistant) translating for this surveyor, R6 stated the current year was 1950. Then later stated the current year was 1940. R6 stated she did not know who the current president.On 05/30/2026 at 12:11pm with V10 translating for this surveyor, R5 was mumbling when inquiring about the current year. V10 stated she could not talk. On 05/29/2026 at 11:03am with V5 inside R1 and R2's room, there was a basin with a tube of Vitamin A and D and bottles of perineal wash cleanser on top of R1's side table. V5 picked up the basin and put it inside the toilet room. R2 entered the room and walked towards her bed. V5 stated she (R2) can walk without assistance; she is sometimes confused but she can talk.On 05/29/2026 at 11:09am, R2 stated she could not remember how long she has been at the facility, and the current year was 2024. On 05/29/2026 at 11:13am, R1 stated it is Monday or Tuesday, and it is got to be around 1980.On 05/30/2026 at 2:08pm, V12 stated the residents on the third floor have dementia diagnosis. The third floor is the memory care unit of the facility. On 05/30/2026 at 11:41am, V2 (Director Of Nursing) stated in the Memory Care unit, the facility try to limit hygiene products; any type of hazard should be limited, in case there is a confused resident misusing this hygiene products; like drinking shampoo. It is not gonna kill them but it could potentially make them sick.R1's admission Record documented that R1's diagnoses include but are not limited to hypertensive chronic kidney disease, dementia with behavioral disturbance, and COPD (Chronic Obstructive Pulmonary Disease). R1 was born on [DATE].R1's (03/27/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 05. Indicating the resident's mental status was severely impaired. R1's (Target Date: 08/26/2026) care plan documented, in part Focus: has an ADL Functional Performance Deficit secondary to confusion, impaired cognition. Goal: will tolerate ADL (Activities of Daily Living) assistance from staff. Interventions: Barrier cream with incontinent care. Provide supplies necessary for grooming and hygiene tasks.R2's admission Record documented that R2's diagnoses include but are not limited to acute on chronic congestive heart failure, dementia, and Type 2 Diabetes Mellitus. R2 was born on [DATE].R2's (Target Date: 06/30/2026) care plan documented, in part Focus: has an ADL Functional Performance Deficit due to fall risk, generalized weakness, occasional incontinence, use of high-risk medications and confusion (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	due to Dementia. Goal: will participate in selfcare activities. Interventions: Assist resident with set up for supplies of bathing as needed. Assist with personal hygiene as needed. Assist with toileting needs as necessary.R5's admission Record documented that R5's diagnoses include but are not limited to Alzheimer's disease, dementia with behavioral disturbance, and hallucinations. R5 was born on [DATE].R5's (04/14/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: no entry. C0700. Short-Term memory Ok: 1 memory problem. C0800. Long-Term Memory Ok: 1. Memory Problem. Section GG - Functional Abilities. GG0130: C. Toileting hygiene (The ability to maintain perineal hygiene): 01 - Dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity).R5's (Target Date: 07/13/2026) care plan documented, in part Focus: has an ADL Functional Performance Deficit secondary to confusion/severe cognition impairment, fall risk, dysphagia, incontinence, impaired mobility, delirium and weakness due to Early Onset Alzheimer's Dementia,Parkinson's, seizure. Goal: will be able to perform activities within physical limits. Interventions: Barrier cream with incontinent care. Provide needed level of assistance and support to complete Activities of Daily Living. Provide supplies necessary for grooming and hygiene tasks. R5's (Target Date: 07/13/2026) care plan documented, in part Focus: with potential for alteration in skin integrity d/t (due to) Alzheimer's, Dementia, Incontinent of bladder, Incontinent of bowel. Goal: Skin will remain intact. Interventions: Barrier cream to areas exposed to moisture/incontinence. Pericare after incontinent episodes. R6's admission Record documented that R6's diagnoses include but are not limited to Alzheimer's disease, epilepsy, dementia, and hypertension. R6 was born on [DATE].R6's (03/30/2026) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 06. Indicating the resident's mental status as severely impaired. Section GG - Functional Abilities. GG0130: C. Toileting hygiene (The ability to maintain perineal hygiene): 01 - Dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity).R6's (Target Date: 06/28/2026) care plan documented, in part Focus: has an ADL Self Care Performance Deficit due to confusion, Decreased Functional Ability, Dementia. Goal: will tolerate ADL assistance from staff. Interventions: Assist with personal hygiene as needed. Assist with toileting needs as necessary. Barrier cream with incontinence care. Provide supplies necessary for grooming and hygiene tasks.The (undated) Memory Care Unit policy and procedure documented, in part Hazards and rooms. No toiletries in room.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interview, and record review, the facility failed to ensure staff wear appropriate PPE (personal protective equipment) when turning and repositioning a resident on EBP (enhanced barrier precaution) and failed to ensure PPE bin was outside the room of a resident on EBP. These failures affected 1 of 5 residents (R3) reviewed for infection control in the sample of 9. The findings include:The (05/29/2026) Order Listing Report with Order Description: EBP (enhanced barrier precaution). Order Status: Active include R3. On 05/29/2026 at 10:31am with V4 (Licensed Practice Nurse), there was an EBP sign posted by R3's door, no PPE bin outside the room. V4 stated if there is an EBP sign, there should be a PPE bin outside of his room so staff can wear appropriate PPE prior to performing high contact care.On 05/29/2026 at 10:34am with V4, this surveyor knocked in the room, V6 (Certified Nursing Assistant) yelled Patient Care. Informed V6 that this surveyor needed to observe the Patient Care. Upon entering the room, there was a PPE bin inside R3's room. V6 had mask and gloves on, not wearing a gown. R3 was lying on his right side. V6 held a pillow, touched R3's left knee, and placed the pillow between R3's knees. V4 who was also observing V6 stated (V6) should be wearing a gown. V6 stated R3 has to be turned every two hours because he has a wound on his left hip, and he should be turned every two hours. V6 stated turning and repositioning a resident is a high contact care because he was touching the resident, and he should be wearing a gown and gloves when repositioning a resident on EBP. V6 also stated he did not put the PPE bin inside R3's room and maybe the management moved it inside R3's room.On 05/29/2026 at 10:48am, V4 stated she observed him (V6) doing patient care; he was giving direct care to the resident, touching the resident and wearing only gloves and mask; he was not wearing a gown. V4 stated he should be wearing gown and gloves when giving direct care to the resident; turning and repositioning a resident is a direct care because he was touching the resident. The purpose of wearing gown and gloves is to not give infection to the resident or take infection from the resident; to prevent transferring infection from a resident to the staff or from the staff to the resident. V4 stated if he did not don a gown, he (V6) could transfer the organism to anybody in the floor including other residents, other staff, and visitors because staff mingle with each other. V4 stated each CNA has 10-11 residents. On 05/29/2026 at 3:48pm, V2 (Director of Nursing) stated the PPE bin should be outside of the resident's room making it easily accessible to staff. Staff are expected to don appropriate PPE prior to performing high contact care. The PPE bin should not be inside the resident's room because then they are contaminating the whole thing. V2 stated the staff needs to don gloves and gown when repositioning a resident, because when the resident is on EBP the resident is at risk of getting infection from the staff because it is in the environment, there are something in the air or surface and they did not want to be bring that to the residents. V2 stated best practice is to gown up when repositioning a resident. On 05/30/2026 at 11:26am, V2 stated EBP exists because they are attempting to protect vulnerable residents from any nosocomial infection from another resident which could be carried by staff. If staff is not donning appropriate PPE when performing high contact care these could potentially affect another resident, another staff, and visitors. R3's admission Record documented that R3's diagnoses include but are not limited to cellulitis of right upper limb (onset date: 4/28/2026), pressure ulcer of left hip stage 4, and dementia. R3's (Active Order as Of: 05/29/2026) Order Summary Report documented, in part EBP for chronic wound. Active: 04/28/2026.R3's (Target Date: 07/27/2026) care plan documented, in part Focus: has an ADL Functional Performance Deficit secondary to aggressive Behavior (resistant to care), non-verbal/unable to make needs known, unable to move to and from a lying position without staff assist, fall risk, incontinence, Weakness/deconditioning and Activity Intolerance related to advanced dementia, s/p fall/hospitalization, wounds and debility. Goal: will improve current level of ADL function through next review. Interventions: Enhanced Barrier Precautions will be implemented during high contact resident care activities.R3's (Target Date: 07/27/2026) care plan documented, in part (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: with PUI (Pressure ulcer/injury) to the Left Hip, resident digging/picking in both wounds, Toenails long, generalized dryness. Combative during care. Removes dressings. Recent Hospitalizations. Goal: Site(s) will show signs of healing through next review. Interventions: Enhanced Barrier Precautions will be implemented during high contact resident care activities for chronic wounds including, but not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers. Position body with pillows/support devices. Turn and reposition every two hours and as needed. The (08/2025) Enhanced Barrier Precautions policy and procedure documented, in part Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) in nursing homes. As well as to prevent multi-drug resistant organism acquisition of those with an increased risk of acquiring MDROs including residents with a chronic wound or an indwelling medical device. GUIDELINES: 1. EBP involves gown, and gloves use during high-contact resident care activities for residents known to be infected or colonized with MDROs when contact precautions do not otherwise apply. As well as residents with a chronic wound and/or indwelling medical device. PROCEDURE: 1. High-Contact Resident Care Activities include the following:a. Dressing. b. Bathing/Showering. c. Transferring. d. Changing linens. e. Providing hygiene. f. Changing briefs or assisting with toileting. g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. h. Wound care. 5. Make PPE available and accessible outside of the resident's room (each room does not need their own set-up).