

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  03/21/2025
NAME OF PROVIDER OR SUPPLIER  Alden Town Manor Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40066</p> <p>Based on interviews and records reviewed the facility failed to meet residents' needs when they utilize the call lights for assistance. This failure affected 5 ( R283; R75; R121; R115; and R16 ) residents reviewed for call light concerns out of a sample of 54 residents.</p> <p>Findings include:</p> <p>A. During Resident Council interview on 03/18/25 at 11:21 AM R19, Resident Council President gave consent for the surveyor to review the council meeting notes. R283 said If I pull the light they come when they want. I call and sometimes I might wait up to an hour. R283 said yesterday I requested an oatmeal that my sister brought me at 4:00am, I used to work nights so that is when I eat. R283 said they didn't bring it in until 8:00AM with breakfast. R283 said I can hear them talking, laughing, and carrying on in the hallway. R283 said why can't they just bring me what I ask and then they can carry on and I'll be taken care of?</p> <p>On 03/19/25 at 11:04 AM R75 and R121 said the staff will turn the call light off and say I will be back in a minute and they don't come back. R75 said it feels like the call lights are on and they forget about you. R75, R121, and R19 said if they comeback at all to help you it takes a long time. R121 said it takes more than half hour to get help for towels, when your sick, or just need some help.</p> <p>On 3/20/25 at 12:45PM V12, RN (Registered Nurse), said R283 told her that he would like food at night, but we didn't know that before. V12 said we will have it for him now that we know.</p> <p>R283 minimal data set section C (Cognitive Pattern) brief interview for mental status dated 3/3/25 documents a score of 15, cognitively intact.</p> <p>R121 minimal data set section C (Cognitive Pattern) brief interview for mental status dated 2/10/25 documents a score of 15, cognitively intact.</p> <p>R75 minimal data set section C (Cognitive Pattern) brief interview for mental status dated 1/10/25 documents a score of 15, cognitively intact.</p> <p>B. R115's minimal data set section C (Cognitive Pattern) brief interview for mental status dated 3/3/25 documents a score of fourteen which indicate cognitively intact.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/18/25 at 11:05AM, R115 said, she pushed the call light on the overnight shift because she was vomiting and coughing but no staff came to answer her call light all night.</p> <p>Concern form dated 3/18/25 documents: R115 stated, she pressed call light on night shift and no one came. Follow-up action taken: In-service provided to staff nurse. Time date and person notified of outcome of concern 3/18/2025 at 1:45pm.</p> <p>C. On 3/19/25 at 12:28PM R16 stated facility staff take hours to answer the call light. R16 reported R16 waits the most on night shift. R16 stated about one month ago R16 waited four hours to be changed. R16 reported asking an unknown CNA to be changed around 4:00AM but no staff came to change R16 until around 8:00AM on the next shift. R16 stated telling V11, Unit Manager, about not being changed and call light wait time. R16 reported V11 did not follow up with R16 with R16's concerns.</p> <p>On 3/20/25 at 10:22AM V11 stated V11 heard R16 telling the surveyor about the long call light response time. V11 denied R16 talking to V11 previously about the call lightwait time. The surveyor asked V11 if V11 addressed the concern R16 voiced about the call lights. V11 denied talking to R16 about call light wait because R16 did not come up and talk with V11 personally about the issue.</p> <p>A concern form dated 3/18/25 for R115 states resident states she pressed the call light on night shift and no one came. Follow up action documented 3/18/25 states Inservice provided to nurse.</p> <p>January Resident Council Minutes for January 22, 2025 notes Department/Concern documents Residents have began to complain about call light response time again.</p> <p>A call light inservice dated 3/18/25 was provided by the facility.</p> <p>Call light Policy no date documents: To ensure that resident needs are met.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40102</p> <p>Based on observation, interview, and record review, the facility failed to keep residents free from physical restraints for two (R2 and R10) out three residents reviewed for restraints in a total sample of 54.</p> <p>Findings Include:</p> <p>R2 is a [AGE] year old with the following diagnosis: cerebrovascular disease, neuromuscular dysfunction of the bladder, and acquired absence of bilateral legs above the knee.</p> <p>On 03/18/25 at 9:35am R2 was observed sitting across from the nurse's station in a manual wheelchair with back rest not reclined. A tan/gray canvas strap device tied in a knot to left and right arm rest of wheelchair. Blanket was over chest/abdominal area so the front of R2 was not able to be seen.</p> <p>On 03/18/25 02:43 PM, R2 was lying in bed. Lap belt strap noted tied to each arm rest on the wheelchair.</p> <p>On 03/19/25 12:40 PM, R2 was sitting in a manual wheelchair straight up. The lap belt was tied to each side of the wheelchair and velcroed around R2's waist. V19 (CNA) stated R2 wears this strap while up in a wheelchair due to R2 sliding out. R2 was asked to moved R2's arms to try to remove the strap and R2 could not remove the strap unassisted. R2 wears a splint to the right hand and has lack of control to the left arm.</p> <p>03/21/25 at 11:32AM - V18 reported the facility is a restraint free facility. V18 stated R2 should not be wearing a lap belt and the lap belt needs an order. V18 reported R2 does not have the strength or dexterity to remove the lap belt unassisted. V18 reported restraints are not used because the objective is to not restrict movement. V18 stated a physician must be called and an order must be placed if the lap belt is used. V18 reported R2 uses a splint to the right hand due to a contracture and receives passive range of motion to both hands for joint mobility. V18 stated the lap belt has been discontinued because R2 needs to be using a high back reclining chair. V18 reported the high back reclining chair is more comfortable and safer for R2 than to use a manual wheelchair and lap belt. V18 stated R2 does not have the hand strength or dexterity to remove the lap belt unassisted. V18 reported if the lap belt is currently being used then a physician needs to put in an order and a consent must be obtained.</p> <p>3/21/25 12:12PM V14 (Regional Nurse Consultant) stated if a lap belt is in use the resident must be able to remove the belt themselves. V14 reported if it cannot be removed without assistance then it is considered a restraint. V14 stated a physician order and consent is needed for a lap belt. V14 reported it also must be documented that the restraint is taken off for rest period during the day and skin checks must also be documented.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Restorative Nursing assessment dated [DATE] documents R2 uses a manual wheelchair and a splint to the right hand during the day. R2 will continue to receive a passive range of motion program to right hand and the two middle fingers of the left hand for contractures. There is no documentation that a high back reclining wheelchair should be in use for R2. There is also no documentation that a lap belt is currently being used for R2.</p> <p>The Restraint Consent dated 1/10/25 documents consent was received from R2's family for the use of the lap belt. There is no witness signature on the form. Two signatures are needed for consent.</p> <p>The Minimum Data Set Section P dated 1/12/25 documents no physicals restraints are in use for R2.</p> <p>The Physician Order Sheet was reviewed and there is no current order for a lap belt to be used.</p> <p>The Care Plan dated 1/20/12 documents R2 is at high risk for falls related to dementia and multiple sclerosis. An intervention dated 7/5/18 documents R2 should use a high back wheelchair in a slight recline position when not having meals. There is no intervention in this care plan that a lap belt should be used while sitting in a wheelchair. The Care Plan dated 5/23/12 documents R2 has limited range of motion related to multiple sclerosis, contracted muscles, and lack of coordination. The Care Plan dated 3/20/25 documents R2 has difficulty sitting upright in a basic wheelchair and uses a high back reclining chair to maintain comfort and promote proper body alignment secondary to stroke, poor muscle control and posture, and multiple sclerosis.</p> <p>R10 is a [AGE] year old with the following diagnosis: chronic kidney disease stage 3, bipolar, schizoaffective disorder, and chronic obstructive pulmonary disease.</p> <p>03/18/25 09:48 AM R10 has the upper side rails in place on both sides of the bed. Bed bolsters are also noted on each side of the bed. R10 was lying on R10's back. The surveyor asked R10 to roll over to the side. R10 reached for the upper side rail but was unable to move legs to roll to the side due to the close positioning of the bed bolsters.</p> <p>03/19/25 9:22 AM - R10 again is lying on R10's back. The side rails and bed bolsters are still in the same place. The surveyor again asked R10 to roll to the side and R10 was unable.</p> <p>03/21/25 at 10:52AM- R10 is lying on R10's back. Bilateral side rails and bilateral bed bolsters are in place. V17 stated R10 has a behavior of getting out of bed and lying on the floor so an interventions was to put bolsters in place. V17 reported R10 has not had the behavior of getting out of bed and lying on the floor since the end of last year. V17 stated R10 needs assistance with turning and repositioning and is mechanical lift for transfers. V17 removed the blankets from R10. The surveyor and V17 asked R10 to attempt to get out of bed. R10 was unable to turn to the side unassisted and was unable to lift legs over the bolsters. V17 reported R10 has calmed down and has not attempted to get out of bed since the end of last year. The surveyor asked V17 what is it called when a resident cannot get out of bed unassisted due to the side rails and bed bolster being in place and the V17 responded that it is considered a restraint.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11:32AM V18 (Restorative Nurse) stated R2 is dependent and needs assistance with all ADL care and mobility. V18 has poor trunk control and is non-ambulatory. V18 reported R2 has had falls in the past but had not had one in the past 90 days. V18 stated R2 has bed bolsters in place. V18 reported R10 has a behavior of sliding out of bed to lie on the floor. V18 denied ever seeing R10 slide out of bed or dangle R10's legs out of the bed but stated that is what staff tells V18. V18 stated R10 has side rails up for assistance with turning. V18 confirmed a restorative assessment was completed by V18 on 3/18/25. V18 denied noting any new changes and reported R10 was still able to get out of bed to at the time of assessment. V18 stated during the assessment the resident is asked to turn to the side and move around the bed but staff still assist the resident. V18 stated if a resident cannot get out of bed unassisted and the bed exit is being blocked by side rails and bed bolsters then it is considered a restraint. V18 defined a restraint as restriction of movement. V18 reported the facility is a restraint free facility.</p> <p>12:12PM V14 (Regional Nurse Consultant) stated R10 has a habit of putting the legs out of the bed and that R10 is confused at baseline. V14 was unsure of the time frame but stated R10 has not had a fall in a while. V14 was not able to state what interventions R10 has in place for falls or getting out of bed. The surveyor notified V14 that throughout the survey R10 has had both side rails and bilateral bed bolsters in place. The surveyor then told V14 that R10 was instructed to attempt to get out of bed with the side rails and bed bolsters in place but was not able to get out. The surveyor asked V14 what it is called when a resident cannot get out of bed due to it being blocked with side rails and bolsters and V14 responded it would be considered a restraint.</p> <p>The Restorative Nursing assessment dated [DATE] documents R10 uses bilateral quarter side rails. A recommendation is to have R10 in the bed mobility program to assist with turning side to side.</p> <p>The Side Rail assessment dated [DATE] documents R10 does not have a history of falls within the last six months. It documents the side rails would not keep R10 from voluntarily getting out of bed.</p> <p>The Minimum Data Set Section P dated 2/4/25 documents no physical restraints are in use for R10.</p> <p>The Physician Order Sheet was reviewed and there is no current order for any restraints to be used. There is no documented consent for restraints.</p> <p>The Care Plan dated 11/06/2015 documents R10 is at risk for falls due to bipolar and heart disease. R10 is noted to crawl out of low bed to floor and slides from the geri-chair. An intervention dated 8/26/24 documents bed bolsters are applied to the mattress.</p> <p>The policy titled, Restraint (Physical/Devices), dated 09/2020 documents, Policy: It is the philosophy of this facility to support a restraint free environment. In accordance with federal and State laws, the use of the device will only be considered when determined to be necessary through the assessment and care planning process. CMS Definition: Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Procedure: .2. Restraints will be ordered by a physician, based on the assessment of the resident capabilities, based on consultation with health care professionals, and demonstrated by the care planning process as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental, or psychosocial well-being.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39340</p> <p>Based on interview and record review, the facility failed to accurately code the minimum data set (MDS) assessment for four (R9, R34, R48 and R160) of eight residents reviewed for hospice. In addition, the facility failed to accurately code the weight assessment for one resident (R70) who was identified to have a greater than 10 percent weight loss in 6 months but not identified on the MDS for one of thirteen reviewed for nutrition in a total sample of 54.</p> <p>Findings Include:</p> <p>R160</p> <p>R160 was admitted to the facility on [DATE] with a diagnosis of cerebrovascular accident.</p> <p>R160's Minimum data set (MDS) dated [DATE] under section J1400 prognosis (Does the resident have a condition or chronic disease that may result in a life expectancy of documents a code 0 which indicates No.</p> <p>R160 hospice admission orders dated 8/29/24 terminal diagnosis of senile degeneration of the brain with 6 months or less to live.</p> <p>On 3/21/25 at 10:15AM, V6(minimum data set, MDS nurse) said a resident receiving hospice services on their minimum data set, MDS section J1400 should be coded as a yes if the documentation is available. Staff have up to 7 days to try to obtain certification if paperwork is not available in the medical record.</p> <p>CMS RAI version 3.0 manual dated October 2024 documents under J1400 coding instructions: code yes if the medical record includes physician documentation: 1)resident is terminally ill; or 2) the resident is receiving hospice services.</p> <p>R9</p> <p>R9 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease.</p> <p>R9 Minimum data set (MDS) dated [DATE] under section J1400 prognosis (Does the resident have a condition or chronic disease that may result in a life expectancy of documents a code 0 which indicates No.</p> <p>R9 hospice admission orders dated 1/14/23 terminal diagnosis of Alzheimer's with 6 months or less to live. R9's physician certification dated 12/19/24 documents: the patients prognosis is six months or less if the disease runs its normal course.</p> <p>On 3/21/25 at 10:15AM, V6(minimum data set, MDS nurse) said a resident receiving hospice services on their minimum data set, MDS section J1400 should be coded as a yes if the documentation is available. Staff have up to 7 days to try to obtain certification if paperwork is not available in the medical record.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>CMS RAI version 3.0 manual dated October 2024 documents under J1400 coding instructions: code yes if the medical record includes physician documentation: 1)resident is terminally ill; or 2) the resident is receiving hospice services.</p> <p>R34</p> <p>R34 is a [AGE] year old with the following diagnosis: Parkinson's disease, type 2 diabetes, and neuromuscular dysfunction of the bladder.</p> <p>On 3/20/25 at 3:05PM, V14 (Regional Nurse Consultant) stated R34 originally admitted to hospice in January 2023 but was discharged from hospice in December 2023. V14 reported R34 readmitted to hospice in December 2024.</p> <p>The Hospice Certification Statement dated 1/10/23 documents the physician certified that R34 is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. The Recertification Statement dated the effective date of certification as 12/10/24. The physician certified that R34 is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. This certification is good until 2/7/25. R34 was again recertified for hospice on 2/8/25 by the physician with a life expectancy of six months or less if the terminal illness runs its normal course.</p> <p>The Care Plan dated 12/11/24 documents R34 was admitted to hospice due to Parkinson's disease. All interventions are documented on 12/11/24.</p> <p>The Minimum Data Set (MDS) Section J dated 12/18/24 documents R34 does not have a life expectancy of less than six months. This is not correctly coded.</p> <p>On 3/21/25 at 10:15AM, V6(minimum data set, MDS nurse) said a resident receiving hospice services on their minimum data set, MDS section J1400 should be coded as a yes if the documentation is available. Staff have up to 7 days to try to obtain certification if paperwork is not available in the medical record.</p> <p>CMS RAI version 3.0 manual dated October 2024 documents under J1400 coding instructions: code yes if the medical record includes physician documentation: 1)resident is terminally ill; or 2) the resident is receiving hospice services.</p> <p>R48</p> <p>R48 is an [AGE] year old with the following diagnosis: congestive heart failure, type 2 diabetes, and atrial fibrillation.</p> <p>The Hospice Certification Statement dated 1/15/25 documents the physician certified that R48 is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. R48 is certified to receive hospice services through 4/14/25.</p> <p>The Care Plan dated 1/16/25 documents R48 requires hospice. All interventions are documented on 1/16/25.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Minimum Data Set (MDS) Section J dated 1/17/25 documents R48 does not have a life expectancy of less than six months. This is not correctly coded.</p> <p>On 3/21/25 at 10:15AM, V6(minimum data set, MDS nurse) said a resident receiving hospice services on their minimum data set, MDS section J1400 should be coded as a yes if the documentation is available. Staff have up to 7 days to try to obtain certification if paperwork is not available in the medical record.</p> <p>CMS RAI version 3.0 manual dated October 2024 documents under J1400 coding instructions: code yes if the medical record includes physician documentation: 1)resident is terminally ill; or 2) the resident is receiving hospice services.</p> <p>40066</p> <p>R70's diagnosis include but are not limited to Hypertension, Gastro Esophageal Reflux Disease, Incontinence, Muscle Weakness, Chronic Pain, Anxiety, Dysphagia, Facial Weakness following Cerebral Infarction, Hemiplegia and Hemiparesis, Major Depressive Disorder, Muscle Wasting and Atrophy, Non Pressure Chronic Ulcer of Foot (Bunions), Chronic Pain, Recurrent Depressive Disorder, Pneumonia, and Osteoarthritis.</p> <p>On 03/20/25 at 10:22 AM V9, Registered Dietician, said I asked about the MDS for R70. V9 said R70 definitely had 10% loss in 6 months and 4.2% loss for 1 month. V9 said R70's weight in July 2024 was 146 pounds, she had a 28% weight loss. V9 said in January 2025 R70's weight was 113.2 pounds and her current weight is 111 pounds.</p> <p>On 03/20/25 at 11:04 AM V6, MDS Nurse, said I do section K (Swallowing/Nutritional Status) of the MDS, I gather information from the Registered Dietician. V6 said I then enter the information into the assessment. On follow up interview at 11:34 AM V6 said R70 had a significant weight loss x 1 month and 6 months. V6 said I made a correction for the 1/9/25 MDS. V6 said R70 was 146 pounds 6 months ago. V6 said I am not part of the weight meeting. At 12:05PM V6 said I updated the care plan and notified the nurse.</p> <p>MDS dated [DATE] section K0300 states 0 for weight loss. Current weight is 113 pounds The corrected MDS V6 presented on 3/20/25 notes Weight loss 2- yes, not on prescribed weight loss regimen.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40102</p> <p>Based on interview and record review, the facility failed to coordinate getting residents (R16, R156, R76 and R84) a level II PASRR assessment for residents with severe mental illness diagnosis for four out of five residents reviewed for PASRR screening in a total sample of 54.</p> <p>Findings Include:</p> <p>R16 is a [AGE] year old with the following diagnosis: major depressive disorder and post traumatic stress disorder (PTSD).</p> <p>R156 is a [AGE] year old with the following diagnosis: bipolar disorder.</p> <p>R76 admitted in the facility on 5/31/2017 with diagnoses but not limited to: Dementia, Bipolar Disorder and Major Depressive Disorder.</p> <p>R84 admitted in the facility on 6/20/23 with diagnoses of but not limited to: Dementia with other behavior disturbance, schizoaffective disorder, and anxiety.</p> <p>R156 was unable to be interviewed due to mental status.</p> <p>On 3/19/25 at 12:28PM, R16 stated R16 is diagnosed with depression and PTSD. R16 confirmed R16 receives medication daily for managing symptoms. R16 reported R16 also attends psychotherapy sessions for mental health diagnosis. R16 denied being aware if a Level II screen was completed.</p> <p>On 03/19/25 11:08 AM, Reviewed Notice of PASSR Level 1 Screen Outcome dated 3/20/25 reads in part: PASSAR Level 1 Determination: Refer for Level II Onsite. Suspected or Confirmed PASSAR Conditions: (MH) Mental Health Disability.</p> <p>On 03/20/25 12:23 PM, reviewed Notice of PASSR Level 1 Screen Outcome dated 3/20/25, reads in part: PASSAR Level I Determination: Refer for Level II Onsite. Suspected or confirmed PASSAR Conditions: (MH) Mental Health Disability.</p> <p>On 3/20/25 12:47 PM -V7 (Admissions Director) stated V7 gets PASRRs from the hospitals but to renew them. V7 reported social services is responsible for renewing them. V7 reported V7 has never had a need for level 2. V7 was unsure of all the diagnosis that need a level II screen but confirmed if a resident has bipolar then a level II is needed. V7 stated the facility also has marketing team that helps to review PASRRs and will notify the facility if anything is incorrect or missing.</p> <p>(continued on next page)</p>		

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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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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3/20/25 1:03PM - V4 (Social Services) stated that if there is a mental diagnosis the facility submits for a referral for a level II. V4 reported any diagnosis like major depression, schizophrenia, bipolar, or any other mental disorder would qualify for level II assessment. V4 admitted to reviewing the level I assessments when they are complete. V4 stated they have found level I PASRRs have that been completed incorrectly that should have been a level II assessment. V4 was unable to name which residents had incorrect assessments. V4 reported Maximus will usually come within a week to complete a level II screen if needed. V4 stated the importance of completing a level II screen gives the facility interventions to provide for a resident with a mental health diagnosis. V4 was unaware of R156's exact diagnosis but reported if R156 does have a serious mental illness then a level II should have been completed. V4 reported completing the level I screen, and the program generated a level II was not needed. V4 reported refuting the findings with maximus on today 3/20/25. V4 was unable to state R16's mental health diagnosis. V4 stated R16's level I screen was completed yesterday and findings include R16 does not need a level II screen. V4 denied refuting the findings with maximus. V4 was unable to answer why PTSD was not listed on the level I screen as part of R16's diagnosis.</p> <p>The PASRR Level 1 Screen dated 3/19/25 documents the determination as no level II required due to no serious mental illness. R16's diagnosis of PTSD is not listed on the Level I screen that was submitted by the facility.</p> <p>The PASRR Level 1 Screen dated 2/13/24 documents the determination as no level II required due to no serious mental illness. The facility was unable to provide any other documents in the Level I screen besides the determination. The request for a level II screen was submitted to maximum on 3/20/25 at 11:13AM.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>39340</p> <p>Based on observation, interview and record review, the facility failed to follow doctor's orders for one resident(R89) with a diagnosis of lymphedema by not following physician recommendations of elevating bilateral legs for one of three residents reviewed for quality of care.</p> <p>Findings Includes:</p> <p>R89 has diagnosis of Dementia, Pulmonary Hypertension, Lymphedema and Atherosclerotic Heart Disease.</p> <p>During the survey, (3/18-/3/21/25) R89 was observed with legs flat in the bed in her room. There were no additional pillows available for use to place under her legs.</p> <p>On 3/21/25 at 11:48AM, V23(restorative nurse) said he was not aware of any recommendations to elevate R89's legs.</p> <p>On 3/21/25 at 11:53AM, V22(memory care director) said she was not aware of any recommendations to elevate</p> <p>On 3/21/25 at 11:59AM, V21(nurse practitioner) said she would expect any doctor recommendations to be followed</p> <p>as ordered. V21 said if any resident refuses, she would expect to be notified and the behavior to be documented. V21 said R89 was recommended to keep her legs elevated to help with circulation and prevent fluid from pooling. V21 said she was not aware of any resident refusals. R89's legs.</p> <p>R89's physician progress notes dated 3/7/25 documents: reported patient lymphedema is getting worse in bilateral lower extremities. Keep legs elevated at all times. Under plan documents: elevate legs when in bed on three pillows.</p> <p>R89's physician progress notes dated 3/14/25 documents: follow up for bilateral lower extremity edema pitting. Discussed with staff Keep legs elevated. Under plan documents: elevate legs when in bed on three pillows.</p> <p>R89's progress notes do not indicate any refusal of legs being elevated.</p> <p>R89's point of care task list does not indicate to assist with leg elevation.</p> <p>R89's care plan documents: R89 with Lymphedema Date Initiated: 03/17/2025. Interventions include Encourage and cue resident to elevate edematous extremity while seated or in bed as able and as tolerated. Assist as needed with positioning. Date Initiated: 03/17/2025.</p>

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066</b></p> <p>Based on interviews, observation, and records reviewed the facility failed to identify and evaluate interventions for one (R70) of 13 residents reviewed for nutrition in sample of 54. This failure resulted in R70 having an unplanned significant weight loss of 28% over 7 months.</p> <p>The findings include:</p> <p>R70's diagnosis include but are not limited to Hypertension, Gastro Esophageal Reflux Disease, Incontinence, Muscle Weakness, Chronic Pain, Anxiety, Dysphagia, Facial Weakness following Cerebral Infarction, Hemiplegia and Hemiparesis, Major Depressive Disorder, Muscle Wasting and Atrophy, Non Pressure Chronic Ulcer of Foot (Bunions), Chronic Pain, Recurrent Depressive Disorder, Pneumonia, and Osteoarthritis.</p> <p>On 3/20/25 at 12:35PM V24, CNA, said R70 has contracted hands but she can participate with feeding. V24 said R1 needs assistance, it changes with her sometimes she feeds herself.</p> <p>On 3/20/25 at 12:40PM R70 in her room, in bed, lunch of chopped meat and potatoes and gravy with spoon in it. R70 said I didn't touch it.</p> <p>On 3/20/25 at 12:45PM V12, RN said R70 appetite is poor, she feeds herself. V12 said she refuses what we do. V12 said she is supposed to go to the gastric doctor. V12 said R70 don't eat, we did a calorie count.</p> <p>On 03/20/25 at 10:22 AM V9, Registered Dietician, said I asked about the MDS for R70. V9 said R70 definitely had 10% loss in 6 months and 4.2% loss for 1 month. V9 said R70's weight in July 2024 was 146 pounds, she had a 28% loss of weight. V9 said in January 2025 R70's weight was 113.2 pounds and her current weight is 111 pounds.</p> <p>On 03/20/25 at 11:04 AM V6, MDS Nurse, said I do section K (Swallowing/Nutritional Status) of the MDS, I gather information from the Registered Dietician. V6 said I then enter the information into the assessment. On follow up interview at 11:34 AM V6 said R70 had a significant weight loss x 1 month and 6 months. V6 said I made a correction for the 1/9/25 MDS. V6 said R70 was 146 pounds 6 months ago. V6 said I am not part of the weight meeting. At 12:05PM V6 said I updated the care plan and notified the nurse.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/21/25 at 11:12AM V20, Nurse Practitioner, said R70's weight loss started in October 2024. V20 said sometimes R70 will eat and other times not at all. V20 said the CNAs told us that R70 was not eating at all even though R70 told us she ate. V20 intervention include trying to get her into a GI doctor, encourage her to eat, we provided supplements, and appetite stimulants. V20 said for the calorie counts we see she may eat breakfast and no lunch or dinner. V20 said we discussed hospice with the progression of her Rheumatoid Arthritis, and I increased her pain medication. V20 said R70 said she doesn't want a feeding tube. She went recent to GI, I called the office, we are questioning her cognitive ability. V20 said R70's agrees to eat but then she does not do it. V20 said we are going based on what the CNAs tell us. V20 said the staff were supposed to do weekly weights based on my conversation with the Dietician. V20 said of course R70 is someone we would be concerned for weight. V20 said R70 is a slow feed, since her hands are arthritic she needs a lot of time.</p> <p>On 3/21/25 at 12:53PM V9, said the extent of the calorie count is all they do with it. There is not a section with the calorie calculation, not for this facility.</p> <p>On 3/20/25 the surveyor requested from V1 evidence of Weight Committee procedures #2, 3, 4 and 5 for R70. Information was not provided by 3:30PM</p> <p>On 3/21/25 11:05AM requested from V1 documentation for weight committee, at 1:27PM the documentation has not been provided.</p> <p>3/21/25 1:25PM V14, Regional Nurse Consultant, said we are still working on getting the progress notes.</p> <p>Review of Progress notes for R70 written by V9 include 12/10/24; 12/11/24 and 2/17/25</p> <p>No documented evaluation of calorie count. Review of Progress Notes written by V20 include notes on 11/6/24 and 2/5/25, there is no evaluation of calorie count. Nurse progress notes include 12/9; 12/16; 24; 1/3/25; 1/4/25; 1/9/25; and 1/10/25. No evaluation of calorie count.</p> <p>On 3/21/25 at 2:02PM the facility provided the progress notes for R70.</p> <p>R70 MDS dated [DATE] section K0300 states 0 for weight loss. Current weight is 113 pounds The corrected MDS V6 presented on 3/20/25 notes Weight loss 2- yes, not on prescribed weight loss regimen.</p> <p>Three day Calorie Count reviewed for R70 dated 12/10/25 at 10:45AM and 6:23PM and 12/12/25 at 9:38PM. No total of calorie count, protein count, or total intake percentage.</p> <p>Care Plan reviewed for R70 nutritional support. Interventions include meal monitoring and recording, monitor labs.</p> <p>Review of R70's Order Summary Report includes Check Weight weekly x 4 ordered 1/8/25 and end date 2/5/25.</p> <p>Review of R70's January Medication Administration Record includes 1/8/25; 1/15/25; and 1/29/25 with weight NA. 1/22/25 weight is 113.2.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Monthly Weight Report for R70 includes weights December 2024 118.8 pounds; January 116.0 pounds; 109.0 February; and March 111.3 pounds. (V9 said R70's weight in July 2024 was 146 pounds, she had a 28% loss of weight since.</p> <p>Policy for Weight Committee dated 2023 states the purpose to reduce the risk of altered nutritional status. Committee will discuss residents with significant weight change, root cause for weight loss and intervention. The committee will also identify individual with insidious weight loss, gradual weight loss, and develop plan of care. The weigh committee will meet weekly to discuss residents with weekly weights. The committee will evaluate the nutritional status of the resident, identify root cause and develop interventions. Information discussed in Weight Committee to be documented via progress note and care plan as needed. The Weight Committee meeting will be obtained via PCC exception reports.</p> <p>Policy for Weights dated 9/2020 states residents will be weighted to establish a baseline weights and identify trends of weight loss and weight gain. Report any weight loss or gain greater than 5% within one month, 7.5% within three months or 10% within 6 months.</p> <p>Policy for Calorie Count dated 9/20 states a calorie count is to monitor adequacy of resident's calorie intake. 5. If a resident refuses a meal or does not eat any of the items, document the reason why the meal was missed and indicate amount consumed with a zero. (See calorie count, this is not documented.) 6. Dietary services will evaluate and document results and will make appropriate recommendations.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41758</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview and record review, the facility failed to date oxygen tubing and to properly store nebulizer mask while not in use for one of three (R13) residents reviewed in a total sample size of 54.</p> <p>Findings Include:</p> <p>R13' physician order sheet dated 3/18/25 documents: respiratory: oxygen per nasal cannula at two to four liters per minute continuous .order dated (3/13/25). Albuterol sulfate nebulization solution 1.5milliliter inhale orally via nebulizer every six hours as needed for respiratory symptoms order dated (3/13/25)</p> <p>On 3/18/25 at 10:48am, R13 was observed with a nasal cannula on with oxygen running. R13's oxygen tubing was not dated. R13's nebulizer mask was observed laying in R13's second night stand drawer which was partially opened without a bag. V6 (nurse) said, R13 was readmitted last night. R13's oxygen tubing should be dated and R13's nebulizer mask should be stored in a plastic bag to prevent contamination.</p> <p>On 3/20/25 at 3:59pm, V14 (regional nurse consultant) said, the oxygen tubing should be dated so that staff will know when to change it. Nebulizer mask should be stored in a plastic zip lock bag when not in use for infection control. A nebulizer mask should never be laying inside of the drawer without a bag.</p> <p>Oxygen therapy device- nasal cannula policy dated 9/2020 documents: A nasal cannula will be changed monthly and as needed. Equipment Change Schedule Policy documents: Equipment will be changed following established schedule to prevent cross contamination. Oxygen tubing, nasal cannula and mask are changed every month and as needed.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>40066</p> <p>Based on interviews and records reviewed the facility failed to submit accurate and complete data on the Payroll Based Journal. This failure has the potential to affect all 184 residents in the facility.</p> <p>The findings include:</p> <p>On 03/19/25 at 12:55 PM V1, Administrator, said we have no staffing waivers.</p> <p>On 03/20/25 at 09:35 AM V14, Nurse Consultant, said the Interim Director of Nursing, is here at least 5 days, for at least 8 hours. V14 said the DON clocks in (the surveyor requested time cards for 14 days).</p> <p>On 3/20/21 at 10:21AM V1 said Payroll Based Journal (PBJ) data is submitted quarterly and resident census is not included.</p> <p>On 03/20/25 at 12:08 PM V1, Administrator, provided January - March 2025 PBJ Reports. V1 reported unfortunately, for the date of July 2024, August 2024, and September 2024 - there was an error in submission with the integrated file. Therefore, no data was shown for 4th Quarter of 2024. CMS and IDPH were notified of the submission error. On follow up interview, of the same day, V1 was asked by the surveyor for evidence of Director of Nursing included in PBJ and after saying she would check with corporate, V1 said it is not there.</p> <p>Review of the facility PBJ report submitted for the quarter and provided for the surveyors review has no Director of Nursing included.</p> <p>The Centers for Medicare &amp; Medicaid Services Electronic Staffing Data Submission Payroll Based Journal Long Term Care Facility Policy Manual Version 2.6 June 2022, states facilities are required to submit facility census and Director of Nursing Hours on the PBJ.</p>