

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER Aledo Rehab & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 304 S.W. 12th Street Aledo, IL 61231	

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 0606</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Not hire anyone with a finding of abuse, neglect, exploitation, or theft.</p> <p>33970</p> <p>Based on interview and record review the facility failed to check the nursing license status of a nurse prior to employment. This failure has the potential to affect all 48 residents who reside in the facility.</p> <p>Findings Include:</p> <p>The Facility's Nurse Staffing Policy dated 12/07/2017 documents No person may provide direct resident care without a certification and records check.</p> <p>The Facility's Administrator job description documents Personnel Functions: Ensure that appropriate identification documents are present prior to the employment of personnel and that and that appropriate documentation is filed in the employee's record in accordance with state and federal regulations.</p> <p>The Facility's Nursing Schedule for February and March 2024 documents V5 (Licensed Practical Nurse) worked the following days: 02/10/24,02/11/24,02/13/24,02/14/24,02/15/24,02/19/24,02/20/24,02/22/24,02/25/24,02/27/24,02/29/24,03/04/24,03/05/24,03/07/24,03/09/24,03/10/24,03/12/24.</p> <p>The Illinois Department of Professional and Financial Regulation website shows that V5's LPN license was suspended effective 02/05/24 for posing an imminent danger to the public.</p> <p>On 03/24/25 at 9:00AM V2 (Licensed Practical Nurse/MDS Coordinator) stated Someone told me they thought that (V5/LPN) did not have a license so I checked it on 03/12/24 and found that it was suspended, I immediately alerted (V1/Administrator in Training and V20/Corporate Registered Nurse) and was instructed to ask (V5/LPN) to leave and I did that.</p> <p>On 03/24/24 at 10:30 AM V1 (Administrator in Training) stated I did not check (V5/Licensed Practical Nurse) license prior to her employment and I should have.</p> <p>The Facility's Resident Roster dated 03/24/24 documents 48 residents who currently reside in the facility.</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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>33970</p> <p>Based on interview and record review the facility failed to have a licensed Administrator and failed to thoroughly investigate an incident of finding used needles and syringes. This failure has the potential to affect all 48 residents who currently reside in the facility.</p> <p>Findings Include:</p> <p>The Facility's undated Administrator job description documents Job Summary: The Administrator is responsible for directing the day to day functions of the facility in accordance with current local, state and federal standards and guidelines and regulations that govern long term care facilities to assure that appropriate care is provided in the facility. The Administrator is responsible for delegating the Administrative authority, responsibility necessary for carrying out duties.</p> <p>The Facility's Administrator job description also includes qualifications: Must possess a current unencumbered Nursing Home Administrator's License or meet the license requirements of this state.</p> <p>1. On 3/24/24 at 9:30 AM V1 (Administrator in Training) stated she had been an Administrator in Training for about three or four years. V1 stated I have flunked the test twice now. V1 confirmed that she is the Administrator on a daily basis at the facility with over sight of V6 (Corporate Administrator) who makes visits to the facility and communicates with V1 via phone and email.</p> <p>V1's application for employment dated 10/10/2020 documents that V1 was applying for an Administrator in Training position and had never worked as an Administrator in Training prior to this employment. V1's Personnel file documents her first day as Administrator in Training was 10/10/2024.</p> <p>2. A Police Report dated 3/7/24 at 8:59 AM documents V17 (Police Officer) responded to a call from V1 (Administrator in Training) and reported to the facility due to the discovery of an unknown white powdery substance and syringes. V17's report documents that V17 spoke with V1 and V18 (Certified Nurse Aide) who found the objects. V18 reported to the officer that she found the substance in a white cap in the clean utility room and had found a syringe that appeared to be used and still had some clear liquid in it. V17 documented V18 as saying that she suspected V5 (Licensed Practical Nurse) due to V5 acting very strange. V18 also voiced that she had been finding similar items on the same shelf for a couple of months. When V17 spoke with V1 (Administrator in Training) V17 relayed this to V1 who reported that V5 had worked at the facility for a couple months, the same time frame in which things began to be discovered. The police officer documented that she did not have a field kit to test the substance but wrote Based on my years of police experience and research completed online, I believe the substance to be consistent with crystal methamphetamine, based on appearance.</p> <p>(continued on next page)</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 3/24/24 at 9:05 V3 (Licensed Practical Nurse) stated I have found what looked like used needles twice in the clean utility room. Both times I reported this to (V1/Administrator in Training) both times. I was not asked for any further information or statements. When they found the white powder and syringes, I went to (V1/Administrator in Training) and voiced my concerns that V5 (Licensed Practical Nurse) spent a lot of time in the bathroom and acted very sporadically after she came out. Sometimes she acted confused. I can't specifically say she was acting intoxicated, she was acting weird that is for sure.</p> <p>On 3/25/24 at 10:30 AM V19 (Housekeeper) stated (V5/Licensed Practical Nurse) was weird. I told them (V1/Administrator in Training) and V2 (License Practical Nurse/MDS Coordinator) that she seemed like she was on something. She would walk around and not seem to get anything done. (V5/Licensed Practical Nurse) spent a lot of time in the bathroom and being very unfocused and ditz. I told them both (V1 Administrator in Training and V2 Licensed Practical Nurse/MDS Coordinator) on the day that the cops were here (3/7/24).</p> <p>On 3/25/24 at 1:00 PM V1 (Administrator in Training) stated she called the police upon discovery of the used needles and syringes with white substance. V1 confirmed that the white powder and needle had been found in a clean utility room which all staff have a key to so that narrowed it down to the staff that work at facility and not a resident or visitor that left these items behind. V1 also confirmed that she did not question any staff present, or question any residents about potential staff behavior. V1 did acknowledge that some people were telling her that V5 (Licensed Practical Nurse) had issues. V1 confirmed that she did not interview or investigate V5 in any way when staff members told her that V5 was acting weird.</p> <p>3. The Facility's Nursing schedule documents V5 continued to work after 3/7/24 on 3/9,3/10 and 3/12/24 until she was asked to leave the premises for not having a valid nursing license. Cross reference F606.</p> <p>The Facility's Resident Room Roster dated 3/24/24 documents 48 residents currently reside in the facility.</p>		