STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aledo Rehab & Health Care Center	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)
F 0580 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33970 Based on observation, interview and record review the facility failed to notify the family of one resident (R1) of a condition change of three residents reviewed for falls. Findings Include: The facility's Notification for Change in Resident Condition or Status dated 7/1/2012 documents The facility and/or facility staff shall promptly notify appropriate individuals (i.e. Administrator, DON, Physician, Guardian, HCPOA, etc) of changes in the resident's medical/mental condition and/or status. The nurse supervisor/charge nurse will notify the DON, physician, and unless otherwise instructed by the resident, the resident's next of kin or representative when the resident has any other afore mention situations. b. an accident or incident involving the residentg. Refusal of treatment or medications (i.e. three or more consecutive times. h. A need to transfer the resident to a hospital/treatment center. R1's Medical Record documents that R1 was admitted to the facility's Alzheimer's Unit on 10/5/2022 with diagnosis of dementia, unspecified severity without behavioral disturbances, senile degeneration of the brain, anxiety, bipolar 1 disorder and depression. R1's Cognitive assessment dated [DATE] documents R1 scored 9/15 on BIMS (Brief Interview for Mental Status) indicating she was moderately impaired cognitively. R1's Face Sheet lists V4 as R1's Health Care Power of Attorney and V5 as R1's second emergency contact. R1's Nurse's Notes document that on 4/30/24 she was found on the floor of her room with a hematoma and a laceration to her left upper forehead. R1's Nurse's Notes document that family notified on 4/30/24. Message left. R1's documentation did not indicate which family member did not answer or where the voicemail was left or any further attempts to contact the remaining family member. (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 10:30 AM V3 (Registered Nurse) stated When (R1) got to the hospital (V3/R1 Health Care Power of Attorney) and (V4/R1's brother/second emergency contact) were present and both were upset that they did not know that (R1) had fallen on 4/30/24 and sustained a head injury. They told me that the hospice nurse is the one who called and told them. On 5/14/24 at 10:50 AM V5 (R1's brother/second emergency contact) stated They (the facility) keep saying that they do call us when they don't. I have my phone on me all the time and I answer all calls, we have made it clear to them (the facility) if they cannot get ahold of (V4/R1's HCPOA) then they can call me. On 5/14/24 at 11:00 AM V4 (R1's Health Care Power of Attorney) stated I am very upset that I didn't know (R1) had fallen or that she had hit her head. When I told the facility that they said they tried and didn't get me which is a lie, but even if that were true then why did they not call her second emergency contact if they can't get ahold of the first one? We have told them this multiple times. Especially V6 (Registered Nurse) he got an attitude with me and said oh well, I tried. I would be willing to have my phone searched for any indication of that missed call and I also did not get any voicemail. (V5) lives with me and he can and does answer all phone calls. The facility has been made aware that it is ok to notify him if I don't answer and he can tell me. Hospice called me and told me she had fallen and hit her head so I went out there and told them (facility staff) to send her to the emergency room . On 5/14/24 at 9:30 AM R1 stated (V4) is my power of attorney but (V5) is my brother and helps me a lot. If you have questions, you can call either one. They live together. Throughout the survey V6 (Registered Nurse) did not return calls for a statement on notifying the family.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 33970 These failures resulted in two deficient practices. A. Based on record review and interview the facility failed to monitor a resident after a fall and failed to initiate new interventions to prevent falls for two residents (R1 and R3) of three residents reviewed for falls with injury. B. Based on record review and interview the facility failed to assess one resident (R3) for the potential to harm himself after a suicidal statement of three residents reviewed for accidents and supervision. Findings Include: The Facility's Fall Prevention policy dated 08/2006 documents the policy is to provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. The Facility's Fall Prevention policy dated 08/2006 documets that the Charge Nurse will Complete a 72 hour fall intervention and place in the MAR (Medication Administration Record); place the resident on the 24 hour report with fall and new intervention to be initiated; document in the resident's record all the information collected for the forms, assessment of the resident, notifications made and new intervention initiated; submit all forms completed to the DON; Document on the resident for three days vital signs, physical assessment, new intervention effectiveness, changes in resident condition, transfer/gait/mobility abilities; educate hands on care givers of new interventions. The Facility's Fall Documentation Guide dated 08/2006 documents The Charge Nurse will document at least every shift for at least three days any relevant physical assessments including ROM (Range of Motion), pain and vital signs, results of new interventions initiated, resident response to new intervention and gait. transfer abilities and techniques used. 1. R1's Nurse's Notes dated 4/29/24 at 6:10 PM document that R1 was found on the floor of her room laying on her left side with dark red blood draining from a small laceration to left temporal (area) above eye brow. R1's Neuro/Head Trauma assessment dated [DATE] documents Record vital signs in appropriate box. Place (DNA) in the box if the resident does not exhibit the symptom. Place an (X) in each box for each symptom found. Notify the physician if any abnormal results are found. Assess as follows: a) initially and every 15 minutes x4; b) every 30 minutes x 1 hour; c) every 1 hour x 4 hours; d) every 4 hours x 8 hours; and e) every shift for remainder of 72 hours. R1's Neuro/Head Trauma Assessment documents that on 4/30/24 at 8:30 PM, 9:30 PM, 10:30PM, 11:00PM, and 12:00 AM R1 was asleep and neurological examinations were not done. The Neuro/Head Trauma Assessment has no documentation on 5/2/24 at 8:00PM, 5/3/24 at 8:00 AM, 5/3/24 at 8:00 PM, 5/4/24 at 8:00AM and 5/4/24 at 8:00 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Nurse's Notes did not include any other mention of the fall or assessments of R1 until 5/7/24 when hospice requested that the family come to the facility and V4 (R1 Health Care Power of Attorney) and V5 (R1's brother) arrived and requested R1 be evaluated at the hospital for being more confused and lethargic. On 5/14/24 at 11:30 AM V2 (Director of Nursing) confirmed that there was no documentation of any assessments of R1 after her fall on 4/29/24. V2 also confirmed that the Neuro/Head Trauma Assessment was not complete and that R1 should have been woken up to complete neurological checks after a fall with a head injury. R1's discharge papers from the emergency room dated 5/7/24 document that R1's laceration from her fall on 4/29/24 was infected and R1 was put on Rocephin 1 Gram daily for 7 days for cellulitus of the head wound on left upper head. R1's current care plan dated 9/21/2023 did not document R1's fall on 4/29/24 or the resulting injury to R1's head. On 5/14/24 at 11:30 AM V2 (Director of Nursing) confirmed that there were no new interventions in place after R1's fall on 4/29/24 and there should have been. 2. R3's Nurse's Notes dated 2/4/24 at 9:15 PM R3 was found on the floor in his room next to his wheelchair. R3 complained of upper jaw and lip pain. R3's face on his left side was reddened and swollen. R3's Nurse's Notes did not include any other mention of R3's fall with injury on 2/4/24. R3's Neuro/Head Trauma assessment dated [DATE] did not have any documentation on 2/6/24 on first shift or on any shifts on 2/7/24. On 5/15/24 at 1:00 PM V2 (Director of Nursing) confirmed there was no further assessments or documentation regarding R3's fall on 2/4/24. V2 also confirmed that R3's Neuro/Head Trauma Assessment for the fall on 2/4/24 was not complete and that 2/6/24 first shift and on 2/7/24 all shift should have had documentation of neurological assessments for R3. B. The Facility's Suicide Precautions policy dated 10/2006 documents It is the policy of (This Corporation) to provide a safe and caring environment for all residents by identifying and meeting physical and psychological needs. Attention will be given to residents with potential behaviors associated with causing self harm. Any resident with past history of suicide attempt or suicidal ideations or verbalize suicidal thoughts shall be assessed for precaution needs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Suicide Precautions policy documents The nurse shall: 1. Actively observe and listen to residents for behavioral and verbal changes such as increased insomnia, anxiety, poor concentration, anorexia, etc . 2. Interview the resident by using clear, direct questions using the Suicidal Potential Assessment form. 3. Should potential for self harm be identified, the Suicidal Attempt Checklist or Suicidal Treat Checklist shall be completed. 4. Evaluate resident responses and discuss them with the IDT (Interdisciplinary Team) and resident for development of care plan needs. 5. Notify family or responsible party of the care plan needs based on the psychological assessment if they are unable to attend care plan conference. 6. Encourage resident to reports feeling and needs to staff. If verbalizing or acting on suicidal ideation, resident room safety precautions will be implemented. 7. Implement Resident Room Reviews as IDT deems necessary to remove harmful objects from resident access (sharp objects, shoe laces, bets, plastic bags, call cords.) 8. Initiate resident checks every 15 minutes or 1:1 as IDT deems necessary. 9. Notify physician of resident behavior or suicidal ideation. R3's Medical Record documents that R3 is a [AGE] year old man with advanced Parkinson's, multiple falls and inability to take care of himself at home. R3 was admitted to the facility on [DATE]. R3' cognitive assessments on 12/19/2023 and 3/26/2024 both document that resident scored a 12 out of possible 15 on BIMS (Brief Interview for Mental Status) indicating moderately impaired cognitive ability. R3's Social Service Admission assessment dated [DATE] documents Resident's reaction to health status: upset, dealing with it. R3's Nurse's Notes dated 02/04/24 at 9:45 PM documents that R3 had fallen and when he was asked what he attempting to do when he fell R3 stated I wanted to die. R3's fall investigation dated 2/4/24 at 9:45 PM documents Other behavioral changes (describe) wanting to die. On 5/13/24 at 2:00 PM R3 confirmed that he had stated that he wanted to die after his fall on 2/4/24. I get frustrated with all of this (gestured towards his body/involuntary movements). But I wasn't trying to harm myself when I fell and I wouldn't hurt myself. R3 confirmed that no staff member had asked him about his statement of wanting to die after his fall on 2/4/24. R3's Medical Record does not contain any more information or psychological assessments regarding R3's statement of wanting to die or any increased monitoring of R3. On 5/15/24 at 10:00 AM V2 (Director of Nursing) stated (R3) can say pretty dark things when he is in a bad mood. I don't think he means them. V2 confirmed that there was no further assessments of R3's potential for self harm. V2 stated That would have been (V8/previous Administrator in Training) and (V9 Licensed Practical Nurse) that didn't investigate his statements and they should have.