| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145736 | A. Building<br>B. Wing | 12/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Alden Town Manor Rehab & Hcc | 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.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22499<br><br>Based on observation, interview, and record review the facility failed to implement interventions to manage behaviors for residents with a diagnosis of Dementia. This failure applies to three of three residents (R1, R2, R3) reviewed for Dementia Care in the sample of three.<br><br>Findings include:<br><br>On 12/6/24 at 10:00 AM R2 was lying in her bed in her room. R2 was able to answer simple questions but when asked about the incidents on 9/7/24 and 10/6/24 R2 stated she did not remember.<br><br>At 12:00 PM R1 was seated in her geri chair in the common area by the nurse's station. R1 called out for Surveyor and wanted Surveyor to bend her 2 fingers. Surveyor spoke to R1 and asked if she was hungry and R1 stated no. Surveyor then told R1 it was almost lunch time and R1 started yelling out, can you bring me some food. At 12:30 PM R1 was moved to the dining room for lunch and she continued to call out, Miss, can I have my food, please!, over and over again until staff were able to bring her her food and sit down to assist her.<br><br>At 12:00 PM Surveyor asked (V5- Registered Nurse, RN) at the nurse's station where (R3) was. V5 whispered, That is her behind me. Don't let her know we are talking about her- it won't be good. Surveyor approached R3 by saying Hello. R3 snapped back- No talk- keep going.<br><br>R2's Face Sheet printed on 12/6/24 shows that R2 is a [AGE] year old female resident who was admitted to the facility on [DATE] with a diagnosis of Unspecified Dementia.<br><br>The Facility Reported Incident dated 10/6/24 states, (R1) and (R2) were in the dining room when the disagreement occurred. Initial interviews with the resident revealed the following statements. (R1) stated, I was yelling out and she told me to be quiet and shut up. I yelled back and she got up. (R2) stated, She was bothering me. Two CNAs were present in the dining room at the time providing assistance to other residents. Staff interviews revealed that (R1) was speaking loudly regarding her food and (R2) yelled at her from a distance and proceeded to abruptly stand up and walk over to (R1). (R2) swatted towards (R1) and attempted to make contact. A CNA in the dining room (V3) was able to intervene and provide immediate separation .<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R2's Progress Notes dated 10/6/24 states, Reported by CNA that during dinner in dining room resident walked up to other resident, invaded personal space and was standing close with finger pointed at resident, angry, looked like she wanted to strike her. Resident's were separated. Asked her why she did that, she responded that she couldn't take other resident yelling. Resident's were separated and brought by nursing station for observation. Asked other resident what happened but she did not say anything but start crying and yelling again .<br><br>On 12/6/24 at 1:20 PM V3 (Certified Nursing Assistant- CNA) state, I was in the dining room and (R1) was yelling- like she always does- this is one of her behaviors. I saw (R2) get up and walk towards her and before I could get there I saw (R2) swat at (R1). She did not make contact with her- I guess I got there too fast. They were at 2 different tables .<br><br>The facility Reported Incident dated 9/7/24 states, Interviews with residents revealed that (R2) began speaking to another female resident on the unit. (R3) stated that she wanted more time with (R2) and was jealous of their new friendship. (R2) said she heard (R3) call her a name and she made a bad decision to pour some lemonade on (R3) .<br><br>R2's Progress Notes dates 9/7/24 state, Reported by one of resident's in facility (R3) that (R2) came up to her and threw lemonade in her face and on her head. Resident (R2) stated that she did that because she was screamed at and called names. Residents were separated .<br><br>On 12/6/24 at 10:10 AM V4 (Registered Nurse- RN) stated, (R2) has Dementia, she walks around with her walker but sometimes she forgets it. She refuses care a lot and sometimes the CNAs call me because she will not let them change her. Her son said she was very independent and she is ashamed that someone should have to help her. I was here for both incidents and sent her to hospital both times. With (R3)- she is very provoking- she yells things in Spanish and won't stop so (R2) went over to her and threw a glass of lemonade in her face. I saw it happen. We cannot redirect (R3) but we can redirect (R2)- most of the time. With (R1) I came into the dining room and (R2) was standing over (R1) and she looked like she was ready to snap. I think she did some things without thinking- I felt bad sending a [AGE] year old woman to the Psychiatric (psych) floor. Not that is is okay but the other residents have behaviors too and they provoke her.<br><br>R2's Physician's Progress Note dated 10/29/24 states, Dementia. Was recently sent out to the hospital for behavioral issues. Was admitted to psych unit. Started on Hydroxyzine (Antihystamine) for the behaviors, discharged back to the facility. Outside hospital chart reviewed by me, vitals reviewed by me, labs reviewed by me. In house psych consult .<br><br>R2's Psychiatric Progress Note dated 9/9/24 and 11/11/24 both state the same thing. These notes state, (R2) is alert, calm, cooperative, confused with memory impairment, progressive cognitive decline, assist needed with ADLs. Mood euthmic. No agitation or acute behaviors at this time, will continue to monitor.<br><br>R2's Care Plan initiated on 12/29/23 states: (R2) is at risk for abuse related to:wandering into other residents' personal space. Diagnosis of Dementia, socially inappropriate behaviors such as physically and verbally aggressive, history of abuse from the resident towards someone. R2's care plan shows no interventions added after the incident on 9/7/24 with R3. |