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	02/14/2024

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066 Based on interview and record review facility failed to protect a resident from sexual abuse from another resident with a known history of sexually inappropriate behavior. This failure applied to two (R136, R585) of six residents reviewed for abuse and resulted in R136 being sexually abused by R585. The Immediate Jeopardy began on 10/22/2023 when R136 was sexually abused by R585. V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 02/08/2024 at 02:38 PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed, and the deficient practice corrected, on 10/27/23, prior to the start of the survey and was therefore Past Noncompliance. Findings include: R136 is a [AGE] year-old female admitted to the facility on [DATE] with diagnosis including but not limited to Alzheimer's Disease, Essential Hypertension, Dementia, and Cerebral Cyst. According to R136's MDS (Minimum Data Set) assessment dated [DATE] under section C, R136 has BIMS (Brief Interview of Mental Status) score of 2 indicating severely impaired cognition. According to R136's MDS (Minimum Data Set) assessment dated [DATE] under section G, R136 required Total Dependence, Two+ person physical assist with bed mobility transfers. R136's care plan dated 01/18/2023 reads in part, (R136) is at risk for abuse; Interventions: Check and assure physical comfort. R136's Abuse Risk assessment dated [DATE] reads in part, (R136) is at risk for abuse due to dx (diagnosis) of dementia. R585 is a [AGE] year old male admitted to the facility 1/13/2023 with diagnosis including but not limited to Alzheimer's Disease, Dementia, Major Depressive Disorder, Hypertensive Chronic Kidney Disease, and Type 2 Diabetes. According to R585's MDS (Minimum Data Set) assessment dated [DATE] under section C, R585 has BIMS (Brief Interview of Mental Status) score of 14 indicating intact cognition. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to R585's MDS (Minimum Data Set) assessment dated [DATE] under section G, R585 required Limited Assistance, One person physical assist with transfers. R585's care plan dated 01/18/2023 reads in part, (R585) is sexually inappropriate with staff; Interventions: Compliment resident for appropriate social interactions. No intervention pertaining to monitoring R585 noticed in the care plan. R585's Abuse Risk assessment dated [DATE] reads in part, Is there a history of/current socially inappropriate behavior? Yes. R585's Psychiatric Progress Note date 09/26/2023 reads in part, (R585) Previously hospitalized d/t (due to) auditory hallucinations, increase confusion, combative behavior, displays inappropriate sexual behavior. On 02/06/24 at 12:59 PM Surveyor observed R136 in the dining room. Surveyor attempted to interview R136, R136 able to say yes', and no, and speaks only Spanish. Surveyor attempted to utilize Spanish translator; however, R136 did not answer when asked about the incident. On 02/06/24 at 02:04 PM Surveyor interviewed V14 (Memory Care Director) who related the following in summary: I was notified of the incident on the morning of 10/23/2023. The incident happened over night from 10/21/2023 to 10/22/2023, and as a result, R585 was transferred out of the facility on 10/23/2023 to provide safety to other residents. On the early morning of 10/22/2023, staff found R585 in R136's room. From what I was told, R136 was calling for help and when staff came into the room, R585 was seen pulling down R136's briefs but was fully clothed. R136 and R585 resided in two different hallways in the dementia unit. They had no know relationship. R585 had history of sexually inappropriate behavior, but only towards staff. R136 was assessed by the nurse on duty and there were no apparent injuries, so she was not sent out to the hospital. The doctor was made aware and assessed her on 10/27/2023. On 02/06/24 at 04:23 PM Surveyor interviewed V1 (Administrator) who related the following in summary: There is no police report or hospital record pertaining to the incident involving R136 and R585 on 10/22/2023. We called V17 (R136's family) and gave details of the incident, we asked if they wanted police to be involved or if they wanted R136 go to the hospital, but V17 refused. V17 was mostly concerned about R585 being removed from the facility, which he was on 10/23/2023. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/07/24 at 10:02 AM Surveyor interviewed V15 (Certified Nursing Assistant) who related the following in summary: I was working night shift on 10/21/2023 (11:00 PM to 7:00 AM). When I was rounding at the beginning of my shift, R585 was sitting in the wheelchair outside of his room. It was unlike him, so I encouraged him to go back to his room. I asked him why he's not asleep, R585 said, he was awake all day and doesn't feel sleepy, but went back into his room. I moved on and continued my rounds. At about 1:20 AM, I was sitting on my hall (highest numbers of 300 of the dementia unit). R585's room was in the adjacent hallway to where R136's room was located; I was assigned to the hallway where R136 was residing at the time. The first time, R585 attempted to come through the shower room. The shower room connects two hallways. One of those hallways was where R136' room was located. R585 made an echo when he was propelling through the shower room, so that's how I realized he was trying to get to R136's hallway. I said to R585, I thought you were going to sleep? Are you ready to go back to your room? R585 said Yes. I pushed him back to his room. I closed the shower room doors, on both ends, and returned to my hallway. Around 2:30 AM, R585 propelled down his hallway, around the nursing station and down to R136's hallway. I didn't hear him this time; I just heard R136 saying, No, no, stop, help!. R136 is quiet, she doesn't really talk, so when I heard her calling for help, it was different. R136 was clearly calling for help, that's what made me think something was wrong and I jumped and ran into her room. When I came in, I saw R585 in the bed, on top of R136. R585 had no pants, but his brief and t-shirt were on. R136's brief was off her and folded neatly underneath. I don't believe R585's private parts were out, but his hands were on his diaper, like he was trying to take it off. I separated them, said to R585 stop it and told him to get off R136. I helped R585 to his wheelchair. After that, I reported it to the nurse who met me in the hallway when I got him out of R136's room and pushing back to his room. I reported it to the unit manager and called V1 (Administrator) as well. The incident itself occurred around 2:30-3:00 AM, I called my immediate supervisor right away and V1 around 4:00 AM. V1 talked to me the following morning and I gave her my statement. There were four CNAs and two nurses on the unit that night. One nurse was in the nursing station and the other one was in another resident's room at the time of the incident. Not sure where were other CNAs. Nobody else responded but me. On 02/07/2024 at 10:32 AM Surveyor interviewed V16 (Agency Registered Nurse) who related the following in summary: On 10/22/2023, I was working 11:00 PM-7:00 AM shift. V15 (CNA) was doing her round and came to let me know that R585 was on the top of another resident (R136) in her room. There was no roommate in R136's room at the time. V15 (CNA) said that R585 could not remove himself and that she needs help removing him off R136. R585 was clothed when I came into R136's room. R585 had his t-shirt, diaper, and shorts on. R136's brief was down, and she had her gown on. We placed R585 in his wheelchair and V15 (CNA) took him back to his room. I assessed R136; I performed head-to-toe assessment. I looked at R136 head, looked for any scratches or lacerations. I looked into her mouth, at her neck and shoulders. I looked at her abdomen and legs. Her brief was already pulled down, so I looked at her pubic area, as it was already exposed, but I didn't look between her legs. I moved down her legs, ankles, and feet. R136 doesn't speak but moans when in distress, she didn't display any sort of distress at the time of assessment. I documented it in the electronic medical record. Both residents were monitored for the remaining of the shift. The incident happened between 2:00 AM - 3:00 AM. I notified V21 (Clinical Leader) around 3:30 AM - 4:00 AM, I believe I left her a voicemail and texted her too. I didn't notify anyone else. I did not hear back from her or anybody else. This is the first time I'm giving statement about this incident. The facility never presented abuse policy to me, I'm not familiar with it. My agency provides abuse in-services, I did one in August 2023. We were told to contact elderly services in case of knowledge of any adult abuse, but I did not contact them after this incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/07/24 at 10:41 AM Surveyor interviewed V17 (R136's family) who related the following in summary: We visit R136 once or twice a week. R136 is not able to talk or have a conversation, she can only say yes and no. The facility notified me, at the end of last year (2023), maybe in November, that somebody was trying to touch or hurt R136. They didn't tell me who was the perpetrator but told me that they were separating men to one side and women to the other side of the unit, and they were getting rid of the perpetrator. The facility never asked me if they can call police or send R136 to the hospital at the time of the incident. On 02/07/24 at 11:03 AM Surveyor interviewed V18 (Medical Director) who related the following in summary: The facility notified me that R585 pulled brief off R136 and was on top of her, not sure the exact date, but I remember they called me in the morning. Staff talked to V17 (R136's family) and they refused to send her out to the hospital. They sent R585 to the hospital due to aggressive behavior. R136 was assessed by V16 (Agency Registered Nurse) and she appeared to be ok, had no injuries. I didn't feel like R136 should have been sent out to the hospital for further assessment. I see R136 every Friday, so I also assessed R136 on the following Friday (10/27/2023). R136 is demented, so she is not a good historian, and she is on hospice care. When residents are on hospice care, it is not recommended to send them to the hospital. I would recommend rape kit, if there were abrasions, or obvious signs of distress. In this case, R136 couldn't give us a statement and we didn't see any signs of rape, so we didn't send her out for further evaluation. On 02/07/2023 at 1:28 PM Surveyor interviewed V19 (Licensed Practical Nurse) who related the following in summary: The incident occurred in October of 2023. Upon beginning of my shift (7:00 AM), I was told by V16 (Agency Registered Nurse) that R585 went into R136's room and tried to get into bed with her. I sent R585 out to the hospital for inappropriate behavior from previous night at around noon on 10/22/2023. R585 was able to transfer out of the bed and into the wheelchair independently. R136's all needs were met with full assist from staff. R136 didn't really speak. When I assessed her on the morning of 10/22/2023, I looked for grimacing because that's how she displayed distress. I didn't talk to R136 about the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/07/2024 at 2:34 PM Surveyor interviewed V1 (Administrator) who related the following in summary: The incident occurred on the early morning of 10/22/2023. V15 (Certified Nursing Assistant) called me in the morning of 10/22/2023, not sure about exact time, it was early though. She said, she was doing rounds and heard R136 saying stop and went into her room. V15 saw R585 laying on R136 with her briefs down. I instructed V15 (CNA) to have R585 on 1:1 monitoring. I also called V16 (Agency Registered Nurse) and told her to do full body assessment. I arrived in the facility around 7:00 AM. I spoke to V19 (Licensed Practical Nurse), she said R585 was on 1:1 monitoring, and she was working on sending him out for change in behavior. I don't remember when V18 (Medical Director) was notified, but it was per her order, to send R585 to the hospital. After that, I started in-servicing staff on abuse. I also notified V14 (Memory Care Director) about the issue and called V17 (R136's family) to give them details. I asked if they want police to be involved or send R136 to the hospital, but they refused. I took a statement form V15 (CNA) and V16 (Agency RN) who were witnesses and additional staff who worked R585 and R136. General investigation for sexual abuse consists of removing perpetrator and initiation of investigation. I also report it to IDPH. The date and time of the fax confirmation is not accurate, it says I reported this incident the day before the incident occurred, it's inaccurate. There is no way to confirm the date and time of when this incident was reported. I called the facility to send a report before I arrived at the facility on the morning of 10/22/2024. I had no indication that rape, or penetration occurred in case of R136 and R585 based on staff's statements and assessment. Surveyor clarified if there was anyone in the room at the time of the incident to witness whether rape actually occurred, V1 stated that V15 (CNA) went in there right after she heard R136 screaming, and she didn't see R585 penetrating R136. V1 continued stating that V16 (Agency RN) is an appropriate person to conduct post sexual abuse assessment. Normally, we send sexual abuse victims to the hospital and involve local police, but in this case, R136 didn't have any injuries, so there was no necessity to send her out. I'm not sure when the rape kit should be done. On 02/07/2024 at 5:20 PM Surveyor interviewed V27 (Assistant Director of Nursing) who related the following in summary: R585 was sexually inappropriate towards staff, flash his penis. We thought R585 knew what he was doing, he had dementia but was one of the higher functioning residents, that's why we were looking for placement for him. When R585 was sent out for assessment after the sexual abuse incident involving R136 and himself, we refused to take him back because he already had a placement in a different facility. 4. Progress note dated 10/27/2023 written by V18 (Medical Director) reads in part, Chief Complaint: follow up for Deconditioning, Dementia, Pacemaker, Unable to take care of herself. (R136) seen and evaluated today for follow up on Alzheimer's disease, hypertension, deconditioning, high risk for falls. No indication of assessment pertaining sexual abuse noticed. Progress note dated 10/22/2024 at 11:36 AM reads in part, (R585) sent out to (the local) hospital. Ambulance left at approximately 12:29 PM. R585 was transferred out of the facility approximately 10 hours after the incident occurred. According to record review, no progress note nor assessment documented by V16 (Agency Registered Nurse) pertaining to R136's post incident assessment noticed in the electronic medical record. V1 (Administrator) did not provided V16's (Agency RN) Sexual Assault Nurse Examiner certificate per surveyor's request. V1 (Administrator) did not provide R585's 1:1 monitoring documentation per surveyor's request. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Abuse policy dated 09/2020 reads in part, The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents. Sexual Abuse is non-consensual sexual contact of any type with a resident. This includes, but not limited to, sexual harassment, sexual coercion, or sexual assault. Prevention: As part of social service assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on regular basis. Protection of Residents. The Immediate Jeopardy that began on 10/22/23 was removed on 10/27/23 when the facility took the following actions to remove the immediacy. The deficient practice was corrected on 10/27/23 after the facility took the following steps to correct the noncompliance prior to start of current survey: Corrective Action Taken: 1. The alleged victim R136 was reassessed by the nurse on 10/22/23 and further assessed by the social worker for risk for abuse on 10/23/23 after the alleged incident occurred and deemed as at risk for abuse. 2. R585 was sent out to the hospital for evaluation on 10/22/23. 3. The plan of care for the alleged victim was reviewed and updated pertaining to her risk for abuse initiated on 10/22/2023 and completed on 10/24/2023. 4. On 10/22/2023 the DON, Administrator, Nurse Consultant and Medical Director reviewed the facility policies related to the occurrence: Abuse, Supervision to prevent incidents/accidents, Routine Resident Checks, No changes were made, completed 10/23/2023. 5. Abuse in-services initiated 10/22/2023 with completion date of 10/26/2023. 6. Other resident on the unit were re-assessed by social services for risk for abuse on 10/24/23 and completed on 10/26/2023. All new admissions risk assessment will be completed within 24 hours upon admission and interim care plan will be initiated based on the assessment, and will be reassessed every three months, and as needed. 7. Residents that are identified as at risk and high risk for abuse had review of care plan and care plans were updated by social services based on the assessment. Initiated on 10/22/2023 and completed 10/25/23. 8. On 10/22/23, interviews were conducted by the Administrator with staff and residents, and completed on 10/26/2023. The alleged victim is not interviewable. 9. Staff, including managers are being reeducated policies and procedures on routine resident checks, abuse prevention, and incidents/accidents, The re-education was provided on 10/22/23 and will be completed on 10/27/23. The Administrator is responsible for ensuring the re-education. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. A review of compliance using Quality Assurance Audit tool for abuse prevention and supervision started Date 10/22/23 and completed 10/27/2023. 11. Audits will be done weekly for four weeks, then monthly x 2 months, and then randomly by Administrator/designee. The Administrator shall ensure that the QAPI Committee meets to review the results of the QA Audits and to make frequency recommendations after two months. 12. Audits on residents requiring supervision to prevent abuse will be reviewed by the Administrator weekly to ensure timely completion 10/22/2023. All audits will be reviewed by QAPI committee with evaluation of trends/patterns and corrective action implemented as indicated. This will be monitored by the Administrator, and completed on 10/27/2023. 13. An emergency QA meeting was held on 10/24/23 by the Administrator with the Interdisciplinary Care Team and Medical Director. Abuse prevention and supervision were discussed along with plans of correction. Medical Director and Interdisciplinary Care Team approved the plan of correction. This will be monitored by the Administrator for completion date of 10/27/2023.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46066 Based on interview and record review, the facility failed to implement their abuse prevention policy by failing to thoroughly investigate allegations of resident sexual abuse and injury of unknown origin for three (R136, R585, R536) of five residents reviewed for abuse on the sample list of 71. Findings include: 1. On 02/05/2024 at 11:30 AM V1 (Administrator) presented Facility Reported Incident pertaining to R136 and R585 with investigation documents. The investigation consisted of: an Initial and Final copy of a Facility Reported Incident and seven staff interviews. On 02/06/24 at 04:23 PM V1 (Administrator) related the following in summary: There is no police report or hospital record pertaining to incident involving R136 and R585 on 10/22/2023. We called V17 (R136's family) and gave details of the incident, we asked if they would want police to be involved or if they wanted R136 go to the hospital, but V17 refused. V17 was mostly concerned about R585 being removed from the facility which R585 was on 10/23/2023. On 02/07/2024 at 10:32 AM V16 (Agency Registered Nurse) related the following in summary: On 10/22/2023, V16 was working 11pm-7am. V15 (CNA) was doing her rounds and came to let me know that R585 was on the top of another resident (R136) in her room. There was no roommate in R136's room at the time. V15 (CNA) said that R585 could not remove himself and that she needs help removing off R136. R585 was clothed when I came into R136's room. R585 had his t-shirt, brief, and shorts on. R136's brief was down, and she had her gown on. We placed R585 in his wheelchair. I assessed R136; I performed head-to-toe assessment. I looked at R136 head, looked for any scratches, lacerations. I looked into her mouth, at her neck and shoulders. I looked at her abdomen and legs. R136's brief was already down, so V16 looked at her pubic area, as it was already exposed, I didn't look between her legs. I moved down her legs, ankles, and her feet. R136 is non-verbal but moans when in distress. R136 didn't display any sort of distress at the time of assessment. I documented in the electronic medical record. Both residents were monitored for the remaining of the shift. The incident happened between 2-3am. I notified V21 (Clinical Leader) around 3:30a-4a, I believe I left her a voicemail and texted her. I didn't notify anyone else. I did not hear back from her or anybody else. This is the first time I'm giving statement about this incident. The facility never presented the abuse policy to me, I'm not familiar with it. The agency provides abuse in-services, I did one in August 2023. We were told to contact elderly services in case of knowledge of any adult abuse, but I did not contact them after the incident. According to record review, no progress or assessment note documented by V16 (Agency Registered Nurse) pertaining to R136's post incident assessment in the electronic medical record. On 02/07/24 at 10:41 AM Surveyor interviewed V17 (R136's family) who related the following in summary: The facility notified me, around end of last year (2023), maybe November, that somebody was trying to touch or hurt R136. They didn't say who was the perpetrator but told me that they were separating men to one side and women to the other side of the unit, and they were getting rid of the perpetrator. The facility never asked me if they can call police or send R136 to the hospital at the time of the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/07/24 at 11:03 AM V18 (Medical Director) related the following in summary: R136 is demented, so she is not a good historian, and she is on hospice care. When residents are on hospice care, it is not recommended to send them to the hospital. I would recommend rape kit, if there were abrasions, or obvious signs of distress. In this case, the R136 couldn't give us statement and we didn't see any signs of rape, so we didn't send her out for further evaluation. On 02/07/2024 at 2:34 PM V1 (Administrator) related the following in summary: I had no indication that rape, or penetration occurred in case of R136 and R585 based on staff statements and assessment. V16 (Agency RN) is an appropriate person to conduct head to toe assessment. Normally, sexual abuse victims are sent out to hospital and police is involved. I'm not sure when would rape kit be appropriate to use. Facility Abuse policy dated 09/20 reads, Investigation: Appoint an Investigator. Once an allegation has been made, the administrator or designee will investigate the allegation and obtain a copy of any documentation related to the incident. The final report shall include facts determined during the process of the investigation, review of medical records, personnel files and interview of witnesses. The final investigation shall also include a conclusion of the investigation based on known facts. 40718 45395 2. R536's medical record indicated resident last admitted to facility on 12/13/2021 and discharged from facility on 10/10/2023. Resident has a past medical history not limited to: hypertension, epilepsy, anemia, wandering, urinary tract infection, vascular dementia, and history of falling. R536's Care Plan with closed date of 10/13/2023 reads in part: at risk for falls related to history of falls, incontinence, seizure disorder and poor safety awareness and wandering secondary to dementia; at risk for abuse related to diagnosis of severe mental illness and/or dementia. Facility presented fall incident list on, and dated 02/05/2024 for date range of 09/05/2023 to 02/05/2024. R536 was not listed. Facility presented initial and final report investigation completed by V1 (Administrator) both dated 10/10/2023 with inconsistencies throughout both reports. Initial report dated 10/10/2023 indicated V1 was notified of injury of unknown origin, a discoloration was noted to R536's right eye. Final report dated 10/10/2023 indicated under occurrence that V1 was notified of injury of unknown origin and discoloration was noted to R536's right eye but under conclusion, report indicated R536 was sent to hospital for a raised discolored area to resident's forehead and upon readmission from hospital, R536 was noted with discoloration under eye that was not present upon initial assessment. Nurses Note dated 10/8/2023 13:28 indicated aide informed nurse on duty that upon getting R536 dressed in the morning, she noticed a bump on the middle of her forehead that was painful to touch. Physician was notified and ordered to sent R536 to the hospital for further evaluation and diagnostic testing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Town Manor Rehab & Hcc	6120 West Ogden Cicero, IL 60804

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewed R536's hospital paperwork dated 10/09/2023 that indicated R536 was seen for hematoma to her right eyebrow, staff noted bump on head and stated possible fall between 8pm-11am, only trauma noted is hematoma to right eyebrow. Interviews provided by facility all of which indicated R536 had a tendency to bump into objects while walking. Statement by nurse on duty dated 10/12/2023 indicated aide reported to her on morning of 10/08/2023 that R536 had a raised area to the center of her forehead and was sent to local hospital. Report did not suspect abuse, and did not mention injury was status post fall. Nurses Note dated 10/10/2023 06:58 indicated R536 had a small skin tear to her left elbow. Nurses Note dated 10/10/2023 12:00 indicated R536's power of attorney (POA) took resident out on pass at 12:00 PM. Nurses Note dated 10/10/2023 15:15 indicated POA called facility and stated that she was taking R536 to the hospital for evaluation post occurrence. On 02/07/2024 at 3:00 PM, when asked if the complete investigation for both of R536's injuries were provided, V1 (Administrator) said yes then added that abuse was not suspected because it was assumed R536 bumped into something. V1 then said R536's raised area to forehead was observed on 10/08/2023 and reported on 10/10/2023. No documentation found indicating R536 has a history and/or behavior related to bumping into objects while walking. On 02/08/2024 at 10:30 AM, facility presented timeline of incidents for R536. Per V1 and V2 (DON), R536's forehead incident on 10/08/2023 was sustained post fall and that R536's POA alleged abuse after the skin tear that found on 10/10/2024. Timeline indicated investigation was initiated. Surveyor requested interview, none was provided by facility. Survey team reviewed facility reportable incidents upon entering facility and during course of survey for last six months with no report found for R536's 10/10/2023 injury or abuse investigation alleged by 536's daughter/power of attorney. As of 02/08/24 03:46 PM, no further documentation received from facility for R536. Incident/Accident Reports policy dated 09/2020 reads: Policy: The Incident/Accident Report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors or other, and resident-to-resident altercations. Procedure: An accident refers to any unexpected or unintentional incident, which may result in injury or illness to resident. This does not include adverse outcomes that are a direct consequence or treatment or care that is provided in accordance with current standards of practice (e.g., drug side effects or reaction). 1. all serious accidents or incidents of residents 2. all injuries of staff, families, and visitors 3. all unusual occurrences (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. all situations requiring the emergency services of a hospital, the police, fire department, or coroner 5. any type of resident abuse 6. resident to resident altercation 7. suicide or attempted suicide 8. any condition resulting from an incident requiring first aid, physician visit, or transfer to another health care facility 9. an incident/accident report is to be completed and shall complete and shall include: a. date and time of incident/accident b. description and possible cause of incident, physical assessment, injuries noted, vital signs, treatment rendered, and notification of appropriate parties. 10. The facility shall maintain a file of each incident and accident affecting a resident that is not expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's note of that resident. 12. The Director of Nursing, Assistant Director of Nursing or Nursing Supervisor must notify: a. The Illinois Department of Public Health (IDPH) of any serious incident or accident, Serious means any incident or accident that causes physical harm or injury to a resident. b. The facility shall, by fax or phone, notify the regional office within 24 hours after each reportable incident or accident. c. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven (7) days after the occurrence. 13. e. A minimum of seventy-two (72) hours of documentation by all three shifts on resident status after the incident or accident, vital signs, mental and physical state, follow-up, tests, procedures, and findings are to be determined. 14. All incident/accident reports are reviewed, signed, and investigated by: a. the administrator; and b. the director of nursing or the assistant director of nursing 15. Facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is to be noted, that facility policy indicated that physical harm or injury does not include a skin tear or bruise or something covered with a band-aid which is a contraindication of policy's introduction statement as mentioned above.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49740 Based on interview and record review, the facility failed to provide restorative services after skilled therapy was completed. This failure applied to one of one (R181) resident reviewed for rehabilitation services on the sample list of 71. Findings include: According to electronic medical records, R181, is a [AGE] year-old female admitted on [DATE], with medical diagnosis that include but are not limited to: muscle weakness generalized, unsteadiness on feet, and lack of coordination. On 02/05/2024 at 11:15am, R181 said I came here after surgery. I started receiving physical therapy on 01/11/2024, and I was discharged on [DATE]. I am waiting to start with restorative services. On 02/06/2024 at 11:42am, R181 said, I have wanted to walk and move about the facility since my physical therapy ended, but no one from restorative therapy has ever come to assist me with walking. I fear losing all my gains obtained from physical therapy since I am inactive. My goal is to be able to go home walking out of the facility. On 02/06/2024 at 12:09pm, V38 (Therapy Director) said, R181 was in physical therapy from 01/11/2024 to 02/01/2024. I completed a Direct Therapy Restorative Recommendation form as a referral for restorative services, I do not know if they started the services or not. On 02/07/2024 at 10:15am, V30 (Restorative Aide) said, I was not familiar with R181 but V5 (Restorative Nurse) told me yesterday we need to start seeing her and place her on various restorative programs, including walking, bed mobility, and grooming. I plan on seeing her today for the first time to implement these programs, as we should be implementing them as soon as we receive the referral from therapy. On 02/07/2024 at 11:15am, V39 (Restorative Aide) said, I provide restorative therapy to residents throughout the entire facility but have not provided it to R181 because the resident's restorative referral has not been input into the facility's system. In addition, I perform other duties making me unavailable for restorative services. V5 oversees the process of inputting resident referrals into the facility system, after that I will follow through with them. On 02/08/2024 at 4:58pm, V2 (Director of Nursing) provided a copy of the facility's Restorative Nursing Program policy, dated 03/10/2022, which declares: the purpose of a restorative nursing program is to maintain or improve functional abilities in ADL's (activities of daily living) and/or promote ability and wellness where possible, prevent decline or loss of independence, and/or enable residents to attain or maintain their highest practicable level of functioning. A restorative nursing program may be established in conjunction with formalized rehabilitation therapy. Activities provided by restorative nursing staff include walking. The restorative nurse will review the functional assessment and care plan with involved nursing staff and therapy to assure specific needs are identified, plan implemented, and resident placed in the appropriate restorative program(s).

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F 0689 Level of Harm - 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** 34071 Based on observation, interview, and record review, the facility failed to follow their policy and procedures for fall prevention by failing to implement personalized fall prevention interventions and failing to supervise a dependent resident with impulsive behaviors. These failures applied to three of 15 residents (R17, R73, R109, R535) reviewed for accidents/supervision and resulted in R17 sustaining a left femur fracture and R73 sustaining a subarachnoid hemorrhage. Findings include: R73 is a [AGE] year-old, male, admitted in the facility on 04/07/2017 with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side; Aphasia Following Cerebral Infarction; and History of Falling. Per MDS (Minimum Data Set) dated 09/08/23, R73 has BIMS (Brief Interview for Mental Status) score of 11, which means moderate impairment in cognition. According to incident report dated 11/19/23, V6 (Registered Nurse, RN) was notified that R73 had a fall in the smoking patio. V6 went to see R73 and was observed lying on the ground with his head pointed towards the left side of his motorized wheelchair. V7 (Activity Director) who was present at the time of incident stated that he started to tilt to the left and she (V7) tried to brace his fall but could not. Progress notes dated 11/19/23 indicated that he (R73) was not strapped in at the time of fall. On 02/06/24 at 11:05 AM, R73 was observed smoking on the outside patio. R73 is alert, oriented, with right hand contracture. He had right above knee amputation. He is unable to talk and carry a full conversation but able to say yes or no, nods head, moves left hand and left leg and can communicate with gestures. He (R73) is using a motorized wheelchair and had the safety belt fastened and secured. R73 was asked regarding fall incident last 11/19/23. R73 communicated via gestures, that he was at the smoking patio, in his motorized wheelchair. He was repositioning himself in the wheelchair and slid. He also communicated that there were staff on the patio, and he tried to ask for help by raising his left hand, but staff did not respond. On 02/06/24 12:05 PM, V7 (Activity Director) was interviewed regarding R73's fall last 11/19/23. V7 replied, That incident with R73, it was the 11 AM smoke. I was the designated staff to supervise. I was lighting cigarettes of other residents. I was on the other side of the table where he (R73) was sitting. I noticed that he was actively tilting. I went there and not able to catch him on time. He fell . He didn't call my attention. He is non-verbal but he can raise his right hand for assistance. Progress notes dated 11/19/23 documented that R73 was assessed and was transferred out to the emergency room for further evaluation and management. R73's Hospital records under Trauma Progress Notes dated 11/24/23 recorded: Diagnosis: Acute right subarachnoid hemorrhage. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 02/06/24 at 1:43 PM, V2 (Director of Nursing) was asked regarding R73. V2 stated, They called me when that incident happened. V7 was with them. She (V7) was distributing the smoking materials like bib, cigarettes when he (R73) was tilting from the wheelchair. She (V7) was about to stop the fall but was too late. When I investigated, the seatbelt was loose when he was smoking outside. The order was to release it during activities. Smoking is an activity, so she (V7) kept it loose. R73 has a safety belt in his wheelchair. He slid from the wheelchair on his left side. He has poor trunk control related to hemiplegia on his right dominant side. A follow-up interview with V2 was conducted on 02/08/24 at 1:12 PM. V2 was again asked if R73's seat belt was loose at the time of incident. V2 stated, His safety belt was totally released. It was totally not secured, it was released, it was not put on. V7 should be monitoring if his (R73) safety belt is on or secured and if he has a problem with repositioning. Designated staff during smoking should be closely monitoring residents, and should be in close contact to all the residents during activities or during smoking. R73's POS (Physician Order Sheet) dated 02/22/22 documented: Self release safety belt while up in wheelchair, check and release every two hours and PRN (when needed), during activities and during meals. V13 (Physician) was asked on 02/07/24 at 11:22 AM regarding R73. V13 verbalized, He uses an electric wheelchair. During smoking, his safety belt should still be secured, not off, not loose. The expectation is that the belt helps him from falling out of the wheelchair. It should be secured/fastened during smoking since he is up in his wheelchair. Care plan regarding at risk for falls dated 04/08/2017 documented interventions: R73 to be escorted to the patio and monitored while on the patio smoking. R73 has a care plan formulated related to the use of self-release safety belt for medical reasons while up in the electric wheelchair related to poor trunk control. 40718 2. R17 is a [AGE] year-old female with a diagnoses history of Fracture of Left Femur, Partial Paralysis due to Cerebrovascular Disease Affecting Left Non-Dominant Side, History of Falling, Generalized Anxiety Disorder, and Nicotine Dependence who was admitted to the facility 05/13/2019. On 02/06/24 at 11:25 AM R17 stated she fell 2 to 3 months ago but has no memory of the fall. R17 stated she was on blood thinners, and her head filled up with fluid, so she was afraid touch it. R17 stated she also fell 6 months ago because she couldn't get any help when she needed it. R17 stated she broke her femur during the last fall. R17 stated she had a metal rod in her leg and broke it because she fell so hard. R17 stated the doctors told her they had never seen anything like that. R17 stated she's a sleepwalker and wonders if she was trying to walk when she fell and broke her leg. R17 stated last night they put something on the right side of her bed so she couldn't move because she keeps leaning towards that side. R17 stated she's been in a lot of pain since her fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R17's current care plan initiated 05/23/2019 documents she has an ADL (Activities of Daily Living) Self Care Performance Deficit secondary to weakness, history of CVA (Coronary Vascular Accident) with left hemiplegia/limitation in range of motion, wheelchair being primary mode of locomotion, COPD/shortness of breath (continues to smoke), impaired balance, history of falls, occasionally incontinent, chronic pain and anxiety; has behaviors of not asking for help although she requires it, and often refuses help; her ADL's tend to fluctuate related to this behavior with interventions including: Encourage palm protector to left hand; Allow enough time for completion of ADL tasks. Do not rush the resident; Assist with ADL tasks as needed; Assist with personal hygiene as needed; Assist with toileting needs as necessary; Encourage resident to participate as able in ADL's, Encourage to participate to the fullest extent possible with each interaction; Nurse encourage use of call light for assistance when needed; Monitor for any signs and symptoms of pain/discomfort during ADLs; Offer as needed analgesics prior to ADL activities and/or rehab if indicated; Palm protector to left hand, encourage resident daily to allow staff to apply; Provide needed level of assistance and support to complete Activities of Daily; Physical/Occupational Therapy evaluation and treatment as per physician orders. R17's current care plan initiated 05/23/2019 documents she is at risk for falls secondary to history of falls, incontinence, left partial paralysis, anxiety, pain, use of opiates, use of psychotropic medication and hypertension., R17 is impulsive, does not always wait for assistance for transfers, noted with impulsive behaviors, continued poor safety awareness and judgement with interventions including: Add Call Don't fall Posters in several areas of room for reminders to ask for assist; Encourage appropriate use of wheelchair; Encourage R17 to ask for assist with all transfers including toileting; Encourage resident to Call, don't fall; encourage resident to report falls as they happen; Encourage R17 to be aware of her surroundings; Encourage the use of a reacher for hard to reach places; Encourage/Remind R17 to wait for assist and if she feels it's taking a bit longer than she expects, call reception to let them know you are waiting for assist rather than doing on her own; Ensure resident is positioned in middle of bed; Evaluate multiple falls to determine commonalities or patterns; Promote placement of call light within reach; Provide 1:1 supportive counseling, reiterating the importance of becoming/remaining treatment plan compliant, especially as it relates to R17's safety; Provide an environment clear of clutter; Provide proper, well maintained footwear; Staff to ensure resident removes her shoes before bed and place in wheelchair for her; Supply a clock resident can see during night time hours; Will review care plan on return from Hospital (Date Initiated: 09/05/2023). R17's physician progress note dated 9/1/2023 at 09:42 AM documents Pain assessment interview was conducted for R17 today; she states frequent Left Hip and neck pain in the last 5 days. R17 describes the pain as stabbing and crushing that make it hard to sleep at night. Incident Report dated 09/02/2023 states at approximately 10 AM R17 self-reported a fall, no visible signs of injury noted, when she was interviewed, she was not really able to state how fall occurred. R17 complained of pain in right hip area, and x ray was ordered, and results were negative for a fracture. However, she continued to complain of pain in left lower extremity on 09/04/2023, an x-ray was ordered and results were positive for a fracture of left femur. Physician was notified with orders received to send her to the emergency room for further evaluation. R17 uses a low bed and floor mats and was not able to state exactly what happened. Per staff R17 was last observed in her bed at 10PM. Predisposing factors include gait imbalance, poor safety awareness, and weakness. R17's X Ray results dated 09/04/2023 documents a positive result for fracture of left distal femur. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R17's progress note dated 9/5/2023 2:14 PM documents: This writer was made aware the resident has a fracture on her left distal femur and received order from physician to send her to the emergency room for further evaluation and treatment. R17 verbalized pain to her left hip and had been administered an opioid at 6 AM. R17 refuses to go to hospital because she has not been able to smoke. The restorative RN spoke to R17. R17 was transferred from the first floor to the emergency room and left the facility at approximately 09:30 AM. The incident investigation paperwork provided by the facility did not include documentation of a thorough investigation. This paperwork includes two undated witness statements from V41 (Morning Shift Certified Nursing Assistant) stating R17 could not remember exactly when she fell but she remembered landing on her matt. She has a habit of forgetting to use the call light for assistance; and from V21 (Restorative Nurse) stating R17 can't recall exactly what day and time she fell but remembered landing on her floor mats. R17 forgot to call for assistance and just got herself up to bed. R17's Post Occurrence Documentation progress note dated 1/13/2024 04:40 PM documents: Resident was observed on the floor by her bedside in a right side lying position, R17 was transferred back to bed by two nursing staff. On 02/08/24 at 01:21 PM V5 (Restorative Nurse/LPN/Fall Coordinator) stated R17 refuses assistance and won't wait for assistance especially if trying to go out and smoke. V5 sated R17 might have been half asleep when she fell [DATE]. V5 stated R17 often falls asleep in her chair. V5 stated she has had many conversations with R17 about safety awareness and she will listen but will not always correct her behaviors. V5 stated sometimes R17 will be receptive to redirection and sometimes she will continue to do as she pleases. V5 stated normally R17 has a fall when transferring herself when going to smoke. V5 stated we've tried to have someone go out with R17 when she wants to smoke to accommodate her smoking times but often she won't wait for assistance. V5 stated in January it seems R17 missed the chair when getting ready to go smoke. V5 stated R17 likes to smoke before she eats. V5 stated revising R17's care plan interventions for falls may not be received well from R17. V5 stated R17's current fall interventions are sometimes effective in preventing her from falling. V5 stated besides assisting R17 when going to smoke she could not provide any additional personalized interventions to prevent her from falling. V5 stated educating R17 and constant monitoring when she wants to smoke are some possible interventions for preventing her from falling. 3. R109 is a [AGE] year-old female with a diagnoses history of Partial Paralysis due to Brain Hemorrhage, Epilepsy, and History of Falling who was admitted to the facility 10/21/2023. On 02/05/24 at 11:34 AM Observed R109 sitting on the edge of a geriatric chair leaning forward in the 2nd floor dining area unsupervised by staff for several minutes. V42 (Certified Nursing Assistant) stated R109 is not a fall risk. On 02/06/24 at 11:09 AM Observed R109 seemed uncomfortable & didn't look well. R109 reported she had a fall yesterday and a couple of days ago. R109 stated she has some pain on her right upper arm and the right side of her head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R109's current care plan initiated 11/20/2023 documents she is at risk for falls, she has an ADL (Activities of Daily Living) Functional, Performance Deficit; she is a confused [AGE] year-old female readmitting to the facility after being stabilized at hospital post a suspected internal hemorrhage; she experiences weakness and gait abnormality with the Diagnosis of: End Stage Renal Disease, partial paralysis following a brain hemorrhage, COPD, Diabetes Mellitus 2, Hypertension, bacteremia, epilepsy, GERD (Gastro Intestinal Reflux Disease, Non Rheumatic valve stenosis, anemia in chronic kidney disease, cataracts, dependence on renal dialysis, hyperlipidemia, and hypothyroidism; she requires substantial max assistance with most ADLs and is incontinent of both bowel and bladder; and she has a documented history of falls within the last 6 months with interventions including: assist with ADL tasks as needed., Cue resident to grasp side rail and pull herself up to a sitting position or to the side of bed, Monitor/document/report to Nurse any as needed changes in ADL ability, any potential for improvement, reasons for inability to perform ADLs, Provide needed level of assistance and support to complete Activities of Daily Living; Assure resident is wearing eyeglasses; Encourage appropriate use of walker; Promote placement of call light within reach; Provide an environment clear of clutter; Provide proper, well maintained footwear; psych consult for anxiety medication. R17's current care plan initiated 12/12/2023 documents she has potential for injury related to seizure disorder with interventions including: Keep call light within reach. R109's current care plan initiated 12/04/2023 documents she has anxiety symptoms, as evidenced by constantly putting herself on the floor next to her bed, delusions such as stating that a person she knows is present but not there, and false accusations with interventions including: Assure bilateral mats are next to bed. Incident Report/Post Occurrence Documentation 11/20/2023 at 10:30 AM documents at approximately 10:30 A.M. CNA (Certified Nursing Assistant) reported that resident was on the floor in her room. Nurse immediately went to resident's room and observed her on the floor on the left side of her bed lying on the floor mat with her upper body under the bed facing the window. Nurse and staff pulled her out from under the bed. Resident was wearing gown, clean and dry brief and one sock on her right foot. Both quarter side rails were up and in a locked position. Lighting was adequate and floor was dry. Resident was very restless. Resident was observed by nurse approximately 20 minutes prior to incident and was very restless and grabbing at left side rail. Resident was redirected and calmed. Predisposing factors include confusion, gait imbalance, poor safety awareness, recent change in medications, recent illness, weakness, and improper footwear. Fall was unwitnessed. Incident Report dated 01/27/2024 at 5:21 PM documents R109 reported she fell yesterday but didn't tell anyone. Fall was unwitnessed. Predisposing factors include recent change in cognition. R109 was last observed prior to incident by nurse at 3:45 PM. R109's Progress note dated 1/28/2024 at 06:58 AM documents local hospital was called, nurse stated resident admitted into hospital due to fall. R109's hospital report dated 01/28/2024 documents she was placed on high fall risk interventions while in the emergency room ; she presented from nursing facility with chief complaint of shortness of breath, she also fell . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Incident Report/Post Occurrence Documentation dated 2/3/2024 11:52 PM documents R109 was observed in a sitting position with wheelchair behind her in her room outside the washroom door. R109 stated she was trying to get up from her wheelchair to use the washroom and slid down to a sitting position on the floor. Assisted back to bed with another nursing staff. Was encouraged and educated on use of call light and waiting for assistance from staff, was educated as well on locking wheelchair, resident demonstrated proper locking of wheelchair and use of call light. Predisposing factors include noise, and poor safety awareness. R109 was last observed prior to incident at 10:15 PM. Fall was unwitnessed. R109's Progress note dated 2/4/2024 10:45 AM documents reminded patient to call for assistance. Do not get up without assistance. Patient did not follow instructions. Patient got into wheelchair minutes after I reinforced to use call light, which is close to her. She insisted to go bathroom and not wait. R109's Progress note dated 2/6/2024 10:53 PM documents Notified by CNA (Certified Nursing Assistant) that resident had unwitnessed fall last night and hit her head 1st then right shoulder on bed and slid to the floor. Some discomfort to right shoulder with range of motion. On 02/08/24 at 01:21 PM V5 (Restorative Nurse/LPN/Fall Coordinator) stated she understands R109's urgency in going to the bathroom because she is diabetic. V5 stated in addition to R109's medical acuity, many times she says she needs to use the bathroom and tries to transfer herself. V5 stated R109 is impulsive and has anxiety and requires constant education on safety awareness and using call light to let CNA's (Certified Nursing Assistants) know she needs assistance. V5 stated re-education has not prevented R109 from falling. V5 stated additional fall interventions for R109 may include educating the staff on anticipating her needs, and possibly having her moved closer to the nurses station with the family's approval. V5 stated R109 is one of the facility's falling stars residents. V5 stated falling stars are residents considered high fall risks and they are constantly being monitored by staff. V5 stated every morning during the standup meeting residents who are high fall risk and residents who require frequent monitoring are discussed. V5 stated when R109 is out of her room she should be in the presence of staff. V5 stated if residents are high fall risks and are up and, in their wheelchairs, they should be kept engaged in activities and out of their room. V5 stated most of R109's falls are unwitnessed, and she seems to have a pattern of falling in the evenings which is when she seems to be more active. V5 stated during those times R109 should possibly be monitored more frequently. V5 stated these interventions would be more personalized for R109. 4. R535's medical records indicated resident admitted to the facility on [DATE] and discharged on [DATE]. Resident had a past medical history not limited to: hypertension, tremors, anemia, syncope and collapse, psychotic disorder with delusions, vascular dementia, insomnia, palliative care, and Parkinson's disease. R535's care plan with closed date of 01/25/2024 reads in part: had an actual fall with minor injury of small laceration to left eyebrow due to unsteady gait, poor safety awareness and poor endurance and trunk control (11/12/2023) with interventions to continue interventions on the at-risk plan (11/13/2023), monitor/document/report as needed x 72 hours to physician for signs/symptoms of pain, bruises, change in mental status, or new onset of confusion, sleepiness, inability to maintain posture, agitation (11/13/2023); resident will be monitored and placed on high traffic areas for close monitoring and frequent monitoring (11/13/2023). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Care plan also indicated that R535 was a high risk for falls secondary to altered elimination pattern, cardiovascular disease, cognitive deficits, history of fall(s), medications that could affect functional level, level of consciousness, gait, visual acuity or cognitive ability, muscle weakness, poor safety awareness, use of assistive devices, use of psychotropic medication and Parkinson's with tremors; notify family and physician of any new fall (04/29/2022). Care plan also indicated R535 had a potential for alteration in skin integrity due to history of laceration to the right eyebrow and multiple medical diagnoses. R535's Fall Risk assessment dated [DATE] indicated resident fall risk score at 11. Scoring guidelines per assessment indicated, for scores 0-11 at risk-implement general safety interventions. Facility presented fall incident list dated 02/05/2024 for date range of 09/05/2023 to 02/05/2024 that indicated R535 had fall incidents on 11/11/2023 at 08:30 PM and 11/23/2023 at 11:30 AM. Facility presented final report investigation completed by V2 (Director of Nursing) dated 11/17/2023 that indicated on 11/11/2023, R535 was observed with active bleeding to his left eyebrow, and was sent out emergently to a local hospital for further evaluation. R535 returned to facility with laceration to left forehead that was closed with skin glue. R535's Nurses Note dated 11/11/2023 20:55 indicated the same. Reviewed hospital after visit summary dated 11/11/2023 that indicated R535 was seen for a laceration that was repaired with skin glue. Facility investigation report indicated R535 was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4, and fall incident was unwitnessed yet concluded that R535 reported slipping and sliding while ambulating from bathroom, fell and then crawled to his bed where he had hit his forehead on the bedframe while pulling himself back into bed. Resident was discharged from facility during investigation and was not available for interview. On 02/07/2024, upon further record review, noted Hospice Note dated 11/12/2023 11:19 that indicated R535 had been increasingly weaker and had two falls with injury within 24 hours. Nurses Note dated 11/23/2023 11:12 indicated writer was informed by housekeeping that resident was on the floor, in another patient's room laying on the floor when found by the writer; patient will be transferred to local emergency department for further observations. Hospice Note dated 11/27/2023 22:37 indicated R535 had an unwitnessed fall in his room and was found between his roommate's bed and the wall and sustained a 2.5 centimeter (cm) x 0.3cm laceration to the right brow with active bleeding. First aid was provided and fall protocol was initiated. On 02/07/2024, requested complete fall incident investigations for the following fall incidents: second fall within 24 hours indicated in 11/12/2023 hospice note, and for fall incidents on 11/11/2023, 11/23/2023, and 11/27/2023. V1 (Administrator) only provided a typed, undated and unsigned statement by the nurse on duty at time of incident related to R535's 11/11/2023 fall incident. On 02/08/2024, facility presented hospice certification of terminal illness statement dated 01/03/2024 that indicated R535 had multiple falls over the last few moths and difficulty maintaining trunk strength signed by V28 (Medical Director). No other investigation reports were provided by facility for R535. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility provided document titled, Management of Falls policy dated 08/2020 reads in part: Policy: The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident ' s plan of care in order to minimize the risks for fall incidents and/or injuries to the resident. Procedure: 1. Complete a Fall Risk Assessment upon admission, re-admission, with significant change, post-fall, quarterly, and annually. 2. Orient resident to room, call light, unit and location of the nurse ' s station upon admission to the facility. 3. Develop a plan of care to include goals and interventions which address resident ' s risk factors. Risk factors may include but are not limited to the following: Contributing diagnoses/disorders/disease processes / active infections/other comorbidities, history of fall incidents, Incontinence, Medications (Narcotics, Anti-hypertensives, etc.), assistance required with ADL ' s, gait/transfer/balance issues, Behaviors, and/or cognitive status. 4. Provide assistive devices for mobility, hearing and vision as appropriate for the resident. 5. Assess appropriateness for resident to participate in skilled therapy or restorative programming in order to maintain or improve physical function of resident. 6. Assess and monitor resident ' s immediate environment to ensure appropriate management of potential hazards. 7. Monitor for changes in medical condition and notify physician as necessary to manage changes in status of the resident. 8. Conduct Care Plan Meetings with Resident, Responsible Party, and Facility Interdisciplinary Team quarterly and as needed. 9. Review and/or modify the resident ' s plan of care at least quarterly and as needed in order to minimize risk for fall incidents and/or injury. Facility provided document titled, Incident/Accident Reports policy dated 09/2020 reads in part: Policy: The Incident/Accident Report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors or other, and resident-to-resident altercations. Procedure: An accident refers to any unexpected or unintentional incident, which may result in injury or illness to resident. This does not include adverse outcomes that are a direct consequence or treatment or care that is provided in accordance with current standards of practice (e.g., drug side effects or reaction). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. All serious accidents or incidents of residents 2. All injuries of staff, families, and visitors 3. All unusual occurrences 4. All situations requiring the emergency services of a hospital, the police, fire department, or coroner 5. Any type of resident abuse 6. Resident to resident altercation 7. Suicide or attempted suicide 8. Any condition resulting from an incident requiring first aid, physician visit, or transfer to another health care facility 9. An incident/accident report is to be completed and shall complete and shall include: a. date and time of incident/accident b. description and possible cause of incident, physical assessment, injuries noted, vital signs, treatment rendered, and notification of appropriate parties. 10. The facility shall maintain a file of each incident and accident affecting a resident that is not expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's note of that resident. 12. The Director of Nursing, Assistant Director of Nursing or Nursing Supervisor must notify: a. The Illinois Department of Public Health (IDPH) of any serious incident or accident, Serious means any incident or accident that causes physical harm or injury to a resident. b. The facility shall, by fax or phone, notify the regional office within 24 hours after each reportable incident or accident. c. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven (7) days after the occurrence. 13. e. A minimum of seventy-two (72) hours of documentation by all three shifts on resident status after the incident or accident, vital signs, mental and physical state, follow-up, tests, procedures, and findings are to be determined. 14. All incident/accident reports are reviewed, signed, and investigated by: a. the administrator; and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. the director of nursing or the assistant director of nursing 15. Facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Facility policy: Smoking Policy, dated 8.2023: Policy: The facility will assess hazards and risk factors associated with smoking, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care to minimize the risks of incidents/accidents associated with smoking. The facility's policy for Management of Falls reviewed 02/08/2024 states: The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the resident's plan of care in order to minimize the risks for fall incidents and/or injuries to the resident. Develop a plan of care to include interventions which address resident's risk factors. Review and/or modify the resident's care plan as needed in order to minimize the risk for fall incidents and/or injury.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 44570 Based on observation, interview, and record review, the facility failed to follow their policy of obtaining resident weights, failed to document meal intake, and failed to update an individualized care plan for one of two residents who were reviewed for nutrition. This failure applied to one of one (R166) resident reviewed for weight loss and resulted in R166 demonstrating an unintended weight loss of 29% during the first two months of admission. Findings include: R166 was admitted to the facility 10/4/23 with diagnoses that included hypertension, pressure ulcers and dysphagia. During this survey R166 was observed to receive lunch meals in bed, and on 2/6/24 observed to eat 0% of the meal provided. When R166 was interviewed at 1:00PM and observed siting up in bed alert and conversive. R166's arms and face appeared thin, and R166 refused further assessment due to room temperature. R166 mentioned that R166 was not very hungry and didn't want the meal. According to hospital transfer records and the facility's electronic health record, R166 was admitted at a weight of 146 lbs (pounds). During the second week of admission, R166 recorded weight was 145 lbs and the next recorded weight thereafter was recorded to be 103.4 lbs for a total weight loss of 29.18%. On 2/8/24 at 12:00PM V2 DON (Director of Nursing) was interviewed regarding the weight loss of R166. V2 said that it was the policy of the facility that residents who were newly admitted to the facility should have be weighed at least once weekly for four weeks to establish a baseline and pattern for meal habits and intake. After the baseline is established, the resident should have weights recorded at least monthly or daily as appropriate to condition or diagnosis. V2 said this is especially important for residents with wounds because nutritional status greatly affects wound healing. V2 reviewed the recorded weights with the surveyor and noted that the Weight Report for R166 was missing weight results for the third and fourth week of October, and no weight was recorded for November. V2 said that although some nutritional supplements were ordered and in place for R166, it was expected that when the weight loss was identified, that the care plan for nutrition would be revised to provide a more individualized plan. While referring to the Weight Report, V2 said that since the weight loss was identified in December, it remains stable and has even increased with weights reported on 1/5/24 at 107.8 lbs and 2/1/24 106 lbs. R166's Care Plan initiated 10/5/23 states in part; {R166} requires nutritional support {related to} {diagnosis} of dysphagia and presence of pressure wounds; receiving general pureed, {protein supplement} and fortified cereal. Scored malnourished on mini nutrition assessment due to moderate decrease in food intake, bed bound, and BMI (Body Metabolic Index) above 23. Interventions of the care plan were also initiated 10/5/23 and did not indicate any revisions had taken place. Interventions included Monitor labs and wight for signs of effective disease management and Weekly weights. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Facility policy titled Weights revised 9/2020 states in part; Policy: Residents will be weighed to establish baseline weights and identify trends of weight loss or weight gain. Procedure: 1. A baseline weight will be established upon admission. The resident will be weighed weekly for 4 weeks after admission and monthly thereafter.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 34071 Based on observation, interviews, and record reviews, the facility failed to administer medications as ordered; failed to ensure medication is available during medication administration; and failed to follow policy in the administration of eyedrops and insulin pen. There were 25 opportunities with five errors resulting in a 20% medication error rate. The errors involved four (R119, R137, R170 and R184) of 16 residents in the sample of 71 reviewed for medications. Findings include: On 02/05/24, the following were observed during medication pass: 11:00 AM: V9 (Registered Nurse, RN) was about to give Humalog on R170, however, the medication was not currently available. V9 stated, His Humalog is not available; there is nothing in the convenient box, nothing in the main medication box and even in the insulin boxes. I will order it now. R170's POS (Physician Order Sheet) recorded: Humalog KwikPen SQ (subcutaneously) 100 units per milliliter (u/ml) inject 8 units before meals. At 12:27 PM, V10 (Licensed Practical Nurse, LPN) was observed preparing R119's eyedrop medication. R119 has an order of Systane Solution 0.4 - 0.3% 1 drop in both eyes four times a day. During eyedrop administration, R119 closed her right eye tightly while V10 tried to pull her (R119) upper eyelid upwards as she (V10) tried to instill one drop directly into the center of her R119) eye. R119 closed her eyes tightly several times as she (V10) pulled the upper eyelid and attempted to administer a drop until she (V10) was able to put one drop in her (R119) right eye. V10 did the same procedure when instilling one drop in her (R119) left eye. V10 verbalized, There was a tiny drop that went in to her left eye. At 12:40 PM, V10 was preparing R137's Humalog pen injection. R137's POS documented: Humalog Kwikpen SQ Solution Pen Injector 100u/ml inject as per sliding scale; and Humalog Kwikpen SQ Solution Pen Injector 100u/ml inject 5 units SQ after meals. R137's blood sugar was 303mg/dl (milligrams per deciliter) requiring 5 units of insulin per sliding scale. R137 will receive 10 units. V10 took her (137) Humalog Kwikpen from the cart, turned the dose knob to 2 units and pushed the injection button once. She (V10) then attached a needle to the pen and turned the dose knob to 10 units and administered to R137's right arm. At 1:21 PM, She (V10) did the same preparation on R184's Humalog Kwikpen by turning the dose knob to 2 units then pushed the injection button. She set the dose to 3 units, attached the needle to the pen and then administered to her (R184) left arm. R184's POS recorded: Humalog Kwikpen SQ Solution Pen Injector 100u/ml inject 3 units SQ three times a day. Also, R184 has an order of Calcium Acetate 667mg 1 tablet by mouth with meals for therapeutic supplement related to diagnosis of End Stage Renal Disease. V10 administered her (R184) Calcium Acetate after meals. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/06/24 at 10:00 AM, V2 (Director of Nursing) was interviewed regarding availability of medications and administration. V2 stated, We always educate nurses that if only 10 pills are left, nurses will send a message via electronic health records and it goes to Pharmacy. Pharmacy will dispensed and deliver it. They deliver every day, which is early morning at 8 AM and at noon, at 6 PM and midnight. For insulin, we should have it in our main secure medication storage. I don't know what happened to R170's insulin. Also, Nurses need to follow medication orders as scheduled and follow manufacturer's guidelines; and correct administration. Facility's policy titled Medication Administration: General Guidelines, dated 03/2021 documented in part but not limited to the following: A.Policy: To ensure that medications are administered safely as prescribed. D.Procedure: 10. All necessary items/supplies should be readily available for the proper administration of medication. Facility's policy titled Insulin Pen (Non-Mix) dated 09/2020 documented in part but not limited to the following: Policy: Ensure safe and proper set-up and administration of insulin utilizing the insulin pen. Procedure: 3. Attach the new needle. Keep the needle straight as you attach it. 4. Perform a safety test. Always perform this test before each injection! This removes air bubbles and ensures that the pen and needle are working properly. a. Select a dose of 2 units. b. Take off the outer needle cap and keep it to remove the used needle after injection. c. Take the inner needle cap and discard it. Then hold the pen with the needle pointing upward. d. Tap the reservoir gently so any air bubbles rise up to the needle. e. Press the injection button all the way in. Check if insulin comes out of needle. If insulin does not come out, check for air bubbles and repeat test two more times to remove them. If no insulin comes out the third time, try again with a new needle. 5. Select the dose. 6. Inject your dose. Facility's policy titled Medication Pass Guidelines dated 03/2021 stated in part but not limited to the following: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	19. Eye Medications To administer drops: Drop the medication into the conjunctival sac. Ask resident to gently close eyes for several minutes; do not squeeze eyes shut, which will wash out medication. Punctal occlusion may be used for several minutes if resident is unable to follow instruction. Wait 3 to 5 minutes between drops to make sure the resident is getting proper dosage and avoid washing out of drops.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036 Based on observation, interview, and record review, the facility failed implement transmission-based precautions in a timely manner for residents who tested positive for RSV (Respiratory Syncytial Virus) and failed to follow their infection control policy by not wearing appropriate Personal Protective Equipment in an RSV isolation room. These failures applied to two of two residents (R8, R139) reviewed for infection control and has the potential to affect 23 residents being cared for by staff. Findings include: On day one of survey 02/05/2024 between 10:00 AM and 12:30 PM no isolation precautions were observed to be in place for R8 and R139. During observations on the unit, multiple staff were noted to provide care and enter the room without personal protective equipment such as gowns, gloves and face shields. On the following day 02/06/2024 at 12:19 PM contact and droplet isolation sign observed to be in place for R8 and R139 room. At 1:33 PM V37 (Registered Nurse) was interviewed and said that she collected the swabs for R8 and R139 on 1/25/2024 and sent to the lab. During the interview V37 referred to documentation in the electronic medical record that indicated the results of the nasal swabs were reported to the facility 02/02/2024. V37 confirmed that isolation precautions should have been in place for both residents at the time the results were reported, however, according to the physician orders for both resident's, orders were placed on 02/05/2024 which is three days after results were reported. On the third day of the survey 02/07/2024 at 09:56 AM V9 (Registered Nurse) was seen going in to provide care for R8 in the room and it was noted that V9's face mask was not covering V9's nose. At 9:58 AM V9 demonstrated that the proper application of the face mask covered the nose and mouth when donned and said they was caring for residents from rooms 201 to 213. Later V40 (Certified Nursing Assistant) was observed in room without gloves and gown arranging items for R8. V40 said, I don't have to wear gloves just to be in the room, I just have to wear a face shield and mask. V40 said, today I am on the shower team but assisting all residents from room [ROOM NUMBER] to room [ROOM NUMBER]. According to the facility isolation signs for contact precautions, personal protective equipment for all staff and providers include wearing gloves and gown upon entry and removing prior to exiting the room. On 02/08/2024 at 11:58 AM V2 (Director of Nursing/Infection Preventionist) said that R8 and R139 were displaying cold symptoms, which is what prompted the need for a nasal swab. R8 and R139 should have had isolation precautions in place at the time the results were reported from the laboratory. V2 said delay in applying isolation precautions could have potentially put other residents and staff at risk of contracting RSV. V2 said that RSV is a droplet transmitted virus and that contact precautions were used as extra measure. (continued on next page)

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	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Town Manor Rehab & Hcc	6120 West Ogden Cicero, IL 60804

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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 - Some	The Facility provided a document titled Guideline for Isolation Precautions (Centers for Disease Control) updated 7/2023 which states in part; Respiratory syncytial virus infection (RSV), in infants young children and immunocompromised adults: Type of Precaution- Contact and Standard [for the] duration of illness. Wear mask according to Standard Precautions. In immunocompromised patients, extend the duration of Contact Precautions due to prolonged shedding. Reliability of antigen testing to determine when to remove patients with prolonged hospitalization s from contact Precautions uncertain. Infection Prevention and Control Manual: Transmission-Based Precautions revised 12/2023 states in part; Policy: Transmission based precautions are used for residents who are known to be suspected of being infected or colonized with infectious agents, including pathogens that require additional control measures to prevent transmission. Transmission based precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for resident's who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent transmission. There are 4 categories of transmission-based precautions. Standard precautions apply to all residents. 1. Contact Precautions- The purpose of contact precautions is to prevent transmission of infections that are spread by direct (i.e., person to person) or indirect contact with the resident's environment. Contact precautions require the use of appropriate PPE [personal protective equipment], including a gown and gloves upon entering the room or making contact with the resident or the resident's environment. When leaving the room, PPE will be removed, and hand hygiene performed.