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 ______	05/03/2007

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ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

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F 000	INITIAL COMMENTS Annual Licensure and Certification This was a FOSS Survey. An extended survey was conducted. VALIDATION SURVEY FOR SUBPART U: ALZHEIMER UNIT The facility is in compliance with Subpart U, 77 Illinois Administrative Code, Section 300.7000	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another	F 164		

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

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.

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	145736	A. BUILDING ____ B. WING ____	05/03/2007

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F 164	Continued From page 1 healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, 2 of 26 sampled residents (R1 and R4), were not provided privacy during care provided by staff. Findings include: 1) On 4/11/07 at 2:30 P.M., R1 was observed being assisted with a slide board transfer from bed to wheelchair by E18 (nurse aide) and Z3 (physical therapy aide). R1's bedroom door and privacy curtain were wide open during this transfer. R1 was wearing a dress and no undergarment or diaper and as R1 scooted on the slide board, her dress raised up and partially exposed R1's genitalia. R1 was transferred on the left side of her bed toward the doorway. Surveyor observed other people in the hallway, to look into R1's room during the transfer. 2)On 04-13-07, surveyor observed E13 (nurse) perform a pressure sore dressing change for R4. E13 removed R4's clothing from the waist down. R4 was observed through out the procedure naked from the waist down. No curtain was pulled and the door to the resident room was open enabling R4 to be seen from the corridor.	F 164		
F 165 SS=D	483.10(f)(1) GRIEVANCES A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.	F 165		

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 ______	05/03/2007

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F 165	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that residents are able to voice a complaint / grievance without fear of reprisal. This failure occurred for 1 of 26 sampled resident (R15) and 1 resident (R31) outside the sample. Findings include; 1)During the initial entrance on 04-10-07, E1(administrator) stated the facility had no allegations of abuse in the past six months. On 04-17-07 at 11:00 AM, surveyor interviewed R15 who stated it bothered her the way the certified nurse aide (CNA) treated her and she was afraid of being put out of the facility if she voiced it. R15 stated she reported to E8(director of nursing), that she put her call light on and that E11 (CNA) responded "you need to lay low on the light". R15 stated after reporting to the supervisor about the call light she began getting cold treatment from the other CNAs on the floor. R15 stated one CNA snatched her covers off and stated "turn over". R15 stated I get nervous anticipating E11 working the weekends. On 04-17-07 at 3:00 p.m., E8 stated R15 indeed reported this to her. E8 stated R15 did not express any fear. E8 stated we normally do a concern form and give it to the administrator but no concern form had been done. E8 stated no investigation had been done. E8 stated she conducted an inservice regarding call lights. E8 stated E11 was R15's CNA the evening of the complaint.	F 165		

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 165	Continued From page 3 No documentation was noted in the facility's concern book regarding call lights. Surveyor requested documentation of the inservice on call lights numerous times through out the survey. Facility presented documentation 04-26-07 of an inservice on call lights dated 04-16-07. 2)On On 04-12-07 during the group interview, R31 stated she was scared of E12 (certified nurse assistance). R31 stated that she put her call light on for incontinent care. E12 responded to the call light, by showing me her fist, turning off my call light and told me, " I don't work over here". R31 stated she never received incontinent care that night. During a 4-17-07 interview, E8 stated R31's family complained that she was being mishandled. E8 stated that the facility did an investigation and concluded the allegation was unfounded. After numerous requests for documentation of the abuse investigation through out the survey (beginning 04-12-07), the facility produced an abuse investigation 04-26-07 which included; -a disciplinary memo dated 03-04-07 which stated E12 was suspended pending allegation of abuse - a interviews of E12, the family and R31's roommate dated 03-05-06 - a letter to public health dated 03-05-07 stating the facility was unable to substantiate allegations of abuse.	F 165		
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the	F 166		

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 166	Continued From page 4	F 166		

facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

This REQUIREMENT is not met as evidenced by:
Based on interviews and records reviewed, facility failed to document and thoroughly investigate all grievances brought to the attention of facility staff.

Findings include:

-During the 4/12/07 resident group meeting, surveyor was notified of an un-resolved, reported grievance by R30. R30 stated that on 4/07/07 E15 (social service director) and E16 (activity director) were notified that 5 packages of cigarettes had been taken from a drawer in R30's room. R30 said that facility has not gotten back to her on the result of the investigation related to this grievance.

E15 told surveyor during a 4/18/07 individual interview that about 1 1/2 - 2 weeks ago, R30 voiced a concern about 4 or 5 packs of cigarettes being taken from her room. E15 said that R30 accused R14 of taking her cigarettes, so E15 searched R14's room and no cigarettes were found.

E15 said that the facility replaces missing items but not cigarettes because there is no proof that the cigarettes were in the facility. E15 admitted that there was no written grievance report about R30's missing cigarettes.

E15 also told surveyor that "Last week,

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 166		F 166		

Continued From page 5

E1(Administrator) told all department heads to remove potentially hazardous compounds (hair spray, aerosol sprays and items that residents could ingest) from all resident rooms". E15 said that residents and resident family members were upset about the items being taken and wanted the items back. E15 admitted that there is no written grievance reports related to these complaints.

E1 told surveyor during a 4/18/07 individual interview that the facility does not always complete a grievance form with every grievance reported.

The Facility's Grievance / Missing item protocol stated that once a staff member receives a concern or missing item complaint, it will be addressed immediately. Concern forms are completed by the resident, visitor or employee and sent to the administrator or designee, who will conduct an investigation. The individual will be notified of the status of the investigation with in a one calender week.

The Facility's Admission packet included a copy of Residents Rights, these right stated:
#5 " that if property is missing , the facility must try to find it."

On 4/18/07, E1 provided surveyor with a grievance report dated 4/18/07 documenting that "Last week R30 stated that she was missing 5 packs of a brand named cigarettes to E15." The follow-up was that the "Items were replaced."

-On 04-17-07 during a individual resident interview, R15 complained of being mistreated by E11(certified nurse aide) . R15 also voiced fear

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F 166	Continued From page 6 of CNAs after having reported the incident to a supervisor E8(director of nursing). R15 stated she received cold treatment from the other CNAs after reporting the incidence. On 04-17-07, E8 stated R15 did complain to her regarding E11 telling her to lay low on the call light. E8 stated a concern form is usually filled out and given to E1(administrator). E8 stated no concern form was ever filled related to R15's above complaint. No documentation was provided during the survey of an investigation. On 04-10-07, E1 stated the facility has had no abuse allegations / investigation in the past six months.	F 166		
F 172 SS=C	483.10(j)(1)&(2) ACCESS AND VISITATION RIGHTS The resident has the right and the facility must provide immediate access to any resident by the following: Any representative of the Secretary; Any representative of the State; The resident's individual physician; The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965); The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act); The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy	F 172		

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 172	Continued From page 7 for Mentally Ill Individuals Act); Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident. The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, the facility failed to provide residents immediate access to all visitors. Findings include: On 4/10, 4/11, 4/12 and 4/13/07, surveyors observed a posted sign at the first floor nursing station, visible to all visitors, stating: "For the safety of our residents and employees at Alden Town Manor, visiting hours will be strictly enforced. Doors will be locked at 8PM. Thank you for you cooperation." During a 4/13/07 interview at 11:25AM, E1 (Administrator) told surveyor that facility has a strict visiting policy posted at the first floor nursing station. This policy stated that the doors	F 172		

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 ______	05/03/2007

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F 172	Continued From page 8 are locked at 8PM. E1 said that this policy is for the safety of the residents and that there is flexibility in visiting hours, that is verbally communicated to residents / families during the admission process. On 4/10/07 during the initial tour between 9:45 a.m. to 10:30 a.m., R14 stated she was told her mother would not be allowed to visit her after 8 p.m. Review of R14's Social Service note dated 2/7/07 documents that R14's family was counseled on the facility's curfew hours. The family member voiced concern with visiting hours due to working all day and can only visit later in the evening.	F 172		
F 224 SS=J	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review facility failed to ensure that 1 of 9 sampled residents with pressure sores (R22), was free from neglect. This was evidenced by the failure of the facility to prevent a twenty-nine (29) day delay in R22 being evaluated by wound care consultant and receiving appropriate treatment recommendations. This failure directly caused R22's left lateral foot stage II pressure sore to progress to a stage IV pressure sore with bone involvement (Osteomyelitis = bone infection). The above failure concerning R22 resulted in an	F 224		

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224		F 224		

Continued From page 9

Immediate Jeopardy. Although the Immediate Jeopardy was identified on 4/26/07 it was determined to have begun on 3/14/07 at approximately 10:00 p.m., when R22 was noted to have a open wound to her left foot and the physician ordered facility to obtain a wound care consultation to evaluate the wound and make treatment recommendations. The delay of promptly notifying the wound care consultant for evaluation and treatment recommendations directly caused R22's pressure sore to progress from a stage 2 to a stage 4 with bone involvement. E1 (administrator) was notified of the Immediate Jeopardy on 4/26/07 at 11:00 a.m.

Findings include:

R 22 is a 80 year old with a diagnosis of Cardiovascular accident, Diabetes, Hypertension, Coronary Artery Disease, Dementia and altered mental status. Documentation denotes that R22 had been assessed to be high risk for the development of pressure sores.

On 4/19/07, surveyor and E10 (nurse), observed R22 to have a stage 4 pressure sore on the left lateral foot, with a moderate amount of foul smelling drainage.

Review of R22's clinical record denotes that on 3/14/07 R22 was noted to have a open sore with drainage to the left inner lateral foot. Documentation denotes that the physician was notified and initial orders were given for a wound care treatment. Documentation denotes that additional orders were given for R22 to be seen by the wound care consultant. Documentation by E10 on R22's 3/14/07 skin alteration form described the wound as a stage 2 pressure sore

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 ______	05/03/2007

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 224	Continued From page 10	F 224		

measuring 1.3cm x 0.5cm x 0.5cm.

Further review of R22's clinical record and the facilities 24 hour report denotes no notification of the wound care consultant to assess and treat R22's pressure sore until 4/12/07, (29 days after the initial order was written). This notification was due to the prompting of R22's family. Documentation denotes that R22's pressure sore had increased in size (1.0x1.5x5), had "lots of drainage" and now had a foul smelling odor.

During a 4/19/07 interview at 10:50 a.m., E10 stated that on 3/14/07 a CNA reported to her that R22 had a pressure sore on her foot. E10 stated that she assessed the wound and noted a 1.3cm x .5cm stage 2 pressure sore with a moderate amount of drainage. E10 stated that she notified the physician and obtained treatment orders. E10 stated that she endorsed in the 24 hour report that R22 needed to be assessed by the wound care consultant for appropriate treatment. E10 stated that she called the wound care consultant on 4/12/07 after R22's family complained about the wound and the bad foul smell. E10 stated that she did not know if the wound care consultant was ever notified prior to 4/12/07.

During a 4/13/07 interview, Z5 (family) stated that approximately 3 weeks ago, Z5 found a sore on R22's foot and immediately notified the nurse. Z5 stated that the sore has gotten bigger over the weeks and has a very bad odor. Z5 stated that the wound stinks so bad that it makes her sick, and that she cannot stay in the room. Z5 stated that she had complained to E8 (DON) about the odor and that R22 was just seen today (4/13/07) by the wound care nurse. Z5 stated that she was told weeks ago that R22 needed to be seen by

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 ___	05/03/2007

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ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

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F 224	Continued From page 11	F 224		

the wound care nurse and that she did not understand why R22 had not been seen prior until today (4/13/07).

During a 4/19/07 phone interview at 3:35PM, Z2(wound care consultant), stated that her initial visit to see R22 was on 4/13/07. Z2 stated that she was called on 4/12/07 and that she does not recall being notified by the facility regarding the consultation prior to 4/12/07. Z2 stated consults are called into her office. Z2 further stated that the process had not changed and that even if she was not in the office she would have received the message. Z2 further stated that she assessed R22's wound to the left lateral foot on 4/13/07 for the first time, and noted a moderate amount of foul smelling drainage. Z2 stated that her immediate impression was that there was some bone involvement, and that the resident would now require a deep tissue culture and bone scan.

During a 4/19/07 phone interview at 3:15PM, Z1 (physician), stated that on 3/14/07 he was notified by the facility that R22 had developed a new pressure sore on her foot. Z1 stated that he gave an initial order for treatment until the wound care consultant could see the patient. Z1 further stated that he also gave a order for a wound care consultant to see the resident. Z1 stated that he was not notified until 4/13/07 that R22 had not been seen by the wound care consultant. Z1 stated that he had expected that the resident would have been seen right away, especially since the facility has a contract with a wound care consultant. Z1 stated that in his opinion, the delay in R22 being evaluated by the wound care consultant and getting the correct treatment, lead to the progression of the pressure sore and newly diagnosed bone infection (osteomyelitis,

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 ______	05/03/2007

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 224		F 224		

Continued From page 12

confirmed by bone scan on 4/18/07). Z1 stated that R22's condition progressed so quickly and that it required immediate interventions. Z1 stated that his next step is to consult with a infectious disease specialist, because R22 will need to have an Peripherally Inserted Central Catheter (PICC), line which is an invasive procedure, and about 6 weeks of intravenous antibiotic therapy to treat the problem.

R22's diagnosis, which include cardiac problems / affecting circulation and Diabetes directly negatively impact on R22's heel pressure ulcer ability to heal.

The Immediate Jeopardy was removed on 4/26/07 at 3:15 p.m. and the surveyor confirmed that the facility took the following actions to remove it, which reduced the severity to a level 2.

Corrective actions taken are as follows:

1. In-services were initiated on 4/26/07 for all nursing staff, covering:
Mistreatment
The facility ' s skin program including protocol for wound care consultant referrals are made in a timely manner.

All nursing staff off on 4/26/07 or on vacation will be in serviced upon their return to the facility before starting their next shift.

2. Policy and procedure regarding skin program was reviewed on 4/26/07 and no changes were made.
3. All physicians will be notified starting on 4/26/07 by telephone that the facility no longer has an in house nurse practitioner so all wound

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	**6120 WEST OGDEN CICERO, IL 60804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 13 consultants will be off site. All physicians will be notified by 4/27/07. All appointments will be made by the charge nurse by the end of the next business day that the wound care clinic is open. 4. A complete chart audit was done on 4/26/07 to ensure no other wound care consultant orders were not addressed. The chart audit was completed on 4/26/07. 5. An ongoing QI/QA monitoring tool was developed regarding wound care consultant referrals to ensure compliance. The DON/Designee will monitor compliance on admission and weekly there after with the monitoring tool.	F 224		
F 226 SS=F	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that it developed a policy and procedure to prohibit and investigate allegations of abuse that encompassed the key area of screening, training, prevention and identification. Facility also failed to thoroughly follow-up/ investigate an allegation of mistreatment voiced by 1 of 26 residents in the sample (R 15). Findings Include: During the entrance conference on 4/10/07, E1 (administrator) was asked to provide a copy of the facility's policy and procedure to prohibit and investigate allegations of abuse within 24 hours.	F 226		

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 14 On 4/11/07 a two (2) page document entitled {Operations manual policy and procedure Abuse Resident} was submitted to the survey team. E1 was asked on 4/11/07 and again twice during an interview on 4/18/07, if the two (2) page document submitted was the facility's only Abuse protocol and E1 responded "yes".. Review of the 2 page document, described as the facilities Abuse protocol, submitted by the facility denotes that the key components of screening, training, prevention and identification are not incorporated into this policy. During interview on 4/18/07 E1 (administrator/ abuse coordinator), stated that he was the abuse coordinator for this facility and that he has been a Abuse coordinator designee in the past for previous administrators at other facilities while the Abuse coordinators were on vacation/absent from the facility. E1 also stated that the components of the facilities abuse policy and the process of conducting an abuse investigation included: - suspension of the person involved - start investigation - notify state agency within 24 hours of notification - interview, resident, family and any witnesses and person involved - send final report to state agency 2. During the initial entrance on 04-10-07, E1(administrator) stated the facility has had no allegations of abuse in the past six months. During a 4-17-07 interview at 11:00 a.m., R15 stated it bothered her the way the certified nurse aide (CNA) treated her and was afraid of being put out of the facility if she voiced a complaint.	F 226		

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 15 R15 stated she reported to E8(director of nursing) that she put her call light on and the E11 (CNA) responded "you need to lay low on the light". R15 stated after reporting to the supervisor about the call light she began getting cold treatment from the other CNAs on the floor. R15 stated one CNA snatched her covers off her and stated "turn over". R15 stated I get nervous anticipating E11 working the weekends. On 04-17-07 at 3:00 p.m., E8 stated that R15 did report a complaint about a CNA being rude to her when she put the call light on. E8 said that R15 did not express any fear. E8 stated "we normally do a concern form and give it to the administrator but no concern form had been completed in regards to R15's above complaint. E8 stated that no abuse investigation was completed, only staff inservices regarding call lights were conducted. E8 also stated that E11 was R15's CNA the evening of the complaint. No documentation was noted in the facility concern book regarding call lights. Surveyor made multiple requests to review the documentation of the staff inservices provided on call lights, through out the survey. Facility presented documentation 04-26-07 of an inservice on call lights dated 04-16-07.	F 226		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by:	F 241		

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 ______	05/03/2007

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 241	Continued From page 16	F 241		

Based on observation and interviews, residents are not always treated with respect and dignity by facility staff failing to:
- knock on resident doors and announce their presence prior to entering a resident room
- explain what they are going to do prior to:
  * performing endo-tracheal suctioning on 1 of 26 sampled resident (R2)
  * removing covers off a resident in bed on 1 of 26 sampled resident (R4)
  * entering and searching resident rooms and removing resident personal care items from all residents in the facility.

Findings include:

1) During the 4/13/07 resident group meeting, several residents complained that facility staff routinely enter their rooms without knocking first. The residents complained that sometime last week staff entered and searched all resident rooms and removed resident personal items without resident's permission.

2) On 4/13/07 at 11:00AM, surveyor observed E13 (nurse) enter R4's room without knocking, approach R4's bed and pull R4's covers off of R4 and proceed to do a wound treatment on the resident without explaining what she was going to do first.

3) On 4/11/07 at 2:55PM surveyor observed R2 in be on his left side facing the window. E22 (nurse) reached over R2 from behind and inserted a suction catheter into R2's tracheostomy and suctioned him 3 times in a row, minutes apart without first instructing R2 on what she was going to do. R2 is awake but unresponsive to verbal stimuli. In addition, R2

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 17	F 241		

was observed with extremely long and thick toe nails.

4) During 4/18/07 individual interviews with E15 (social service director) and E16 (activity director), E15 and E16 said that "Last week, E1(Administrator), told all department heads to remove potentially hazardous compounds (hair spray, aerosol sprays, shaving cream, razors, deodorant, mouth wash and items that residents could ingest) from resident rooms". E15 and E16 said that residents and resident family members were upset about the items being taken and wanted the items back. E15 said that the items taken were bagged and stored in the 3rd floor unit managers office, E16 said that the items were placed in the nursing offices on each floor. E15 and E16 said that if a resident was in the room during the search, we explained what we were doing but if the resident was not in the room, we still did the search and explained what we did to those residents later.

5) During 4/18/07 10:35AM individual interview with E14 (Assistant director of nurses), E14 said that about 5-6 weeks ago staff were directed to remove duplicate grooming items (lotion and mouth wash) from resident's bedside to prevent congestion in the room. Then on 4/19/07 at 10:30AM , E14 adamantly stated that the room searches were done prior to E1's date of hire (3/19/07), not with in the last 2 weeks and that there are no personal resident care items stored in the nursing offices.

During a 4/19/07 11:15AM tour of the nursing offices on the 2nd and 3rd floor with E1 and E14, surveyor found multiple boxes and bags stored in these offices containing personal resident

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 ______	05/03/2007

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 241	Continued From page 18 grooming supplies (shampoo, lotions, skin barrier cream, shaving cream, razors, peri-wash, Deoderant, disposable adult diapers, soaps, powders and other grooming items), some were labeled with resident names and others without labels, but all intermingling together in a large bag. These bags were sitting directly on the floor in the 2nd floor nursing office and E8 (Director of nurses), told surveyor that she did not know where these items came from and she was going to throw them all away. Then E8 said that these care items were taken from resident rooms by the nurse aides during routine rounds, 1 - 2 weeks ago. E1 provided surveyor with a packet given to residents / families when they come to tour prior to admit. This packet , labelled "Thank you for considering Alden", includes a section on "What personal belongings should I bring?". This packet stated that facility suggest that the residents bring personal items such as toothpaste, toothbrushes, hair brushes, combs, razors, shaving equipment, toiletries and cosmetics." In addition, facility does not allow or offer the possibility of applying a lock on residents bedside cabinets to protect personal items and grooming supplies.	F 241		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 19 Based on observation, record review and interviews, the facility failed to : - assure lab tests are performed in a timely manner as ordered by the physician, for 3 of 26 sampled residents (R1, R6 and R16) - notify MD of change in condition / development of an unusual skin rash in a timely manner on 1 of 3 residents in the facility with skin rashes (R17), resulting in the resident intermingling with other residents on the skilled care unit for 9 days prior to being placed on isolation for Shingles infection. - assure renal diets were followed on one of 2 residents in the facility on hemo-dialysis (R33), - contact attending MD's for frequency and type of pacemaker monitoring orders on 4 of 6 residents in facility with a pacemaker (R2, R34, R35 and R36). - follow MD orders (to apply heel protectors) for 1 of 26 sampled residents (R13). Findings include: 1) R1 had a 3/22/07 MD order for a stool sample to be tested for Clostridium Difficile (C-Diff), related to chronic diarrhea. R1 was started on Flagyl to treat C-Diff on 3/26/07. R1's stool specimen was not sent for testing until 3/27/07 and results were negative for C-Diff, so the Flagyl was discontinued on 3/27/07. 2) R6 has physician orders for a complete blood count and a basic metabolic profile diagnostic tests to be performed on 4/06/07. These tests were not performed until 4/12/07, after a 4/11/07 inquiry for these lab results by surveyor. The facility provided a requisition form dated 4/6/07 but it did not have any validation on the form that it was sent to the laboratory.	F 281		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ____	05/03/2007

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 281	Continued From page 20 3) R16 was admitted to the facility on 01/23/03 and has 01/24/03 physician orders to include stool for occult blood and urine for micro albumin to be completed every 6 months and mammography every 4 months. R16's medical records and facility staff were unable to provide results or proof that for any of these diagnostic test had ever been completed on R16 to date of 4/11/07. 4) R17 was readmitted to facility on 4/07/07 with small red areas under her left breast and on the mid back area, as was documented on 4/07/07 initial nursing assessment. During 4/18/07 individual interviews of R17 and E26 (nurse aide), surveyor was notified that prior to being placed on isolation (4/15/07), R17 was up in the wheelchair and self propelled herself around the 2nd floor at will. R17 told surveyor that she would eat her meals in the dining room with peers at the table prior to being placed on isolation. R17's medical record included 4/8, 4/9, and 4/10/07 nurses notes that documented R17 was up and about in the wheelchair. R17's MD was first notified of the rash on 4/12/07. R17 was not placed on isolation precautions or provided treatment for the Shingles until 4/15/07. 5) R33 has a diagnosis that includes End stage renal disease. R33 also receives hemo-dialysis three times per week. R33 has physician orders and interventions on her current care plan to maintain a diet of no concentrated sweets, and to restrict certain foods, including oranges. On 4/17/07 surveyor observed 3 packages of chocolate chip cookies with concentrated sweets	F 281		

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 ____	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 21	F 281		

and 2 fresh oranges on top of the bedside cabinet next to the television in room 227 -2. On 4/20/07 surveyor observed 1 package of the same chocolate chip cookies and 1 fresh orange on top of the cabinet next to the television in room 227-2.

R33's record did not include any documentation on current assessments or in the care plan of R33 being non-compliant with her diet.

6) Facility has 6 residents with internal cardiac pacemakers. During interviews of E1 (Administrator),
E8 (Director of nurses) and E21 (corporate administrative consultant), surveyor was notified that 4 of the 6 residents with pacemakers (R2, R34, R35 and R36), have not had their pacemakers periodically monitored.

Review of R2, R34, R35 and R36's medical record validated that their pacemakers had not been monitored since these residents were admitted to the facility. There were no physician orders for monitoring reports of pacemaker monitoring on any of these records. R2 was admitted to facility 9/20/06, R35 was admitted 02/15/07 and R36 was admitted 02/27/07.

Facilities Pacemaker monitoring protocol states that they will be monitored via trans-telephonic system as ordered by the physician.
The protocol also stated that facility should schedule the date and time of initial transmission. Copies of the pacemaker monitoring report will be retained in the residents medical record.

During individual interview on 4/13/07 at 10:45AM of Z4 (Hospice nurse for R2), surveyor

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 22 was told that R2 may be on hospice care but that does not prevent R2's pacemaker from being monitored. 7) On 4/11/07 at 2:45PM, R13 was observed in bed with his heels directly embedded in the mattress. R13 had no support or heel protectors on his feet. On 4/12/07 at 9:15AM, R13 was observed without heel protectors on. R13's left heel was assessed to be redden. R13's medical record documented a MD order for heel protectors to be on at all times. R13 is assessed as being high risk for skin breakdown.	F 281		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facilities failed to ensure that 9 of 24 residents within the sample (R 1,2,5, 13,15, 29, 37,38 and 39) received assistance with oral hygiene, skin care, dressing and incontinence care. Findings included: 1. R1 was observed on 4/10/07 during the initial tour of the facility. R1 was noted to have a build up of thick peeling skin on his feet, long thick toe	F 312		

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 23	F 312		

nails, and long sharp finger nails. R1 was noted to scratch herself with her finger nails, leaving open areas on her posterior thighs.

On 4/12/07 E18(CNA) was observed to provide care to R1 at the bedside. E18 was noted to carry wet towels from the bathroom multiple times to clean R1 (no basin was used). E18 provided no foot and lower extremity care nor did E18 provide any oral hygiene care until prompted by the surveyor.

Per interview on 4/10/07 at 11:00 a.m. (during tour) and 4/11/07 at 11:30 a.m., R1 stated that she had not received any incontinence care or grooming since the evening before. Both times R1 was observed to be lying in feces.

Per Minimum Data Set, R1 requires total assistance with all activities of daily living.

2. R2 was observed on 4/11/07 during the initial tour of the facility. R2 was noted to have a build up of thick peeling skin on his feet and long thick toe nails. Per Minimum Data Set, R2 requires total assistance with all activities of daily living.

3. R5 was observed at 11:05 a.m. on 4/11/07 in a wheelchair sitting along the corridor in the hall on the 2nd floor. R5 was noted to be wearing a black pair of fleece pants. Food stains were observed on the legs and lap section of the pants. R5 was observed again at 9:25 a.m. on 4/12/07 sitting next to the nurses station in a wheelchair on the 2nd floor. R5 was observed to be wearing the same food stained black fleece pants that he had on 4/11/05. R5 was observed at 11:20 a.m. in the dining room area. R5 was noted to be saturated from wetness from the waist to lower knee area.

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 24	F 312		

Continued From page 24

R5 was taken to his room after prompting by surveyor to be changed by E25 (CNA).

Per interview E25 stated that R5 was her assigned resident for the day. E25 stated "I only cleaned him a little", E25 also stated "I have not changed his clothes today".

Per Minimum Data Set, R5 requires total assistance with all activities of daily living.

4. R13 was observed at 11:45 a.m. on 4/11/07 in a gheri chair in his room. R13"s teeth, tongue and gums was observed to be heavily embedded with a thick sticky substance. R13's lips were observed to be partially covered with dry thick cracked skin.

Per Minimum Data Set, R13 requires total assistance with all activities of daily living.

5. R15 was observed on 4/10/07 at 11:10 a.m. during the initial tour of the facility. R15 was noted to have thick flaky skin on her feet. R15 was also observed to be wet in bed.

R15 stated that she had not be cleaned since 8:00 p.m. the night before.

On 4/11/07 at 11:45 a.m., E 27(CNA) was observed to give R15 a bed bath. E27 was observed to carry wet towels from the bathroom to clean R15 (no basin was used). After care was provided R15 stated to the surveyor that she did not feel clean.

Per Minimum Data Set, R15 requires total assistance with all activities of daily living.

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 25	F 312		

6. R29 was observed during tour on 4/10/07. R29 was noted to have with dry flaky skin on her arms, legs and torso. R29's toe nails were noted to be long and thick.

Per Minimum Data Set, R29 requires total assistance with all activities of daily living.

7. R37 was observed on 4/10/07 during the initial tour of the facility. R37's was noted to have a dark black substance embedded in his finger nails.

Per Minimum Data Set, R37 requires total assistance with all activities of daily living.

8. R38 was observed during tour on 4/10/07 at 11:15 a.m. R38 was observed with thick flaky skin on his feet.

Per Minimum Data Set, R38 requires total assistance with all activities of daily living.

9. R39 was observed during tour on 4/10/07. R39 was observed with a thick substance and debris embedded on her teeth.

Per Minimum Data Set, R39 requires total assistance with all activities of daily living.

Review of the Facility's Certified Nursing Assistant Job Description denotes the following:
-Assist residents with daily dental and mouth care.
-Assist residents with bath functions.
-Assist residents with back rubs, hair, care functions, nail care/foot care, shaving, skin care.....

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 _______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 26 Per the Facility's Bed Bath Policy, the staff is to use a basin and to frequently change the water throughout the procedure.	F 312		
F 314 SS=J	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that 1 of 9 sampled residents with a pressure sore (R22), received timely wound consultant evaluation, resulting in a delayed appropriate treatment recommendations. This failure directly resulted in the progression of a stage 2 pressure sore to a stage 4 and the developement of a bone infection.rovide evaluation and recommendations for treatment for the wound. This failure resulted in an Immediate Jeopardy. The above failure concerning R22 resulted in an Immediate Jeopardy. Although the Immediate Jeopardy was identified on 4/26/07 it was determined to have begun on 3/14/07 at approximately 10:00 p.m., when R22 was noted to have a open wound to her left foot and the physician ordered facility to obtain a wound care consultation to evaluate the wound and make treatment recommendations. The delay of	F 314		

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 ____	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314		F 314		

Continued From page 27

promptly notifying the wound care consultant for evaluation and treatment recommendations directly caused R22's pressure sore to progress from a stage 2 to a stage 4 with bone involvement. E1 (administrator) was notified of the Immediate Jeopardy on 4/26/07 at 11:00 a.m.

In addition the facility failed to;
- To provide pain management interventions associated with pressure sore dressing changes, for 1 of 9 sampled residents with pressure sores (R 15).
- To provide the correct wound treatment as ordered by the physician for 1 of 9 sampled residents with pressure ulcers (R2).
- To maintain the integrity of dressings applied to pressure sores for 2 of 9 sampled residents with pressure sores (R2 and R4).
- To ensure that 3 of 9 sampled residents with pressure sores and assessed high risk for skin breakdown are not left lying in urine and feces (R1, R4 and R15).
- To ensure that staff used clean barriers while providing pressure sore wound care treatments, for 1 of 9 sampled residents with pressure sores (R4).

1.R 22 is a 80 year old with a diagnosis of Cardiovascular accident, Diabetes, Hypertension, Coronary Artery Disease, Dementia and altered mental status. Documentation denotes that R22 had been assessed to be high risk for the development of pressure sores.

On 4/19/07, surveyor and E10 (nurse), observed R22 to have a stage 4 pressure sore on the left lateral foot, with a moderate amount of foul smelling drainage.

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 ______	05/03/2007

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 314	Continued From page 28 Review of R22's clinical record denotes that on 3/14/07 R22 was noted to have a open sore with drainage to the left inner lateral foot. Documentation denotes that the physician was notified and initial orders were given for a wound care treatment. Documentation denotes that additional orders were given for R22 to be seen by the wound care consultant. Documentation by E10 on R22's 3/14/07 skin alteration form described the wound as a stage 2 pressure sore measuring 1.3cm x 0.5cm x 0.5cm. Further review of R22's clinical record and the facilities 24 hour report denotes no notification of the wound care consultant to assess and treat R22's pressure sore until 4/12/07, (29 days after the initial order was written). This notification was due to the prompting of R22's family. Documentation denotes that R22's pressure sore had increased in size (1.0x1.5x5), had "lots of drainage" and now had a foul smelling odor. During a 4/19/07 interview at 10:50 a.m., E10 stated that on 3/14/07 a CNA reported to her that R22 had a pressure sore on her foot. E10 stated that she assessed the wound and noted a 1.3cm x .5cm stage 2 pressure sore with a moderate amount of drainage. E10 stated that she notified the physician and obtained treatment orders. E10 stated that she endorsed in the 24 hour report that R22 needed to be assessed by the wound care consultant for appropriate treatment. E10 stated that she called the wound care consultant on 4/12/07 after R22's family complained about the wound and the bad foul smell. E10 stated that she did not know if the wound care consultant was ever notified prior to 4/12/07. During a 4/13/07 interview, Z5 (family) stated	F 314		

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 29	F 314		

that approximately 3 weeks ago, Z5 found a sore on R22's foot and immediately notified the nurse. Z5 stated that the sore has gotten bigger over the weeks and has a very bad odor. Z5 stated that the wound stinks so bad that it makes her sick, and that she cannot stay in the room. Z5 stated that she had complained to E8 (DON) about the odor and that R22 was just seen today (4/13/07) by the wound care nurse. Z5 stated that she was told weeks ago that R22 needed to be seen by the wound care nurse and that she did not understand why R22 had not been seen prior until today (4/13/07).

During a 4/19/07 phone interview at 3:35PM, Z2(wound care consultant), stated that her initial visit to see R22 was on 4/13/07. Z2 stated that she was called on 4/12/07 and that she does not recall being notified by the facility regarding the consultation prior to 4/12/07. Z2 stated consults are called into her office. Z2 further stated that the process had not changed and that even if she was not in the office she would have received the message. Z2 further stated that she assessed R22's wound to the left lateral foot on 4/13/07 for the first time, and noted a moderate amount of foul smelling drainage. Z2 stated that her immediate impression was that there was some bone involvement, and that the resident would now require a deep tissue culture and bone scan.

During a 4/19/07 phone interview at 3:15PM, Z1 (physician), stated that on 3/14/07 he was notified by the facility that R22 had developed a new pressure sore on her foot. Z1 stated that he gave an initial order for treatment until the wound care consultant could see the patient. Z1 further stated that he also gave a order for a wound care consultant to see the resident. Z1 stated that he

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 30	F 314		

was not notified until 4/13/07 that R22 had not been seen by the wound care consultant. Z1 stated that he had expected that the resident would have been seen right away, especially since the facility has a contract with a wound care consultant. Z1 stated that in his opinion, the delay in R22 being evaluated by the wound care consultant and getting the correct treatment, lead to the progression of the pressure sore and newly diagnosed bone infection (osteomyelitis, confirmed by bone scan on 4/18/07). Z1 stated that R22's condition progressed so quickly and that it required immediate interventions. Z1 stated that his next step is to consult with a infectious disease specialist, because R22 will need to have an Peripherally Inserted Central Catheter (PICC), line which is an invasive procedure, and about 6 weeks of intravenous antibiotic therapy to treat the problem.

R22's diagnosis, which include cardiac problems / affecting circulation and Diabetes directly negatively impact on R22's heel pressure ulcer ability to heal.

2. On 04-10-07 at 11:00 A.M. during a pressure sore treatment observation, R15 was heard by surveyor grunting and stating "it hurts". E22(licensed nurse) stated R15 had received Vicodin at 9:00 a.m.. R15 responded "it takes some time". E22 preceded and completed the treatment without any further intervention. During an interview on 04-17-07 when questioned about the wound treatments, R15 stated "it feels like they are ripping my skin off".

Per clinical record review R15 is alert and oriented and verbally able to express pain. Per

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 ____	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 31	F 314		

review of the 4/07 physician (MD) order sheet and 3/25/07 through 4/22/07 medication record assessment (MAR), R15 has 3/02/07 MD orders for Vicodin 500mg 1-2 tablets every 6 hours as needed and Tylenol 500mg 2 tablets every 6 hours as needed. The MAR documented the Vicodin was administered 9 times 3/25 through 4/22/07 and the Tylenol was not administered at all.
R15 has 4/05/07 MD sacral wound treatment orders to perform the treatment every 3 days and as needed and treatment to the right ischium wound daily and as needed.

Per R15's 04-05-07 care plan and the facility 04-07-07 pressure wound list, R15 has a stage II to the sacrum.

The Facility's Pressure Sore Policy states the facility is to initiate a pain management program with the physician or the nurse practitioner and offer analgesic, as ordered prior to the dressing change.

On 04-10-07 during the initial tour, after 10AM, surveyor observed R15 in bed, on urine soaked bed sheets with no dressing on sacral wound. R15 told surveyor that she had not received incontinence care since the night before.

R15's 04-05-07 care plan included interventions to inspect skin during care daily.

3. R2 is totally dependent for all areas of activities of daily living (ADL's), is unable to move any extremity at all by himself and is semi comatose. R2 has 4 documented stage 4 pressure sores (sacral, right hip and left heel). During 4/10/07 initial tour with E22(nurse),

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 ____	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 32	F 314		

surveyor observed R2's left heel dressing off the heel and up around his ankle, leaving the left heel wound without a dressing. On 4/11/07 at 2:55 p.m. surveyor observed E22 perform R2's wound treatments and measurements. The left heel was assessed by E22 to be 1.4cm x 1.1cm covered 100% with a thick necrotic/slough tan colored tissue in the center of the wound, draining scant amounts of sero-sanguinous drainage and to have erythema surrounding the wound. The sacral wound measured 7cm x 5cm x 5cm with 3.8cm undermining at 5:00 and the wound had moderate amounts of sero-sanguinous drainage. The sacral wound size was increased compared to the 4/07/07 documented assessment (6cm x 6cm x 3.5cm) and no undermining documented. The right hip wound measured 1.8cm x 1.5cm x 2.2cm with 3cm undermining at 10:00 and moderate amount of sero-sanguinous drainage and 90% slough present.
In addition surveyor observed the old heel dressing and heel to have dried brownish colored drainage on it. R2 had a prior treatment order for Betadine solution (brown in color liquid), to be applied to the left heel daily but this treatment was discontinued 4/07/07 and changed to application of Ethezyme ointment (which is clear in color).

R2 was readmitted to facility on 01/03/07 and his 01/16/07 initial wound consultation documented bilateral heels with eschar. R2 has physician orders for dressings to be applied to all 3 of these wounds at all times. On 01/06/07, R2's right hip wound was assessed to be a 3cm x 3.6cm fluid filled blister with a pink moist wound bed.

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 ____	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 33	F 314		

4. On 04-13-07 at 11:00 a.m. surveyor observed R4's sacral dressing to be half off exposing the stage 2 sacral wound.

Per interview on 04-13-07 E13(licensed nurse) stated it is the certified nurse's responsibility to inform nursing when the dressing comes off. E13 stated she was not aware of the integrity of R4's sacral wound.

R4's physician order dated 04-05-07 documented Hydrocolloid every 3 days and as needed. R4's care plan dated 04-15-07 states to inspect skin with cares daily.

5. R1 was initially admitted to facility 01/31/07 and readmitted from the hospital 3/14/07. R1's 02/07/07 and 3/24/07 Minimum Data Set Assessments (MDS), document that R1 had no pressure sore wounds or skin rashes, R1 only had a surgical wound from a hip replacement. R1 is totally dependent on staff for turning, repositioning, transferring and incontinence care. R1 is assessed at risk for breakdown and care plan included interventions to keep skin clean and dry and turn and reposition every 2 hours. R1 was treated for Clostridium Difficile diarrhea in 3/07.

On 4/10/07 at 10:00 a.m. R1 was observed in bed incontinent of urine and stool and with excoriation noted to the peri area and both heels were directly resting on mattress. R1 told surveyor that she had not received incontinence care since the night before. On 4/10/07 at 11:00 a.m. R1 was still in bed incontinent with urine and stool. and again R1 told surveyor she had not been cleaned up since the evening before. At 11:00 a.m. surveyor observed E20 (nurse aide)

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 34	F 314		

enter the wing of rooms in which R1 resided. E20 was asked if she had cleaned up any of the residents on this wing yet 4/10/07 and E20 said no, "I was finishing up with my other residents on the other wing first and now I'm coming to work with these residents (including R1)."

On 4/11/07 at 10:00 a.m. R1 observed in bed incontinent of urine and stating that she had not received incontinence care since the night before. Surveyor asked E18 (R1's nurse aide for the day shift 4/11/07), to let surveyor know when he was going to provide incontinence / morning care to R1. R1 was observed at 12:20 p.m. to receive incontinence / morning care by E18. R1 was observed to have several open sores on her left upper posterior thigh, severe excoriation in bilateral axillary, under breast and in the abdominal folds and on peri / anal area and posterior thighs. R1 has physician orders for barrier creams to be applied, care plan includes intervention to keep R1 clean and dry.

R1 told staff that her skin burns from the urine being on it.

During 4/13/07 11:20 a.m. individual interview of Z2 (wound consultant), Z2 stated that R1's excoriated rashes in the perineal area are basically "diaper rash".

On 4/04/07, R1 had low albumin level of 3.0 (norm = 3.4-4.8), a low total protein level of 4.8 (norm = 5.6-8.3),and low RBC of 3.13, low Hgb of 8.7 and low Hct of 25.9. R1 has diagnosis to include diabetes, anemia and lymphedema (all of which can inhibit healing).

6. On 04-13-07 at 11:00 a.m., surveyor observed

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 ____	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 35	F 314		

E13(licensed nurse) perform pressure sore dressing changes on R4's sacrum(stage 2) and right heel(unstageable). E13 was observed to perform both dressing changes without using a clean barrier.

The Immediate Jeopardy was removed on 4/26/07 at 3:15 p.m. and the surveyor confirmed that the facility took the following actions to remove it, which reduced the severity to a level 2.

Corrective actions taken are as follows:

1. In-services were initiated on 4/26/07 for all nursing staff, covering:
Mistreatment
The facility ' s skin program including protocol for wound care consultant referrals are made in a timely manner.

All nursing staff off on 4/26/07 or on vacation will be in serviced upon their return to the facility before starting their next shift.

2. Policy and procedure regarding skin program was reviewed on 4/26/07 and no changes were made.
3. All physicians will be notified starting on 4/26/07 by telephone that the facility no longer has an in house nurse practitioner so all wound consultants will be off site. All physicians will be notified by 4/27/07. All appointments will be made by the charge nurse by the end of the next business day that the wound care clinic is open.
4. A complete chart audit was done on 4/26/07 to ensure no other wound care consultant orders were not addressed. The chart audit was completed on 4/26/07.
5. An ongoing QI/QA monitoring tool was

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 36 developed regarding wound care consultant referrals to ensure compliance. The DON/Designee will monitor compliance on admission and weekly there after with the monitoring tool.	F 314		
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, the facility failed to provide documentation on base-lines, measurable goals and objectives in order to show improvement, decline and/or maintenance for 5 residents (R6, R7, R9, R19 and R21) inside the sample of 26. The finding include: 11) R6 was admitted on 7/25/03 and re-admitted on 2/28/07 with a diagnosis that includes left-sided Cerebral Vascular Accident, Obesity and is bed-bound per resident request. The care plan dated 1/8/07 documents passive range of motion (PROM) to left upper and lower extremities every day due to decreased mobility and weakness as a problem. The care plan does not document any ranges or goals. It does say to do 8 to 10 repetitions and to monitor for further deterioration. The restorative nursing flow record (April 2007) documents R6 is to reposition self by pushing side to side using side rails and to stand	F 318		

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 37 during transfers but the form does not address the ranges for the left extremities achieved during PROMs. The Functional Limitation in Range of Motion dated 3/1/07 documents limitations to the left arm, elbow, hand, wrist, hip, knee, foot and toes but there are no documented ranges/base-lines established. The form also recommends PROM to left upper and lower extremities and that there is partial voluntary movement loss to the left side. The Minimum Data Set (MDS) dated 10/30/06 and 1/29/07 documents partial loss to one side. R6 does have a physician's order dated 3/23/07 for PROMs to left upper and lower extremities as tolerated. On 4/13/07 at 4 p.m., R6 was asked to lift her left arm and was only able to lift it 6 inches off the bed and it shook terribly. R6 did say the staff comes into the room and exercise her extremities. R6 was observed to be in bed at all times during the survey per her request. 2) R7 was admitted on 3/15/06 and re-admitted on 3/23/06 with a diagnosis that includes Cerebral Vascular Accident, Dementia, Degenerative Joint Disease and Parkinson's Disease. Per R7's care plan, he is to receive PROMs to both upper extremities and not to advance beyond the point of pain but there are no base-lines, quantitative measurements or objectives documented. The Functional Limitation in Range of Motion dated 3/25/07 documents limitations in the functional range of motion for the right side of the neck and there is voluntary partial loss for both arms and both sides of the neck. The MDS dated 12/26/06 documents partial loss to both legs, feet and neck. The 3/20/07 MDS documents partial voluntary loss to the hands and neck. The review of the Restorative Nursing Flow Record documents R7	F 318		

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 ____	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 38 is to walk from bed to bathroom, will maintain present range of motion and will perform active range of motion exercises daily and it is initialed but there are no distances or ranges documented. The recommendation is for PROM to both upper extremities and active range of motion to lower extremities. There was 3/24/07 entry on the back side of the Functional Limitation in Range of Motion that states ambulates with extensive assist due to weakness of both lower extremities and uncoordinated lost movement related to Parkinson's Disease. R7's care plan dated 3/20/07 documents decreased range of motion to both upper extremities as a problem but the approaches do not show quantitative objectives or goals. R7 has a physician order dated 3/24/07 to do PROM to both upper extremities as tolerated. 3) R21 was admitted 1/7/05 and has a diagnosis that includes Alzheimer's Disease and neck pain. Review of 1/9/07 MDS documents limitation to both legs and feet with partial voluntary loss. The 4/9/07 MDS documents partial voluntary loss to both legs and arms. The care plan dated 4/9/07 (original date was 7/12/06) documents functional limitation to lower extremities and potential for contractures due to weakness and decreased muscle strength and mobility as a problem. The approaches are vague. There are no measurable goals or objectives. The Restorative Nursing Flow sheet documents the goal to bear weight on legs and pivot on left to right leg but there is no quantitative measurement or repetitions documented. Nor does the form document any other exercises done on other extremities. R21's current Physician Order Sheet has a physician's order dated 8/20/05 to do PROM to both upper and lower extremities daily as tolerated. The	F 318		

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 ____	05/03/2007

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F 318	Continued From page 39 Functional Limitation in Range of Motion dated 3/16/07 documents limitations in both arms and both hips, and partial voluntary loss to both arms, elbows, hips and knees and recommends PROM for both upper and lower extremities. 4) R19 was admitted 7/25/05 with a diagnosis that includes Pre-Senile Dementia, Myoclonic Jerks, and gait problems. The Functional Limitation in Range of Motion (ROM) dated 3/21/07 documents uncoordinated hand movements and walks with assist with unsteady gait. The restorative care plan dated 4/12/07 (the original date being 1/25/06) documents resident unable to perform ambulation without assistance from staff/family member as a problem. The assessment on the back-side of the Functional Limitation ROM sheet dated 3/22/07 documents unable to follow instruction to move voluntarily upper and lower extremities. The approaches document to formulate an ambulation goal based on prior level of function and potential for improvement. There are no measurable goals. R19 was observed on 4/18 at 2:30 p.m. and 4/19/07 at 9:30 a.m. in her room, sitting a upright recliner-type chair. R19 was observed to be thrusting and jerking the torso and arms in uncoordinated movements. 5) Interview with E28 (Restorative nurse) on 4/17/07 at 11:05 a.m. stated that she is in the process of changing the restorative flow sheets so that they will reflect measurable goals and indicated that the care plan should reflect the measurable goals. Surveyor informed E28 that the care plans also don't reflect measurable goals and she acknowledge it. 6)Per clinical record review R9 has a diagnosis	F 318		

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 318	Continued From page 40 including Osteomyelitis. R9's clinical record physician order dated 07-10-07 documented passive range of motion (prom) to upper and lower extremities daily. Per R9's functional limitation in range of motion form dated 02-27-07 the facility assessed resident, recommending prom for the following extremities 1)having partial loss of movement in right and left hands-fingers(ring finger slight contracted 2)leg-hip, knee partial loss of movement-right above knee amputee-prom to upper extremities and lower left extremities. No documentation in clinical record indicating any measurable objectives or goals. On 04-18-07 surveyor observed both of R9's 1)wrist to be slightly bent 2) the 4th and 5th fingers on both hands slightly bent and unable to fully extend. On 04-18-07 surveyor observed E28(restorative nurse) perform prom for R9. On 04-18-07 E28 stated she is responsible for performing proms to resident with contractures and the certified nurse(cna) aide does prom for residents with out contractures. E8 stated prom is performed to the extent of pain or resistance. E8 stated she is in school and is unable to to assess resident for measurable objectives.	F 318		
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and record review, facility failed to transfer 3 of 26 sampled residents (R1,	F 324		

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 324	Continued From page 41 R11 and R22), in a safe manner. Findings include: 1) On 4/11/07 at 2:30PM, R1 was observed being assisted with a slide board transfer from bed to wheelchair by E18 (nurse aide) and Z3 (physical therapy aide). E18 did not have a gait belt with him to utilize with transfer activity. During 4/11/07 individual interview with Z3, surveyor was told that R1 is totally dependent on staff for assist with transfer activities, is fearful and tends to resist transfer activities. R1's medical record documented that R1 has a history of falls with a hip fracture, that required surgical intervention. R1 currently has an infection in the hip surgical wound. During multiple observations made on 4/11/07 of E18 providing care to residents, surveyor did not see E18 with a gait belt. 2) On 4/17/07 surveyor observed R11 being assisted by E8 (Director of nurses), E18 (nurse aide) and E23 (nurse) with transfers from wheelchair to bed and then bed to wheelchair without the use of a gait belt. E8, E18 and E23 did not have a gait belt with them to use during this transfer. E18 was observed to firmly grasp the back waistband of R11's pants and pull up on the pants as the staff lifted R11 up off the wheelchair and pivoted R11 onto the bed. R11 had no control or strength in her lower extremities and did not assist at all in the transfer. R11's record documented that R11 is total assist with transfer and ambulation, cognitively impaired, hallucinates, is paranoid and is	F 324		

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F 324	Continued From page 42 non-compliant and resistant with care. R11 has a history of falls. 3) On 4/19/07 at 11:50AM in room 310 surveyor observed E24 (nurse aide), assisting R22 with a transfer from bed to a wheelchair by grasping R22 under her arm and pivoting R22 to the wheelchair without the use of a gait belt. During a 4/19/07 interview of E24, surveyor was notified that E24 had received an in-service instructing staff to transfer residents by using a gait belt for safety and to prevent injury, especially bruising caused by lifting the residents under their arms. Review of the Facility's Certified Nurse Aide(CNA) job description revealed that CNA's must have and use a gait belt during transfers. Review of the Facility's Policy on gait belt use, revealed that gait belts are used to provide relatively safe method of assisting unstable balance and limited weight bearing residents with transfers from bed to wheelchairs, wheelchairs to bed, chair or commode.	F 324		
F 327 SS=E	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation made 3 days of the survey on the skilled care unit, record reviews and resident interviews; the facility failed to provide each resident with sufficient, accessible fluids	F 327		

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 327		F 327		

Continued From page 43
(water at the bedside), to maintain hydration for 14 residents (4 of 26 sampled residents = R1, R15, R16 and R17, and 10 residents from outside the sample = R27, R33, R36, R38, R40, R41, R42, R43, R44 and R45).

Findings include:

On 4/10, 4/11 and 4/17/07 surveyor observed no accessible fresh water at the bedsides for R1, R15, R16, R17, R27, R33, R36, R38, R40, R41, R42, R43, R44 and R45.

During observations and resident interviews the following residents were observed asking staff for water and / or told surveyor that they are not provided with fresh water daily at the bedside and that they wanted it because they get thirsty (R1, R15, R27, R38, R41, R43 and R45).
R16 and R36 both told surveyor that staff do not provide water at the bedside, if they wanted a glass of water, they would have to get it from the bathroom sink. Surveyor found no cups available in R16 or R36's room or bathrooms for use.

Record reviews revealed the following residents were identified at risk for dehydration and / or had clinical symptoms that placed them at risk for dehydration and were not identified with swallowing problems:
- R1 was identified at risk for dehydration and care plan included offering fluids as an intervention. R1 is receiving a anti-hypertensive medication (Prinivil), with diuretic effects, has diagnosis to include chronic diarrhea and Diabetes mellitus, has had a recent Clostridium Difficile infection (C-Diff) and has a current wound infection. R1 is assessed with moderately impaired cognition, dependent on staff for

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F 327	Continued From page 44 transfer and ambulation activities and incontinent for bowel and bladder. R1 was observed with thick, dry flaking skin on her feet and lower extremities. - R15 was identified at risk for dehydration and currently has C-Diff infection with loose watery stools. R15 was observed 4/10 and 4/11/07 with dry oral mucus membranes and thick, dry flaking skin on both of her feet. In addition, R15 has diagnosis to include Diabetes and is receiving diuretic therapy. - R16 was observed 4/10, 4/11 and 4/13 with dry cracked lips. R16's physician (MD), progress note of 02/08/07 included that R16 had dry cracked lips with small scabs on them and had slight dry oral mucosa. R16's 3/30/07 BUN / Creat ratio was elevated = 22 (normal range 12-20). R16's record and daily observations validated that R16 rarely leaves her bed. R16 is assessed as being withdrawn and with paranoid behaviors. - R17 observed lethargic, very sleepy and in bed on isolation for Shingles. R17 has diagnosis to include UTI and Hypertension. R17 is receiving anti-hypertensive medication (Lisinopril), with diuretic effects. R17 was not assessed by facility to be at risk for dehydration, but was assessed to require hands on assist to transfer and to be incontinent of bowel and bladder. R17's 02/09/07 nutritional progress note included a goal to maintain hydration. - R27 has diagnosis to include brittle Diabetic, Hypertension and peripheral vascular disease (PVD). R27 was not identified at risk for dehydration on most recent assessments (11/30/06). R27's current care plan and 02/09/07 nutritional progress note included need to encourage oral fluids and/ or maintain hydration as interventions for PVD and potential for bowel	F 327		

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F 327	Continued From page 45 alteration problems and nutritional goal. R27 has had recent falls and on 4/04/07 R27's Bun / Creat Ratio was elevated = 35 and the potasium was also elevated = 5.4 (norm = 3.5-5.1). R27 requires total assist with transfer and ambulation and is assessed with modified independent cognition and incontinent of bowel and bladder. - R33 has diagnosis to include end stage renal disease and receives hemo-dialysis 3 times a day. R33 is not on fluid restrictions and bowel alteration problem on care plan included interventions to encourage fluids. R33's 4/11/07 Bun was 32 and creat 5.4 (both elevated). - R38 has diagnosis to include Hypertension, hypernatremia, recurrent bouts of Urosepsis and Urinary Tract Infection(UTI). R38 is receiving a anti-hypertensive (Vasotec), with diuretic effects and has pressure sores. R38 is alert and oriented X3 but requires total assist by staff for transfer and ambulation and is on tube feedings and oral fluids. R38 was triggered at risk for dehydration 10/15/06 and the current care plan for bowel alteration includes encouraging fluids as an intervention. R38 was observed with thick, dry and flaking skin on both of his feet. - R40 was initially admitted to facility 3/02/07 with diagnosis to include Hypertension and since admit has fallen at least 4 times to date of 4/17/07. R40 is receiving anti-hypertensive medications with diuretic effects, has decreased cognition, incontinent of bowel and bladder and requires 2 assist with transfers. R40's 4/11/07 BUN=54 and Creat=2.0, this is even more elevated than the prior result = BUN=26 and Creat=1.5 from 3/08/07. R40 is not identified as being at risk for dehydration. There is a 4/17/07 MD order for staff to encourage oral fluids and the 4/16/07 nutritional recommendation stated to maintain hydration.	F 327		

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F 327	Continued From page 46 - R41 has diagnosis to include Hypertension and Congestive Heart Failure. R41 was placed on antibiotics 3/26/07 for a UTI. R41 has decreased cognition, requires total assist from staff with transfers and is incontinent for bowel and bladder. R41's current care plan included interventions to maintain adequate hydration and increase fluid intake. - R42 has diagnosis to include chronic constipation and a 4/10/07 MD order for staff to encourage fluids. R42 is incontinent of bowel and bladder, independent cognition, has full loss of range of motion to bilateral lower extremities and requires total assist with transfer activities. R42's 01/18/07 BUN was 27 and then on 4/11/07 it raised to 40. R42 is not triggered at risk for dehydration on the 10/06 assessment but has 4/09/07 nutritional goals to maintain hydration. - R43 is assessed to have modified independent cognition, require total assist with transfers and to be at risk for dehydration due to diuretic medication use. R43's current care plan includes intervention to hydrate the resident. The 3/12/07 nutritional assessment included a goal to maintain hydration. - R44's diagnosis includes Dementia with decreased cognition. R44 was not identified at risk for dehydration but was observed 4/17/07 asking for something to drink. - R45 is assessed with modified independent cognition, no behavior problems and to require total assist from staff with transfers. R45 was not identified at risk for dehydration but the 4/09/07 nutritional goals included maintaining hydration and recommended providing R45 with extra fluids between meals. R45's current care plan included interventions to encourage oral fluids and the 4/09/07 MD orders included an order for staff to encourage extra fluids between meals.	F 327		

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 ____	05/03/2007

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F 327	Continued From page 47 The Facility's Water Pass Policy and Procedure did not include frequency, quanity or who was to provide fresh water to the residents. The Facility's job description for Certified Nurse Aide (CNA) stated that one of the responsibilities of the CNA was to provide fresh water in a clean pitcher every shift.	F 327		
F 407 SS=E	483.45(b) SPECIALIZED REHABILITATIVE SERVICES Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility records reviewed, facility failed to assure specialized rehabilitative services are provided by qualified personnel and failed to employee a Certified Restorative Nurse. Findings include: During a 4/17/07 11:05AM interview of E28 ("Restorative Nurse"), E28 told surveyor that E28 is currently enrolled in a Restorative / Rehabilitation Certification course and still has 4 more weeks of classes to attend before receiving her certification. E28 was placed in the position as the facilities restorative nurse in 02/07. E28's personnel file did not include a certification for Restorative nursing. On 4/17/07 facility staff provided surveyor with a letter dated 4/18/07, stating that E28 was currently enrolled in a	F 407		

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 407	Continued From page 48 Restorative / Rehabilitation Certification course for licensed nurses that began 3/07/07. This letter also stated that "At this time, E28 has 3 courses to complete in order for her to receive her Restorative Nursing Certification with the 60 hours required by Illinois Administrative Code 300.1210 ." E28 also stated on 4/17/07 that E18 (nurse aide), was the assigned rehab aide today for R7. At 10:55 a.m , E18 was unsure on how to answer questions about range of motion when asked to explain how he exercises the resident's limbs and where he documents the progress. Review of E18's in-services and 4/17/07 interview of E28 revealed that E18 had not been trained on how to perform range of motion to joints as of yet. On 4/17/07 surveyor observed E18 assisting R11, a cognitively impaired, totally dependent and non-ambulatory resident with transfers to and from wheelchair and bed without the use of a gait belt for safety. E18 was observed to firmly grasp the back waistband of her slacks and pull up, lifting R11 off of the chair during the transfer..	F 407		
F 425 SS=D	483.60 PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. This REQUIREMENT is not met as evidenced	F 425		

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F 425	Continued From page 49 by: Based on observations made in 1 of 3 medication rooms and record review, facility failed to assure Novolin Insulin is not used beyond the federal guidelines for Novolin Insulin discard date (30 days from being opened). Findings include: During the 4/11/07 environmental tour of the 3rd floor medication room, with E1 (Administrator), E2 (Housekeeping supervisor), E3 (Director of environmental relations) and E4 (Maintenance Director), surveyor found a 3/09/07 dated vial of Novolin Insulin belonging to R46, being stored in the 3rd floor medication refrigerator. This is a 34 day use of this vial and the federal regulations guidelines stated that Novolin Insulin vials are to be discarded 30 days after being opened. Facility policy on Insulin use stated that the Insulin vials are to be discarded 1 year after being opened.	F 425		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and policy review, the facility failed to do hand washing after performing a treatment to a pressure sore for 1 resident (R4) of 26 sampled residents.	F 444		

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 ______	05/03/2007

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F 444	Continued From page 50	F 444		

Findings include;

On 04-13-07 at 11am , surveyor observed E13 (licensed nurse) perform a treatment to R4's sacral area. After sacral wound treatment was performed, E13 removed her gloves, walked out of R4's room, down the hall and into the medication room, located across from the nurses' station. E13 entered the medication room and retrieved supplies for treatment to R4's right heel wound. E13 returned to R4's room, put on clean gloves at which time E13 stated she did not have everything she needed. E13 again removed the gloves, left R4's room and returned to the medication room a second time without hand washing. E13 returned to R4's room after retrieving more supplies and proceeded to do a treatment on R4's right ankle wound.

On 4/17/07 when surveyor asked for the Facility's Infection Control Protocol, E1(administrator) stated that the Facility's Infection Control Program consisted of:
1)staff inservices, 2) the isolation tracking log and 3)the facility hand washing policy. E1 stated that this concluded the infection control program for the facility.

The Facility's Policy on Hand Washing dated 10-04 documents proper hand washing is used to decrease the risk of transmission of infection. The facility's policy and procedure for skin breakdown states to wash hands, assemble the equipment and supplies necessary before going to the patient room. The policy also states to put on gloves to remove old dressing, discard gloves and wash hands.

F 490 SS=F	483.75 ADMINISTRATION	F 490		

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 ________	05/03/2007

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 490	Continued From page 51 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on substandard quality of care deficiencies cited under F-224,and I-J's cited under F-226 and F-314, the facilities failed to ensure that it was maintained in a manner that provided the highest practicable physical, mental and psychosocial well-being of all residents. Finding include: 1. The facilities failure to promptly notify the wound care consultant for one resident R22 who developed a stage II pressure sore that progressed to a stage IV pressure sore with bone involvement. 2. The facilities failure to ensure that 1 of 9 residents within the sample with pressure sores was free from neglect, as evidence by the failure of the facility to prevent a twenty-nine (29) day delay in the notification of the wound care consultant to assess and treat a pressure sore that caused the wound to decline. 3. The facilities failure to ensure that it developed a policy and procedure to prohibit and investigate allegations of abuse that encompassed the key area of screening, training, prevention and identification.	F 490		
F9999	FINAL OBSERVATIONS	F9999		

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	**6120 WEST OGDEN CICERO, IL 60804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 52	F9999		

LICENSURE VIOLATIONS

300.1210a)
300.1210b)1)2)3)5)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care

a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include at a minimum the following procedures:
b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered.
2) All treatments and procedures shall be administered as ordered by the physician.
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who

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	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 53 enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regualtions are not met as evidenced by the following: Based on observation, interview and record review, the facility failed to ensure that 1 of 9 sampled residents with pressure sores (R22) was free from neglect. This was evidenced by the failure of the facility to prevent a twenty-nine (29) day delay in R22 being evaluated by a wound care consultant and receiving appropriate treatment recommendations. This failure directly caused R22's left lateral foot stage II pressure sore to progress to a stage IV pressure sore with bone involvement (Osteomyelitis = bone infection). In addition the facility failed: - To provide pain management interventions associated with pressure sore dressing changes, for 1 of 9 sampled residents with pressure sores (R 15). - To provide the correct wound treatment as ordered by the physician for 1 of 9 sampled residents with pressure ulcers (R2). - To maintain the integrity of dressings applied to pressure sores for 2 of 9 sampled residents with	F9999		

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 ____	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 54	F9999		

pressure sores (R2 and R4).
- To ensure that 3 of 9 sampled residents with pressure sores and assessed high risk for skin breakdown are not left lying in urine and feces (R1, R4 and R15).
- To ensure that staff used clean barriers while providing pressure sore wound care treatments, for 1 of 9 sampled residents with pressure sores (R4).

Findings include:

R22 is an 80 year old with a diagnosis of Cardiovascular accident, Diabetes, Hypertension, Coronary Artery Disease, Dementia and altered mental status. Documentation denotes that R22 had been assessed to be at high risk for the development of pressure sores.

On 4/19/07, surveyor and E10 (nurse) observed R22 to have a stage 4 pressure sore on the left lateral foot, with a moderate amount of foul smelling drainage.

Review of R22's clinical record denotes that on 3/14/07 R22 was noted to have an open sore with drainage to the left inner lateral foot. Documentation denotes that the physician was notified and initial orders were given for a wound care treatment. Documentation denotes that additional orders were given for R22 to be seen by the wound care consultant. Documentation by E10 on R22's 3/14/07 skin alteration form described the wound as a stage 2 pressure sore measuring 1.3cm x 0.5cm x 0.5cm.

Further review of R22's clinical record and the facilities 24 hour report denotes no notification of the wound care consultant to assess and treat

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 ______	05/03/2007

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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F9999	Continued From page 55	F9999		

R22's pressure sore until 4/12/07, (29 days after the initial order was written). This notification was due to the prompting of R22's family. Documentation denotes that R22's pressure sore had increased in size (1.0x1.5x5), had "lots of drainage" and now had a foul smelling odor.

During a 4/19/07 interview at 10:50 a.m., E10 stated that on 3/14/07 a CNA reported to her that R22 had a pressure sore on her foot. E10 stated that she assessed the wound and noted a 1.3cm x .5cm stage 2 pressure sore with a moderate amount of drainage. E10 stated that she notified the physician and obtained treatment orders. E10 stated that she endorsed in the 24 hour report that R22 needed to be assessed by the wound care consultant for appropriate treatment. E10 stated that she called the wound care consultant on 4/12/07 after R22's family complained about the wound and the bad foul smell. E10 stated that she did not know if the wound care consultant was ever notified prior to 4/12/07.

During a 4/13/07 interview, Z5 (family) stated that approximately 3 weeks ago, Z5 found a sore on R22's foot and immediately notified the nurse. Z5 stated that the sore has gotten bigger over the weeks and has a very bad odor. Z5 stated that the wound stinks so bad that it makes her sick, and that she cannot stay in the room. Z5 stated that she had complained to E8 (DON) about the odor and that R22 was just seen today (4/13/07) by the wound care nurse. Z5 stated that she was told weeks ago that R22 needed to be seen by the wound care nurse and that she did not understand why R22 had not been seen prior until today (4/13/07).

During a 4/19/07 phone interview at 3:35PM, Z2

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 56	F9999		

(wound care consultant) stated that her initial visit to see R22 was on 4/13/07. Z2 stated that she was called on 4/12/07 and that she does not recall being notified by the facility regarding the consultation prior to 4/12/07. Z2 stated consults are called into her office. Z2 further stated that the process had not changed and that even if she was not in the office she would have received the message. Z2 further stated that she assessed R22's wound to the left lateral foot on 4/13/07 for the first time, and noted a moderate amount of foul smelling drainage. Z2 stated that her immediate impression was that there was some bone involvement, and that the resident would now require a deep tissue culture and bone scan.

During a 4/19/07 phone interview at 3:15PM, Z1 (physician) stated that on 3/14/07 he was notified by the facility that R22 had developed a new pressure sore on her foot. Z1 stated that he gave an initial order for treatment until the wound care consultant could see the patient. Z1 further stated that he also gave an order for a wound care consultant to see the resident. Z1 stated that he was not notified until 4/13/07 that R22 had not been seen by the wound care consultant. Z1 stated that he had expected that the resident would have been seen right away, especially since the facility has a contract with a wound care consultant. Z1 stated that in his opinion, the delay in R22 being evaluated by the wound care consultant and getting the correct treatment, lead to the progression of the pressure sore and newly diagnosed bone infection (osteomyelitis, confirmed by bone scan on 4/18/07). Z1 stated that R22's condition progressed so quickly and that it required immediate interventions. Z1 stated that his next step is to consult with an infectious disease specialist, because R22 will need to

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 ____	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 57	F9999		

have a Peripherally Inserted Central Catheter (PICC) line which is an invasive procedure, and about 6 weeks of intravenous antibiotic therapy to treat the problem.

R22's diagnosis, which includes cardiac problems affecting circulation and Diabetes directly negatively impact on R22's heel pressure ulcer ability to heal.

2. On 04-10-07 at 11:00 A.M. during a pressure sore treatment observation, R15 was heard by surveyor grunting and stating "it hurts." E22 (licensed nurse) stated R15 had received Vicodin at 9:00 a.m. R15 responded "it takes some time." E22 preceded and completed the treatment without any further intervention. During an interview on 04-17-07 when questioned about the wound treatments, R15 stated "it feels like they are ripping my skin off."

Per clinical record review R15 is alert and oriented and verbally able to express pain. Per review of the 4/07 physician (MD) order sheet and 3/25/07 through 4/22/07 medication record assessment (MAR), R15 has 3/02/07 MD orders for Vicodin 500mg 1-2 tablets every 6 hours as needed and Tylenol 500mg 2 tablets every 6 hours as needed. The MAR documented the Vicodin was administered 9 times 3/25 through 4/22/07 and the Tylenol was not administered at all.

R15 has 4/05/07 MD sacral wound treatment orders to perform the treatment every 3 days and as needed, and treatment to the right ischium wound daily and as needed.

Per R15's 04-05-07 care plan and the facility

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 ______	05/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999		F9999		

Continued From page 58
04-07-07 pressure wound list, R15 has a stage II on the sacrum.

The Facility's Pressure Sore Policy states the facility is to initiate a pain management program with the physician or the nurse practitioner and offer analgesic, as ordered, prior to the dressing change.

On 04-10-07 during the initial tour, after 10:00AM, surveyor observed R15 in bed, on urine soaked bed sheets with no dressing on sacral wound. R15 told surveyor that she had not received incontinence care since the night before.

R15's 04-05-07 care plan included interventions to inspect skin during care daily.

3. R2 is totally dependent for all areas of activities of daily living (ADL's), is unable to move any extremity at all by himself and is semi comatose. R2 has 4 documented stage 4 pressure sores (sacral, right hip and left heel). During 4/10/07 initial tour with E22 (nurse), surveyor observed R2's left heel dressing off the heel and up around his ankle, leaving the left heel wound without a dressing. On 4/11/07 at 2:55 p.m. surveyor observed E22 perform R2's wound treatments and measurements. The left heel was assessed by E22 to be 1.4cm x 1.1cm covered 100% with a thick necrotic/slough tan colored tissue in the center of the wound, draining scant amounts of sero-sanguinous drainage and to have erythema surrounding the wound. The sacral wound measured 7cm x 5cm x 5cm with 3.8cm undermining at 5:00, and the wound had moderate amounts of sero-sanguinous drainage. The sacral wound

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 ______	05/03/2007

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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F9999	Continued From page 59 size was increased compared to the 4/07/07 documented assessment (6cm x 6cm x 3.5cm) and no undermining documented. The right hip wound measured 1.8cm x 1.5cm x 2.2cm with 3cm undermining at 10:00 and moderate amount of sero-sanguinous drainage and 90% slough present. In addition surveyor observed the old heel dressing and heel to have dried brownish colored drainage on it. R2 had a prior treatment order for Betadine solution (brown in color liquid), to be applied to the left heel daily but this treatment was discontinued 4/07/07 and changed to application of Ethezyme ointment (which is clear in color). R2 was readmitted to facility on 01/03/07 and his 01/16/07 initial wound consultation documented bilateral heels with eschar. R2 has physician orders for dressings to be applied to all 3 of these wounds at all times. On 01/06/07, R2's right hip wound was assessed to be a 3cm x 3.6cm fluid filled blister with a pink moist wound bed. 4. On 04-13-07 at 11:00 a.m. surveyor observed R4's sacral dressing to be half off exposing the stage 2 sacral wound. Per interview on 04-13-07 E13 (licensed nurse) stated it is the certified nurse's responsibility to inform nursing when the dressing comes off. E13 stated she was not aware of the integrity of R4's sacral wound. R4's physician order dated 04-05-07 documented Hydrocolloid every 3 days and as needed. R4's care plan dated 04-15-07 states to inspect skin with cares daily.	F9999		

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 ____	05/03/2007

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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F9999	Continued From page 60	F9999		

5. R1 was initially admitted to facility 01/31/07 and readmitted from the hospital 3/14/07. R1's 02/07/07 and 3/24/07 Assessments document that R1 had no pressure sore wounds or skin rashes, R1 only had a surgical wound from a hip replacement. R1 is totally dependent on staff for turning, repositioning, transferring and incontinence care. R1 is assessed at risk for breakdown. Care plan included interventions to keep skin clean, dry, turn, and reposition every 2 hours. R1 was treated for Clostridium Difficile diarrhea in 3/07.

On 4/10/07 at 10:00 a.m. R1 was observed in bed incontinent of urine and stool and with excoriation noted to the peri area and both heels were directly resting on mattress. R1 told surveyor that she had not received incontinence care since the night before. On 4/10/07 at 11:00 a.m., R1 was still in bed, incontinent with urine and stool. and again R1 told surveyor she had not been cleaned up since the evening before. At 11:00 a.m. surveyor observed E20 (nurse aide) enter the wing of rooms in which R1 resided. E20 was asked if she had cleaned up any of the residents on this wing yet 4/10/07 and E20 said no, "I was finishing up with my other residents on the other wing first and now I'm coming to work with these residents (including R1)."

On 4/11/07 at 10:00 a.m., R1 was observed in bed, incontinent of urine, stating that she had not received incontinence care since the night before. Surveyor asked E18 (R1's nurse aide for the day shift 4/11/07) to let surveyor know when he was going to provide incontinence/morning care to R1. R1 was observed at 12:20 p.m. to receive incontinence/morning care by E18. R1

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 ______	05/03/2007

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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F9999	Continued From page 61	F9999		

Continued From page 61

was observed to have several open sores on her left upper posterior thigh, severe excoriation in bilateral axillary, under breast and in the abdominal folds and on peri/anal area and posterior thighs. R1 has physician orders for barrier creams to be applied, care plan includes intervention to keep R1 clean and dry.

R1 told staff that her skin burns from the urine being on it.

During 4/13/07 11:20 a.m. individual interview of Z2 (wound consultant), Z2 stated that R1's excoriated rashes in the perineal area are basically "diaper rash."

On 4/04/07, R1 had low albumin level of 3.0 (norm = 3.4-4.8), a low total protein level of 4.8 (norm = 5.6-8.3), low RBC of 3.13, low Hgb of 8.7 and low Hct of 25.9. R1 has diagnosis to include diabetes, anemia and lymphedema (all of which can inhibit healing).

6. On 04-13-07 at 11:00 a.m., surveyor observed E13 (licensed nurse) perform pressure sore dressing changes on R4's sacrum (stage 2) and right heel (unstageable). E13 was observed to perform both dressing changes without using a clean barrier.

(A)