		I AND HUMAN SERVICES					APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	URVEY
		145736	B. WI	NG _			C 0/2010
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN T	OWN MANOR REHA	B & HCC		-	5120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F	000			
	Complaint Investiga 1091011/IL46391	ation					
F 323 SS=J	An extended surve 483.25(h) FREE O HAZARDS/SUPER	F ACCIDENT	F	323			4/1/10
	environment remain as is possible; and	nsure that the resident ns as free of accident hazards each resident receives on and assistance devices to					
	by: Based on interview failed to: -asses a severely in after a fall , -follow facility policy injuries; - assess, develop in effectiveness of interventions, super resident (R3). These failures results sustaining a head a resulted in Cardio-F resident (R3) was r staff from the floor with proper emerged	NT is not met as evidenced and record review, the facility njured resident on the floor y for resident's with head nterventions, re-evaluate the erventions, attempt alternative rvise, after previous falls, for 1					
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/30/2010

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/30/2010 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145736	B. WI	NG _			
	ROVIDER OR SUPPLIER	B & HCC			REET ADDRESS, CITY, STATE, ZIP CODE 6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	These failures resul Jeopardy, has pote in the facility who a The Immediate Jeop begun on 03/6/10. Immediate jeopardy 3:00pm., The Admi Administrator, Regi Operation were not The Immediate Jeo 03/16/10 at 5:00pm compliance at seve Finding Include: R3 was a 83 year of Diabetes Mellitus, A Toe, Coronary Arte Failure, Arthritis, Go Chronic Renal Failu Accident, Dementia Insufficiency, Dege Gastro Esophagus The Minimum Data in Section B. (4). Co Decision-Making de impaired decisior required. Section G resident moves to a turns side to side, a) was score 3/2 (Ex person physical ass Continued Review of	Ited in an Immediate ntial to effect all 183 residents re at risk for falls. pardy was determine to have / was called on 03/15/10 at nistrator, Assistant onal Nurse and Director of ified on 03/15/10 at 3:00 pm. pardy was removed on but the facility remains out of rity level 2. Id black female with diagnosis Anemia, Cellulitis Right Big ry Disease, Congestive Heart but, Glaucoma, Hypertension, ure, Old Cerebral Vascular a Behavior, Renal nerative Joint Disease and Regurgitate Disease. Set dated 12/19/10 denoted ognitive Skill For Daily enoted R3 was moderately as poor; cues/supervision :: (a). Bed Mobility (How and from from lying positions, and position body while in bed ktensive assistance/one	F	323			

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		AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145736	B. WI	1G _		(03/3() 2010
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN	TOWN MANOR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	The Fall Risk Asses 02/19/10 denoted F The Nurses Notes a 11/20/09 7:00 pm - stood up, lost balar wheelchair. Reside buttock. No injury n 11/29/09 - 9:00 am entered a resident r sitting on floor next nurse and Certified injuries noted. Resi other resident and a monitor. 03/06/10 Approxima noise while nurse's resident on the floo position. E2 (Nurse additional help. Approximately 7:15 to assess injuries. I forehead that angle Neuro checks initia time. Resident was physical stimuli. Pu Respiration Rate 22 was applied per na Pressure applied to 7:20 pm Resident r to detect pulse. Nur Pulmonary Resusc resident being a ful 7:25 pm Paramedic	Assment Quarterly dated assment Quarterly dated assment Quarterly dated as was score 12 - high risk. State on the following dates: Resident while in dining room ince, tried to sit back on nt missed the chair landing on oted. Will continue monitor. - As housekeeping staff room she observed resident to wheelchair. She notified Nurse Aide. No physical dent currently in room with staff present will continue to ately 7:10 pm Staff heard station. Upon rounds noted r in bedroom in a prone) called down the hallway for pm Resident was rolled over Noted a 21/2 laceration to left up over residents left brow. ted, eyes were fixed at this unresponsive to verbal and lse palpable 96 and 2. 911 was called. Oxygen sal canula at oxygen 2 liter. of orehead. emain unresponsive. Unable rese initiated Cardiac tation compression due to I code. ss Arrive. They immediately he Emergency room at for	F	323			

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		AND HUMAN SERVICES			FORM	: 08/30/2010 APPROVED : 0938-0391	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		145736	B. WING	i	– C 03/30/2010		
NAME OF F	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN 1	OWN MANOR REHA	B & HCC		6120 WEST OGDEN CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 323	10:00 pm Called to They stated that res 03/07/10 1:00 am V resident status, Em reported resident e 03/06/10 with Diago Trauma, Intracrania Hemorrhage. The Z3 (fire departo dated 03/06/10 stat 19:17 - Unresponsi some gastric fluids Laceration - Large right side forehead 19:32 - Primary Imp secondary to fall. T 6 feet." The Z3 Narratives of Crew called to the f arrival crew walked elderly victim lying moving. Crew aske they responded that noted 6- 7 staff in ro in. Crew noted 83 y facility bed, Unresp appearing to be app patient got into her the staff, put here b the fall were never asked 3 different tin given was that staff room and found the a head wound. Cre laceration to the pa bleeding. Wound all	o receive a status on resident. sident is still being evaluated. /erified at hospital regarding hergency Room Nurse xpired at 10:20 pm on nosis Cardiac Arrest, Blunt al and Subarachnoid ment) Patient Care Report	F 32				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/30/2010 APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145736	B. WI	NG _		C 03/30/2010		
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN 1	OWN MANOR REHA	3 & HCC			6120 WEST OGDEN CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	both of the patients Patient was "No Sp prior to arrival. Crew in fact apneic and p disbelief, but obviou patient was in Card Crew immediately b immobilized patient noted fluid in patien appears to be gastr in Asystole until tra- ventricular tachycar Hospital report date Complaints: Status and cardiac arrest. arrived after having Arrest was witness unknown period. Hi was found on the fl heard a thud. Patie the floor. She had l She was put back i noted to be unresp medical treatment of Presentation: Unco is a C shape 3 lace Pupil (s) the right at Diagnosis Cardiac Intracranial injury a with a loss of uncor duration. Patient wa pm."	nares. Blood appear dried. inal Precaution" taken by staff w then noted that patient was pulseless. Staff expressed usly did not notice that the iac Arrest prior to arrival. began CPR and spinally . Patient intubated, Crew it airway, suctioned what ic contents out. Patient stayed nsport, converted to rdia with no pulse." ed 3/06/10 stated," Chief Post fall with head trauma History and Physical - Patient sustained a cardiac arrest. ed and downtime was an story at time of arrival: Patient for at nursing home staff after in was found face down on aceration to mid forehead. In bed by the staff. She was onsive and Emergency was called. Patient Status and insciousness, intubated. There ration on the mid fore head. Ind the left are nonreactive. Arrest, Blunt Trauma: ind Subarachnoid Hemorrhage isciousness of unknown as pronounced dead at 10:22 e head and Cervical Scan /10 Stated," Mild extra clavicle in the frontal region is seen. ippreciate any acute calvarial	F	323				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/30/2010 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145736	B. WI	1G		– C - 03/30/2010		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN 1	OWN MANOR REHA	3 & HCC			6120 WEST OGDEN CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	attenuation along th parietal lobe which examination compa Subarachnoid hem cervical spine demo base of the Odonto posterior displacem process with respen- vertebral body. Imp Subarachnoid or Su free convexity of the parietal lobe. In add base of the Odonto Type II fracture." s E3 (Nurse) on 03/1 conference room st E2 (Acting Director at medication cart in were talking about said did you hear th heard noise. E4 (Co sitting at nurse stati bumped in chair. E2 E2 left at that time a She went toward th rooms. So, when sh yelling for help. E4 (Nurse) came into t floor face down. E7 responded and roll to be fixed. My first not have a pulse. W pulse, she had a pu breathing. By then I saw the blood on th stabilized her neck coming from. It was	he free convexity of the left was not seen on the previous tible with a subtle Subdural or prrhage. Evaluation of the onstrates a fracture of the id Process. There is a minimal tent of the tip of the Odontoid ct to the base of the C2 pression - A Subtle ubdural Hemorrhage along the e left dition there is fracture at the id process compatible with a	F	323				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/30/2010 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145736	B. WII	NG _		C 03/30/2010		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN 1	OWN MANOR REHAI	3 & HCC			6120 WEST OGDEN CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	pressure. Someone chart for what statu with oxygen tank. E the bed and she sa we rolled her on a b bed. I was still apply to forehead. The part talked to them." Surveyor asked E3 the head and neck who told them put F E3 stated," None," (E2) realized they st the floor E4 (CNA) on 03/11, conference room st nursing station. I wa got ready to get up bumped the nurse's heard that? I explai bumping the desk. something, and beg she got down to en my name E4! E4! E to R3's room. Wher was lying face down R3. R3 was lying in extended out from to of blood. Her bed w head was in the con face down in the V the wall. E2 told me "Do Not Resuscitate pulse. They had to was cleaning the he E2 told us we had t	e yelled to call 911 and check s she was. Someone came in 2 was standing at the foot of id we got to get her up. So, blanket and got here up in ying pressure with a ice pack aramedics came in and E2 what did they use to stabilize before putting R3 in bed, and	F	323				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		145736	B. WING	G	– C 03/30/2010		
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN	TOWN MANOR REHA	B & HCC		6120 WEST OGDEN CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	She had saturated went to get the tow said "you can not c told E2 she was dir the ambulance com to get her up!". I tol E2 said we have to stabilized her. E2 s bed. I said we had on the floor. E2 was to bed. They (E5, E pick her up with arr and two at the bott a sheet to lift her. I under her body. We lift her in bed. I don head. I did not wan floor. E2 persisten I said look like her r pack on the head. I noodle. E3 said," I said "Do you think" on the floor?". I Sai putting her back on asked what happer paramedics were v we should not have inservice that a res not to be moved." E5 on 03/11/10 at 1 room stated," The t passed trays 5:00 p residents in the din feeding residents ir head of the bed wa R3 was lying face of was found. I was put	ge 7 with urine and stool. When E5 el, so we could clean her. E2 lean her from down there". I ty needed to be clean before he. She (E2) said "No!" We got d E2 we could not move her. get her back to bed and aid we have to get her into the inservice to leave the resident s persistent in putting her back (8, E4 and E3) was going to ins and legs. Two at the top om. I said stop. I would go get took the sheet and put it e held the side of the sheet to 't know if anyone held her t to lift this women off the e on lifting her in bed. E3 and heck was broken. They put ice her neck was very loose like a think her neck is broken". E2 we should put her back down d NO! He No! I am not the floor. The paramedic hed and who moved her. The ery angry at the staff. He said e moved her. We had a ident with head injury should 11:00 am in the conference ray came up at 5:00 pm. We om - 5:30 pm. We have to feed ing room. I got through in dining room at 6:30 pm. The s in a sitting position for R3. down on the floor when she utting another resident to bed. ck to bed. It was I, E4, E8 and	F 32				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		145736	B. WII	NG _		C 03/30/2010	
NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN	TOWN MANOR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	E3 that put her in b her in bed. We put other two others we not see the blanket was covered with b bed and cabinet wir know how she fell. E3 said we are not not to put her back a person fall on the move them. We ha we are not suppose when on the floor. V is assessed. E2 to her in bed because bed. E2 said we should refused to put her b E2 on 03/11/10 at f room stated," I was nurse E3. Then I h heard that?. They r it was from her cha sound like a chair. I started from the n room. When I got to yelled out for help. into room, observed the floor. I checked pulse. The nurse an the room. I looked a DNR and got oxy thought she had ex her and with E3 at floor to the bed. We was no pulse. I did the ambulance per	bed. We lifted her up and put a blanket under the legs and ere holding the shoulders. I did under shoulder or head. She lood. She was between the th her head on the wall. I don't When we put her back in bed. put her in bed. E3 said we are in bed because she fell. When floor we are not supposed to d inservice on head injury and e to touch or move residents We have to wait until resident Id us to put her in bed. We put E2 told us. After we put her in ould not have put her in bed. I put her on the floor. The staff	F	323			

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		AND HUMAN SERVICES			FORM	: 08/30/2010 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145736	B. WING	3	C 03/30/2010		
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP COD	 =		
ALDEN 1	OWN MANOR REHA	B & HCC		6120 WEST OGDEN CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	We moved her off t	ige 9 he floor. I thought she had e moved her off the floor."	F 32	23			
	stated," I thought sl	did moved off the floor. E2 he was dead. E3 made a have a head or spinal injury them."					
	telephone stated," I all went down hall. (R3) was lying face a pool of blood arou rolled her over to a and pupils fixed. W had moved her hea verbally. I told E2 to call 911. E3 applied	11/10 at 12:15 pm per I heard E2 nurse yelling. We We went into the room. She e down on the floor. There was und her head. E3 the nurse ssess her. She had a pulse hen I called her name, she ad. She did not say anything o check the chart for DNR and d pressure to the forehead and t that point I ran out of the					
	resident with head E7 stated," We are a head, neck or bac	re you suppose to move or possible cervical injury"? not to move the resident with ck injury. We had a inservice back injury. She had a pulse ad not expired."					
	conference room st E4 call ask me if I h brought them towel the room, I saw R3 the forehead. They into bed. I knew it v bed. We had inserv floor do not touch o us to put her back i	/10 at 3:35 pm in the tated," I was working that day. had towels on the cart, so I is to the room. When I was in on the floor. I saw blood on ask me to help put R3 back was wrong to put her back in vice on if a resident on the or move from the floor. E2 told n bed. I saw her eyes was ook dead. The inservice was					

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		I AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145736	B. WI	NG _		C 03/30/2010		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN 1	TOWN MANOR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	long time ago. But i move someone on of bed." Surveyor asked E8 bed"? E8 stated," It was E the bed. I told her th not to move resider there injury. Z2, (Paramedic) on telephone stated," I standing around the Resident was in ful put the resident in b her in bed. I asked patient. They said of did not know if she spine. She was in of during anything for hospital. She had d Cervical Spinal Inju also saw a large jag patient's forehead, inch length with the critical injury and w when we arrival. W put the patient in be equipment under he they had used a bla The Head Injuries N Date 03/09 denoted 3). Determine base a). Conduct neu c). Evaluate pup	"who told you put resident in "who told you put resident in 2 who told us to put her on here was inservice that we are hts from the floor to bed if 03/15/10 at 9:00 am per Upon arrival found 5- 7 staff e resident. Staff did nothing. I cardiac arrest. I asked who bed. The staff said they put did they immobilized the did not immobilize her. They had a fracture of her C2 cardiac arrest. They were not her. She had arrest X 3 in the liagnosis Cardiac Arrest, iry and Multi Brain Injury. I gged laceration on the light bleeding, wound about 1 e skull visible. This patient was as in full code cardiac arrest e were very angry that they ed with no immobilized er to put in bed. A CNA said anket to put her in the bed."	F	323				

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		I AND HUMAN SERVICES			FORM	08/30/2010 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145736	B. WING			C 0/2010
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN 1	OWN MANOR REHA	B & HCC		6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
TAG F 323	Continued From pa g). Assess for in 8). Document emer The Neurological A Procedure dated 02 2). Observe, asses level of consciousn grasp and vitals sig Review of the care updated revisions a interventions or app prevent resident fro additional fall asses address the resider The facility submitter remove the Immedi > An action plan wa Administration on 0 supervison and hea > The interim Direct were reassessed a have identified thos for Fall/Falling Star completed by 3/12/ ongoing basis via th Plan were updated implemented. > All staff in all dep housekeeping, laur maintenance and a inserviced on super	Ige 11 juries to other organ systems. gency measure taken. ssessment Nursing Policy and 3/09 denoted: s and document the resident's ess, speech, pupils, hand ins. plan denoted there was no after the first two falls; broaches were not changed to om any additional falls. No esments were found either to onts previous falls ed the following plan for F323: ed the following plan to facy for F323: as imitated by the 13/06/10 addressing ad injuries. tor of Nurses and four nurses Il residents in the facility and se residents that are High Risk Program. The initial list was 10 and will be updated on ne daily AIMMs meeting. Care and intervention were artments including dietary, odry, activities, nursing, Il department heads were rvision and Falling Star	F 32	DEFICIENCY)	OPRIATE	DATE
	otherwise not on du in-serviced before t	 Staff who are on vacation or uty, and new staff, will be hey go on duty. nandatory, directed inservices 				

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		HAND HUMAN SERVICES				FORM	: 08/30/2010 APPROVED 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTI	ICIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145736	B. WII	NG _			C 0/2010
NAME OF PROVIDER OR	SUPPLIER	•	-		TREET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN TOWN MAN	OR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804		
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
starting 0 Procedur First Aid, condition, assessme otherwise in-service > A QA/C discuss th prevent fu designee the meeti > All resu be provid thereafter conducteF 490 SS=JA facility i enables it efficiently practicab well-beingThis REC by: Based on administr and servi for a resid resulted i head and Cardio-Pu moved po into bed v	sing staff 3/06/10 a es on Hea MD Notifi a fall or of ent. Staff not on d d before I meeting in result of and pre- station faud effective TRATION must be a to use its to attain e physica g of each UIREME record re- ation faile ce to pror lent R3 in n R3 fallir neck inju ulmonary st fall by vithout sta	including nurses and CNAs nd reviewed the Policies and ad Injuries, (11 Notifications, cation of a change in other injury and neurological who are on vacation or uty, and new staff, will be they go on duty. was held on 03/13/10 to of the action plan and to dent. The DON and/or id and presented the audits at its and additional findings will QA?QI committee quarterly N and/or designee will sent the audits at the meeting. E I/RESIDENT WELL-BEING dministered in a manner that is resources effectively and or maintain the highest al, mental, and psychosocial		490	3		4/1/10

Facility ID: IL6013353

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		AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145736	B. WI	NG _		C 03/30/2010	
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN 1	OWN MANOR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 490	Continued From pa being transferred to	-	F	49(0		
		lted in an Immediate ential to effect all 183 residents re at risk for falls.					
	began on 03/06/10 The Administrator,	Assistant Administrator, d Director of Operation were					
		ppardy was removed on but the facility remains out of prity level 2.					
	Findings Includes:						
	Diabetes Mellitus, A Toe, Coronary Arte Failure, Arthritis, G Chronic Renal Failu Accident, Dementia Insufficiency, Dege	old black female with diagnosis Anemia, Cellulitis Right Big ry Disease, Congestive Heart out, Glaucoma, Hypertension, ure, Old Cerebral Vascular a Behavior, Renal nerative Joint Disease and Regurgitate Diseases.					
	conference room st E2 (Acting Director at medication cart i were talking about said did you hear th heard noise. E4 (C sitting at nurse stat bumped in chair. E E2 left at that time She went toward th	1/10 at 10:10 am in tated," It was about 7:00 pm. of Nurse) and I was standing n the medication room. We things, I wanted to do. She nat noise. I said no, I did not ertified Nurse Aide -CNA) was ion in chair. She said E3, I 2 said "No", I heard a thud. So and started making rounds. he room. She looked in all he got room 313 she started					

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		HAND HUMAN SERVICES				FORM	: 08/30/2010 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		145736	B. WII	NG			C 0/2010
	PROVIDER OR SUPPLIER	B & HCC		6	REET ADDRESS, CITY, STATE, ZIP CODE 5120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	yelling for help. E4 (Nurse) came into t floor face down. E7 responded and roll to be fixed. My first not have a pulse. W pulse, she had a pu- breathing. By then saw the blood on th stabilized her neck coming from. It was of forehead. Ice par pressure. Someone chart for what statu with oxygen tank. E the bed and she sa we rolled her on a b bed. I was still appl to forehead. The par talked to them." Surveyor asked E3 the head and neck who told them put F E3 stated," None," (E2) realized they s the floor E4 (CNA) on 03/11, conference room st nursing station. I wa got ready to get up bumped the nurse's heard that? I explai bumping the desk. something, and beg she got down to en my name E4! E4! E	and I ran into the room. E7 the room. R3 was lying on the 7 called her name. She (R3) her eyes, then they appeared 5 impression was that she does When E7 went to palpate a ulse. It was rapid and she was I am yelling to get a ice pack. I he floor. E7 and I tried to to see where the blood was is a laceration on the left side cked was applied with e yelled to call 911 and check is she was. Someone came in E2 was standing at the foot of aid we got to get her up. So, blanket and got here up in lying pressure with a ice pack aramedics came in and E2	F	490			

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		AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		145736	B. WI	NG _			0/2010
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN T	TOWN MANOR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 490	was lying face dow R3. R3 was lying in extended out from to of blood. Her bed whead was in the co- face down in the V the wall. E2 told me "Do Not Resuscitat pulse. They had to was cleaning the he E2 told us we had to (CNA) attempted to She had saturated went to get the tow said "you can not c told E2 she was dir the ambulance corr to get her up!". I tol E2 said we have to stabilized her. E2 s bed. I said we had on the floor. E2 was to bed. They (E5, E pick her up with arr and two at the bott a sheet to lift her. I under her body. We lift her in bed. I don head. I did not wan floor. E2 persistence I said look like her pack on the head. I noodle. E3 said," I	age 15 n on the floor. E2 was across a pool of blood that had the body. It was large amount vall was shaped like a V. Her rner of the V shape. She was shape with her head touching e to check to see if she was a e". E3 checked and got a turn her on the her back. E3 ead to see what was going on. to clean her up. I and E5 o clean her bottom on the floor. with urine and stool. When E5 el, so we could clean her. E2 lean her from down there". I ty needed to be clean before he. She (E2) said "No!" We got d E2 we could not move her. o get her back to bed and aid we have to get her into the inservice to leave the resident s persistent in putting her back E8, E4 and E3) was going to ms and legs. Two at the top took the sheet and put it e held the side of the sheet to i't know if anyone held her t to lift this women off the e on lifting her in bed. E3 and neck was broken. They put ice her neck was very loose like a think her neck is broken". E2 we should put her back down	F	490			
	on the floor?". I Sai putting her back on asked what happer paramedics were v	id NO! He No! I am not the floor. The paramedic ned and who moved her. The ery angry at the staff. He said e moved her. We had a					

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		I AND HUMAN SERVICES			FORM	08/30/2010 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		145736	B. WING			C 0/2010
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN T	OWN MANOR REHA	B & HCC		6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	Continued From paral inservice that a rest not to be moved." E5 on 03/11/10 at 1 room stated," The t passed trays 5:00 p residents in the dim feeding residents in head of the bed wa R3 was lying face of was found. I was put I helped put R3 back E3 that put her in the her in bed. We put other two others we not see the blanket was covered with b bed and cabinet witk know how she fell. E3 said we are not not to put her back a person fall on the move them. We hav we are not suppose when on the floor. N is assessed. E2 to her in bed because bed. E2 said we should refused to put her to E2 on 03/11/10 at 1 room stated," I was nurse E3. Then I h heard that?. They r it was from her cha sound like a chair.	ident with head injury should if 1:00 am in the conference ray came up at 5:00 pm. We om - 5:30 pm. We have to feed ing room. I got through a dining room at 6:30 pm. The s in a sitting position for R3. down on the floor when she utting another resident to bed. kk to bed. It was I, E4, E8 and bed. We lifted her up and put a blanket under the legs and ere holding the shoulders. I did under shoulder or head. She lood. She was between the th her head on the wall. I don't When we put her back in bed. put her in bed. E3 said we are in bed because she fell. When floor we are not supposed to d inservice on head injury and e to touch or move residents We have to wait until resident Id us to put her in bed. We put E2 told us. After we put her in ould not have put her in bed. but her on the floor. The staff back on the floor."	F 490	DEFICIENCY)		
	sound like a chair. I started from the n					

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		I AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145736	B. WI	NG _			C 0/2010
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN 1	OWN MANOR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 490	yelled out for help. into room, observed the floor. I checked pulse. The nurse and the room. I looked a DNR and got oxy thought she had ex her and with E3 at I floor to the bed. We was no pulse. I did the ambulance peot the laceration of the We moved her off t expired that why we Surveyor ask why of stated," I thought sl comment "if people then we don't move E7, (Nurse) on 03/1 telephone stated," I all went down hall. (R3) was lying face a pool of blood arou rolled her over to as and pupils fixed. W had moved her heav verbally. I told E2 to call 911. E3 applied applied ice pack. A room for oxygen."	All the nurses came. I went d R3 in the prone position on for pulse; I did not feel a nd CNA was in the room. I left at the chart to see if there was gen. I came back to room. I pired. We put a blanket under head, rolled her up from the e checked the pulse. There the three compressions and ople took over. We checked e head. We applied ice pack. he floor. I thought she had e moved her off the floor. E2 he was dead. E3 made a have a head or spinal injury e them." 1/10 at 12:15 pm per heard E2 nurse yelling. We We went into the room. She down on the floor. There was und her head. E3 the nurse ssess her. She had a pulse hen I called her name, she id. She did not say anything o check the chart for DNR and d pressure to the forehead and t that point I ran out of the re you suppose to move or possible cervical injury"? not to move the resident with ck injury. We had a inservice back injury. She had a pulse	F	490			

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		AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145736	B. WII	NG _		C 03/30/2010		
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN 1	OWN MANOR REHAI	B & HCC			6120 WEST OGDEN CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 490	Continued From pa	ge 18	F	490	ס			
	conference room st E4 call ask me if I h brought them towel the room, I saw R3 the forehead. They into bed. I knew it w bed. We had inserv floor do not touch o us to put her back i open. She did not k long time ago. But i move someone on of bed." Surveyor asked E8 bed"? E8 stated," It was E the bed. I told her th not to move resider there injury. Z2, (Paramedic) on telephone stated," I standing around the Resident was in full put the resident in th her in bed. I asked patient. They said of did not know if she spine. She was in of during anything for hospital. She had d Cervical Spinal Inju also saw a large jag patient's forehead, inch length with the	 /10 at 3:35 pm in the ated," I was working that day. ad towels on the cart, so I is to the room. When I was in on the floor. I saw blood on ask me to help put R3 back was wrong to put her back in the room the floor. E2 told in bed. I saw her eyes was book dead. The inservice was n school, you were told not to the floor whom had fallen out "who told you put resident in the floor to be if the floor arrival found 5- 7 staff eresident. Staff did nothing. I cardiac arrest. I asked who bed. The staff said they put did they immobilized the floor immobilize her. They had a fracture of her C2 ardiac arrest. They were not her. She had arrest X 3 in the iagnosis Cardiac Arrest, ry and Multi Brain Injury. I gged laceration on the light bleeding, wound about 1 skull visible. This patient was as in full code cardiac arrest. 						

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		HAND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/30/2010 APPROVED : 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		145736	B. WII	NG _			C 0/2010
NAME OF P	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN 1	TOWN MANOR REHAI	B & HCC			6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	when we arrival. We put the patient in be equipment under he they had used a bla The Head Injuries N Date 03/09 denoted 3). Determine base a). Conduct neu c). Evaluate pup e). measure bloo respiration. g). Assess for in 8). Document emer The Neurological A Procedure dated 03 2). Observe, assess level of consciousn grasp and vitals sig Review of the care updated revisions a interventions or app prevent resident fro additional fall assess address the resider The facility submitter remove the Immedi > An action plan wa Administration on 0 supervison and hea > The interim Direct were reassessed at have identified thos	Ve were very angry that they ed with no immobilized er to put in bed. A CNA said anket to put her in the bed." Nursing Policy and Procedures d: eline condition of the resident. irological assessment. oil size and reaction to light. od pressure, pulse and hjuries to other organ systems. rgency measure taken. Assessment Nursing Policy and 3/09 denoted: as and document the resident's bess, speech, pupils, hand gns. plan denoted there was no after the first two falls; proaches were not changed to om any additional falls. No ssments were found either to nts previous falls ed the following plan for F323: as imitated by the 03/06/10 addressing	F	490			

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		AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145736	B. WI	NG _			C 0/2010
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN 1	OWN MANOR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	ongoing basis via the Plan were updated implemented. > All staff in all dep housekeeping, laur maintenance and a inserviced on supe Program as 3/12/10 otherwise not on du in-serviced before the > The facility held r for all nursing staff starting 03/06/10 and Procedures on Heat First Aid, MD Notific condition, a fall or of assessment. Staff wo otherwise not on du in-serviced before the > A QA/QI meeting discuss the result of prevent further include designee conducted the meeting. > All results of audi be provided to the of thereafter. The DO	10 and will be updated on he daily AIMMs meeting. Care and intervention were artments including dietary, hdry, activities, nursing, all department heads were rvision and Falling Star D. Staff who are on vacation or aty, and new staff, will be they go on duty. mandatory, directed inservices including nurses and CNAs and reviewed the Policies and ad Injuries, (11 Notifications, cation of a change in other injury and neurological who are on vacation or aty, and new staff, will be they go on duty. was held on 03/13/10 to of the action plan and to dent. The DON and/or d and presented the audits at ts and additional findings will QA?QI committee quarterly N and/or designee will sent the audits at the meeting. TONS		490 999			

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		AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		145736	B. WI	NG _			C 0/2010
	ROVIDER OR SUPPLIER	B & HCC		6	REET ADDRESS, CITY, STATE, ZIP CODE 6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 21	F9	999			
	Section 300.1030 M	ledical Emergencies					
	committee shall der to be followed durin emergencies that m long-term care facil emergencies incluct things as: 1) Pulmonary emer obstruction, foreign respiratory distress 2) Cardiac emergen pain, cardiac failure Section 300.1210 C Nursing and Person a) The facility must and services to atta practicable physical well-being of the re each resident's com plan of care. Adequinursing care and per to each resident to personal care need measures shall incl following procedure b)6) All necessary passure that the resi as free of accident nursing personnel s	ncies (for example, ischemic e, or cardiac arrest). General Requirements for nal Care provide the necessary care in or maintain the highest I, mental, and psychological sident, in accordance with nprehensive assessment and late and properly supervised ersonal care shall be provided meet the total nursing and s of the resident. Restorative ude at a minimum the					
	and assistance to p Section 300.1220 S	revent accidents. Supervision of Nursing					

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		I AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		145736	B. WIN	IG		C 03/30/2010		
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN T	OWN MANOR REHA	B & HCC			120 WEST OGDEN CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F9999	Continued From pa Services	ge 22	F99	999				
		upervise and oversee the the facility, including:						
	for each resident bacomprehensive ass and goals to be accorders, and person Personnel, represe nursing, activities, of modalities as are of be involved in the p plan. The plan shall reviewed and modified needed as indicate	p-to-date resident care plan ased on the resident's sessment, individual needs complished, physician's al care and nursing needs. nting other services such as dietary, and such other rdered by the physician, shall oreparation of the resident care I be in writing and shall be fied in keeping with the care d by the resident's condition. eviewed at least every three						
	a) An owner, licens	ee, administrator, employee v shall not abuse or neglect a						
	These Regulations by:	were not met as evidenced						
	failed to: - assess, develop in effectiveness of inter- interventions and s for 1 resident (R3). -asses a severely in after a fall,	and record review, the facility nterventions, re-evaluate the erventions, attempt alternative upervise after previous falls njured resident on the floor y for resident's with head						

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		AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		145736	B. WI	NG _			0/2010
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN 1	OWN MANOR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999		ne resident who went into	F9	999			
	sustaining a head a resulted in Cardio-F resident (R3) was n staff from the floor i with proper emerge	Ited in R3 falling from bed and and neck injury which then Pulmonary Arrest. The moved post fall by the facility into bed without stabilization ency equipment. The resident transferred to the hospital.					
	Diabetes Mellitus, A Toe, Coronary Arte Failure, Arthritis, Ge Chronic Renal Failu Accident, Dementia Insufficiency, Dege	old black female with diagnosis Anemia, Cellulitis Right Big ery Disease, Congestive Heart out, Glaucoma, Hypertension, ure, Old Cerebral Vascular a Behavior, Renal enerative Joint Disease and Regurgitate Disease.					
	in Section B. (4). Co Decision-Making de impaired decision required. Section G resident moves to a turns side to side, a	a Set dated 12/19/10 denoted ognitive Skill For Daily enoted R3 was moderately ns poor; cues/supervision G: (a). Bed Mobility (How and from from lying positions, and position body while in bed xtensive assistance/one sist).					
	denoted in Section	of the Minimum Data Set J. (4). Accidents (b). Fell in was marked with a X.					
		ssment Quarterly dated R3 was score 12 - high risk.					

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		AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145736	B. WI	NG _			C 0/2010
	ROVIDER OR SUPPLIER	B & HCC	-	6	REET ADDRESS, CITY, STATE, ZIP CODE 6120 WEST OGDEN		
				(CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 24	F9	999)		
	The Nurses Notes a 11/20/09 7:00 pm - stood up, lost balar wheelchair. Reside buttock. No injury n 11/29/09 - 9:00 am entered a resident n sitting on floor next nurse and Certified injuries noted. Resi other resident and a monitor. Review of the care updated revisions a interventions or app prevent resident fro additional fall asses address the resider 03/06/10 Approxima noise while nurse's resident on the floo position. E2 (Nurse additional help. Approximately 7:15 to assess injuries. N forehead that angle Neuro checks initia time. Resident was physical stimuli. Pu Respiration Rate 22 was applied per nas Pressure applied to 7:20 pm Resident r	state on the following dates: Resident while in dining room ice, tried to sit back on int missed the chair landing on oted. Will continue monitor. - As housekeeping staff room she observed resident to wheelchair. She notified Nurse Aide. No physical dent currently in room with staff present will continue to plan denoted there was no ifter the first two falls; proaches were not changed to m any additional falls. No esments were found either to nts previous falls. ately 7:10 pm Staff heard station. Upon rounds noted r in bedroom in a prone) called down the hallway for pm Resident was rolled over Noted a 21/2 laceration to left e up over residents left brow. ted, eyes were fixed at this unresponsive to verbal and lse palpable 96 and 2. 911 was called. Oxygen sal canula at oxygen 2 liter. o forehead. emain unresponsive. Unable res initiated Cardiac itation compression due to					

		AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145736	B. WI	NG _		C 03/30/2010		
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN 1	OWN MANOR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F9999	7:25 pm Paramedic transferred her to the evaluation. 7:30 pm Medical Do 10:00 pm Called to They stated that res 03/07/10 1:00 am V resident status, Em reported resident e 03/06/10 with Diago Trauma, Intracrania Hemorrhage. The Z3 (fire departs dated 03/06/10 stat 19:17 - Unresponsi some gastric fluids Laceration - Large right side forehead 19:32 - Primary Imp secondary to fall. T 6 feet." The Z3 Narratives of Crew called to the f arrival crew walked elderly victim lying moving. Crew aske they responded that noted 6- 7 staff in ro in. Crew noted 83 y facility bed, Unresp appearing to be app patient got into her the staff, put here b the fall were never asked 3 different tin given was that staff	cs Arrive. They immediately ne Emergency room at for octor notified. o receive a status on resident. sident is still being evaluated. /erified at hospital regarding nergency Room Nurse xpired at 10:20 pm on nosis Cardiac Arrest, Blunt al and Subarachnoid ment) Patient Care Report red," ve - Patient not breathing, in back of airway. Head vertical jagged laceration to	F9	999				

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM OMB NO.	08/30/2010 APPROVED 0938-0391	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		145736	B. WI	NG _			0/2010	
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ALDEN 1	OWN MANOR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F9999	a head wound. Cre laceration to the pa bleeding. Wound al skull visible. Crew a both of the patients Patient was "No Sp prior to arrival. Crew in fact apneic and p disbelief, but obviou patient was in Card Crew immediately k immobilized patient noted fluid in patien appears to be gastr in Asystole until tra- ventricular tachycar Hospital report date Complaints: Status and cardiac arrest. arrived after having Arrest was witness unknown period. Hi was found on the fl- heard a thud. Patie the floor. She had k She was put back i noted to be unresp medical treatment of Presentation: Unco is a C shape 3 lace Pupil (s) the right a Diagnosis Cardiac J Intracranial injury a with a loss of uncor duration. Patient wa pm."	w did note a large jagged tient's forehead, light bout 1 inches length with the also noted blood coming from nares. Blood appear dried. inal Precaution" taken by staff w then noted that patient was bulseless. Staff expressed usly did not notice that the iac Arrest prior to arrival. began CPR and spinally . Patient intubated, Crew at airway, suctioned what ic contents out. Patient stayed nsport, converted to	F9	999				

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		HAND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/30/2010 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		145736	B. WI	NG _			C 0/2010
NAME OF P	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN 1	TOWN MANOR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΞIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Report dated 03/06 soft tissue swelling However, I do not a fracture. There is a attenuation along th parietal lobe which examination compa Subarachnoid hem cervical spine demo base of the Odonto posterior displacem process with respe vertebral body. Im Subarachnoid or Si free convexity of th parietal lobe. In add base of the Odonto Type II fracture." E3 (Nurse) on 03/1 conference room si E2 (Acting Director at medication cart i were talking about said did you hear th heard noise. E4 (C sitting at nurse stat bumped in chair. E E2 left at that time She went toward th rooms. So,when sh yelling for help. E4 (Nurse) came into the floor face down. E7 responded and roll to be fixed. My first not have a pulse. V pulse, she had a pu	6/10 Stated," Mild extra clavicle in the frontal region is seen. appreciate any acute calvarial subtle area of high he free convexity of the left was not seen on the previous atible with a subtle Subdural or orrhage. Evaluation of the onstrates a fracture of the oid Process. There is a minimal nent of the tip of the Odontoid ct to the base of the C2 pression - A Subtle ubdural Hemorrhage along the	F9	999			

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		AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391	
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145736	B. WING	G			C D /2010	
NAME OF F	ROVIDER OR SUPPLIER		:					
ALDEN 1	OWN MANOR REHA	B & HCC		6120 WEST OGDEN CICERO, IL 60804				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORREC RECTIVE ACTION SHOI RENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F9999	stabilized her neck coming from. It was of forehead. Ice par pressure. Someone chart for what statu with oxygen tank. E the bed and she sa we rolled her on a b bed. I was still appl to forehead. The par talked to them." Surveyor asked E3 the head and neck who told them put F E3 stated," None," (E2) realized they se the floor E4 (CNA) on 03/11 conference room se nursing station. I we got ready to get up bumped the nurse's heard that? I explai bumping the desk. something, and beg she got down to en my name E4! E4! E to R3's room. Wher was lying face dow R3. R3 was lying in extended out from so of blood. Her bed w head was in the co face down in the V the wall. E2 told me	he floor. E7 and I tried to to see where the blood was is a laceration on the left side cked was applied with e yelled to call 911 and check is she was. Someone came in E2 was standing at the foot of id we got to get her up. So, blanket and got here up in ying pressure with a ice pack aramedics came in and E2	F99					

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		HAND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/30/2010 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		145736	B. WII	NG			0/2010
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN 1	TOWN MANOR REHA	B & HCC			120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	pulse. They had to was cleaning the he E2 told us we had to (CNA) attempted to She had saturated went to get the tow said "you can not c told E2 she was dir the ambulance com to get her up!". I tol E2 said we have to stabilized her. E2 s bed. I said we had on the floor. E2 was to bed. They (E5, E pick her up with arr and two at the bott a sheet to lift her. I under her body. We lift her in bed. I don head. I did not wan floor. E2 persisten I said look like her in pack on the head. I noodle. E3 said," I said "Do you think we on the floor?". I Sai putting her back on asked what happer paramedics were v we should not have inservice that a res not to be moved." E5 on 03/11/10 at 1 room stated," The to passed trays 5:00 p	age 29 turn her on the her back. E3 ead to see what was going on. to clean her up. I and E5 o clean her bottom on the floor. with urine and stool. When E5 rel, so we could clean her. E2 clean her from down there". I ty needed to be clean before ne. She (E2) said "No!" We got d E2 we could not move her. o get her back to bed and said we have to get her into the inservice to leave the resident s persistent in putting her back E8, E4 and E3) was going to ms and legs. Two at the top tom. I said stop. I would go get took the sheet and put it e held the side of the sheet to o't know if anyone held her it to lift this women off the ce on lifting her in bed. E3 and neck was broken. They put ice her neck was very loose like a think her neck is broken". E2 we should put her back down id NO! He No! I am not in the floor. The paramedic ned and who moved her. The rery angry at the staff. He said e moved her. We had a ident with head injury should	F9	999			

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM OMB NO.	08/30/2010 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		145736	B. WI	NG _)/2010
	ROVIDER OR SUPPLIER	B & HCC		6	REET ADDRESS, CITY, STATE, ZIP CODE 6120 WEST OGDEN		
					CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 30	F9	999	,		
F 9999	head of the bed wa R3 was lying face of was found. I was put I helped put R3 bac E3 that put her in b her in bed. We put other two others we not see the blanket was covered with b bed and cabinet wit know how she fell. E3 said we are not not to put her back a person fall on the move them. We hav we are not suppose when on the floor. N is assessed. E2 to her in bed because bed. E2 said we sh She said we should refused to put her b E2 on 03/11/10 at 1 room stated," I was nurse E3. Then I h heard that?. They r it was from her cha sound like a chair. I I started from the n room. When I got to yelled out for help. into room, observed the floor. I checked pulse. The nurse an the room. I looked a DNR and got oxy thought she had ex	s in a sitting position for R3. lown on the floor when she utting another resident to bed. k to bed. It was I, E4, E8 and bed. We lifted her up and put a blanket under the legs and ere holding the shoulders. I did under shoulder or head. She lood. She was between the th her head on the wall. I don't When we put her back in bed. put her in bed. E3 said we are in bed because she fell. When floor we are not supposed to d inservice on head injury and e to touch or move residents We have to wait until resident Id us to put her in bed. We put E2 told us. After we put her in ould not have put her in bed. I put her on the floor. The staff	Fð	222			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145736	B. WIN	G			C D /2010
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN 1	OWN MANOR REHA	B & HCC			20 WEST OGDEN ICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	was no pulse. I did the ambulance peot the laceration of the We moved her off t expired that why we Surveyor ask why of stated," I thought sl comment "if people then we don't move E7, (Nurse) on 03/1 telephone stated," I all went down hall. (R3) was lying face a pool of blood arou rolled her over to as and pupils fixed. W had moved her hea verbally. I told E2 to call 911. E3 applied applied ice pack. A room for oxygen." Surveyor asked: "a resident with head E7 stated," We are a head, neck or bac on head, neck and on the floor. She has E8 (CNA) on 03/11 conference room st E4 call ask me if I h brought them towel the room, I saw R3 the forehead. They	e checked the pulse. There the three compressions and ople took over. We checked e head. We applied ice pack. he floor. I thought she had e moved her off the floor." did moved off the floor. E2 he was dead. E3 made a e have a head or spinal injury e them." 11/10 at 12:15 pm per I heard E2 nurse yelling. We We went into the room. She down on the floor. There was und her head. E3 the nurse ssess her. She had a pulse hen I called her name, she ad. She did not say anything o check the chart for DNR and d pressure to the forehead and t that point I ran out of the re you suppose to move or possible cervical injury"? not to move the resident with ck injury. We had a inservice back injury. She had a pulse	F99	99			

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TAG REGULATORY OR LISC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE F9999 Continued From page 32 bed. We had inservice on if a resident on the floor do not touch or move from the floor. E2 told us to put her back in bed. I saw her eyes was open. She did not look dead. The inservice was long time ago. But in school, you were toid not to move someone on the floor whom had fallen out of bed." F9999 Surveyor asked E8 "who told you put resident in bed"? E8 stated," It was E2 who told us to put her on the bed. I told her there was inservice that we are not to move residents from the floor to bed if there injury. Z2 (Paramedic) on 03/15/10 at 9:00 am per telephone stated." Upon arrival found 5-7 staff standing around the resident. Staff did nothing. Resident was in full cardiac arrest. I asked who put the roi hed. I asked did they immobilized the patient. They said did not timobilize they put her in bed. I asked afacture of her C2 spine. She was in cardiac arrest. They wer not doing anything for her. She had arrest X 3 in the hospital. She had diagnosis Cardiac Arrest, Cervical Spinal Injury and Multi Brain Injury. I also saw a large jagged laceration on the badu t1 inch length with the skull visible. This patient was critical injury and was in full code cardiac arrest when we arrival. We were very angry that they put the patient in bed. A CNA said they had used a blanket to put her in the bed." The Head Injuries Nursing Policy and Procedures			HAND HUMAN SERVICES & MEDICAID SERVICES				FORM	2: 08/30/2010 APPROVED . 0938-0391
Index 145736 B. WING OB330/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE ALDEN TOWN MANOR REHAB & HCC SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE COMMARY CITY OR LSCI DENTIFYING INFORMATION) PREFX PREFX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCIES Commary Comparison of the Comparis				` '			(X3) DATE S COMPLE	SURVEY ETED
ALDEN TOWN MANOR REHAB & HCC B120 WEST OGDEN CICEND, IL 60804 (Y4) ID PREFX TAC SUMMARY STATEMENT OF DEFICIENCIES (EACH ORRECTINC) ID RECK DREFX (EACH ORRECTINC) COMPLETO (EACH CORRECTION EACH C			145736	B. WI	NG _			
ALDEN TOWN MANOR REHAB & HCC CICERO, IL 60804 (%4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INCOMATION) ID PROVIDER SPLAN OF CORRECTIVE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY 009; CROSS-REFERENCED TO THE APPROPRIATE 009; CROSS TO THE APPROPRIATE 009; C	NAME OF P	ROVIDER OR SUPPLIER						
PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMMENTION DEFICIENCY F9999 Continued From page 32 F9999	ALDEN T	OWN MANOR REHA	B & HCC					
 bed. We had inservice on if a resident on the floor do not touch or move from the floor. E2 told us to put her back in bed. I saw her eyes was open. She did not look dead. The inservice was long time ago. But in school, you were told not to move someone on the floor whom had fallen out of bed." Surveyor asked E8 "who told you put resident in bed"? E8 stated," It was E2 who told us to put her on the bed. It there was inservice that we are not to move residents from the floor to bed if there injury. Z2 (Paramedic) on 03/15/10 at 9:00 am per telephone stated," Upon arrival found 5-7 staff standing around the resident. Staff did nothing. Resident was in full cardiac arrest. I asked who put the resident in bed. The staff said they put her in bed. I asked did they immobilized the patient. They said did not immobilize ther. They did not know if she had a fracture of her C2 spine. She was a large jagged laceration on the patient's forehead. light beding, wound about 1 inch length with the skull visible. This patient was cirtical injury and Multi Brain Injury. I also saw a large jagged laceration on the yat the patient in bed with no immobilized erarest when we arrival. We were very angry that they put the patient in bed with no immobilized erarest when we arrival. We were very angry that they put the patient in bed with no immobilized erarest when we arrival. We were very angry that they put the patient in bed with no immobilized erarest when we arrival. We were very angry that they put the patient in bed with no immobilized erarest when we arrival. We were very angry that they put the patient in bed with no immobilized equipment under her to put in bed. A CNA said they had used a blanket to put her in the bed." 	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	-IX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
Date 03/09 denoted: 3). Determine baseline condition of the resident.	F9999	bed. We had inserv floor do not touch of us to put her back if open. She did not he long time ago. But if move someone on of bed." Surveyor asked E8 bed"? E8 stated," It was E the bed. I told her th not to move resider there injury. Z2 (Paramedic) on telephone stated," If standing around the Resident was in ful put the resident in th her in bed. I asked patient. They said of did not know if she spine. She was in of doing anything for H hospital. She had do Cervical Spinal Inju also saw a large jag patient's forehead, inch length with the critical injury and w when we arrival. W put the patient in be equipment under he they had used a bla The Head Injuries I Date 03/09 denoted	vice on if a resident on the or move from the floor. E2 told in bed. I saw her eyes was ook dead. The inservice was in school, you were told not to the floor whom had fallen out 8 "who told you put resident in E2 who told us to put her on here was inservice that we are nts from the floor to bed if 03/15/10 at 9:00 am per Upon arrival found 5- 7 staff e resident. Staff did nothing. Il cardiac arrest. I asked who bed. The staff said they put did they immobilized the did not immobilize her. They had a fracture of her C2 cardiac arrest. They were not her. She had arrest X 3 in the diagnosis Cardiac Arrest, ury and Multi Brain Injury. I gged laceration on the light bleeding, wound about 1 e skull visible. This patient was vas in full code cardiac arrest 'e were very angry that they ed with no immobilized er to put in bed. A CNA said anket to put her in the bed."	F9	999	9		

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		AND HUMAN SERVICES				FORM	08/30/2010 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145736	B. WI	NG _			C 0/2010
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN T	OWN MANOR REHA	B & HCC			6120 WEST OGDEN CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	-IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	 c). Evaluate pup e). measure blo respiration. g). Assess for in 8). Document ement The Neurological A Procedure dated 02 2). Observe, asses 	pirological assessment. bil size and reaction to light. od pressure, pulse and hjuries to other organ systems. rgency measure taken. Assessment Nursing Policy and B/09 denoted: s and document the resident's ess, speech, pupils, hand	F9	999			

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