STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013353	A. BUILDING: _____ B. WING _____	C 11/09/2018

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

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S 000	Initial Comments Statement of Licensure Violations Complaint Investigations 1896952/IL106783 1896898/IL106721 1896890/IL106716	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or	S9999		

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S9999	Continued From page 2 neglect a resident. These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to monitor and supervise a cognitively impaired resident by leaving an exit door to a unit open and unattended and failed to stop the resident from exiting the front entrance unsupervised. This failure affected 1 of 3 residents (R1) reviewed for accidents and incidents in a total sample of 3 and has the potential to affect 4 cognitive residents (R2, R3, R4 & R5) residing on the facility's first floor. This failure resulted in R1, a cognitive impaired resident, self-propelling out of the facility in a wheel chair and falling down 5 concrete stairs sustaining multiple brain bleeds, facial and spinal fractures leading to death. Findings Include: The Face Sheet documents that R1 was admitted to the facility on 5/5/16 with a diagnosis of Dementia with behavioral disturbance and muscle weakness related to a stroke. The current care plan documents that R1 is a high fall risk and has poor safety awareness. R1 has behaviors of exploring and seeking familiar settings as evidenced by being unable to find the resident's room. The Minimum Data Set (MDS) dated 10/15/18 documents that R1 has a Brief Interview for Mental Status (BIMS) Score of 6 indicating that the resident has severe cognitive impairment. The Physician Order Sheet (POS) dated 10/7/18 documents that R1 may go out on pass while	S9999		

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S9999	Continued From page 3 being accompanied by another person. The Incident Report dated 10/19/18 documents that R1 self-propelled through the lobby in a wheelchair at approximately 1:00pm and went outside where the resident tumbled down 5 concrete stairs and landed on the pavement. R1 was transported to the local hospital and diagnosed with 2 lacerations to the right forehead, extensive acute bilateral brain bleeds, multiple right facial fractures, a cervical spine fracture, and right frontal facial, neck hematomas. The CT scan of the chest showed a collection of fluid in the throat so R1 was intubated to protect the airway. R1 was transferred to a trauma intensive care unit at another hospital for further treatment. While hospitalized, R1 expired on 10/24/18. The Death Certificate was reviewed on 10/31/18 and documents the cause of death as complications related to a fall. On 10/30/18 at 9:30am the surveyor noted 5 concrete stairs and a wheelchair assessable ramp leading to the main entrance of the facility. There is a manual double door and a small foyer area followed by another manual door leading to the lobby. Upon entering the lobby the receptionist desk is adjacent to the manual door used to enter a resident's nursing/living unit on the facility's 1st floor. On 10/31/18 at 11:45am the facility's video footage was reviewed and shows that on 10/19/18 at 12:00pm the double doors on the first floor leading to the lobby and the manual door exiting the lobby leading to the foyer area was propped open. At 12:58pm R1 self-propelled through the lobby passing the receptionist sitting	S9999		

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at the desk and proceeded in the direction of the opened door. A staff member was seen walking behind the resident towards the administrative offices as R1 self-propelled towards the open door. At 12:59pm the receptionist stepped away from the desk and R1 exits the opened door and can be seen in the foyer area. A visitor is seen following the resident and moving pass the resident as R1 exited the building. At 12:59pm R1 self-propelled towards the 5 concrete steps and fell down the steps and onto the pavement.

On 10/30/18 at 1:33pm V4 (Medical Records/Transporter) stated "R1 normally is not left alone outside. R1 visits with family every day and family is always with the resident."
On 10/31/18 at 11:00am V6 (Receptionist viewed on the video footage) stated "Another resident and R1 was coming from the first floor nursing station. The other resident was an elopement risk so I paid more attention to that resident. I went to go get the other resident some candy and I left the desk. When I came back R1 was gone and I don't know what happened after that. I would see R1 outside with family a lot, but never alone."

On 10/31/18 at 11:15am V7 (Family) stated "R1 was never allowed to go outside alone because R1 was a high fall risk."

On 10/31/18 at 12:47pm V2 (DON) stated "The door is normally propped open so that it is easier for the residents in wheelchairs or walkers to get outside and sit on the patio if they're able. Sometimes it's a lot of traffic and the receptionist keeps the door open."

On 10/31/18 at 12:51pm the double doors leading from the first floor nursing unit to the lobby was

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observed propped open and the manual door exiting the lobby and leading to the foyer area was propped open.

On 11/2/18 at 9:45am the double doors leading from the first floor nursing unit to the lobby was observed propped open. It was noted that R2, R3, R4 & R5 had moderate to severe cognitive impairments and all self-propelled on the first floor using a wheelchair.

On 11/2/18 at 10:09am V8 (Social Service Director) stated "R1 has a diagnosis of Dementia and I know the BIMS Score was low. R1 was not allowed outside alone. We do an Elopement Risk Assessment to determine if residents can go out alone. The Elopement Risk wasn't done on R1 because the resident had no previous attempts of leaving the facility. Residents that are not an elopement risk and are cognitively impaired, its staff responsibility to keep an eye on them and use their intuition."

On 11/2/18 at 10:43pm V1 (Administrator) stated, R1 had a pass privilege to leave with family and it's a Physician order.

On 11/2/18 at 11:17am V1 stated, We know R1 wandered and was unsafe. The resident wasn't one that we would send out alone. The receptionist before had an Elopement Risk List at the desk. We revised the list to now include other residents that we are concerned about, and that was given to the receptionist.

On 11/8/18 at 10:10am V6 stated, No one can really cover for me on the weekends when I step away from the desk. During the week, the manager on duty covers for me for breaks. When the door is propped open, I watch more

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S9999	Continued From page 6 closely for the residents coming in and out. On 11/8/18 at 10:39am V9 (Physician) stated, R1 was hemiplegic and wheelchair bound and also had dementia pretty bad. R1 is severely cognitively impaired and should not have gone out alone. From my understanding, the door was propped open, and R1 got outside alone. On 11/8/18 at 11:21am, V1 stated, The cameras are for monitoring purposes. I have to contact the information technology team to watch anything. The receptionists are the gate keepers of the facility. They watch for the elopement risk residents and now get passes for residents coming and going. (A)	S9999		