	-				FORM APPROVED
					MB NO. 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		145736	B. WING _		C 11/22/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION
F 000	INITIAL COMMENT	rs	F 00	0	
	Complaint Investig	ation			
	Alden Town Manor	Rehab & HCC			
	1696387/ IL 89709,	no deficiency			
	1696421/ IL 89756,	-			
	1686402/ IL 89727,	-			
	1696200/ IL 89508,	no deficiency			
F 157 SS=G	1696536/ IL 89877 483.10(b)(11) NOT (INJURY/DECLINE		F 15	7	
	consult with the res known, notify the res or an interested fan accident involving ti injury and has the p intervention; a signi physical, mental, or deterioration in hea status in either life t clinical complication significantly (i.e., a existing form of treat consequences, or ti treatment); or a deo the resident from th §483.12(a).	ediately inform the resident; ident's physician; and if esident's legal representative nily member when there is an he resident which results in potential for requiring physician ificant change in the resident's r psychosocial status (i.e., a lth, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge he facility as specified in			
	and, if known, the roor interested family	esident's legal representative member when there is a			
		ER/SUPPLIER REPRESENTATIVE'S SIGN		TITI F	(X6) DATE

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

......

TITLE

(X6)

PRINTED: 12/01/2016

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	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY
		145736	B. WING				C 22/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/4	22/2010
ALDEN T	OWN MANOR REHA	B & HCC		-	120 WEST OGDEN		
				С	ICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Continued From par change in room or or specified in §483.1 resident rights under regulations as spect this section. The facility must react the address and ph legal representative This REQUIREMENT by: Based on interview failed to follow its or notification by failing physician of a chan worsening of arteria residents reviewed a sample of five rest R3's admission to the bilateral gangene to above the knee am limb. Findings include: On 11/16/16 at 12 stated that R3 develop foot while at the fac R3's feet were alwar Z1 stated that on 11 and discovered that was black and told Z1 stated that since	ge 1 roommate assignment as 5(e)(2); or a change in er Federal or State law or ified in paragraph (b)(1) of cord and periodically update one number of the resident's e or interested family member. NT is not met as evidenced and record review, the facility wn policy governing physician g to notify one resident's (R3) ge in condition regarding al wounds, for one out of three for change in condition, out of sidents. This failure resulted in he hospital on 11/6/16 for both feet and subsequent putation of R3's right lower :15pm, Z1 (complainant) eloped a blister on the right ility. Z1 stated that both of tys wrapped when Z1 visited. I/2/16, Z1 finally saw R3's feet t the skin on R3's right foot the facility to transfer R3 out. e then, R3 has had the right above the knee due to lack of	F 15	57			
		om documentation dated					

Facility ID: IL6013353

If continuation sheet Page 2 of 11

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	l		IPLETED C
		145736	B. WING				
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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	 11/6/16 reads "83 y emergency departin gangrene. R3 is wi that she has been r toes and heels for p left dry exchar at po at posterior heel an digits 1 and 2, disco gangrenous appear foot, and dry escha lschemic changes or right foot gangrene R3's emergency roo x 6cm necrotic deor cm and right lateral necrotic base, posit and second toe. Va R3's facility wound 10/19/16 read "Righ has become moist the moist areas, so culture taken." R3's lab report date culture final report N clinical notes dated 10 results to Z2. Z2 is facility." There is no MRSA lab result. C (Administrator) stati what happened. R3's surgical consu "RLE (right lower ex hallux and 2nd digit 	age 2 rear old male seen in nent for bilateral foot ith family member who states noticing discoloration of R3's past couple of weeks. Skin - psterior heel, right dry eschar ad dry ischemic changes of ploration of remaining 3 digits, ring and foul smell from right r at lateral aspect of right foot. of right digits. Impression - and left heel decubitus ulcer." om notes read "Left heel 6 cm ubitus. Right heel 4.5 cm x 5 l foot 3 cm x 4 cm - both tive gangrene to right great toe ascular surgery evaluation. care evaluation notes dated ht great and second toe eschar in the inferior parts. Debrided me purulent drainage noted, ed 10/22/16 reads "Wound MRSA - growth many." R3's 10/24/16 read that Z2 n) was notified on 10/24/16. 0/24/16 read "Relayed lab s going to see R3 in the o further follow up to R3's Dn 11/17/16 at 3pm, E1 red that she does not know		157			

If continuation sheet Page 3 of 11

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FOR	D: 12/01/2016 M APPROVED D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		ATE SURVEY
		145736	B. WING _		1	C I/ 22/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			<i>1/22/2010</i>
ALDEN	FOWN 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 PREFIX TAG	((EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 157	plantar aspect of for region. Dry eschar of 5th metatarsal a 3 cm. Foul odor." that R3 had a abov On 11/17/16 at 12:: Physician) stated th bad R3's right foot nursing home on 1 wounds were gettir ordered R3 to be si- that he received R3 lower extremity rep stated showed "mil Z2 stated that he w doctor or any nurse regarding how bad until 11/6/16. Z1 (c visited R3 on 11/2/ facility to send R3 to 3:30pm, E2 (Direct soon as she saw R sent R3 to the hosp E8 (Wound Nurse) if he reported to Z2 E8 stated refer to V Skin Alteration) forn Z2 on 11/6/16 beca bigger and Z2 state Z2's clinical notes of admitted to the hosp R3's WASA form di cm x 2 cm. R3's W reads right heel 4 of 10/27/16 right heel cm, 90% eschar, o	age 3 bot down to the mid metatarsal '5 cm x 2 cm on lateral aspect ind dry eschar over heel 3 cm x R3's notes dated 11/9/16 read re right knee amputation." 30pm, Z2 (Attending nat he was not aware of how was until he was called by the 1/6/16 with a report that R3's ing bigger. Z2 stated that he ent to the hospital. Z2 stated 3's arterial doppler bilateral bort dated 10/24/16 which Z2 d peripheral vascular disease." //as not notified by the wound e at the nursing home R3's right foot had become complainant) stated that she 16 and Z1 stated she told the to the hospital. On 11/17/16 at 3's right foot on 11/6/16, she bital. On 11/17/16 at 1:00pm, stated that he can't remember that R3's right foot was black. VASA (Weekly Assessment of ms. E8 stated that he called ause R3's wounds were getting ed to send R3 to the hospital. dated 11/6/16 read "R3 spital with right foot gangrene." ated 8/1/16 reads right heel 2 VASA form dated 10/21/16 cm x 6 cm, 90% eschar, on measured 4 cm x 6cm x 0.3 n 11/2/16 right heel measured cm, 90% eschar. R3's WASA	F 15	57		

Facility ID: IL6013353

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DEPART	FORM	APPROVED					
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(-)	E SURVEY PLETED
						(С
		145736	B. WING			11/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER				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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	that Z2 was notified R3's WASA form of great toe 0.5 cm x 1 10/14/16 0.5 cm x 1 on 8/1/16. R3's WA reads "Right toes (g cm, 100% eschar. I was no documentati that Z2 was notified worsened in size ar R3's WASA form da lateral foot 1 cm x 1 evaluation form dat lateral foot post deb color black, 80% es dated 11/2/16 read cm, 75% eschar, M no documentation t manner regarding F increasing size and color. The facility's change 2/14 reads "Purpos resident's physician responsible party w resident's condition physicians or physic	16, 10/27/16 and 11/2/16 read 16, 10/27/16 and 11/2/16 read 1 on 9/28/16. 1 cm. R3's WASA form dated 1 cm. no eschar. MD notified ASA form dated 10/21/16 great toe) 2 cm x 3 cm x 0.2 MD notified on 8/1/16. There tion in R3's WASA forms that 1 that R3's right great toe nd had eschar. ated 10/21/16 reads "Right cm." R3's wound care ed 10/26/16 reads "Right oridement size 4 cm x 3.5 cm, schar." R3's WASA forms "Right lateral foot 4 cm x 3.5 D notified 9/7/16. There was hat Z2 was notified in a timely R3's right lateral foot 75/80% eschar, black in e in condition policy dated e is to ensure that the //physician on call/NP and kept informed regarding the n condition. Policy: The or physician on call/NP and ill be notified of changes in a . Procedure - Attending	F 1	157			
F 309 SS=G	condition." 483.25 PROVIDE C HIGHEST WELL BI	CARE/SERVICES FOR EING	F3	309			

Facility ID: IL6013353

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		AND HUMAN SERVICES				FORM	: 12/01/2016 APPROVED	
STATEMENT OF DEFICIE		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF CORRECT	ION	IDENTIFICATION NUMBER:					COMPLETED	
		145736	B. WING				C 22/2016	
NAME OF PROVIDER O	R SUPPLIER		<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE	,		
ALDEN TOWN MAI	NOR REHA	B & HCC			120 WEST OGDEN CICERO, IL 60804			
(X4) ID S	UMMARY STA	ATEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECT	NC	(X5)	
		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC		COMPLETION DATE	
			 		DEFICIENCY)			
F 309 Continue	d From pa	age 5	F 3	09				
		t receive and the facility must						
		ary care and services to attain hest practicable physical,						
mental, a	and psycho	osocial well-being, in						
accordar and plan		e comprehensive assessment						
This REC	QUIREME	NT is not met as evidenced						
Based o		v and record review, the facility						
Staphylo	coccus Au	SA (Methicillin- Resistant ireus) infection in one out of						
		3), reviewed for wounds in a was identified with a wound to						
the right	great toe.							
		d in R3's lack of treatment for uent admission to the hospital.						
Findings								
R3 was a	admitted to	the nursing home on 7/29/16.						
R3's face	e sheet list	s the following diagnoses: hypertension, atrial fibrillation,						
hyperten	sive heart	disease and chronic kidney						
		failure, hemiplegia and ing cerebral infarction affecting						
left- nond	dominant s	side, seizures, hypothyroidism,						
		a, cerebrovascular disease, neoplasm of prostate and						
	al vascular							
R3's WA	SA (Weeł	kly Assessment of Skin						
		ted 10/14/16 reads "Right						
10/14/16	0.5 cm x	1 cm. R3's WASA form dated						

Facility ID: IL6013353

If continuation sheet Page 6 of 11

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN O	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILD	NG	à	C	
		145736	B. WING				22/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 6120 WEST OGDEN		
ALDEN TOWN MANOR REHAB & HCC					CICERO, IL 60804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	cm, 100% eschar. I R3's facility wound of 10/19/16 read "Righ has become moist in the moist areas, so culture taken." R3's lab report date culture final report A clinical notes dated (Attending physician R3's notes dated 10 results to Z2. Z2 is facility." There is no MRSA lab result. C (Administrator) state what happened. On 11/17/16 at 12:3 Physician) stated th bad R3's right foot y nursing home on 11 wounds were gettin ordered R3 to be set that he received R3 lower extremity repo stated showed "mike Z2 stated that he we doctor or any nurse regarding how bad until 11/6/16. Z1 (cr visited R3 on 11/2/1 facility to send R3 to	ge 6 great toe) 2 cm x 3 cm x 0.2 MD notified on 8/1/16. care evaluation notes dated at great and second toe eschar in the inferior parts. Debrided me purulent drainage noted, d 10/22/16 reads "Wound MRSA - growth many." R3's 10/24/16 read that Z2 n) was notified on 10/24/16. D/24/16 read "Relayed lab going to see R3 in the of further follow up to R3's 0n 11/17/16 at 3pm, E1 ed that she does not know 80pm, Z2 (Attending hat he was not aware of how was until he was called by the /6/16 with a report that R3's g bigger. Z2 stated that he ent to the hospital. Z2 stated i's arterial doppler bilateral ort dated 10/24/16 which Z2 d peripheral vascular disease." as not notified by the wound at the nursing home R3's right foot had become omplainant) stated that she 6 and Z1 stated she told the o the hospital. On 11/17/16 at or of Nursing) stated that as	F3	309			
	sent R3 to the hosp	3's right foot on 11/6/16, she ital. On 11/17/16 at 1:00pm, stated that he can't remember					

Facility ID: IL6013353

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	UI LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			à	COMPLETED	
						(0
		145736	B. WING			11/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 6120 WEST OGDEN		
ALDEN TOWN MANOR REHAB & HCC					CICERO, IL 60804		
(X4) ID					PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLÉTION DATE
			l				
F 309	Continued From pa	-	F 3	09)		
		that R3's right foot was black. VASA forms. E8 stated that he					
		6 because R3's wounds were					
		Z2 stated to send R3 to the					
		al notes dated 11/6/16 read hospital with right foot					
	gangrene."	noopital man igni loot					
	R3's emergency roo	om documentation dated					
	11/6/16 reads "83 y	ear old male seen in					
		nent for bilateral foot th family member who states					
	that she has been r	noticing discoloration of R3's					
		bast couple of weeks. Skin -					
		osterior heel, right dry eschar d dry ischemic changes of					
	digits 1 and 2, disco	ploration of remaining 3 digits,					
		ring and foul smell from right rat lateral aspect of right foot.					
		of right digits. Impression -					
	right foot gangrene	and left heel decubitus ulcer."					
		om notes read "Left heel 6 cm ubitus. Right heel 4.5 cm x 5					
		foot 3 cm x 4 cm - both					
	necrotic base, posit	tive gangrene to right great toe					
	and second toe. Va	ascular surgery evaluation.					
		It report dated 11/6/16 reads					
		xtremity): mummification of , necrosis of dorsum of foot to					
		ng toes, also extending to					
	plantar aspect of fo	ot down to the mid metatarsal					
		5 cm x 2 cm on lateral aspect nd dry eschar over heel 3 cm x					
	3 cm. Foul odor."	R3's notes dated 11/9/16 read					
	that R3 had a above	e right knee amputation."					
		on control policy p.9 reads ns may be considered for					

Facility ID: IL6013353

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DEPART	FORM	APPROVED					
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
						(C
		145736	B. WING			11/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN TOWN MANOR REHAB & HCC					5120 WEST OGDEN CICERO, IL 60804		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 309	Continued From no	~~ 0	Бо				
F 309	Continued From pa	MRSA (Methicillin- Resistant	F 3	509			
		reus). Contact precautions					
	are intended to prev	vent transmission of infectious					
		idemiologically important hich are spread by direct or					
		the resident or the resident's					
		e was no follow up from the					
	,	if R3 needed contact other treatment for R3's					
	MRSA lab report.						
F 314	483.25(c) TREATM		F 3	814			
SS=D	PREVENT/HEAL P	RESSURE SORES					
		rehensive assessment of a					
		must ensure that a resident					
		ity without pressure sores ressure sores unless the					
	individual's clinical of	condition demonstrates that					
		ble; and a resident having eives necessary treatment and					
		e healing, prevent infection and					
	prevent new sores f						
	This REQUIREMEN	NT is not met as evidenced					
	by:	, and was and was done that facility					
		and record review, the facility identify risk for pressure ulcer					
	development and fa	ailed to demonstrate what					
		ires were in place prior to and					
		ent of a stage 2, facility ulcer, for one out of 3					
	residents (R3), revie	ewed for pressure ulcers in a					
		was identified as low risk for					
	pressure ulcer deve	elopment.					
	Findings include:						

Facility ID: IL6013353

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/01/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		145736	B. WING	à			22/2016
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN 1	OWN 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		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	R3 was admitted to R3's face sheet list Muscle weakness, hypertensive heart disease with heart hemiparesis followi left- nondominant s gout, hyperlipidemi dementia, benign r peripheral vascular R3's Braden scale "Score 18 - mild rist for predicting press procedure reads "M moderate risk: tota score 10-12 and se less. R3's Braden reads under mobilit and frequent chang (Minimum Data Se section G reads "B moves to and from side, and positions alternated sleep fut facility failed to ider pressure ulcer devia admission assessi R3's nursing notes "MASD (moisture a buttock 3.8 cm x 3 evaluation dated 10 appropriate mattres prominences under recommended." R report dated 10/19/ pressure ulcer mea	b the nursing home on 7/29/16. s the following diagnoses: hypertension, atrial fibrillation, disease and chronic kidney failure, hemiplegia and ing cerebral infarction affecting side, seizures, hypothyroidism, a, cerebrovascular disease, neoplasm of prostate and disease. score dated 8/20/16 reads k." The facility's Braden scale sure sore risk policy and <i>l</i> ild risk: total score of 15-18, I score of 13-14, high risk: total evere risk: total score of 9 or assessment dated 8/20/16 ty "No limitation, makes major ges in position." R3's MDS t) dated August 5, 2016 under ed mobility - how a resident lying position, turns side to body while in bed or rniture - 2 person assist." The ntify R3 as a higher risk for elopment based on his ment. dated 10/10/16 at 13:56 read associated skin damage) on 5 cm. R3's wound care D/12/16 reads "Stage ss and avoid bony	F	314			

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		AND HUMAN SERVICES			FORM	12/01/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145736	B. WING		C 11/22/2016	
NAME OF I	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALDEN 1	OWN 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	recommended." R 10/23/16 read low a at 1pm, E8 (Wound noncompliant with g The facility's prever breakdown policy d will properly identify clinical conditions in skin integrity and p implement prevent appropriate treatme	ences under direct pressure 3's clinical notes dated air loss mattress. On 11/16/16 d Nurse) stated that R3 was	F 31			

Facility ID: IL6013353

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