IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

January 8, 2019

Mary Chelotti-Smith, Registered Agent
Alden-Town Manor Rehabilitation and Health Care Center, Inc.
4200 W. Peterson Avenue, Suite 140
Chicago, Illinois 60646

RE:	Complaint #:	IL 106716, IL 106721, IL 106783
	Survey Date:	November 9, 2018
	Docket #:	18-C0539
	Violation Type:	A Violation with Fine

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Alden Town Manor Rehab & HCC.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Alden Town Manor Rehab & HCC/November 9, 2018/18-C0539/RegAgent/kk

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: ALDEN TOWN MANOR REHAB & HCC COMPLAINT #: 0106716
LIC. ID #: 0038000
DATE COMPLAINT RECEIVED: 10/19/18 13:09:00

IDPH Code	Allegation Summary	Determination
211	SAFETY PROBLEMS	1

K The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: ALDEN TOWN MANOR REHAB & HCC COMPLAINT #: 0106721
LIC. ID #: 0038000
DATE COMPLAINT RECEIVED: 10/22/18 08:35:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	
131	RESIDENT INJURY	1/1

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

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3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: ALDEN TOWN MANOR REHAB & HCC COMPLAINT #: 0106783
LIC. ID #: 0038000
DATE COMPLAINT RECEIVED: 10/23/18 14:14:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. ALDEN-TOWN MANOR REHABILITATION AND HEALTH CARE CENTER, INC., D/B/A, ALDEN TOWN MANOR REHAB & HCC Respondent.	))))))))	Docket No. NH 18-C0539

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation conducted by the Department on November 9, 2018 at Alden Town Manor Rehab & HCC, 6120 West Ogden, Cicero, Illinois 60804. On January 7, 2019, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Alden Town Manor Rehab & HCC, 6120 West Ogden, Cicero, Illinois 60804 on May 2, 2018. The Facility's current license number is 0038000. The term of the conditional license shall be from February 8, 2019 to August 7, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON FEBRUARY 8, 2019.

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$25,000.00**, as follows:

- **Type A violation** of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210d)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department;

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation.

Plans of Correction, Hearing and Waiver Requests can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Dated this 8th day of January, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. ALDEN-TOWN MANOR REHABILITATION AND HEALTH CARE CENTER, INC., D/B/A, ALDEN TOWN MANOR REHAB & HCC Respondent.	)))))))))	Docket No. NH 18-C0539

PROOF OF SERVICE

The Conditional License will follow under a separate cover letter.

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Plan of Correction Required; Notice of Conditional License; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Mary Chelotti-Smith
Licensee Info:	Alden-Town Manor Rehabilitation and Health Care Center, Inc.
Address:	4200 W. Peterson Avenue, Suite 140 Chicago, Illinois 60646

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 8th day of January, 2019.

Sammye Geer

Sammye Geer
Administrative Assistant
Long Term Care- Quality Assurance
Office of Health Care Regulations

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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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S9999	Continued From page 4	S9999		

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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S9999	Continued From page 5	S9999		

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		