	T OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
IL6013353		IL6013353	B. WING			C 11/01/2022	
NAME OF PROJECT OF CURE OF			DRESS, CITY, S	DRESS, CITY, STATE, ZIP CODE			
ALDEN 1	TOWN MANOR REHA	B & HCC 6120 WE	ST OGDEN	,			
(1)		CICERO,	IL 60804	<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLET DATE	
S 000	Initial Comments		S 000			. 14	
¥	Investigation of Fa 9/5/2020/IL151620	cility Reported Incident of - F600	+3			11.55	
S9999	Final Observations		S9999	± = •			
(V) ≡.;	Statement of Licen 300.610 300.1210)b 300.3240)a	sure Violation			E E		
g e	Section 300.610 R	esident Care Policies					
	procedures govern facility. The written be formulated by a Committee consist	have written policies and ing all services provided by the policies and procedures shall Resident Care Policying of at least the advisory physician or the	<b>ॐ</b> , •	14 80	# 24	W	
:	medical advisory co of nursing and othe policies shall comp The written policies the facility and shall by this committee,	ommittee, and representatives or services in the facility. The ly with the Act and this Part. Is shall be followed in operating the reviewed at least annually documented by written, signed of the meeting.	2 7	W SES	a e e e e e e e e e e e e e e e e e e e	¥s	
34	Section 300.1210 ( Nursing and Person	Seneral Requirements for nal Care	3	W = 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	5 " =		
T.	and services to atta practicable physica well-being of the re each resident's con plan. Adequate and care and personal of	provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care I properly supervised nursing care shall be provided to each a total nursing and personal			achment A Licensure Violations		

(X6) DATE

Illinois C	Department of Public	<u>Health</u>			FORIV	APPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	IL6013353		B. WING		C 11/01/2022		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADI			DRESS, CITY, STATE, ZIP CODE			
ALDEN '	TOWN MANOR REHA	B & HCC 6120 WES	ST OGDEN 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 CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	age 1	S9999				
	care needs of the r	esident.					
	Section 300.3240 A	Abuse and Neglect				23	
Œ	a) An owner, licens agent of a facility st resident. (Section 2	ee, administrator, employee or hall not abuse or neglect a 2-107 of the Act)	2			= 1	
	These Regulations	were not met as evidence by:					
	failed to prevent an sexual assault, the staff member to proabuse investigation affected 1 of 3 (R1) abuse. This failure grabbed, pulled and (V7), R1 also said	and record review, the facility incident of staff to resident facility also allowed the same ovide care to R1 after the was concluded. This failure residents reviewed for resulted in R1 having his penish scratched by facility staff he felt uncomfortable having or him after this incident.		24 12 12 12 12 12 12 12 12 12 12 12 12 12		**	
	Findings Include:						
±1	be alert and oriente said, V7 (C.N.A.) er rounds to check my open. I had a foley wrapped her hand a lasked V7 what she playing. I told V7, I o (Nurse). I felt uncorincident initially, bed	7pm, R1 who was assessed to d to person, place and time, need my room during normal adult brief. My brief was at the time. V7 (C.N.A.) around my penis and pulled it. e was doing. V7 replied, I'm don't play like that. I told V4 mfortable. I didn't report the cause I was embarrassed. V7 a. V7 still works with me which ortable.			<i>3</i> *		
VX	reported that on 8/1	10am, V4 (nurse) said, R1 1/22, V7 manhandled him and is, he did not describe how V7				# 1 20	

Illinois D	epartment of Public		20		FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A DOILDING	· — — — — — — — — — — — — — — — — — — —		C .	
	[L6013353		B. WING			01/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ALDEN 1	TOWN MANOR REHA	B & HCC 6120 WES CICERO,	ST OGDEN IL 60804		- St 10	F1200
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
S9999	Continued From pa	ge 2	S9999		10	
*** 17. ***	manhandled him. I R1 has never made staff.	reported to V1 (administrator). a false allegation against	۸	*e	S.	
	On 10/27/22 at 4:36 sexual abuse is phy residents perceived	opm, V1 (administrator) said, sical contact that the as inappropriate.	Ja <sup>All</sup>			N.O.
	D.O.N.) said, I woul	8pm, V2 (Director of Nursing, d not have an employee resident working with that	B=			5 7 23
lja:	said, V7 worked wit abuse. V7 worked v	9pm, V3 (Assistant D.O.N.) h R1 after the allegation of vith R1 on 10/12/22, 10/14/22, 10/21/22, 10/24/22, 10/25/22	9.			8.5
33 [2]	be working with R1. R1, if R1 reported h providing care. A sta still working with any allegation of abuse	pm, V1 said, V7 should not V7 should not be work with e felt uncomfortable with V5 aff member accused of abuse y residents that made an would be considered a form of not aware of R1 making false ff.			AL 6	e:
	the room with staff witness other staff p IDPH reportable dat said, his usual cna ( was inappropriate a	ed 9/5/22 document: IL (R1) V7) touched him in a way that and uncomfortable. IL (R1) as "playing with his penis."		â	.E	
123	affirms the right of o	9/20 documents: The facility ur residents to be fee from e is non-consensual sexual	94			E- 700

Illinois Department of Public Health

PRINTED: 01/06/2023 FORM APPROVED

	<u> Illinois C</u>	Department of Public					FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
ļ	IL6013353		B. WING	i-dis-			C 01/2022	
l	NAME OF PROVIDER OR SUPPLIER STREET ADD			DDRESS, CITY	, STATE, ZIP CODE		117	01/2022
ALDEN TOWN MANOR REHAB & HCC 6120 WEST OGDEN CICERO, IL 60804								
	(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPE	D BE COMPLETE	
l	S9999	Continued From pa	ge 3	S9999	D <sub>e</sub>		Ž.	5
	1.0	contact of any type with a resident. This includes, but is not limited to, sexual harassment, sexual coercion or sexual assault. Mental Abuse includes, but is not limit to, humiliation, harassment and threats of punishment or deprivation. Mental abuse may occur through either verbal or nonverbal contact which has the			00			
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		potential to cause the	ne resident to experience tion, fear, shame, agitation or		i i	10		STI .
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