STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003529	A. BUILDING: _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEDO REHAB & HEALTH CARE CENTER	304 S.W. 12TH STREET ALEDO, IL 61231

(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 FRI of 7/27/2023/IL162667	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6 300.3210t) 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. Section 300.1010 Medical Care Policies 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	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003529	A. BUILDING: _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEDO REHAB & HEALTH CARE CENTER	304 S.W. 12TH STREET ALEDO, IL 61231

(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
S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These Requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to adequately supervise a resident (R2) with a known history of wandering to prevent them from attempting to enter a resident's room for one of four abuse allegations reviewed. This failure resulted in R2 being pushed by R1 when R2 attempted to enter R1's room. R2 fell and obtained a comminuted mildly displaced fractures of the left superior and inferior	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003529	A. BUILDING: _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEDO REHAB & HEALTH CARE CENTER	304 S.W. 12TH STREET ALEDO, IL 61231

(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
S9999	Continued From page 2 pubic rami. Findings include: The facility assessment, dated 1/10/23, documents, "The IDT (Interdisciplinary) will meet and identify any new needs or resources needed to provide care and support for the person (resident)." The assessment also documents, "The facility provided various services for the residents we care for. The residents' care is based on their individual needs and preferences and are reflected in the individuals care plan. General care: Mental Health and Behavior. Specific Care or Practices: Manage the medical conditions and medication-related issues related to dementia and those causing psychiatric symptoms and behavior, identify and implement, interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities." 1. On 8/14/23 at 10:55 a.m., R2 was self propelling herself down the hallway aimlessly with no staff present. R2's Behavior Care plan, dated 7/21/22, documents, "R2 known to wander may seek to leave home. Related diagnosis include memory loss. R2 has periods of forgetting where she is causing her to want to leave the facility. R2 can be easily redirectable from staff cues." R2's Psychosocial Assessment, dated 7/21/23, documents that R2 exit seeks, wanders, paces, and enters bedrooms uninvited four to six times in a seven day timespan.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003529	A. BUILDING: _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEDO REHAB & HEALTH CARE CENTER	304 S.W. 12TH STREET ALEDO, IL 61231

(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
S9999	Continued From page 3 R2's Elopement Evaluation, dated 7/22/23, documents that R2's has an inability to identify safety needs, has altered perception of awareness leading to seeking exit/escape, her level of agitation has required supervision, and she wanders in the vicinity of exit doors. R2's ED Physician notes, dated 7/27/23, document, "R2 brought in by paramedics after she was reportedly pushed by another resident of the nursing home and sustained ground level fall with subsequent left hip pain." R2's Pelvis and Lateral Hip left Final Report, dated 7/27/23, documents, "Indication: Ground Level fall with left hip pain. Impression: Comminuted mildly displaced fractures of the left superior and inferior pubic rami." R2's Hospital Discharge Instructions, dated 7/27/23, document, "Your diagnoses from this visit: Closed pelvic fracture, hip pain-swelling, Unspecified dementia severe with agitation, Urinary tract infection." The facility's Final Report to the State Agency, dated 8/1/23, documents, "R2 has a history of wandering into other rooms. V1 (Administrator in Training) was notified by V3 (Care plan coordinator) that R1 shoved R2 causing R2 to land on her left hip and left arm. R2 was complaining of left hip pain. R2 was sent to the Emergency Room for evaluation and treatment. After further investigation it was determined that R1 was walking out of his room while R2 was walking in. R1 lightly shoved R2 with his left hand in the shoulder area causing R2 to lose her balance and land on her left side and left arm. R1 stated that he did not mean for her to fall and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003529	A. BUILDING. _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEDO REHAB & HEALTH CARE CENTER	304 S.W. 12TH STREET ALEDO, IL 61231

(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
S9999	Continued From page 4 that he was moving her out of his way so he could leave his room, because he was going out and she was going in. R2 returned to the facility with a pelvic fracture." V4's (Occupational Therapy Assistant) written statement, dated 7/27/23 at 3:45 p.m., documents, "I was walking out of the bridges unit on west side of building when I noticed (R2) walk up to (R1's) door. (R1) was standing at his doorway at that time. He shoved (R2) with his left hand on her right shoulder area. (R2) landed on her left hip and left arm. I asked (R1) why he pushed her. He said because she was coming in and I was going out." On 8/10/23 at 9:45 am, V7 (CNA-Certified Nursing Assistant) stated, "She was an independent ambulator who would wander in the hallways. Since the incident, she's now in a wheelchair, and self propels wandering throughout the halls." On 8/10/23 at 10:15 am, V6 (Dementia Unit Coordinator) stated, "I was here that day and heard (R2) screaming. I was in the dining room and when I went out she was sitting outside of (R1's) room. He had pushed her and she fell. She would wander and enter rooms at times especially if she was looking for a bathroom." On 8/14/23 at 10:00 a.m. V4 stated, "That day I was leaving the unit after treating a patient. (R1) was standing in his doorway. R2 was wandering in the hallway, like she always does, in the direction of his room. When she got to the area around his room, she turned left and started walking towards him. She started to enter his room and his personal space, and he put his left hand out and pushed her. She isn't very steady	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003529	A. BUILDING: _____ B. WING _____	C 08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEDO REHAB & HEALTH CARE CENTER	304 S.W. 12TH STREET ALEDO, IL 61231

(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
S9999	Continued From page 5 as it is. So when he pushed her she fell to the floor onto her left side." On 8/14/23 at 12:40 p.m., V5 (Social Services Director) stated, "(R2) is a wanderer. We try to keep in common areas and redirect her if she is wandering." On 8/14/23 at 1:30 p.m., V11 (CNA) stated, "(R2) wanders constantly and goes into other resident's rooms. Some of them get pretty upset with her when she goes into their rooms." (A)	S9999		