STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145403	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Poplar Creek Rehab & Hcc	1545 Barrington Road Hoffman Estates, IL 60169

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on interview and record review, the facility failed to honor the decisions of a hospice resident's health care Power of Attorney for 1 of 3 residents reviewed for rights exercised by a resident's representative in the sample of 3. The findings include: R1's facility care plan, dated [DATE], showed R1 was under hospice care due to her diagnoses of senile degeneration of the brain, cerebral atherosclerosis, and dementia. R1 was severely cognitively impaired and dependent on staff for cares. The plan showed, Coordinate care and services between facility caregivers and hospice company to ensure all resident needs are met . Obtain advanced care planning wishes of patient and family and incorporate them into the plan of care . R1's Power of Attorney for Health Care form, dated [DATE], showed V10 (Family of R1) was R1's healthcare Power of Attorney (POA). The form showed R1 authorized V10 to make decisions for R1 when R1 could no longer make decisions for herself. The form showed R1 did not want any treatment to prolong her life, but wanted treatment to ensure comfort and no pain. R1's POLST form (Practitioners Orders for Life-Sustaining Treatment), dated [DATE], showed R1 was a DNR (do not resuscitate). R1's facility progress note, dated [DATE], showed R1 began having difficulty swallowing her medications and food. R1's facility progress note, dated [DATE], showed V10 (POA/Family of R1) requested R1 become NPO (nothing by mouth) due to R1's declining condition and continued inability to swallow food or medications. The note showed R1's hospice provider and V3 (Assistant Director of Nursing/ADON) agreed with V10's request to make R1 NPO. R1's physician order, from V5 (R1's Hospice Physician), dated [DATE], showed an order for R1 to be NPO. A physician order for R1, dated [DATE], showed R1's NPO order was discontinued. An order for R1 to receive pleasure feedings, was noted on [DATE]. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's progress notes, dated [DATE]-[DATE], showed R1's condition continued to decline. R1 expired in the facility, under hospice care, on [DATE] On [DATE] at 12:57 PM, V10 (R1's POA) stated, (R1) started having trouble swallowing on [DATE]. I knew what was coming. She has been on hospice a long time and suffered enough. By Monday ([DATE]), I requested for her to be NPO. She couldn't swallow at all. She was gurgling at that point. She wasn't responding at all. Initially, (V3, ADON) told me she was ok with my request for NPO. On Tuesday ([DATE]), (V3, ADON) tells me (R1) can't be NPO because there is some regulation saying she can't be. (V1, Administrator) tells me she can't be NPO because it's some corporate rule. I told them absolutely not. (R1) is actively dying. I was concerned she would choke if they fed her. I just wanted her to die comfortably. On [DATE] at 12:29 PM, V8 (Registered Nurse/RN) stated, By that Monday ([DATE]), (R1) couldn't swallow at all. We weren't feeding her anyway. (V10, R1's POA) told me she wanted (R1) to be NPO. (V7, Hospice Nurse) told me there was an order to be NPO. The next day, (V3, ADON) said she couldn't be NPO. I don't know why. From Tuesday on, we didn't feed her because she couldn't swallow. On [DATE] at 12:09 PM, V3 (ADON) stated R1's NPO order was discontinued because it was unethical to not feed R1 if R1 wanted to eat. V3 denied she told the NPO order was discontinued because of a regulation. V3 stated she had never reviewed R1's hospice care plan, hospice progress notes, or R1's health care Power of Attorney form. V3 stated she never spoke with V5 (R1's Hospice Physician) about discontinuing R1's NPO order. On [DATE] at 10:15 AM, V7 (Hospice Nurse) stated, Yes, we have written orders for our residents to be NPO if they can no longer swallow and the family requests it. By Monday ([DATE]), (R1) could not swallow at all. Her mouth remained open the entire time and she didn't move her tongue at all. She was actively dying. (V10, R1's POA) wanted an order for her to be NPO, so I got an order from (V5, R1's Hospice Physician) to make her NPO. On Tuesday, I got a message from (V3, ADON) saying (R1) couldn't be NPO, and she must be a pleasure feed. I had no idea why (V3) was saying (R1) couldn't be NPO. We did not discontinue the NPO order; the facility did. On [DATE] at 1:24 PM, V1 (Administrator) stated she had never reviewed R1's hospice care plan, hospice progress notes, or R1's health care Power of Attorney form. V1 stated, I spoke with (V10, R1's POA) one time because she was upset the NPO order was changed. I tried to explain why we wanted pleasure feeds for (R1). We looked at it if as we were starving (R1). She still wanted (R1) to be NPO.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on interview and record review, the facility failed to designate a staff member, or implement a process, to ensure effective, ongoing communication and collaboration between the facility, a hospice resident's Power of Attorney for health care (POA), and the hospice provider. The facility failed to ensure facility staff had access to and reviewed a resident's hospice plan of care and hospice progress notes. These failures apply to 1 of 3 residents (R1) reviewed for care and services of a hospice resident in the sample of 3. The findings include: R1's facility care plan, dated [DATE], showed R1 was under hospice care due to her diagnoses of senile degeneration of the brain, cerebral atherosclerosis, and dementia. R1 was severely cognitively impaired and dependent on staff for cares. The plan showed, Coordinate care and services between facility caregivers and hospice company to ensure all resident needs are met . Obtain advanced care planning wishes of patient and family and incorporate them into the plan of care . R1's Power of Attorney for Health Care form, dated [DATE], showed V10 (Family of R1) was R1's healthcare Power of Attorney (POA). The form showed R1 authorized V10 to make decisions for R1 when R1 could no longer make decisions for herself. The form showed R1 did not want any treatment to prolong her life, but wanted treatment to ensure comfort and no pain. R1's facility progress note, dated [DATE], showed R1 began having difficulty swallowing her medications and food. R1's facility progress note, dated [DATE], showed V10 (POA/Family of R1) requested R1 become NPO (nothing by mouth) due to R1's declining condition and continued inability to swallow food or medications. The note showed R1's hospice provider and V3 (Assistant Director of Nursing/ADON) agreed with V10's request to make R1 NPO. R1's physician order, from V5 (R1's Hospice Physician), dated [DATE], showed an order for R1 to be NPO. A physician order for R1, dated [DATE], showed R1's NPO order was discontinued. An order for R1 to receive pleasure feedings was noted on [DATE]. R1's progress notes, dated [DATE]-[DATE], showed R1's condition continued to decline. R1 expired in the facility, under hospice care, on [DATE] (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:57 PM, V10 (R1's POA) stated the facility did not designate a staff member for her to contact when she had questions about R1's cares. V10 stated, I kept getting inconsistent messages depending on who I talked to. I talked with (V3, ADON). I talked with (V1, Administrator). I talked with (V8, Registered Nurse/RN). (R1) started having trouble swallowing on [DATE]. I knew what was coming. She has been on hospice a long time and suffered enough. By Monday ([DATE]), I requested for her to be NPO. She couldn't swallow at all. She was gurgling at that point. Initially, (V3, ADON) told me she was ok with my request for NPO. On Tuesday ([DATE]), (V3, ADON) tells me (R1) can't be NPO because there is some regulation saying she can't be. (V1, Administrator) tells me she can't be NPO because it's some corporate rule. (R1) was actively dying. I was concerned she would choke if they fed her. I just wanted her to die comfortably. On [DATE] at 10:02 AM, V2 (Director of Nursing/DON) stated the facility had not designated a staff member to act as liaison between hospice, the facility, and V10 (R1's POA). This surveyor asked V2 for access to all R1's hospice visit notes, R1's hospice care plan, and the facility's contract with R1's hospice provider, as none of this information was in R1's electronic medical records, or in a binder in the facility. At 10:33 AM, V2 (DON) stated, We don't have any of (R1's) hospice charting or care plan. I had to request it from hospice. I am still looking for the contract. On [DATE] at 12:29 PM, V8 (RN) stated, By that Monday ([DATE]), (R1) couldn't swallow at all. We weren't feeding her anyway. (V10, R1's POA) told me she wanted (R1) to be NPO. (V7, Hospice Nurse) told me there was an order to be NPO. The next day, (V3, ADON) said she couldn't be NPO. I don't know why. From Tuesday on, we didn't feed her because she couldn't swallow. V8 (RN) stated she was never able to find a hospice binder with R1's hospice charting. V8 stated she had never seen R1's hospice plan of care. On [DATE] at 12:09 PM, V3 (ADON) stated R1's NPO order was discontinued because it was unethical to not feed R1 if R1 wanted to eat. V3 (ADON) denied she told V10 (R1's POA) the NPO order was discontinued because of a regulation. V3 stated she had never reviewed R1's hospice care plan, hospice progress notes, or R1's health care Power of Attorney form. On [DATE] at 10:15 AM, V7 (Hospice Nurse) stated, By Monday ([DATE]), (R1) could not swallow at all. (V10, R1's POA) wanted an order for her to be NPO, so I got an order from (V5, R1's Hospice Physician) to make her NPO. On Tuesday, I got a message from (V3, ADON) saying (R1) couldn't be NPO and she must be a pleasure feed. I had no idea why (V3) was saying (R1) couldn't be NPO. V7 stated the facility had not designated a staff member for her to contact and communicate with in regards to R1's hospice cares. V7 stated she would speak with the nurse caring for R1 on the days she would visit R1. On [DATE] at 1:24 PM, V1 (Administrator) confirmed the facility had to call R1's hospice provider on [DATE] to get copies of R1's hospice charting, including R1's hospice plan of care. V1 (Administrator) stated the facility did not designate a staff member to act as liaison between hospice, the facility, and V10 (R1's POA). V1 stated, Hospice staff will communicate with us when they are here seeing our residents, but we need to make sure we have access to any resident's hospice charting, including the hospice care plan. I spoke with (V10, R1's POA) and tried to explain why we wanted pleasure feeds for (R1). She still wanted (R1) to be NPO. I am not sure if anyone from our Social Services department met with (V10) at all during this time. The Memory Care Director (for R1's unit) resigned a couple of weeks ago. She would normally meet with family. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Hospice Program policy, dated ,d+[DATE], showed, When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms.