STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145453	A. Building B. Wing	04/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace of McHenry Rehab	803 Royal Drive McHenry, IL 60050

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were treated in a dignified manner. This applies to 2 of 3 residents (R1 & R2) reviewed for dignity in the sample of 6. The findings include:On 4/4/26 at 9:31 AM, R1 stated, he was upset at V4 Certified Nursing Assistant (CNA). R1 stated that about a week ago, R1 was in the dining room and asked V4 to help a lady who is [AGE] years old who looked like she was pleading for help and can't speak English. V4 CNA refused to help him or the lady. R1 stated, he couldn't remember the resident's name but knows she lives on the 100 hall, is [AGE] years old, and speaks only Spanish. The facility's census showed a resident on the 100 hall that is [AGE] years old (R2). R1 confirmed that it was the resident, and he just needed to hear her name. He stated, V4 CNA is Spanish speaking as well and that is why he asked her to please help R2 because he couldn't understand what she was saying. V4 CNA told him ?no' and to ask the activity aide (V8) for help and left the dining room. On 4/4/26 at 11:30 AM, V8 activity aide stated, she was in the dining room the day R1 asked V4 CNA for help with R2. V8 was doing an activity with other residents. V4 CNA was bringing another resident to the dining room when R1 asked her to help R2. V4 CNA told him, she was busy and not right now. R1 told her it was very important, R2 needed help, and he didn't understand what R2 was saying. V4 CNA said no and told him to ask V8, for help. R1 said V8 stated, she couldn't help either because she does not know any Spanish and R2 is Spanish speaking only. V4 CNA left the dining room without helping R1 or R2. On 4/4/26 at 10:54 AM, V4 CNA stated, she was taking a resident into the dining room after her shower when R1 asked her if she could help R2. She told R1, she would look for R2's CNA to help her and left the dining room to find R2's CNA. V4 stated, she was suspended for about a week because of the incident. On 4/4/26 at 12:26 PM, V1 Administrator stated, R1 was upset because he asked V4 CNA for help with R2, and V4 refused to help R1 or R2. V1 did give V4 CNA disciplinary action for telling him that she was busy and couldn't help them. V1 told V4 CNA that all residents are everyone's responsibility. V1 said, She had two seconds to see what (R2) needed and she should have asked before leaving.V4 CNA's disciplinary memorandum dated 3/25/26 shows, Description of violation: #12 Discourteous behavior to any resident or visitor. Detailed information of violation/corrective action taken: On 3/25/26, it was reported that a resident requested assistance from staff and did not receive a response from you. Failing to acknowledge or respond to a resident's request for help is considered discourteous and does not meet the expectations for resident-centered care. Policy/Expectation: Staff are required to treat all residents with dignity and respect and to respond to requests for assistance in a timely manner, as outlined in facility policies regarding resident rights and customer service standards. The same memorandum shows, she was suspended for 3 days: 3/29/26, 3/30/26 & 3/31/26. R1's Minimum Data Set, dated [DATE] shows he is cognitively intact. The facility did not provide a policy for dignity. On 4/4/26 at 1:49 PM, V1 Administrator stated they did not have a policy on dignity but the residents do have the right to be treated with dignity as the disciplinary memorandum shows.

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