STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145582	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Naperville	1525 South Oxford Lane Naperville, IL 60565

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to ensure that the CPaP (continuous positive airway pressure) machine was changed every three months, failed to keep CPaP parts from environmental contamination, failed to obtain a physician's order for the use of CPaP machine and failed to change a nasal canula every month.These failures affected 2 of 3 (R1 and R3) residents reviewed for respiratory care in the total sample of 10 residents. Findings include: 1. On 05/26/2026 at 11:13am R3's nose piece of R3's CPaP was on the floor. The green tubing connected to the oxygen concentrator and CPaP machine was dated 10/01/2025. V7 (Certified Nursing Assistant) was present and V7 picked up the nose piece of the CPaP and placed it behind the CPaP machine and stated it should not be on the floor. V7 checked the date on the tubing and stated it was dated 10/01/2025. R3 stated she used the CPaP machine at bedtime.On 05/26/2026 at 11:28am, V2 (Director Of Nursing) stated the nose piece of the CPaP should be in the bag when not in use to lower or prevent the risk infection. Oxygen tubing should be changed monthly to lower or prevent the risk of infection also.On 05/26/2026 at 11:30am inside R3's room, V2 to checked the label on R3's tubing which was connected to the oxygen concentrator and the CPaP. V2 unhooked the green oxygen tubing and stated she was going to change the oxygen tubing. V2 was informed of nose piece being found on the floor and that it was placed behind the CPaP machine. R3's admission Record documented that R3 diagnoses include but are not limited to chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and obstructive sleep apnea. R3's (Active Order As Of: 05/27/2026) was reviewed with no order noted for CPaP machine. R3's MDS (Minimum Data Set) assessment of 5/08/2026 documents that R3 is cognitively intact and does not document the use of the CPaP machine. R3's care plan with a target date of 8/06/2026 documents the use of a CPaP machine and to encourage the resident to use the CPaP. 2. On 05/26/2026 at 11:46am R1was in bed with Oxygen being delivered via a nasal cannula. The Oxygen concentrator setting was 2 liters per minute. V8 (Registered Nurse) checked the nasal cannula label and confirmed that no label was present. V8 stated it should be labeled with the date it was changed so they know when the nasal cannula was changed for infection control. R1's admission Record documented that R1's diagnoses include but are not limited to chronic obstructive pulmonary disease, acute on chronic respiratory failure, acute on chronic congestive heart failure, obstructive sleep apnea, and dependence on supplemental oxygen.R1's (Active Order As Of: 05/27/2026) Order summary report documented, in part Respiratory: change O2 (oxygen) tubing monthly and prn (as needed). Respiratory: oxygen per nasal cannula @ 2 liters per minute continuous every shift. The (10/2025) BIPAP policy and procedure documented, in part BIPAP therapy will be administered by a respiratory therapist, or Nurse upon order of a physician. Care of Bipap unit: 4. Tubing will be changed every 3 months and prn. (as needed). The (09/2020) Oxygen Therapy Devices - Nasal Cannula documented, in part Policy: Oxygen delivered per nasal cannula will be used to prevent or reverse hypoxia and improve tissue oxygenation. Procedure: 2. A nasal cannula will be changed monthly and prn (as needed).

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145582	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Naperville	1525 South Oxford Lane Naperville, IL 60565

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that medications were stored appropriately in the medication cart, medication room, or treatment cart.These failures affected 4 residents (R7, R8, R9, and R10) reviewed for medication labeling and storage and had the potential to affect all 28 residents on one dementia unit on the second floor. Findings include:On [DATE], the census on the second-floor dementia unit was 28 residents.On [DATE] at 12:45 PM, a tour of the unit's medication room and nurses' desk was conducted with V22, a Licensed Practical Nurse (LPN). The drawers at the nurses' station contained the following medications and supplies:(1) Two 1,000 mL bags of 5% dextrose IV solution labeled with R9's name.(2) A box containing several 10 mL normal saline flushes.(3) One expired bottle of multivitamin dietary supplement.(4) A box of Relevca lidocaine 4% pain relief patches labeled with R7's name.(5) A tube of B & C ointment for wound dressing labeled with R8's name.(6) Silicone-faced foam and border sacrum dressing labeled with R10's name.(7) TheraHoney gel.(8) Miconazole nitrate cream USP 2% antifungal cream.R7's Electronic Medical Record (EMR) showed that R7 was admitted to the facility on [DATE] with diagnoses including ataxia, dementia, mood disorder, anemia, chronic pain, and psychosis. As of [DATE], R7 had an active order for a 4% lidocaine patch to be applied topically to both knees each morning for bilateral knee pain, left on for 12 hours, then removed for 12 hours per schedule.R8's EMR showed that R8 was admitted to the facility on [DATE] with diagnoses including dementia, stage 3 pressure ulcer of the left buttock, benign prostatic hyperplasia, history of falling, chronic pain, and senile degeneration of the brain. The EMR also showed that R8 died at the facility on [DATE]. A tube of B & C ointment for wound dressing labeled with R8's name remained in the nurses' station drawer.R9's EMR showed that R9 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, chronic kidney disease, benign prostatic hyperplasia, gout, hypothyroidism, and senile degeneration of the brain. The EMR also showed that R9 died at the facility on [DATE]. Two 1,000 mL bags of 5% dextrose IV solution labeled with R9's name remained in the nurses' station drawer.R10's Electronic Medical Record (EMR) showed that R10 was admitted to the facility on [DATE] with diagnoses including dementia, malignant neoplasm of the prostate, thrombocytopenia, stage 3 pressure ulcer, osteoarthritis, and pancytopenia. A box of silicone-faced foam and border sacrum dressing labeled with R10's name was found in the nurses' station drawer.On [DATE] at 12:47 PM, V22 stated that the 5% dextrose IV bags belonged to a deceased resident and should have been discarded. V22 also stated that all nurses working on the unit are responsible for storing medications in either the treatment cart or the nurses' medication cart.On [DATE] at 3:05 PM, V2, the Director of Nursing (DON), stated that medications are stored in the medication rooms and medication carts. V2 further stated that medications are not stored in residents' rooms or at the nurses' stations and are kept in the medication rooms when not in use.On [DATE] at 12:55 PM, V2 (DON) stated that medications should be kept in the nurses' medication cart, wound treatment cart, or medication room. V2 also stated that some of the medications listed above should have been discarded.Review of the facility policy titled Medication Storage, dated 09/2020, showed: When a resident is discharged , all medications shall be stored in one designated area determined by the facility.Review of the facility policy titled Storage/Labelling/Packaging of Medications, dated 12/2023, showed: Each resident's medications are kept separately from others.