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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Long Grove Rehab &hc Ctr	2308 Old Hicks Road Long Grove, IL 60047

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117 Based on observation, interview, and record review the facility failed to ensure a resident who is dependent on staff for toileting received incontinence care. This applies to 1 of 3 residents (R1) reviewed for activities of daily living in the sample of 3. The findings include: R1's face sheet shows he is a [AGE] year-old male with diagnosis including hemiplegia affecting right dominant side, dysphagia, aphasia, muscle weakness and abnormalities of gait and mobility. On 11/22/24 at 9:30 AM, R1 was lying in his bed, his right arm was drawn into his chest. R1's speech was slow with minimal difficulty expressing his words. R1 said he had a stroke and with right sided deficits. He said he waits a long time to be changed. He said he was changed last on the previous shift. R1 pressed his call light for staff assistance. At 9:40 AM, a staff answered the call light, R1 said he needed the CNA (Certified Nursing Assistant) assistance. R1 was told they would let the CNA know. At 10:00 AM, R1 pressed the call light for the 2nd time. V6 (CNA) entered the room. R1 said he was soiled and needed to be changed. R1's incontinent brief was saturated with urine and large amounts of stool on his bottom. Dry stool was on his incontinent pad. V6 provided incontinence care and stated it's so dirty. V6 changed R1's clothing and assisted him to the edge of the bed. V6 moved R1's wheelchair next to the bed, a streak of dry brown matter was on his wheelchair cushion. V8 (R1's spouse) entered the room, she saw the soiled wheelchair cushion, removed it and said the cushion is soiled with stool. On 11/22/24 at 10:39 AM, V6 said residents should be checked and changed for incontinence care every two hours. V6 said she did not know when R1 was changed last, she had not changed him prior. On 11/22/24 at 10:41 AM, V5 (RN) said staff should remove soiled linen and clean up soiled surfaces. R1's Minimum Data Set assessment dated [DATE], shows he is cognitively intact, has limited range of motion with impairments on one side to his upper and lower extremity and dependent on staff for toileting. R1's care plan dated 8/2024 shows he is incontinent of bowel and bladder; interventions include to provide peri-care with episodes of incontinence.

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