

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  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Alden Long Grove Rehab &hc Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>34314</p> <p>Based on observation, interview and record review the facility failed to ensure a resident with a JP (Jackson Pratt) drain dressing was changed as ordered. This failure resulted in R22's JP drain site not being assessed for 11 days and becoming infected. The facility also failed to change non-pressure dressings as ordered and failed to ensure a resident's elastic wraps were applied to lower legs as ordered. This applies to 3 of 32 residents (R22, R37 &amp; R113) reviewed for quality of care in the sample of 32.</p> <p>The findings include:</p> <p>1. On December 2, 2024 at 9:20 AM, R22 was lying in bed. He had a tube with a bulb hanging from his stomach. He stated, that was his JP drain because he needed his gallbladder out. He showed this surveyor the dressing on the drain. The dressing was dated November 21, 2024 (11 days prior). He stated, no one does anything with it. They don't change the dressing or empty it. He empties it himself.</p> <p>On December 3, 2024 at 2:09 PM, V5 (Wound Care Nurse/WCN) was changing R22's dressing to his JP drain. The dressing was still dated November 21, 2024 (same dressing as the day before). She removed the dressing from the drain. The dressing was heavily soiled with a bloody drainage. The site around the tube had crusted dried blood on it, had an odor, was red and tender to touch. V5 (WCN) verified that R22's orders were to be changed daily and it should be done by the staff nurses.</p> <p>R22's progress notes dated December 3, 2024 by V5 (WCN) shows, Pt. (patient) cooperative at this time. Was able to change JP drain dressing. SI. (slight) erythema (redness) to incisions side and few stitches, in place. No s/s (signs and symptoms) of inf. (infection) T dressing applied as ordered post ns (normal saline) cleanse. Pt. nurse at bed side, will monitor erythema. Tx. (treatment) order changed to daytime 11am per pt. request.</p> <p>R22's treatment administration record (TAR) for November and December 2024 shows, JP drain site-cleanse with normal saline, pat dry, cover with T-dressing and secure with tape. The order was signed out every day that the site was assessed and the dressing was changed. The same record did not show, R22 refused or the nurses did not change the dressing.</p> <p>On December 4, 2024 at 11:29 AM, V5 (WCN) stated, she re-assessed R22's JP drain site. The skin around his tube/drain was red and had edema (swollen). She called the doctor and got an order for bacitracin cream (antibiotic ointment) to be applied with the dressing changes.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R22's progress notes dated December 4, 2024 shows, JP drain site assessed with pt. nurse. Assessed with sl. erythema and serosang. (bloody) exudate (drainage). (V11 Nurse Practitioner/NP) made aware with new orders for daily bacitracin (antibiotic ointment) and ca (calcium) alginate and cover with T dressing daily and PRN (as needed).</p> <p>On December 4, 2024 at 11:42 AM, V11 (NP) stated, yes, possibly the staff not changing the dressing or assessing the JP drain site for 11 days could result in needing an antibiotic ointment to the site.</p> <p>R22's physician orders shows, Bacitracin Ointment 500 UNIT/GM (gram) (Bacitracin (Topical), Apply to JP drain site topically one time a day for Skin Condition CLEANSE AREA W/NS (with/normal saline), PAT DRY, APPLY OINTMENT, ca (calcium) alginate and COVER W/T DRSG (dressing) and secure with tape. AND Apply to JP drain site topically as needed for skin condition CLEANSE AREA W/NS, PAT DRY, APPLY OINTMENT, ca alginate and COVER W/T DRSG and secure with tape.</p> <p>R22's electronic medical record did not show any non-compliance/refusals by R22 for dressing changes to the JP drain site.</p> <p>The facility's Jackson Pratt drain care policy dated September 2020 shows, Policy: A Jackson Pratt drain (or grenade drain) will be cared for to prevent incision complications.</p> <p>45540</p> <p>2. On 12/2/2024 at 12:36 PM, R37 was observed sitting up in her room in her wheelchair with a dressing wrapped around her head. R37's dressing had brownish colored drainage on the left side of her head, approximately dime sized. R37 said her dressing was last changed on Friday (11/29/2024) by the wound care nurse. R37 said her dressing doesn't always get changed on the weekends, but the wound care nurse changes it during the week.</p> <p>On 12/3/2024 at 1:30 PM, V6 (Registered Nurse/RN) said R37's dressing change is done daily and as needed. V6 said the nurse or wound care nurse should be doing the dressing changes. V6 said the primary nurse is responsible for the dressing changes on the weekends. V6 said the nurse should document when the dressing change is done or if the resident refuses the dressing change.</p> <p>R37's Treatment Administration Record (TAR) dated 11/1/2024 - 11/30/2024 shows an order for Collagen Micro Scaffold Wound Dressing 4.25 x 4.5 pad (Puracol Plus) Apply to scalp topically every day shift for skin condition related to unspecified open wound of scalp, initial encounter cleanse area w/ns, apply collagen/adaptic, 4x4 and cover with kerlix, order date 10/11/2024.</p> <p>R37's TAR has no documentation listed on 11/16/2024, 11/17/2024 and 11/23/2024, indicating if the dressing change was completed by the nursing staff.</p> <p>The facility provided Prevention and Treatment of Pressure Injury and Other Skin Alterations policy dated 3/2/2021 states, . Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan.</p> <p>33760</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	<p>3. R113's Physician Order Sheet (POS) dated 12/24 shows R113 has diagnoses that include diabetes mellitus with diabetic neuropathy. The same document shows R113 with an order of ace wrap or tubi grip to right foot on in am off at night with an order date of 8/29/24.</p> <p>On 12/2/24 at 1 PM, R113 was sitting in her wheelchair in her room alert and pleasant. R113 said she has neuropathy, this hurts pointed to her legs, pulled her pants up. Both of R113's lower legs were noted to be swollen. no tubigrip or ace wrap was noted.</p> <p>On 12/3/24 at 12:00 PM, R113 was in her room sitting in her wheelchair. R113 showed this surveyor her lower legs again and said still no tubigrip and acewrap noted to her right lower legs.</p> <p>Review of R113's Treatment Sheet for November and December 2024 show R113's tubigrip was being applied.</p> <p>V7 (Registered Nurse/RN) said she does not know why R113's treatment sheet was being signed (with initials) as applied but obviously R113 does not have her tubigrips on.</p> <p>At 12:10 PM, V7 (RN) said ace wrap or tubigrip are applied normally on night shift before the resident gets up. V7 then asked R113 if she wanted her tubigrip on, R113 responded of course I need that. V7 said R113 needs her tubigrip to help decrease her leg swelling. V7 said she will apply the tubigrip now.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>33760</p> <p>Based on observation interview and record review the facility failed to ensure a device was applied to a contracted hand for 1 of 6 residents (R24) reviewed for range of motion in the sample of 32.</p> <p>The findings include:</p> <p>R24's Physician Order Sheet (POS) show R24 has diagnoses of respiratory failure with tracheostomy.</p> <p>R24's facility assessment show R24 has no cognitive impairment. R24 has trach but able to verbalize her needs by mouthing off her words clearly.</p> <p>On 12/2/24 at 11:30 AM, R24 was sitting in her bed, R24's left hand was in a closed tight fist position. A splint was noted by her bedside still in plastic and another splint by her wheelchair. V8 (Registered Nurse) came to R24's room and tried to apply the splint. Then V8 (RN) went to check R24's medical record. V8 said R24's POS did not show any direction regarding when to wear the splint.</p> <p>On 12/3/24 at 10 AM, R24 said no one exercises her hand and now it was hard to open her left hand.</p> <p>R24's progress notes dated 11/26/24 by V10 (Physician Assistant) shows, Left hand contracture . OT to provide with L (left) resting WHO (wrist hand orthotic).</p> <p>On 12/3/24 at 10:30 AM, V9 (Restorative Director) said she was made aware of R24's declined range of motion to her left hand last week. V9 said she went to speak to R24 and R24 agreed to wear a splint to her left hand. V9 said R24's left hand splint should be applied daily.</p> <p>The order written on 12/3/24, shows, splint to left hand, apply in the morning remove in the evening, may remove during ADL and care.</p> <p>The facility policy entitled Restorative Nursing Program dated 3/10/22 show, It is the policy of this facility that a resident is given appropriate treatment and services to enable residents to maintain or improve his or her abilities and to promote the residents ability to adapt and adjust to living as independently and quality as possible. Increased independence fosters self-esteem and promotes quality of life for residents.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>45540</p> <p>Based on observation, interview, and record review the facility failed to label a resident's tube feeding in accordance with professional standards of nursing. This applies to 1 of 3 (R100) residents reviewed for tube feeding in the sample of 32.</p> <p>The findings include:</p> <p>On 12/2/2024 at 11:33 AM, R100's tube feeding bag was observed hanging on the pump with a brownish colored solution in the bag, connected to the resident, with no label indicating what type of tube feeding solution was being administered to the resident at that time.</p> <p>On 12/2/2024 at 11:55 AM, V7 (Registered Nurse/RN) said the tube feeding bag should be labeled. V7 said R100 has an order for tube feeding for Diabetisource tube feeding supplement.</p> <p>On 12/4/2024 at 9:16 AM, V7 said we label the tube feeding bag because we are using the cans or canisters of tube feeding.</p> <p>R100's Order Summary Report as of 12/2/2024 states, Enteral Feed Order every shift for nutritional supplement Diabetisource 1.2 at 60mL/hr (milliliters/hour) total volume to infuse 900ml/day, to start at 7PM.</p> <p>The facility provided Enteral Nutritional Feeding policy dated 9/2020, states . label bag/container with name, date, time.</p>

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<p>F 0777</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.</p> <p>34314</p> <p>Based on observation, interview and record review the facility failed to ensure an x-ray was obtained in a timely manner for a resident with an acute injury. This applies to 1 of 1 residents (R128) reviewed for radiology results in the sample of 32.</p> <p>The findings include:</p> <p>On December 2nd, 3rd &amp; 4th, 2024, R128 was observed at various times up in her wheelchair in the dining room. She had a soft cast on her right wrist.</p> <p>R128's post occurrence documentation dated October 31, 2024 shows, Description of occurrence : Writer was doing evening med (medication) pass down the hallway from residents room when noted resident ambulating with unsteady gait near room doorway. Writer immediately went towards residents room but resident lost balance and fell on her right side when nurse was about 4 feet away. Head to toe assessment done, witnessed resident not hit her head, fell on her right side, ROM (range of motion) intact to baseline, LOC (level of consciousness) intact to baseline, resident c/o (complained of) pain to right wrist, no other complaint of pain or discomfort, able to move bilateral legs and bilateral arms without problem. No SOB (shortness of breath) noted, in no distress. No bumps, no scrapes nor new bruising from fall present on either scalp or skin upon assessment. Resident was assisted back into wheelchair with the use of a gait belt and 2 person assist. Local on-call doctor was contacted with orders for XR (x-ray) to right wrist 2-3 views and neuro (neurological) checks for precaution.</p> <p>R128's physician order dated October 31, 2024 shows, an x-ray ordered to right wrist due to a fall at 6:29 PM.</p> <p>R128's actual x-ray films show the x-ray of her right wrist was done on November 1, 2024 at 8:42 PM (26 hours and 13 minutes after being ordered). The facility did not get the results of the x-ray until November 2, 2024 at 11:34 AM (approximately 14 hours later).</p> <p>On December 3, 2024 at 1:29 PM, V2 (Director of Nursing) stated, she did not know why it took that long to get an x-ray done. X-rays are done within 24 hours if not ordered STAT (immediately).</p> <p>The facility's laboratory/radiology (x-ray) services policy dated September 2020 shows, Policy: Clinical laboratory and radiology services to meet the needs of our residents are provided by our facility. Procedure: 2. The following diagnostic services are available twenty-four (24) hours a day, seven (7) days a week, including holidays: .radiology .</p>		