STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145998	A. Building B. Wing	07/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Des Plaines Rehab & Hc	1221 East Golf Road Des Plaines, IL 60016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 40515 Based on interview and record review, the facility failed to follow physician orders for one resident (R1) in the sample of three. This failure resulted in (R1's) medications not being placed on hold and delay in scheduled surgery. Findings include: R1's diagnosis includes: Acquired Absence of Left Leg Below Knee, Chronic Osteomyelitis with draining sinus, Left Tibia and Fibula, Type 2 Diabetes Mellitus with proliferative Diabetic Retinopathy, Essential (Primary) Hypertension, Anemia Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Long Term (Current) Use of Insulin, Peripheral Vascular Disease, Unspecified R1's BIMS (Brief Interview of Mental Status) dated 7/6/2024 documents score of 15 (cognitively intact). R1's After Visit Summary dated 6/14/2024 at 10:34 am (in part) Today's Visit R1 saw doctor. June 14, 2024 for Pre-Op Exam What's next: June 21, 2024 Revision Below Knee Amputation, Preoperative Instructions You may be also be instructed to stop certain medications 5-7 days prior to surgery and that will also be specified. Additional instructions include: Surgery Med List Medication Multivitamin (Multiple Vitamins) PO tablet Hold prior to surgery For 7 days, ferrous sulfate 325 mg (65mg iron) PO enteric coated tablet Hold prior to surgery For 7 days, aspirin (EC) 81 mg PU TbEC enteric coated tablet Hold prior to surgery For 7 days, IBUprofen (Motrin) 200 mg PO tablet Hold prior to surgery For 7 days, clopidogrel (PLAVIX) 75 mg PO Hold prior to surgery For 7 days R1's June 2024 MAR (Medication Administration Record) documents the following medications given and not put on HOLD as ordered 7 days prior to surgery date of June 21, 2024 Aspirin (EC) 81 mg PU TbEC enteric coated tablet given 6/14/2024 thru 6/20/2024 and not put on hold until 6/21/2024 Clopidogrel (PLAVIX) 75 mg PO given 6/14/2024 thru 6/20/2024 and not put on hold until 6/21/2024 Multivitamin (Multiple Vitamins) PO tablet given 6/14/2024 thru 6/21/2024 and not put on hold until 6/22/2024 IBUprofen (Motrin) 200 mg not put on hold until 6/22/2024 (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ferrous Sulfate 325 mg (65 mg iron) PO enteric coated tablet given 6/14/2024 thru 6/21/2024 (morning dose) and not put on hold until 6/21/2024 evening dose R1's Order Summary Report dated Active Orders as of 6/1/2024 (in part) documents does not document any medications to be put on hold. R1's Progress Notes dated 6/20/2024 10:02 documents (in part) Type: Nurses Note Received order from V14 (Surgeon) to hold aspirin and Plavix for 5 days pre op for his upcoming procedure Author (V10 LPN) R1's Order Details dated 6/14/2024 documents (in part) Follow Up Appointment with V14 (revision below knee amputation) 6/21/2024 R1's Appointment Month: June documents (in part) R1's date/pick up time 6/21/2024 4:45 am with V14 7 am, canceled. R1's rescheduled appointment 6/25/2024 pick up 8:30 am with V14 (surgery) 11 am On 7/12/2024 at 2:30 pm, V8 (RN) stated, he has taken care of R1 and R1 is able to make needs known and lets you know if he needs anything. Surveyor asked V8 if R1 brings after visit summary to nurse when R1 returns from medical visits. V8 stated, Yes he always gives us the report. R1 needs little help and can verbalize his care needs. I did not take care of him on 6/14/2024 when he came back from his doctor's visit. On 7/12/2024 at 3:03 pm, V4 (LPN) stated, I am familiar with him. I remember his doctor visit. I believe he had an appointment in June, I sent him out for the day to appointment and he came back with paperwork that I entered into the system as ordered. He had a couple of dates for surgery and different medications to hold. The appointments mostly were for July and I had to hold medications a week prior to July. I put in meds to be held and as far as I know they were put in to be held. V3 (Assistant Director of Nursing - ADON) was assisting me in putting the meds (medications) in on hold. I am not sure if he had surgery, nothing was brought to my attention, but I do believe he had the surgery since then. I believe the med hold was either for 7 days or 14 days depending on which one I was looking at but most between 7 and 14 days. I have not heard anything else about it. R1 is pleasant and able to make his needs known. Surveyor asked V4 if she reviewed the after-summary visit for R1 for 6/14/2024. V4 stated, Yes, R1 gave me the paperwork and I reviewed the after-visit summary. On 7/12/2024 at 3:18 pm, surveyor asked V3 who gets paperwork when resident goes to the doctor and returns with paperwork and orders. V3 stated, the floor nurse. V3 stated, we keep the original and if the resident requests a copy we give them a copy. I am familiar with R1. The nurse (V4) had R1's summary for 6/14/2024. The nurse was V4. We put in whatever orders were on the paperwork in the system. Surveyor asked, were there medication orders that needed to be put in. V3 stated, Yes, meds needed to be put on hold. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/12/2024 at 3:35 pm, V3 stated, I reviewed the after-visit summary with V4. When we get the after-visit summary, the nurse will put in the orders. Surveyor asked, were R1's medications put in to be held 7 days prior to 6/21/2024 surgery date. V3 stated, I did not know revision meant surgery. He was to have revision. I (V3) just showed the nurse (V4) how to hold medications. Surveyor asked when should R1's medications been held? V3 stated, 7 days prior to surgery. Medications should have been held 7 days prior to 6/21/2024 which would be 6/14/2024. We put the orders in and followed the papers. If there are any questions regarding the after-summary visit, the nurse would call the clinic. Surveyor asked, was R1's surgery delayed. V3 stated, it was rescheduled. On 7/12/2024 at 4:18 pm, V3 stated, orders stated put on hold 7 days prior to surgery and the surgery was scheduled for June 21, 2024. Surveyor asked V3, when were R1's medications actually put on hold. V3 stated, 6/21/2024 5 days prior to rescheduled surgery of 6/26/2024. V4 actually put in the orders, I showed V4 how to put in the orders. I showed her how to put medications on hold. I looked at orders for hold 7 days prior to surgery. I am not sure how it was put in for July 18. I am not sure how this was found out. The nurse is supposed to read through the after-visit summary when they receive it and place orders that are ordered. On 7/12/2024 at 4:26 pm, V2 (Director of Nursing - DON) stated, I am familiar with R1, he voiced a concern the latter part of June. R1 wanted to know who was on shift I believe, Friday June 14, 2024. He wanted the name of the nurse and ADON. I went to go look and asked R1 what was going on. He said they made a mistake and I would like to speak to them. I (V2) believe R1 spoke to them (V3 and V4). I followed up with R1 to see if he still had concerns. R1 said no and thanked me. Surveyor asked V2 did you hear about his surgery being delayed. V2 stated, I was on a call the following week and he was going to go out on 6/25 pre-op so when I saw this I saw the date was different. My understanding is that the medications were not held in time. The order stated 7 days so they had to obtain another order so they held for 5 days for him to have the revision. His scheduled surgery was rescheduled because the medication was not held. The process from appointment is the resident brings us the after care summary. We check to see if any orders for labs or diagnostics and put in medical record then put in scan box where document is ultimately uploaded. We ask for paperwork. Sometimes the resident will not tell us and hold onto it. We do not have access to hospitals records. R1 notified V10 the nurse on the next shift. He let her (V10) know I think they gave me my medication; I don't know if you know. V10 then called the doctor, rescheduled, and got orders of what to hold prior to surgery. That is when I became involved in the situation. I asked R1 why he did not relay this to me. He said V10 handled it and I did not need to talk to you. R1 did not give the nurse any paperwork, he presented it after. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/13/2024 at 9:47 am, V10 (LPN) stated (in part), I am familiar with R1. He used to be on my side. R1 always goes to his appointment at local hospital. R1 makes his own appointments and when he comes back, he always gives me the paper. When we get the paper, we must identify if there is any order and then carry out the order because the doctor will sometimes give an order. We keep a copy and they will usually upload it. The documents go to MISC. I (V10) heard that he was supposed to have meds held when R1 came back from appointment. I was not here on Friday; I am off on Friday. I am not sure what really happened. V10 further stated, after a few days, actually one day prior to scheduled surgery he (R1) told me that he had a scheduled surgery. I told R1 his medication was not held. R1 stated, he would call the doctor himself. I then got a call from the doctor. The doctor told me to hold his aspirin and Plavix for 5 days and they would reschedule the surgery. The process if R1 will bring his summary and the nurse, reviews it to see if there is an order. June 21st was the surgery so we should be holding the meds 7 days prior to surgery. R1 told me it is supposed to be held. I told R1, I only can start today so we have to talk to the doctor. R1 messengered his doctor and the doctor called me back. Under the POS (Physician Order Summary) there is an option to hold and for how many days. R1 always brings back paperwork to us, but if there is nothing new, he will tell me no new order, but he will always give us the paper. I review it to see if there is a new order. The floor nurse is responsible for putting in any new orders from residents visit to doctor. V10 stated, I am not sure, but I think the only order that I saw in the computer was the eye appointments. The doctor just said to hold for 5 days and they would reschedule the surgery. I did not check to see if anything was scanned in the computer. I saw the appointments. The only way to know R1 had any appointments is from looking at the after-visit summary and putting it in record. R1 is very knowledgeable about his care. On 7/13/2024 at 11:26 am, Surveyor asked V2 what the process is when a resident returns from an outside appointment. V2 stated (in part), if the resident is going out on a scheduled visit, normally the nurse will put in a progress note. If going out for a procedure will discharge resident then readmit when resident returns to the facility. Paperwork orders will be entered and documents scanned under miscellaneous. For that appointment (R1's appointment on 6/14/2024) it is an old document, it has not been scanned in R1's chart. Surveyor asked V2 when a resident goes to an appointment, is the after-visit summary scanned into the Electronic Medical Record (EMR). V2 stated, We are supposed to scan in the after-visit summary after each visit. Orders were placed by the nurse on 6/17/2024. R1 did not give us any paperwork. Surveyor asked V2 if R1 has active orders on the 6/14/2024 summary how do you know when R1 has other appointments. V2 stated, We put the order in, it is on the POS (Physician Order Summary). Surveyor asked V2 did that come from the after-visit summary. V2 stated, we did not get the after-visit summary until 6/17/2024 from R1. On 7/13/2024 at 12:11 pm, V12 (Scheduling Coordinator) stated (in part), on 6/21/2024 R1 had a doctor's appointment but it was canceled then rescheduled for 6/25/2024.The nurses get the paperwork and they send me a message in EMR telling me when the resident has an appointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Policy Description Title Staff Nurse (Registered Nurse/License Practical Nurse) dated 1/2015 documents (in part) I. Job Summary Responsible to provide direct nursing care to the customer, and to supervise the day-to-day nursing activities performed by the nursing assistants. Such supervision must be in accordance with current Federal, State, and local standards, guideline and regulations facility policies. The objective is to endure the highest degree of quality care is maintained at all times. II. Qualifications F. Must possess the ability to make independent decisions when circumstances warrant such action. IV. Essential Functions C. Assume all Nursing procedures and protocols are followed in accordance with established policies. N. Place orders for medications and treatments as necessary V. Perform routine charting duties as required and in accordance with out established Charting and Documentation Policies and Procedures X. Prepare and administer medications and treatments if appropriate as ordered by the physician. Y. Review medication record for completeness of information, accuracy in the transcription of the physician's order, and adherence to stop order policies. BB. Arrange for diagnostic and therapeutic services, as ordered by the physician.