

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145998	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2025
NAME OF PROVIDER OR SUPPLIER Alden Des Plaines Rehab & Hc		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 East Golf Road Des Plaines, IL 60016	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to provide incontinence care to dependent residents in a timely manner. This deficiency affects two (R1 and R4) of three residents reviewed for Activity of daily Living (ADL)-Incontinence care.</p> <p>Findings include:</p> <p>R1</p> <p>On 5/13/25 at 10:20AM, Surveyor requested skin assessment for R1. Observed V5 WCN (Wound Care Nurse) and V10 CNA (Certified Nurse Assistant) repositioned R1 to side lying position. Observed disposable brief soaked with urine and leaked through the cloth pad underneath her. Observed V10 provided incontinence care to R1. Observed V10 did not change her gloves after cleaning peri anal area and sacral area of R1. V10 took clean disposable brief and applied to R1 with the same gloves.</p> <p>On 5/13/25 at 10:22AM, V11 Agency CNA said that he is assigned to both R1 and R4. V11 said that he has not provided incontinence care or morning care to both residents. V5 WCN said that CNAs should check dependent resident for incontinence every 2 hours.</p> <p>R1 was admitted on [DATE] with diagnosis listed in part but not limited to Traumatic subdural hemorrhage with loss of consciousness, Respiratory failure, Tracheostomy, Gastrostomy, Moderate protein calorie malnutrition, Encephalopathy, Contractures of muscle right upper arm, Mild neurocognitive disorder. Comprehensive care plan indicated: She has an ADL (Activity of daily living) functional performance deficit related to muscle weakness, impaired balance, incontinence, impaired memory, and underlying medical conditions. Intervention: Provide incontinence care/toileting needs as needed. Bowel and Bladder incontinence. Intervention: Provide peri care with episodes of incontinence.</p> <p>R4</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145998
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/13/25 at 10:33AM, Surveyor requested skin assessment for R4. V10 CNA and V11 CNA repositioned R4 to side lying position. Observed R4 soaked with urine with fecal matter on the disposable brief and rectal area. Observed V10 provided incontinence care to R4. Observed V10 did not change her gloves after cleaning peri anal and sacral area of R4. She took clean disposable brief and applied to R4 with the same gloves. Informed V10 of observation made during incontinence care of using same gloves between soiled and clean briefs for R1 and R4. V10 then changed her gloves and donned on new pair of gloves without hand hygiene. Informed V10 of observation made that she failed to perform hand hygiene before donning new pair of gloves.</p> <p>R4 was admitted on [DATE] with diagnosis listed in part but not limited to Chronic respiratory failure with hypoxia, Tracheostomy, Gastrostomy, Type 2 Diabetes Mellitus, Hand contractures, Muscle weakness, Incontinence without sensory awareness, Encephalopathy, Parkinson's Disease. Comprehensive care plan indicated: She has an ADL functional performance deficit related to underlying medical conditions. Intervention: Provide incontinence care/toileting needs as needed. Bowel and Bladder incontinence. Intervention: Provide peri care with episodes of incontinence.</p> <p>On 5/13/25 at 1:38PM, Informed V1 Administrator and V2 DON (Director of Nursing) of above observations and concerns. Requested for policies.</p> <p>Facility unable to provide policy for Activity of daily Livings and Incontinence care procedure guidelines.</p> <p>Facility's policy on Routine checks 9/2020 indicated:</p> <p>Policy interpretation and implementation:</p> <ol style="list-style-type: none"> 1. To ensure the safety and well-being of our residents, a resident check will be made at least 2 hours throughout each 24-hour shift by nursing service personnel. 2. Routine resident checks involve entering the resident's room to determine if the resident's needs are being met. If there has been a change in the resident's condition, if the resident has any complaints, if the resident is sleeping, needs toileting assistance, etc. 		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to implement its preventive measures and appropriate treatment modalities for skin impairment. The facility also failed to avoid multiple layers of linens when using low air loss mattress as manufacturer's recommendation. This deficiency affects all three (R1, R4 and R5) reviewed for Wound Care Prevention Management.</p> <p>Findings include:</p> <p>R1</p> <p>On 5/13/25 at 9:48AM, Observed R1 lying in bed with LAL (Low air loss) mattress. She is awake but no verbal response. She has bilateral hand splint and heel protector. She receives enteral feeding via GT (Gastrostomy Tube) connected to feeding pump. Her call light is away from her, placed on bedside dresser. V2 DON (Director of Nursing) lifted the top linen and observed cloth pad and flat sheet over the LAL mattress. R1 is wearing a disposable brief. V2 said that R1 should only have flat sheet over the mattress. V2 said resident on LAL mattress should only have flat sheet over the mattress as manufacturer recommendation.</p> <p>On 5/13/25 at 10:10AM, V5 WCN (Wound Care Nurse) said that R1 acquired MASD (Moisture Associated Skin Disorder) on 4/29/25. V5 unable complete wound assessment because she got busy and R1 was sent out to the hospital on 5/5/25. R1 returned on 5/11/25 but she has not updated R1's wound /Skin care plan.</p> <p>On 5/13/25 at 10:15AM Informed V5 WCN of observation made to R1 with V2 DON of having multiple layers of linens on the LAL mattress. V5 said that R1 should only have flat sheet over the mattress and no cloth pad over it. R1 is wearing disposable brief. V5 said that resident on LAL mattress should have flat sheet only as manufacturer recommendation. Multiple layers of linens over the mattress will impede its purpose.</p> <p>On 5/13/25 at 10:20AM, Surveyor requested skin assessment for R1. Observed V5 WCN and V10 CNA repositioned R1 to side lying position. Observed disposable brief soaked with urine and leaked through the cloth pad underneath her. Observed V10 provided incontinence care to R1. Observed V10 did not change her gloves after cleaning peri anal area and sacral area of R1. V10 took clean disposable brief and applied to R1 with the same gloves. V5 said that R1 has healed MASD. No treatment applied after incontinence care.</p> <p>On 5/13/25 at 10:22AM, V11 Agency CNA said that he is assigned to both R1 and R4. V11 said that he has not provided incontinence care or morning care to both residents. He received both residents with cloth pads and flat sheets over the LAL mattress. He said that he did not know that it's not okay to have both cloth pad and flat sheet over the mattress. V5 WCN informed V11 that resident on LAL mattress should only be on flat sheet over the mattress.</p> <p>On 5/13/25 at 10:33AM, Surveyor informed V5 WCN that she did not apply Treatment order of Zinc oxide ointment or barrier cream after incontinent care as indicated in care plan as part of preventive wound/skin impairment management.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1 is admitted on [DATE] with diagnosis listed in part but not limited to Traumatic subdural hemorrhage with loss of consciousness, Respiratory failure, Tracheostomy, Gastrostomy, Moderate protein calorie malnutrition, Encephalopathy, Contractures of muscle right upper arm, Mild neurocognitive disorder. Active physician order sheet indicated: Low air loss (LAL) mattress. Zinc oxide ointment 20% Cleanse with normal saline and apply to perianal topically every shift and as needed for skin condition. Comprehensive care plan indicated: she has potential for alteration in skin integrity related to Braden scale of 11 (High risk), incontinence, requires assistance with bed mobility/transfers, history of sacral pressure injury and underlying medical conditions. Interventions: Barrier cream to areas exposed to moisture/incontinence. Pressure redistribution support (low air or alternation air) in bed. Progress notes dated 4/29/25 documented by V21 RN indicated: MASD (Moisture associated noted on perineal area. Informed to V5 Wound Care Nurse (WCN) and Nurse Practitioner and carried out treatment order. V5 WCN documented on 4/30/24 indicated: Per V21 RN's request, skin check completed. Noted heavy excoriation, MASD to area of perianal. Nurse Practitioner notified and obtained order for Zinc ointment to be applied twice daily and as needed. V6 Family member notified. V5 did not updated R1's comprehensive care plan regarding acquired MASD on 4/29/25. No comprehensive wound assessment/report was completed when wound was identified. R1 was sent out to the hospital on 5/5/25 due to respiratory distress after decannulation. R1 was readmitted on [DATE], still wound/skin care plan was not updated.</p> <p>R4</p> <p>On 5/13/25 at 9:51AM, Observed R4 lying in bed with LAL mattress. She is unresponsive. She has tracheostomy connected to vent. She receives enteral feeding via GT (Gastrostomy Tube) connected to feeding pump. Observed visible cloth pad and flat sheet over the mattress. R4 is wearing disposable brief. Showed observation to V2 DON. V2 said that R4 should only have flat sheet. V2 said that resident on LAL mattress should only have flat sheet over the mattress as manufacturer recommendation.</p> <p>On 5/13/25 at 10:15AM Informed V5 WCN of observation made to R4 with V2 DON of having multiple layers of linens on the LAL mattress. V5 said that R4 should only have flat sheet over the mattress and no cloth pad over it. R4 is wearing disposable brief. V5 said that resident on LAL mattress should have flat sheet only as manufacturer recommendation. Multiple layers of linens over the mattress will impede its purpose.</p> <p>On 5/13/25 at 10:33AM, Surveyor requested skin assessment for R4. V10 CNA and V11 CNA repositioned R4 to side lying position. Observed R4 soaked with urine with fecal matter on the disposable brief and rectal area. Observed V10 provided incontinence care to R4. Observed V10 did not change her gloves after cleaning peri anal and sacral area of R4. She took clean disposable brief and applied to R4 with the same gloves. Informed V10 of observation made during incontinence care of using same gloves between soiled and clean briefs for R1 and R4. V10 changed her gloves and donned on new pair of gloves without hand hygiene. Informed V10 of observation made that she failed to perform hand hygiene before donning new pair of gloves. V5 WCN applied Zinc oxide to perianal and sacral area. V5 said that R4 has ordered for Zinc oxide for MASD. V5 said that R4 is being seen by Wound Care Physician for MASD.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R4 is admitted on [DATE] with diagnosis listed in part but not limited to Chronic respiratory failure with hypoxia, Tracheostomy, Gastrostomy, Type 2 Diabetes Mellitus, Hand contractures, Muscle weakness, Incontinence without sensory awareness, Encephalopathy, Parkinson's Disease. Most recent Braden scale skin assessment dated [DATE] indicated at high risk for skin impairment. Active physician order sheet indicated: Low air loss mattress. Zinc oxide ointment 20% cleanse with normal saline and apply to buttocks/sacral topically every day and evening shift and as needed. Comprehensive care plan indicated: She has actual alteration in skin integrity related to requires extensive assistance with bed mobility, incontinence, and underlying medical conditions. Wound sites: Buttocks- MASD. Interventions: Low air loss mattress. Barrier cream to areas exposed to moisture/incontinence. Wound care Physician wound/skin report dated 5/6/25 indicated: Buttocks/Sacral, MASD, 100% pink epithelization, wound identified: 1/18/25.</p> <p>R5</p> <p>On 5/13/25 at 10:56Am, Observed R5 lying in bed with LAL mattress. Observed LAL machine is on the floor. R5 does not have foot board where the LAL mattress is hanged. V13 Family member at bedside. V13 said that R5 has been in the facility for 3 months and he did not have foot board attached to his bed. V5 WCN said he should have foot board for the LAL machine/pump to be secured or hanged.</p> <p>On 5/13/25 at 11:05AM, Surveyor requested skin assessment for R5. V10 CNA repositioned R5 to side lying position. Observed no dressing covered to R5's sacral wound. V5 WCN said that the dressing probably got soiled and the CNA had to remove the dressing. V5 said that the CNA should inform the nurse so the nurse could cover the wound while waiting for wound care nurse. V5 said that she was not notified that R5's sacral dressing was removed. V5 cleansed the wound. V5 said that R5 has 40% greenish slough formation and 60% reddish tissue granulation. She applied metronidazole for contaminated wound, medi honey, calcium alginate and covered with foam dressing.</p> <p>On 5/13/25 at 11:30AM, Informed V14 Building Manager that R5 does not have foot board. V14 said that he was not aware, and nobody told him.</p> <p>R5 is admitted on [DATE] with diagnosis listed in part but not limited to Stage 4 sacral pressure ulcer, Acute respiratory failure with hypoxia, Anoxic brain damage, Encephalopathy, Necrotizing fasciitis, Tracheostomy, Gastrostomy, Type 2 Diabetes Mellitus. Active physician order sheet indicated: Low air loss mattress. Cleanse sacral stage 4 with normal saline. Apply medihoney paste then maxorb II, metronidazole as needed for contamination and cover with foam dressing daily and as needed. Comprehensive care plan indicated: He has alteration in skin integrity. He is at further risk for skin breakdown due to weakness, requiring total assistance with ADLs, tracheostomy status, incontinence, and underlying diagnosis.</p> <p>Facility is unable to provide policy on Low air loss mattress regarding avoiding of multiple layers of linen as manufacturer recommendation.</p> <p>Facility's policy on Prevention and Treatment of Pressure Injury and other Skin Alterations 3/2/21 indicated:</p> <p>Policy:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Implement preventive measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan.</p> <p>Procedure:</p> <p>2. Evaluate residents for actual pressure injuries or other skin alterations on admission or re-admission by utilizing the initial nursing assessment.</p> <p>5. Develop a care plan for either actual or potential alteration in skin integrity and changes as needed.</p> <p>6. Complete a comprehensive pressure injury evaluation for identified pressure injuries.</p> <p>8. At least daily, staff should remain alert for potential changes I the skin condition during resident care.</p> <p>9. Moisture barrier may be applied as needed.</p> <p>10. Revise care plan approaches as needed based on resident's response and outcomes.</p> <p>Facility's policy on non-sterile dressing change 3/2021 indicated:</p> <p>Guidelines:</p> <p>1. Non-sterile dressings protect open wounds from contamination and absorb drainage.</p> <p>Facility's policy on Management of Low air loss mattress 3/2024 indicated:</p> <p>7. Secure pump unit on the foot end of the bed frame</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to implement physician's order in using red rubber catheter for suctioning resident. The facility failed to implement its policy on suctioning procedure. The facility also failed to have a spare tracheostomy tube, one of the same size and one of a smaller size at bedside that is readily available in case of emergency to ensure resident's airway is secured. This deficiency affects one (R4) of three residents reviewed for Respiratory Care of Resident on Tracheostomy tube.</p> <p>Findings include:</p> <p>On 5/13/25 at 9:51AM, Observed R4 lying in bed. She has tracheostomy tube connected to ventilator. V2 DON (Director of Nursing) unable to locate spare tracheostomy tube set for R4 in her room. V2 called for V8 Respiratory Therapist.</p> <p>On 5/13/25 at 9:53AM, V8 Respiratory Therapist (RT) said that R4 is on trach size Shiley 6. V8 said that they should have a spare tracheostomy set at beside in case of emergency such as accidental decannulation to ensure R4's airway is secured. They should have a replacement tracheostomy tube 1 of the same size and 1 of a smaller size that should be readily available. V8 searched the room but unable to find spare of tracheostomy set in R4's room.</p> <p>On 5/13/25 at 10:26AM, Observed V8 RT suctioned R4 using plastic transparent suction catheter for more than 13 seconds three times (3x), no ventilation provided in between suctioning. R4 gagging/coughing with facial redness as he inserted the catheter. After suctioning, he removes his gloves and donned new pair of gloves without hand hygiene. Then provided tracheostomy care.</p> <p>On 5/13/25 at 10:32AM, V8 RT said that he does not need to provide ventilation in between suctioning because the resident is on ventilator. He said he suctioned R4 for 15 seconds each time. Informed V8 that he removed the oxygen collar mask while suctioning R4 and he suctioned R4 more than 10 seconds each time. He continued suctioning without interval of 30 seconds to 1 minute in between suctioning.</p> <p>On 5/13/25 at 1:38PM, Informed V1 Administrator and V2 DON of above observations and concerns.</p> <p>On 5/14/25 at 11:48AM, V19 Care plan coordinator said that she developed and updated R4's comprehensive care plan. She is not aware that R4 has an order to use a red rubber catheter for suctioning due to tracheal bleeding. R4's care plan was not updated. Informed V1 administrator of above concern that V8 RT did not follow physician order when suctioning R4 and care plan was not updated. Requested to talk with respiratory therapist assigned to R4.</p> <p>On 5/14/25 at 12:20PM, V20 Respiratory Therapist (RT) said that V1 Administrator asked him about the red suction catheter for R4. He was not aware until the administrator told him about the concern. V20 said that they have to follow physician order.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/14/25 at 12:29PM, Rounds made with V20 RT to R4's room. V20 searched R4's room for red rubber suction catheter for suctioning and unable to locate. V20 said that R4 does not have a red rubber suction catheter in her room.</p> <p>R4 is admitted on [DATE] with diagnosis listed in part but not limited to Chronic respiratory failure with hypoxia, Tracheostomy, Gastrostomy, Type 2 Diabetes Mellitus, Hand contractures, Muscle weakness, Incontinence without sensory awareness, Encephalopathy, Parkinson's Disease. Active physician order sheet indicated: Vent orders: AC mode, rate 16, VT350, PEEP 5, FIO2 40%. Vent checks every 6 hours and PRN (as needed). Airvo 40% 60% LPM 34 Celsius every shift for high flow humidified oxygen related to dependence on respirator. Suction every 4 hours and PRN. Use red rubber catheter for suction due to tracheal bleeding. Trach care and collar every shift and PRN. Trach Care: Shiley size 6. In case or emergency, trained nurse may reinsert outer cannula of tracheostomy PRN. Comprehensive care plan indicated: She has potential for complications related to ventilator/respirator use. Intervention: Trach care and suction as ordered. She requires oxygen therapy related to her acute respiratory failure.</p> <p>Facility unable to provide policy on Tracheostomy emergency protocol of having spare replacement tracheostomy tube set of the same size and 1 of a smaller size at bedside readily available in case of emergency to ensure resident's airway is secured.</p> <p>Facility unable to provide Nursing competency skills on Respiratory care such as Tracheostomy care and suctioning.</p> <p>Facility's policy on Physician's order for Medications or Treatments indicated:</p> <p>Policy: Medication will be dispensed and subsequently administered to a resident only upon the clear, complete, signed order of a lawfully authorized prescriber. Each medication order is documented in the resident's medical record with the date and signature of the person receiving the order.</p> <p>Prerequisites:</p> <ol style="list-style-type: none"> 1. Physician orders for medications 2. Physician order sheet (POS), electronic or paper. <p>Procedure:</p> <ol style="list-style-type: none"> 2. The nurse will follow order-specific procedures to submit orders to pharmacy appropriately, which may include transcribing any telephone or transfer sheet orders to the POS. <p>Facility's policy on Suctioning: Tracheostomy 9/2020 indicated:</p> <p>Policy: Suctioning of a tracheostomy will be done upon physician's order and as needed by nurse, respiratory therapist, or speech therapist to maintain a patent airway to facilitate the removal of accumulated tracheal secretions.</p> <p>Procedure:</p> <p>(continued on next page)</p>		

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