

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 09/04/2025
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>(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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview and record review the facility failed to ensure residents who were dependent on staff for clothing change and incontinence care received those services for 1 of 3 residents (R1) reviewed for Activity of Daily Living (ADL) assistance. Findings include: On 9/2/2025 at 10:30am V6(Agency Certified Nursing Assistant-CNA) said that on 7/30/2025 at about 6:30am V7(Nurse) asked V6 to clean up R1 and do incontinence care because he was going out to the hospital. V6 said upon entering the room the smell of emesis, feces and urine was observed. R1 had dried and new emesis with red fluid on his gown, upon removing the top linen R1 had feces and urine soaked on the bed with dried urine and feces rings on the bottom sheet and a red penis, scrotum and buttocks. V6 said she questioned V7 about why R1 was in this condition, V7 said the CNA for R1 had left the facility before she could tell her to clean R1. On 9/2/2025 at 11:40am this writer, V3(Assistant Director of Nursing -ADON), and V5(Certified Nursing Assistant -CNA) observed R1 in the bed with a soiled gown, red scrotum, red bilateral inner thighs, and red buttocks with feces and urine soaked on the bottom bed sheet. On 9/2/2025 at 1:00pm V4(Wound Care Nurse) said R1 has very loose stools and had been treated several times for redness on his scrotum, inner thighs and buttocks. The last treatment was 14 days and ended on 8/30/2025. R1 is now on a barrier cream twice a shift and as needed. I expect the nursing staff to do rounds every one to two hours on residents that are dependent on the staff for care and to inform me when a resident is having skin issues. On 9/2/2025 at 1:10pm V5 said R1 only responds to tactile stimuli and is totally dependent on staff for all care and he could not make his needs known. I do rounds every two hours and I did not change R1's gown, I informed the nurse when I changed R1 that morning that R1 has reddened areas on his scrotum and buttocks. On 9/2/2025 at 1:30pm V7(Nurse) said that on 7/30/2025 she was informed that R1 had an emesis I do not remember who informed me she assessed R1 and observed coffee ground emesis on his gown and top bed linen. V7 said she immediately called the physician and was given orders to send R1 to the local emergency room. V7 said she looked for the CNA for night shift and she was not on the unit, when the day shift CNA arrived, she informed V6 the CNA that was taking over that section to do care on R1 because he was transferring to the hospital. V7 said I did not check to see if R1 needed Peri-care I was concentrating on the coffee ground emesis and calling the ambulance. The CNA staff should make rounds every two hours and as needed, I thought the night CNA made rounds apparently, she did not. On 9/2/2025 at 1:45pm V3 said the bed sheets should not be soaked, I expect the CNA staff to make rounds every two hours and as needed for residents that need more frequent changing. All activity of Daily Living care should be completed for dependent residents. On 7/30/2025 I was informed that R1 had been left in a soiled gown, with urine and feces on the bed linen, and that he was going out to the hospital for having an emesis with blood in it. I did not know the extent until I was told the CNA had complained. On 9/2/2025 at 2:00pm V1(Administrator) said that she was informed about R1's condition of Activity of Daily Living care and incontinence care had not been giving, later that day and the agency CNA could not return to the facility. A resident information document dated 9/2/2025 indicates that R1 has a diagnosis of respiratory failure with hypoxia and hypocapnia, hemiplegia and hemiparesis with a cerebral infarction affecting the left no-dominant side, tracheostomy, gastrostomy, Dysphagia, dependent on supplemental oxygen. A care-plan dated 2/14/2025 for focus that R1 requires total assistance on staff with bed mobility, transfers, and all ADL, incontinence care, A focus of Peri-care after each incontinent episode and monitor for excoriation near peri area. Change clothing PRN as needed after each incontinent episodes dated 2/28/2025. Facility Policy: Perineal Care dated 9/2020 Purpose: To cleanse the perineum to prevent infection and odor to maintain skin integrity</p>		