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	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Des Plaines Rehab & Hc	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)
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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide needed care and services in accordance with resident's plan of care, facility's protocol, and professional standard of practice. This deficiency affects one (R1) of three residents reviewed for Quality of care. Findings include: On 9/16/25 at 1:15PM, V4 Insurance Case manager said that she visited R1 last week and presented to her his concerns that last month, he was being helped into bed by CNA and during the transfer, his right foot got caught under the bed and has been having foot pain since. R1 said that the CNA does not know what he is doing. V4 is concern with resident safe transfer. R1 has a right foot bandage. V4 spoke with Agency nurse and told her that R1's toes have ulceration and receiving antibiotics for cellulitis. V4 said that she did not follow up her concern with nursing management and social service in the facility. On 9/16/25 at 9:59AM, Observed R1 up in wheelchair in his room. He is alert and oriented x3. He can verbalize his needs to staff. He has O2 via nasal cannula at 2 liters per minute. He said that his right foot was hurt last month when CNA was transferring him from wheelchair to bed. The CNA and Nurse were aware and applied bandage to his right foot. He said that the CNA who works with him did not know what he is doing. On 9/16/25 at 10:04AM, V5 LPN said that R1 did not complain of pain to her, but he has scheduled pain medications that she administered this morning- Tylenol 500mg 2 tabs and Diclofenac sodium external topical gel to right knee. She said that R1 has a wound dressing on his right foot. R1 just completed oral antibiotics for his right foot wound infection/cellulitis. On 9/16/25 at 10:25AM, V2 ADON (Assistant Director of Nursing) said that R1 sustained bruise and abrasion on his right foot when CNA transferred him from wheelchair to bed on 8/11/25. V2 said, V6 Interim DON/Nurse Consultant did the bruise and abrasion incident investigation and root cause analysis. R1 was started on antibiotics on 9/3/25 due to wound infection. He was seen by wound care physician on 9/3/25 and treated with betadine swab 10% apply to right foot topically every Monday, Wednesday, and Friday. After cleansing with NSS (normal saline solution), paint with betadine then apply xeroform. Cover with abdominal dressing and wrap with kerlix three times a week and as needed. V2 said, the floor nurses do the wound treatment and weekly documentations. On 9/16/25 at 10:29AM, R1 was transferred to bed by V8 CNA (Certified Nurse Assistant) using transfer board. V2 ADON and R1 giving instruction and assistance to V8 in transferring R1. V2 removed R1's right foot shoe and sock. No dressing observed. R1 has dried dark brownish black scab on 2nd and 3rd toe. R1 can't remember when the dressing fell off. V2 cleansed the 2nd and 3rd toe with NSS then painted with betadine swab. She applied xeroform, covered with gauze and wrap with kerlix bandage. V2 said that she will call physician to evaluate wound treatment. The ABD pads is not appropriate wound covering on R1's right foot skin condition. R1 was only seen once by wound care physician for consultation. 12:21pm Review R1's medical records with V1 Administrator and V6 Interim DON/Nursing consultant. R1 is admitted on [DATE] with diagnosis listed in part but not limited to Parkinson's disease, Hypertensive chronic kidney disease, Poly osteoarthritis, Acute respiratory failure, dependence on oxygen. MDS/resident assessment dated [DATE] indicated: Section C-Cognitive pattern BIMS (Brief interview for mental status) score of 13. Section GG Functional abilities Mobility coded 02 substantial/maximal assistance. Helper does more than half of the effort. Helper lifts, holds or support trunk or limbs but provides more than half the effort. Section M Skin conditions. Marked yes for at risk for developing pressure ulcers/injuries. Marked 0 for arterial and venous ulcers. Marked 0 for other ulcers, wound and skin problems. Comprehensive care plan indicated: he has ADLs (Activity of daily living) self-care deficit. Intervention: transfer board for transfer. He has actual alteration of skin integrity. Intervention: weekly wound progress assessment by nurse. He has impaired mobility. He is on restorative program for transfer. He requires assistance from staff for transfers using sliding board. Interventions: 1 staff assist using sliding board and verbal cuing daily. Use gait belt and other transfer aids as needed. Active physician order sheet indicated: Skin check completed every Monday and Friday. Betadine swab sticks 10% apply to right foot topically every day shift Monday, Wednesday and Friday and as needed, after cleansing with NSS, the apply xeroform, cover with ABD (abdominal dressing) and wrap with kerlix. R1's bruise incident report dated 8/11/25 reported by V10 RN indicated: At approximately 2:30AM, R1 reported that his right foot was hurting particularly on great toe and second toe. V10 assessed and observed blue and purple discoloration on both great and second toes. Observed abrasion on 2nd and 3rd toes. R1 said that he was being transferred by CNA when he banged his foot on the bed. R1 was given pain medication and physician