STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146008	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden of Waterford	2021 Randi Drive Aurora, IL 60505

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40054 Based on interview and record review, the facility failed to notify the physician of a change in condition for a resident. This applies to 1 of 1 resident (R1) who was reviewed for a change in condition. Findings include: On 05/28/2025 at 8:35 AM, V10 (R1's family member) stated that on the evening of 05/22/2025, R1 experienced a change in condition and the facility did not notify the physician before a nurse increased oxygen from 2 liters to 4 liters via nasal cannula. On 05/28/2025 at 1:30 PM, V4 LPN (Agency-License Practical Nurse) stated that she worked with R1 for the first time and took the report from the morning nurse. She was not aware that she had not notified the provider. V4 said the staff involved in assessing R1 said being lethargic is R1's baseline. When R1 was excessively sweating and his oxygen saturation was at 89 percent around 9:00 PM, V10 arrived and requested that R1 be transferred to the hospital. V4 said she called 911 and transferred R1 to the hospital. On 05/28/2025 at 6:00 PM, V3 (LPN) said she worked from 7:00 AM to 7:00 PM, and the incident happened during the turnover of shift. V3 said she assessed R1 along with V4, and took vital signs, which were per his baseline, and then endorsed to V4 since her shift had ended. On 05/22/2025 at 3:11 PM, V7 NP (Nurse Practitioner) stated that she was on call for the facility and did not receive any calls regarding R1's change in condition and transfer to the hospital. On 05/22/2025 at 12:09 PM, V2 (Director of Nursing) stated that it's a standard policy guideline to notify physicians of changes in conditions and any new orders. On 05/22/2025 at 5:28 PM, V8 (R1's NP) stated that they did not hear anything about R1's condition and that the facility should have followed the notification protocol, despite R1's vital signs being at baseline, or R1's previous hospital admissions for failing lungs condition and lethargy. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146008	A. Building B. Wing	05/30/2025

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's EMR (Electronic Medical Records) shows R1 was a [AGE] year-old male admitted to the facility on [DATE], and R1's diagnoses include acute and chronic respiratory failure with low oxygen and high carbon dioxide, chronic obstructive pulmonary diseases, multiple cardiac diseases, stage five chronic kidney/end-stage renal disease, anemia, hemiplegia, and hemiparesis, and dependence on supplement oxygen. R1's Minimum Data Set indicated that R1's cognition was intact. The facility's clinical practice guidelines on Change in Condition, dated September 2020, indicated that the attending physician or physician/Nurse Practitioner on call will be notified of any change in condition. Under the 'Vital Signs section, showed that oxygen saturation below 90 percent should be reported immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146008	A. Building B. Wing	05/30/2025

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Alden of Waterford	2021 Randi Drive Aurora, IL 60505

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40054 Based on the interview and record review, the facility failed to immediately assess a resident after a reported change in condition. This applies to 1 of 5 residents (R1) who was reviewed for quality of care. Findings include: R1's EMR (Electronic Medical Records) shows R1 was a [AGE] year-old male admitted to the facility on [DATE], and R1's diagnoses include acute and chronic respiratory failure with low oxygen and high carbon dioxide, chronic obstructive pulmonary diseases, multiple cardiac diseases, stage five chronic kidney/end-stage renal disease, anemia, hemiplegia, and hemiparesis, and dependence on supplement oxygen. R1's Minimum Data Set indicated that R1's cognition was intact but dependent on staff for activities of daily living. On 05/28/2025 at 10:45 AM, R2 (R1's spouse) said R1 was sick in the evening of Thursday (05/22/2025), and V3 LPN (Licensed Practical Nurse) did not come to check on him when V5 CNA (Certified Nursing Assistant) called her for R1's lethargy and not eating his meals. R2 said she called V10 (R1 and R2's family). On 05/28/2025 at 2:01 PM, V5 (CNA) said on 05/22/2025 around 6:30 PM when she took the meal tray to R1's room, she was not able to wake him up, and she reported to V3 (LPN), V3 and V4 (Agency-LPN) did not assess R1 until around 7:00 PM. On 05/28/2025 at 12:09 PM, V2 (Director of Nursing) stated that on 05/22/2025 around 7:00 PM, V10 (R1's family) called her regarding R1's condition, and V2 advised V3 to check on R1. On 05/28/2025 at 6:00 PM, V3 said she worked from 7:00 AM to 7:00 PM, and the incident happened during the turnover of shift, and she assessed R1 along with V4 around 7:00 PM. On 05/28/2025 at 1:30 PM, V4 confirmed during the turnover of the shift around 7:00 PM on 05/2/2025, V2 called V3 to check on R1 and both went to R1's room to assess. A review of the R1's clinical document revealed that neither change of condition assessment documentation was completed nor was the change of condition assessment form filled out before transferring R1 to the hospital. On 05/22/2025 at 4:00 PM, V2 (Director of Nursing) stated that it's the facility's standard protocol to attend to residents when changes in conditions are reported and complete the change of conditions assessment form.