STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146153	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Shorewood	710 W Black Road Shorewood, IL 60404

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow standard infection control practices, related to gloving and hand hygiene during provisions of medication administration, incontinence care, and handling of soiled linen. The facility also failed to ensure to wear complete personal protective equipment (PPE) when administering intravenous (IV) medication to a resident who is on enhance barrier precaution (EBP). This applied to 5 of 5 residents (R36, R42, R54, R85, R93) reviewed for infection control in the sample of 20. The findings include: 1. According to the face sheet, R36 had multiple diagnoses, including chronic kidney disease, pain in the right knee, hypertension, and muscle weakness. R36's MDS (Minimum Data Set) dated December 28, 2025, showed that R36 was cognitively intact, required supervision or touch-assistance for personal hygiene, and was dependent on staff for toileting hygiene. On December 21, 2026, at 9:40 AM, R36 was lying in bed on an incontinence bed pad, completely soiled and stained with urine and blood. Bed linens were also on the floor next to R36's bedside. V20 came into R36's room with a clean incontinence bed pad and said she had already provided incontinence care to R36 but needed to replace the soiled incontinence pad under R36. V20 said the nurse notified her that R36 had been having blood in her urine. V20 was wearing gloves. V20 removed the soiled incontinence pad under R36 while R36 rolled to the side. V20 placed the soiled incontinence pad covered in urine and blood stains on the floor next to R36's bed. V20 covered R36 with a clean cover and blanket while wearing the same soiled gloves. V20 pushed buttons on the side of R36's bed to elevate R36's head and the foot part of the bed while wearing the same soiled gloves. V20 also picked up R36's call system remote and gave it to R36. V20 picked up a plastic bag from R36's empty trash bin and placed the soiled bed sheets and soiled incontinence pad in the plastic bag. V20 said she usually puts the residents' soiled linens on the leather chair in the residents' room, but she put them on the floor this time because it had blood stains. On December 21, 2026, at 2:49 PM, V2 (DON) said that while handling soiled linens, the CNA should remove gloves and perform hand hygiene with hand sanitizer or soap and water. V2 also said the CNA should re-apply clean gloves before touching the resident or clean surfaces. V2 said that hand hygiene and the application of clean gloves should be performed between dirty and clean tasks to prevent cross-contamination and ensure infection control. V2 also said CNAs are expected to put dirty and soiled linens in a plastic bag and tie them before taking them out to the soiled utility room. V2 said linens and soiled linens should not be placed on the floor in the resident's room to prevent contamination or spread of infection. 2. According to the face sheet, R54 had multiple diagnoses, including stage 4 chronic kidney disease, type 2 diabetes mellitus, severe morbid obesity, and polyneuropathy. R54's MDS (Minimum Data Set) dated October 22, 2025, showed R54 was cognitively intact, required supervision or touch-assistance for personal hygiene, and was dependent on staff for toileting hygiene. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 21, 2026, at 10 28 AM, V16 was providing incontinence care to R54. R54's incontinence brief and bedsheet were soiled with urine. V16 had gloves on and wiped R54's buttocks and groin with disposable wipes. V16 tucked the soiled bed sheet under R54 on the right side of the bed. V16 applied a clean incontinence brief and cream to R54's buttocks while wearing the same soiled gloves. V16 removed the soiled glove. V16 took one glove out of her pocket and went to the bathroom to grab another. V16 wore the gloves without performing hand hygiene. V16 proceeded to apply cream to R54's groin and went to R54's left side to remove the soiled bed sheet on R54's bed. V16 finished strapping R54's incontinence brief at the front using the same soiled gloves. V16 also put on R54's socks and short pants while R54 was lying on the mattress that was soiled with urine. R54 turned to the left side, and V16 placed the total body mechanical sling lift under R54. V16 said she was going to call another CNA to assist her with transferring R54 into the wheelchair using a total body mechanical lift. V16 removed the soiled gloves. V16 picked up the trash bag with the soiled linens, tied it, and walked out of the room without performing hand hygiene. On December 21, 2026, at 2:49 PM, V2 said while performing incontinence care, the CNA should remove gloves after cleaning the resident's urine and perform hand hygiene using hand sanitizer or soap and water. V2 said the CNA should re-apply clean gloves before touching the resident or touching clean surfaces. V2 said V16 should have performed hand hygiene before exiting R54's room. V2 also said that hand hygiene and the application of clean gloves should be performed between dirty and clean tasks for infection control and to prevent cross-contamination. The facility's Hand Hygiene policy dated October 2024 showed, Policy: It is the policy of the facility that hand hygiene (e.g., hand washing and/or Alcohol-based hand rub, also known as Alcohol-based hand sanitizer (ABHS) is to be performed to reduce the potential spread of pathogens. Guidelines: 1. ABHS should be used: a. Immediately prior to touching a resident. b. Before performance of an aseptic technique or handling invasive medical devices. c. When caring for a resident, when moving from a soiled body site to a clean body site of the same resident. d. After touching a resident or the resident's immediate environment. E. Immediately upon removal of gloves and PPE [Personal Protective Equipment]. 2. Hand hygiene with soap and water should be performed: a. when hands are visibly soiled. b. After any contact with blood, body fluids, or contaminated surfaces. 3. On January 20, 2026, at 4:27 PM, V10 (Nurse) administered Insulin Lispro to R42. V10 did not perform hand hygiene before and after med administration. 4. On January 20, 2026, at 4:35 PM, after medication administration to R42 and without hand hygiene, V10 proceeded to prepare and administer two prescribed insulins to R85. V10 also did not perform hand hygiene after R85's medication administration. 5 During observation of medication pass, R93's bedroom door had an EBP sign posted. On January 21, 2026, at 8:57 AM, V11 (Nurse) checked R93's vital signs without gloves and without hand hygiene before and after vital signs check. Then V11 proceeded to prepare R93's medications. On January 21, 2026, at 9:08 AM, V11 (Nurse) administered oral and IV medications to R93 who has a central IV line in his right arm. V11 did not perform hand hygiene and only wore a pair of gloves when she administered R93's IV medication. On January 21, 2026, at 2:27 PM, V2 (Director of Nursing/DON) stated nurses are to perform hand hygiene before and after monitoring vital signs and medication administration to prevent spread of potential infection. V2 also said that when the nurse administers IV medication to a resident, the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurse should follow the EBP protocol of donning gown and gloves, for protection of the resident against infection. The Enhance Barrier Precaution (EBP) Posting on R93's door shows different instructions including cleaning of hands before entering and when leaving the room, and to wear gloves and gown for the following high contact resident care activities including use or care of devices such as central line, urinary catheter, feeding tube, and tracheostomy.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that a resident's advance directive documents, order and care plan were consistent, to reflect the resident's treatment wishes in an event of a medical emergency, based on the facility's advance directives policy and procedure.This applies to 1 of 1 resident (R8) reviewed for advance directive in the sample of 20.The findings include:R8 was admitted to the facility on [DATE] with multiple diagnoses including acute kidney failure, acute on chronic diastolic (congestive) heart failure, and ventricular premature depolarization, based on the face sheet. The same face sheet documented that R8's advance directive was No CPR (Cardiopulmonary resuscitation). Do Not Attempt Resuscitation (DNAR).R8's EMR (electronic medical record) dashboard indicated that the residents advance directive was, No CPR. Do Not Attempt Resuscitation (DNAR).R8's active order summary report as of [DATE] showed an order dated [DATE] for, No CPR. Do Not Attempt Resuscitation (DNAR).R8's active care plan as of [DATE] showed, [R8] has not chosen any Advanced Directives at this time due to personal preference. Code status is full code. This active care plan was initiated by the facility on [DATE].Review of R8's EMR showed no uploaded documentation either an advance directive forms or signed POLST (Practitioner Order for Life-sustaining Treatment) to determine the wishes of the resident in an event of medical emergency.On [DATE] at 9:00 AM, V7 (SSD (Social Service Director)) stated after reviewing R8's EMR, the resident's order summary report showed that the resident has an order for DNR (Do Not Resuscitate), therefore no CPR will be performed if the resident is found to be unresponsive, without pulse and not breathing. V7 stated that for resident's on DNR status, their signed POLST and/or advance directive documents should be uploaded to the EMR to ensure that the wish of the resident is followed. V7 acknowledged that upon her review of R8's EMR, no signed POLST and/or advance directive documents were uploaded in the resident's EMR. V7 stated that since no signed POLST and/or advance directives documents were uploaded in R8's EMR, the facility also requires an actual signed POLST and/or advance directives documentation available in the nursing station inside a black folder for each resident. V7 went to the unit nursing station and looked at the black folder for R8 and stated that there was no actual copy of the POLST and/or advance directive documentations available for the nursing staff to review. During the interview, V7 reviewed R8's active advance directive care plan and stated that based on the care plan, the resident is a full code. V7 acknowledged that there is a discrepancy with regards to R8's code status/advance directive. V7 stated that she will talk to R8 and verify his advance directive wishes because the resident can make decisions for himself. V7 added that R8 has no POA (Power of Attorney) and that R8 is responsible to self.On [DATE] at 9:09 AM, V8 (Registered Nurse) stated that she was the assigned nurse for R8 that morning. V8 was asked what is R8's code status, if the resident was found unresponsive without breathing and pulse. V8 stated that she would first check the EMR dashboard profile and then the active order for the code status which according to V8 showed that R8 was DNR. V8 stated that since R8 had the order for DNR, no emergency action will be performed, if R8 was found unresponsive, without breathing and without pulse. V8 was asked how she will confirm that the DNR order was accurate. V8 responded that a signed advance directives should be uploaded on R8's EMR, which upon V8 checking showed no uploaded advance directive documents. V8 checked the black folder at the nursing station for R8 and acknowledged that there was no actual copy available for review regarding the resident's advance directives. V8 then checked R8's active care plan for advance directive and showed that the resident was a full code. V8 acknowledged that the active order and the active care plan were contradicting and needed to be verified.On [DATE] at 9:12 AM, R8 was in bed, alert and verbally responsive. V7 (SSD) asked R8 if he wanted to be resuscitated, if the staff found him unresponsive, without breathing and without pulse. R8 responded, yes. V7 asked R8 if he wishes (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his code status to be a full code and R8 responded, yes.The facility's advance directive policy and procedure dated [DATE] showed, The Social Service Director and/or designee will assess, care plan and implement Advance Directives. The same policy showed under procedure, 3. Social Service Director and/or designee will assess if resident had pre-existing advance directives. If so, copies of any/all documents will be requested, uploaded to [EMR] upon receipt, and documented in the resident's care plan. 4. If resident or resident representative has not already made advance directive decisions and chooses not to, Social Service Director and/or designee will document that in the resident's care plan. 6. Advance Directives will be reviewed quarterly, annually and upon any significant changes in cognition. 7. All Advanced directive preferences will be documented in the resident's care plan and updated quarterly, annually and upon any significant changes in cognition. 8. If the resident or resident representative chooses to initiate/change any advance directives, the Social Service Director/designee will document changes and update the plan of care. 9. The resident will have a code status order entered in their physician orders in accordance with advanced directives on file.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its policy on gait belt use during the transfer of a resident with an unsteady gait and risk of falls. This applies to 1 of 1 resident (R97) reviewed for transfer supervision in a sample of 20.The findings include:According to the face sheet, R97 was admitted to the facility on [DATE], and had multiple diagnoses, including a history of falling, polyosteoarthritis, other chronic pain, and hypertension.R97's Facility's Fall Risk assessment dated [DATE], showed R97 was at risk for falls, had an unsteady gait, and had had one to two falls in the past three months. R97's fall care plan, initiated on January 21, 2026, showed R97 was at risk for falls due to weakness from recent hospitalization and a history of falling. R97's (ADL/Activity of Daily Living) care plan, initiated on January 21, 2026, showed R97 had a functional performance deficit due to weakness from recent hospitalization. The same care plan interventions included staff assisting R97 with ADL tasks as needed.On January 21, 2026, at 9:01 AM, R97 was sitting on a chair in her room. V20 (CNA/Certified Nursing Assistant) said R97 was newly admitted to the facility the day before, and it was her first time assisting R97. V20 said she would assist R97 with transferring from the bedroom chair to the wheelchair. V20 brought the wheelchair close to R97's chair and asked whether R97 could stand. R97 stood up while V20 held R97's hand to assist her with transferring to the wheelchair. V20 had a gait belt in her pants side pocket, which she did not put around R97's waist to assist with the transfer. V20 said CNAs are supposed to use the gait belt when assisting the residents with transfers.On January 21, 2026, at 2:49 PM, V2 (DON/Director of Nursing) stated that CNAs are required to transfer residents, and that V20 should have used a gait belt with R97 for safety precautions to prevent falls or injuries to R97.The facility's Gait Belt (Transfer Belt) policy dated September 2020, showed, Policy: To assist with a transfer or ambulation. A gait belt will be used with weight-bearing residents who require hands on assistance.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to provide oxygen therapy to a resident as ordered by the physician.This applies to 1 of 2 residents (R87) reviewed for oxygen use in the sample of 20.The findings include: R87's face sheet included multiple diagnoses including COPD (chronic obstructive pulmonary disease), chronic respiratory failure with hypoxia, pneumonia, unspecified organism, need for assistance with personal care, other lack of coordination, other abnormalities of gait and mobility, polyneuropathy, urinary tract infection, site not specified. R87's 5-day MDS (minimum data set) dated January 9, 2026, showed that R87 is cognitively intact and requires substantial maximal assistance in chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair/or wheelchair). R87's Physician Order Sheet for respiratory showed oxygen per nasal cannula at 2 liters per minute continuous every shift. R87's care plan revised January 15, 2026, included that R87 requires oxygen therapy and is on oxygen at 2 liters by nasal canula continuously related to COPD. Interventions included to administer oxygen per MD [Medical Doctor] orders. On January 20, 2026, at 12:10 PM, R87 was seated in a wheelchair in her room beside V12 (R87's POA/Power of Attorney). R87 had a nasal cannula attached to her nostrils, with the tubing connected to a portable oxygen tank that was placed in a holder at the back of R87's wheelchair. R87's oxygen tank setting was unable to be seen as wheelchair was stationed between bed and wall. An oxygen floor concentrator was also seen behind R87's wheelchair. V12 stated She (R87) got here on Wednesday because of pneumonia from the hospital. She was bedridden at hospital and now they are giving her rehab here. R87 stated that an aide got her out of bed to her wheelchair. R87 was unable to remember who her aide was and at what time she got up. On January 20, 2026, at 12:39 PM, R87 was wheeled out by V12 to the hallway and she pointed to the portable oxygen tank and stated that she does not know if the oxygen is infusing. The portable oxygen tank was checked in V12's presence and the dial showed that it was at red zone and oxygen tank was set at 2 (liters). V13 (Registered Nurse) was notified and V13 checked the portable tank and stated that it is empty. V13 stated Whoever got her out of bed switched her from the concentrator to the portable tank. I believe it should be at 2 liters continuous. V13 continued that she believes that her aide was V17 CNA (Certified Nursing Assistant) but does not know if she was the one who got her up. V13 reported back that she learned that V17 did not get up R87 and that it could have been therapy. On January 20, 2026, at 3:20 PM, V14 (Physical Therapy Assistant) stated that therapy did not get R87 up in the morning and that R87 only received therapy in the afternoon. On January 20, 2026, at 3:35 AM, V2 (Director of Nursing) stated that R87 might have got herself up because she had interviewed V17 and other aides on the floor and they all said that they did not get R87 up. V2 added that yesterday the daughter had remarked that R87 is getting stronger as she is able to get out of bed herself. On January 21, 2026, at 9:42 AM, V16 (CNA), stated that she is assigned to R87 that day. V16 stated that she assists R87 to the wheelchair from her bed to her wheelchair by using a gait belt. V16 stated that R87 can put the nasal cannula to her nose but she noticed that R87 only applies it to one nostril only. V16 stated that the CNA's do not disconnect the oxygen from the floor concentrator and connect to portable oxygen tank as only the nurses are allowed to do that. V16 added We call the nurses when after we transfer her to the wheelchair. On January 21, 2026, at 10:44 AM, V17 stated that she worked on January 20, 2026, and that R87 was assigned to her. V17 stated I don't know who got her up. When I brought water for her (between 7:30-8:00). She was sitting on the side of her bed with her oxygen tubing connected to the floor concentrator. The nurses deal with oxygen. The aides don't connect it from the floor concentrator to the one on her chair.On 01/21/2026 at 2:02 PM, V2 (Director of Nursing) stated that the nurses are in charge of connecting the oxygen. V2 stated that R87 should be on continuous oxygen based on physician order for the same.Facility policy (dated September 2020) for Oxygen (Compressed) gas included as follows:Policy: Oxygen will be provided via compressed gas to the resident per the physician's orders by an RN or LPN (Licensed Practical Nurse). Certified Nurse Assistants/rehab aides may adjust or reapply the nasal cannula or mask only.