STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146182	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Courts of Waterford	1991 Randi Drive Aurora, IL 60504

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow standard infection control practices during provisions of care with regards to hand hygiene and changing gloves. The facility also failed to use the required PPE (Personal Protective Equipment) for residents who were placed on EBP (Enhance Barrier Precaution) and Isolation Precaution. This applies to 4 of 16 residents (R3, R24, R29, R36) reviewed for infection control in the sample of 16. The findings include: 1. Face sheet shows that R24 is 81 years-old who has multiple medical diagnoses including neuromuscular dysfunction of the bladder. On August 25, at 10:50 AM, R24 was resting in bed, she had an indwelling urinary catheter. There was an EBP signage posting on her door. V20 (Nurse) stated that R24 has an indwelling urinary catheter due to urinary retention. On August 26, 2025, around 3:00 PM, R24 was sitting in her wheelchair, when V8 (CNA) put the shoes on to R24. V8 then assisted R24 to get on to the sit-to-stand lift machine where V8 started providing peri-care. R24's leg buckled during provision of peri-care, so V8 assisted R24 back to the wheelchair and from the wheelchair R24 was transferred to bed. V8 continued to provide peri-care and urinary catheter care while wearing the same soiled gloves. After she cleaned R24's perineum, V8 changed her gloves and performing without hand hygiene she donned another pair of gloves and applied barrier cream to R24's buttocks. V8 then changed her gloves again without performing hand hygiene she donned another pair of gloves and applied the incontinence brief. V8 provided care wearing only gloves she did not wear any gown. R24's POS (Physician Order Summary) dated June 2, 2025, shows R24 was placed on EBP for device care or use of urinary catheter. 2. R3 was on enhance barrier precaution (EBP) due to wound care. There was a EBP signage posted on R3's bedroom door. On August 26, 2025, at 9:31 AM, V10 (Nurse) with the help of V11 (Certified Nursing Assistant/CNA) provided wound care to R3's left toe. V11 wore a pair of gloves but did not wear a gown. V11 held R3's left foot and right foot one at a time during skin assessment. After the wound care was completed, and while wearing the same gloves, V11 opened R3's closet to get new socks, he changed R3's socks, he put the shoes onto R3's feet while R3 was still in bed, and assisted R3 to transfer from bed to wheelchair. V11 removed his soiled gloves and without performing hand hygiene combed R3's hair. R3's physician order summary dated July 14, 2025, shows R3 was placed on EBP for chronic wound. On August 27, 2025, at 1:08 PM, V15 (Assistant Director of Nursing/ADON) stated when staff is providing care to a resident, the staff must change gloves and perform hand hygiene from dirty to clean task or in between tasks, and prior to exiting the resident's room to prevent spread of infection. In addition, the staff must wear complete personal protective equipment (PPE) such as gloves, gown, (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	and mask, during provisions of care to resident who is placed on EBP due to either IV (Intravenous) line, indwelling urinary catheter, gastric-tube, or wound care, to protect the resident from potential infection. The Enhance Barrier Precaution (EBP) posting shows: Providers and staff must wear gloves and gown for the following high-contact resident care activities: Dressing Transferring Providing hygiene Changing briefs and assisting with toileting Device care or use: central catheter, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. 3. R36's face sheet showed R36 was admitted to the facility on [DATE], with diagnoses that include Alzheimer's disease, dementia, asthma and obstructive sleep apnea. R36 had a diagnosis of Covid-19 dated August 23, 2025. R36 had the following care plan dated August 23, 2025, that showed: R36 noted with a positive Covid 19 test result. Requiring single room contact/droplet isolation. R36 has a physician order dated August 23, 2025, that showed the following: Isolation contact and droplet precautions due to positive covid test result. On August 25, 2025, at 11:13 AM, V19 (Housekeeping) was cleaning R36's room with the door open. There were droplet and contact isolation signs on the outside of the door. The sign showed the following: stop. Everyone must make sure their eyes, nose and mouth are fully covered before room entry. While cleaning R36's room, V19 was wearing a surgical mask, gown and gloves only. V19 was not wearing an N95 mask nor was he wearing googles, face shield or any eye protection. Once V19 left R36's room, V19 stated he should have had on an N95 mask while cleaning R36's room. On August 27, 2025, at 2:00 PM, V15 (Assistant Director of Nursing/Infection Preventionist) stated that staff are required to don a face shield, N95, gown, and gloves before entering a resident's room that is on contact and droplet isolation for Covid-19 to prevent the spread of infection. The facility's Acute Respiratory Illness testing plan and response strategy policy dated February 2025 showed the following: initiate contact and droplet precautions, including gowns, gloves, fit-tested N95 respirator, and eye protection, such as googles or a face shield, for residents with signs of acute respiratory illness. 4. On August 25, 2025, at 10:37 AM, no EBP (Enhanced [NAME] Precaution) sign was posted on R29's door or door frame. While wearing mask and gloves, V3 (RN/Registered Nurse) assisted R29 to stand, pivot and transfer to the bed. V3 unfastened R29's disposable brief. R29 had an indwelling urinary catheter. R29's sacral/coccyx and the surrounding buttock areas were denuded (outer layer of the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	skin was lost) and the exposed skin was pinkish in color. R29 had no dressing in place. V3 went to the bathroom, removed her gloves, washed her hands and put on two pairs of gloves (double gloved). V3 then started cleaning R29's anal area, sacral/coccyx and buttocks area using disposable cloths to remove the pasty stool. After cleaning the above mentioned areas, V3 removed the top glove (one of the double glove) on her right hand, then applied the Zinc Oxide ointment on R29's sacral/coccyx and buttocks areas, using her right gloved hand. V3 then removed her bilateral gloves, put on a new pair of gloves and applied the new disposable brief on R29. There was no hand hygiene performed (hand washing or use of alcohol hand rub) in between the dirty to clean task after removing the gloves. During the above observations and provision of care to R29, V3 was not wearing a gown. On August 27, 2025, at 1:03 PM, V2 (Director of Nursing) stated that R29 is on EBP due to indwelling urinary catheter and pressure injury. V2 stated that an EBP sign should have been posted on R29's door to alert the staff to put on appropriate PPE (Personal Protective Equipment) during high-contact resident care. According to V2, V3 (RN) should have worn a gown when she (V3) provided incontinence care to R29 because the care being provided is considered high-contact care and additionally, the resident had an indwelling urinary catheter and pressure injury on the buttocks. V2 stated that if a staff chooses to use double gloves, those double gloves showed be removed after the dirty task, hand hygiene either hand washing, or use of the alcohol rub should be performed before applying a new pair of gloves to continue with the clean task. According to V2, hand hygiene and using a clean gloves between dirty to clean task is important to prevent cross contamination and infection. The facility's policy regarding EBP dated December 2024 showed, Enhanced Barrier Precautions (EBP) are an infection control prevention designed to reduce transmission of multidrug-resistant organisms (MDRO) in nursing homes. As well as to prevent multi-drug-resistant organism acquisition of those with an increased risk of acquiring MDROs including residents with chronic wound or an indwelling medical device. Under the guidelines of the same policy showed, 1. EBP involves gown and gloves use during high-contact resident care activities for residents known to be infected or colonized with MDROs when contact precautions do not otherwise apply. As well as residents with a chronic wound and/or indwelling medical device. Under the procedure of the same policy showed that high-contact resident activities included the following: changing briefs or assisting with toileting, device care or use, including urinary catheter and wound care. Under the procedure it showed, 4. Post CDC EBP sign outside of the resident's door. a. Gown and gloves use prior to the high-contact care. The facility's policy regarding hand hygiene dated October 2024 showed, It is the policy of the facility that hand hygiene (HH) (hand washing and/or Alcohol-based hand rub (ABHR), also known as Alcohol-based hand sanitizer (ABHS) is to be performed to reduce the potential spread of pathogens. The same policy showed that use of the ABHS is the preferred method of use in most clinical situations. It is the most effective product for reducing the number of germs on the hands of health care providers. ABHS should be used: . e. Immediately upon removal of gloves and PPE.

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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. Based observation, interview, and record review, the facility failed to ensure safe transfer for a resident who requires extensive assistance. This applies to 1 of 1 resident (R24) reviewed for transfer in the sample of 16. The findings include: The Face sheet shows that R24 is 81 years-old who has multiple medical diagnoses including Alzheimer's disease, generalized muscle weakness, abnormalities of gait and mobility, other specified injury of muscle and tendon head, subsequent encounter, and needs for assistance with personal care. R24's Minimum Data Sheet dated July 12, 2025, shows that R24 is cognitively impaired and requires extensive assistance for toileting and transfer. On August 26, 2025, around 3:00 PM, V8 (Certified Nursing Assistant, CNA) assisted R24 to get onto the sit-to-stand lift. When R24 was standing on the sit-to-stand lift, V8 started providing peri-care. R24's legs and knees started buckling, the sling slipped up underneath her breast, and her knees bent to 90 degrees, leaving R24 hanging on a sling from the sit-to-stand lift. R24 looked anxious and was asked twice if she was okay to which she responded No. V8 stopped what she was doing, and assisted R24 back to the wheelchair. While R24 was sitting in her wheelchair, V8 placed a gait belt around R24's trunk. V8 struggled to transfer R24 to the bed. V8 did it by holding/pulling R24's pants, for R24 to stand and pivot. R24 was unsteady and looked weak. V8 transferred R24 to bed, R24's lower extremities were dangling at the edge of the bed. V8 lifted R24's legs to reposition it. On August 27, 2025, at 1:32 PM, V15 (Assistant Director of Nursing/ADON) stated that V8 approached her and informed her that R24 needed to be re-evaluated for transfer because she was not bearing weight. V15 also said that when staff transfers a resident with the use of gait belt, the staff must hold the resident through the gait belt for safety. If the resident has a change of condition and is unable to bear weight, but the resident uses a sit-to-stand machine or transfer through stand and pivot the staff must call another person to help with transfer as a safety measure. V15 further stated V8 should have called another staff to assist with transfer if R24 was not bearing weight.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review the facility failed to provide urinary catheter care, failed to ensure that the urinary catheter tubing was not dragging on the floor during transport and failed to secure the urinary catheter to prevent movement based on the facility's policy.This applies to 1 of 3 residents (R29) reviewed for urinary catheter in the sample of 16. The findings include: R29 had multiple diagnoses including neuromuscular dysfunction of the bladder, based on the face sheet.On August 25, 2025 at 10:35 AM, V3 (Registered Nurse) assisted R29 to stand, pivot and transfer to the wheelchair. V3 took R29 to the room. While transporting R29 to the room, the resident's urinary catheter tubing was observed dragging on the floor.On August 25, 2025 at 10:37 AM, V3 assisted R29 to stand, pivot and transfer to the bed. V3 unfastened R29's disposable brief. R29 had a catheter stabilization/securement adhesive (only) on her right leg, but the actual device to secure the catheter was not present. The urinary catheter was not secure to prevent movement. R29 had a moderate amount of pasty stool. V3 provided bowel incontinence care to R29 while the resident was turned on the right side, but did not reposition R29 to clean the front perineal area. V3 did not provide perineal care to the front area of R29, including the urinary catheter and insertion site. After the provision of care, R29 was assisted back to the wheelchair. V3 did not apply a new urinary catheter stabilization/securement device to secure R29's catheter. At 10:55 AM, V3 started pushing R29's wheelchair towards the unit television room. While V3 was transporting R29, the resident's urinary catheter tubing was observed dragging on the floor and was getting caught on the resident's wheel and feet. V3 was informed of the said observation.On August 27, 2025 at 1:10 PM, V2 (Director of Nursing) stated that for all urinary catheter, a device to secure the urinary catheter should be used to prevent pulling of the urinary catheter and to prevent trauma to the insertion site. V2 stated that the urinary catheter tubing should not be allowed to drag on the floor to prevent pulling and infection. According to V2, the nurse should have provide front perineal care, including urinary catheter and insertion site care to R29, especially because the resident had an episode of bowel incontinence, to ensure good hygiene, cleanliness and to prevent urinary infection.The facility's policy and procedure regarding indwelling urinary catheter dated September 2020 showed, Indwelling catheters will be utilized to facilitate urinary drainage when medically necessary. The same policy under the procedure showed, 4. Secure catheter tubing as appropriate to minimize movement of catheter. 7. Complete indwelling catheter cares by cleansing catheter insertion site daily and as needed.

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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 administered oxygen as ordered by the facility and failed to ensure that the facility's policy regarding oxygen administration was followed.This applies to 1 of 2 residents (R29) reviewed for oxygen therapy in the sample of 16. The findings include:R29 had multiple diagnoses including COPD (chronic obstructive pulmonary disease) and chronic respiratory failure with hypoxia, based on the face sheet.On August 25, 2025 at 10:29 AM, R29 was sitting inside the television room. R29 had an ongoing oxygen via nasal cannula at two liters per minute, using an oxygen concentrator. On August 25, 2025 at 10:35 AM, V3 (RN/Registered Nurse) assisted R29 to stand, pivot and transfer to the wheelchair, because the resident will be taken to the room. After R29's transfer to the wheelchair, V3 removed the nasal cannula from R29, turned off the oxygen concentrator and wheeled the resident inside the room. R29's oxygen nasal cannula and oxygen concentrator was left in the television room.On August 25, 2025 at 10:37 AM, upon arrival in the resident's room, R29 stated I need my oxygen. V3 went out of the room and retrieve the oxygen concentrator from the television room, then placed the oxygen nasal cannula on the resident and started the oxygen concentrator at two liters per minute. At 11:00 AM, after wheeling R29 back to the television room, R29's oxygen concentrator came with the resident. R29's oxygen was ongoing at two liters per minute via nasal cannula.On August 25, 2025 at 12:06 PM, R29 was eating her lunch meal inside the unit dining room. R29 had ongoing oxygen via nasal cannula at two liters per minute using the portable oxygen that was at the back of the resident's wheelchair. V3 was asked to check the oxygen portable tank and confirmed that R29 was receiving two liters per minute of oxygen.On August 26, 2025 at 9:25 AM, R29 was inside the television room. R29 had an ongoing oxygen via nasal cannula at two liters per minute using the oxygen concentrator. V3 was present during this observation. R29 then asked to use the bathroom. V3 turned off the oxygen concentrator and removed the oxygen nasal cannula. V3 assisted R29 to stand, pivot and transfer to her wheelchair. R29 was wheeled to the unit tub room (close to the unit nursing station). During the entire time that the resident was inside the bathroom, R29's had no oxygen ongoing. After using the bathroom, R29 was brought back at the television room, then V3 applied the oxygen nasal cannula and started to administer the oxygen at two liters per minute, using the oxygen concentrator. R29's active order summary showed an order dated July 14, 2025 to administer oxygen continuously via nasal cannula at four liters per minute related to chronic respiratory failure with hypoxia.R29's active care plan initiated on July 5, 2025 showed that the resident had COPD and required oxygen therapy. The same care plan had several interventions including, Administer oxygen per [Physician] orders.On August 26, 2025 at 10:30 AM, V3 was asked to confirm the oxygen order for R29. It was only this time that V3 recognized that the resident should receive four liters per minute of oxygen continuously and changed the oxygen setting to the ordered 4 liters per minute instead of two liters per minute.On August 26, 2025 at 11:52 AM, V4 (Certified Nursing Assistant) assisted R29 to transfer from the chair to the wheelchair. After transferring R29 to her wheelchair, V4 turned off the oxygen concentrator and disconnected the nasal cannula from the concentrator, then proceeded to connect the same nasal cannula tubing to the portable oxygen that was behind the resident's wheelchair, then turned on the portable oxygen, which was set at four liters per minute. V4 then took R29 inside the unit dining room. V4 was asked if the CNAs are allowed to stop and disconnect a resident from the oxygen concentrator and if the CNAs are allowed to connect and start the portable oxygen. V4 stated that she was not sure. At 12:20 PM, V3 (RN) stated that she was not sure if CNAs are allowed to stop and disconnect a resident from the oxygen concentrator and if the CNAs are allowed to connect and start the portable oxygen.On August 27, 2025 at 1:16 PM, V2 (Director of Nursing) stated that R29's oxygen should be administered as ordered by the physician to ensure that the resident receives sufficient oxygen, especially for R29 who has a diagnoses of COPD and chronic respiratory failure with hypoxia. According to V2, it is outside of the CNA's scope of practice to disconnect the oxygen tubing and turn (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	off the oxygen and reconnect the oxygen tubing and start the oxygen. V2 stated that the CNAs can only handle/adjust the nasal cannula or mask to make sure that it is in place. The facility's policy regarding oxygen concentrator dated September 2020 showed, Residents will be administered oxygen via oxygen concentrator upon Physician's order by an RN (Registered Nurse), LPN (Licensed Practical Nurse) or RT (Respiratory Therapist). Certified Nurse Assistants may adjust or reapply nasal cannula or mask only. Under the procedure of the same policy showed, 1. To operate concentrator: .e. Set liter flow dial to LPM (Liter per Minute) prescribed by physician.