| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146186 | A. Building<br>B. Wing | 07/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Alden Estates Cts of Huntley | 12140 Regency Parkway<br>Huntley, IL 60142 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interview, and record review the facility failed to ensure residents oxygen equipment was changed and labeled for 4 of 5 residents (R6, R7, R12, R19) reviewed for oxygen use in the sample of 23. The findings include: On 7/21/25 at 9AM, R6 was in bed with oxygen via nasal cannula connected to an oxygen concentrator. R6's oxygen tubing was not dated. V12 (License Practical Nurse-LPN) said oxygen tubing should be labelled and dated to know when they will be changed. R6's July Physician orders shows Oxygen per nasal cannula 2-5 liters per minute continuous related to COPD (Chronic Obstructive Pulmonary Disease). Oxygen Tubing - Change monthly night shift and as needed. 2. On 7/21/25 at 8:45 AM, R7 was in bed with oxygen via nasal cannula connected to a concentrator. R7's oxygen tubing was not dated. V15 Certified Nursing Assistant-CNA who was at bedside said she does not know who changes and dates/label the oxygen tubing, maybe the nurses. R7's July Physician orders shows Oxygen per nasal cannula 2-4 liters per minute continuous. Oxygen Tubing - Change monthly night shift and as needed. 3. On 7/21/25 at 9:15 AM, R12 was in bed wearing oxygen via nasal cannula that was undated. R12's July Physician orders shows Oxygen per nasal cannula 2-5 liters per minute as needed. Oxygen Tubing - Change monthly night shift and as needed. 4. On 7/21/25 at 8:41 AM- R19 was sitting in dining room. Oxygen on via portable tank. Oxygen tubing was not dated or labeled. R19's July Physician orders shows Oxygen per nasal cannula 2-5 liters per minute as needed. Oxygen Tubing - Change monthly night shift and as needed. R19's July Physician orders shows Oxygen per nasal cannula 2-4 liters per minute as needed. Oxygen Tubing - Change monthly night shift and as needed. On 7/22/25 at 8:50 AM, V17 (Registered Nurse-RN) said oxygen tubing should be labeled and dated to show when they were changed. They are to be changed monthly. On 7/21/25 at 10:11 AM, V4 (Assistant Director of Nursing) Nurses are responsible for dating and changing oxygen tubing some are weekly some monthly depending. V4 stated I do 2nd floor and the former DON (V3) did 3rd floor. We do audit floors and tubing. V3 left last Friday 7/18/25 so 3rd floor might have got missed. Night shift should change out tubing. The facility policy on Oxygen Therapy Devices-nasal cannula documents, oxygen delivered per nasal cannula will be used to prevent or reverse hypoxia and improve tissue oxygenations. 4. A nasal cannula will be changed monthly and PRN (as needed). |

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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure insulin pens were labeled and dated when opened and disposed of when expired, and failed to ensure the medication refrigerator temperature was checked twice a day for 4 of 4 residents (R11, R14, R22 and R23) reviewed for medication storage in the sample of 23. The findings include: On [DATE] at 8:55 AM the 3rd floor medication cart for residents in rooms 3117-3128 was checked with this surveyor and V10 (Licensed Practical Nurse/LPN). Inside the cart was an open Novolog insulin pen labeled as belonging to R14. There was a sticker on the outside of the insulin pen to write the open and expiration dates on but those were blank. Inside the same medication cart was a Novolog insulin pen belonging to R11 the expiration date on the pen was listed as [DATE]. On [DATE] at 8:58 AM, V10 said insulin pens should be dated when they are open and have an expiration date of 28 days. V10 said someone must have opened the insulin pen for R14 and forgot to label it. V10 also said that insulin pens should be disposed of when it is past the expiration date. R11's Medication Administration summary shows he received Novolog insulin at least daily between 7/14-[DATE]. On [DATE] at 9:09 AM, the medication room was on the 3rd floor was checked with this surveyor and V2 (Director of Nursing/DON). There was a refrigerator in the room that had a Medication Refrigerator Temperature Log hanging on the outside of it. The log shows that temperatures for the refrigerator should be checked twice daily. The log sheet shows one signature per day from [DATE]-[DATE], and nothing documented after [DATE]th. Inside the refrigerator were numerous Novolog insulin pens belonging to R11 and R14. Also inside were Humalog Lispro insulin pens belonging to R22 and Aspart insulin pens belonging to R23.On [DATE] at 9:12 AM, V2 (DON) said the refrigerator in the medication room is primarily used to store insulins and other liquid medications that require refrigeration. V2 said the refrigerator temperature should be checked by the nurses and documented 2 times a day to ensure that medications are being stored at the proper temperature. The facility provided Prefilled Insulin Multi-Dose Pen policy dated 3/2021 shows insulin pens should be dated when open and include an expiration date and staff initials and discarded when expired. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview and record review, the facility failed to ensure staff were wearing the right personal protective equipment to follow enhance barrier (EBP) precautions to 1 of 3 residents (R6) reviewed for EBP in the sample of 23. The findings include:R6's electronic face sheet show R6 has diagnoses of benign prostatic hyperplesia, retention of urine, and suprapubic catheter. R6's Physician Order Sheet dated 7/25 documents EBP For Device Care or Use of Urinary Catheter. On 7/21/25 at 9AM, a sign outside R6's room show EBP: wear gown and gloves for a high contact resident care activities V11 (Certified Nursing Assistant-CNA) was with R6 providing morning care, incontinence care/hygiene and changing R6's incontinent brief. V11 (CNA) was only wearing gloves and was not wearing a gown. V12 (License Practical Nurse (LPN) was with this surveyor. V12 said R6 was on EBP due to R6 having a suprapubic catheter. Staff including V11 (CNA) should be wearing gown and gloves when providing care to R6. Wearing the right PPE can prevent the spread of infection or cross contamination. The Facility Policy entitled Enhanced Barrier Precautions (EBP) dated 12/24 show, EBP are on infection control intervention designed to reduce transmission of multidrug resistant organism (MDRO) in nursing homes. As well as to prevent MDRO acquisition of those with an increased risk of acquiring MDROs including residents with a chronic wound or an indwelling medical device. 1. High contact resident care activities include the following: providing bathing, hygiene changing briefs. 2. Residents that have indwelling medical devices, regardless of MDRO status, will be on EBP. |