STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2370883/IL155964	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210a) 300/1210b)3) 300.1210d)4)A)B)C) 300.1210d)5) 300.1230a) 300.1230b) 300.1230b)1) 300.1230b)2) 300.1230b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1 applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 C) Each resident shall have clean, suitable clothing in order to be comfortable, sanitary, free of odors, and decent in appearance. Unless otherwise indicated by his/her physician, this should be street clothes and shoes. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1230 Direct Care Staffing a) For purposes of the minimum staffing ratios in Section 3-202.05 of the Act and this Section, all residents shall be classified as requiring either skilled care or intermediate care. (Section 3-202.05(b-5) of the Act) b) For the purposes of this Section, the following definitions shall apply: 1) "Direct care" - the provision of nursing care or personal care as defined in Section 300.330, therapies, and care provided by staff listed in subsection (i). Direct care staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3 mental and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the facility (e.g., housekeeping). 2) "Skilled care" - skilled nursing care, continuous skilled nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision. (Section 3-202.05(b-5) of the Act) Skilled nursing services are either nursing or therapy care services, furnished pursuant to physician orders, that require the skills of a licensed nurse to treat, manage, and observe a resident's condition and evaluate a resident's care. The skilled nursing services may be provided by a CNA, under the supervision of a licensed nurse to ensure the safety of the patient and to achieve the medically desired result. A resident in a skilled nursing facility is classified as receiving skilled care if: 3) "Intermediate care" - basic nursing care and other restorative services under periodic medical direction. (Section 3-202.05(b-5) of the Act) Services not classified as skilled care will be classified as intermediate care Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by, Based on observation, interview and record review the facility neglected to provide sufficient	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4 numbers of nursing staff to meet the physical and psychosocial needs of residents in the facility. The facility failed to ensure facility residents were free of neglect resulting in the actual or potential physical and/or psychosocial harm to 18 of 18 residents in a sample of 23. This failure resulted in physical harm to R1 who was observed to have two re-opened, previously healed pressure ulcers and scratch marks on her skin from skin irritation, psychosocial harm to R1 after not receiving showering assistance from staff which caused her to become more depressed, physical harm to R16 after R16's previously healed pressure injury reopened, physical harm to R4 after development of a new pressure injury, as well as psychosocial harm to R3 and R10, as well as putting R2, R5-R9, R11, R12, R14, R15, R17, R19 and R20 at serious risk of physical/psychosocial harm. The findings include: On 2/1/23 at 12:45 PM, V6 (C.N.A.-Certified Nursing Assistant) stated the third floor AM shift usually has only two CNAs scheduled on the floor for the 54 total residents. V6 stated each CNA was responsible for 27 residents on 2/1/23. V6 stated six of her residents require two staff to assist with mechanical lifts for transfers and four of her residents require two staff because of behaviors during care. At 12:55 PM, V6 stated when the CNAs have time, they toilet residents before and after breakfast and again before lunch. V6 stated when there are only two CNAs working on the third floor, they are unable to toilet residents after breakfast or before lunch because they need to get residents out of bed that remain in bed for breakfast. V6 stated she had five	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

residents that remained in bed during breakfast. V6 stated the CNAs are unable to give residents showers/bed baths when only two CNAs are scheduled on the third floor. V6 stated they document in the computer when they perform resident showers. V6 stated if there are three CNAs on the floor and a Resident Assistant (RA), the RA helps transport residents and they are sometimes able to give showers.

On 2/1/23 at 12:48 PM, V5 (CNA) stated he was caring for 24 residents - six of which required two staff for mechanical lift transfers. On 2/6/23 at 9:40 AM, V12 (Scheduler/CNA) stated there were only 2 CNAs working for a total of 62 residents residing on the second floor.

Resident Council Minutes, dated 12/26/232, show, "Staffing issues are still working progress and is getting better ...." Resident Council minutes, dated 11/21/22, show, " ...CNA staffing is still being worked on ...."

On 2/1/23 at 1:43 PM with V16 (RN), V12 (CNA/Scheduler) stated the facility census had remained fairly stable for the last couple months and any census changes that did occur did not change staffing needs on the facility floors. V12 stated if she had sufficient staff, she would schedule 5 CNAs on the 2nd floor and 5 CNAs on the 3rd floor during both the AM and PM shifts. V12 stated those 5 CNAs scheduled would be in addition to any restorative staff working in the facility. V12 stated restorative staff only get pulled to help on the second or third floor if only 1 CNA shows up for a shift on a floor. V12 stated she was currently working as one of the two CNAs on the second floor and she alone was caring for 31 residents. V12 stated V10 (CNA) was the only other CNA working on the second

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

floor during the AM shift on 2/1/23 and V12 alone was caring for 32 residents. V12 stated the second-floor census is higher than usual and is almost at capacity as they have 63/68 beds filled. V12 stated there were 24 residents requiring mechanical lifts for transfers in addition to several other residents requiring two staff's assistance for ADLs. V12 stated 2 CNAs on the floor of approximately 63 residents had been typical at the facility for a long time. V12 stated she is only allowed to call staff employed by the facility. V12 stated, "We just do not have the staff to call." V12 stated she has been requesting for the use of agency staff to help fill in the schedule for some time.

Facility Roster, dated 2/1/23, shows the facility census was 160 residents. The roster shows there were 43 residents residing on the first floor, 63 residents residing on the second floor, and 54 residents residing on the third floor.

Review of schedules, dated 1/30/23 to 2/6/23, show on the AM or PM shifts on either the second or third floors of the facility:
1. 13/36 shifts had only 2 CNAs working on the entire floor.
2. 4/36 shifts had three CNAs but one CNA only worked part of the shift
3. 17/36 shifts had only three CNAs working on the entire floor

Review of Facility Nurses and CNAs list, provided 2/8/23, shows the facility only employed 15 full time CNAs, 4 part time CNAs, and 7 casual CNAs.

Facility Assessment, reviewed 11/22/22, shows the facility average census was 153 residents. The assessment shows the total number of CNA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

full time equivalents required at the facility were 34-37. The assessment shows, " ...Facility budgets are established to act as a general guideline for facilities to follow when determining staffing levels needed to provide care to residents being serviced. These budgets are established based on the average resident census along with their projected needs for care and support. Facility budgets are maintained by the Administrator and are flexible based on the actual acuity and unique individual care needs of the residents. To promote continuity of care, and consistent practices, we avoid the use of contract staff and agency staff for direct care positions .... Individual staffing assignments are determined at the facility level and take into consideration the current support/care needs of the residents that include, but are not limited to medical/physical conditions, acuity, physician orders, therapeutic needs, infection prevention and control needs, behavioral support as well as any other special care needs as identified, Consultation with Alden Management Services in customizing and revising individual staffing assignment is obtained, if necessary.

On 2/1/23 at 3:03 PM, V1 (Administrator) stated she was aware of the schedule being short staffed and stated the facility was offering financial incentives for staff to work longer or extra shifts. V1 stated the facility was only able to rely on the staff on the facility payroll and the facility recently lost two CNAs to another facility. V1 stated she was not given permission to utilize agency nursing staff by her corporate supervisors.

1. Face sheet, printed 2/1/23, shows R1's diagnoses included multiple sclerosis, quadriplegia, spinal stenosis, overactive bladder,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

anxiety, and depression. MDS (Minimum Data Set), dated 1/30/23, shows R1 was cognitively intact, was totally dependent on staff for transfers, personal hygiene, eating and dressing, and required extensive assistance from two staff for bed mobility, R1 was always incontinent of bowel and bladder, and R1 had an indwelling urinary catheter. Braden scale, dated 1/28/23, shows R1 was at moderate risk for development of a pressure ulcer and R1 was not able to make even slight changes in body or extremity position without staff assistance.

ADL Care Plan, initiated 8/7/22, shows R1 required a mechanical lift for transfers and requires staff assistance for bathing, toileting, and personal hygiene. Interventions include R1 refuses to take showers on non-scheduled dates. Skin integrity care plan, revised on 2/17/22, shows R1 had a history of skin injuries to her sacrum, had a reopened injury to sacrum and impaired mobility. Interventions include inspect skin with showers and as needed and turn and reposition every two hours and as needed. Depression care plan, revised 1/29/23, shows R1 had a diagnosis of depression and was observed of feeling down and tearful. Incontinence care plan, dated 10/18/21, shows R1 was incontinent of bowel related to multiple sclerosis and quadriplegia and interventions included offering toileting opportunities based on R1's pattern of elimination. Bed mobility care plan, revised 4/19/18, shows R1 was unable to turn and reposition herself in bed without assistance with staff.

On 2/1/23 at 2:00 PM with V14 (Sister) on speaker phone, R1 stated the facility did not have enough staff to care for residents including providing showers, repositioning, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

checking/changing incontinence briefs. R1 stated she had not received a shower for two weeks. R1 stated had not received her showers twice a week for a few months and that was when R1 began having skin irritation. R1 stated not having showers twice weekly caused her to itch and scratch her skin until she bled. R1 had visible, scabbed, scratch marks on her left upper thigh, right upper arm near her shoulder, and bright red scabs on her right breast. R1 stated, "Once I start scratching, I can't stop! It started a couple months ago when it began to be one shower a week. I started itching more as it declined." R1 also stated, "I feel terrible, wouldn't you!? Sometimes I can smell myself!" V14 (Sister) stated, "I have called her and she has been so depressed and feels so bad about herself. She has told me it is depressing." R1 also stated, "They're not turning me. The other day I was not moved for 13 hours." R1 stated she had pressure ulcers and her repositioning schedule is never followed by staff. R1 stated, "When I am left sitting in one position for so long my pressure ulcer starts burning and I call my sister and she calls and talks to nurses and gets them in here." R1 stated she has waited two hours for staff to answer her call light for ADL assistance. R1 had a repositioning schedule over her bed that showed R1 was to be turned every two hours on the even hours.

On 2/6/23 at 3:35 PM, R1 was observed with V8 (Assistant Director of Nursing) and two open areas were noted during the observation - one area on the sacrum and one area on the left buttock. Per V8, these areas had been healed, were previously closed, and now were newly open. Facility's wound report, dated 2/2/23, shows R1's wounds were healed. On 2/7/23 V17 (Wound Physician) stated that he would expect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10 that R1 be repositioned at least every two hours and that R1 has a history of skin breakdown. On 2/9/23 at 8:08 AM, V2 (Director of Nursing) stated R1 could not move her body and would not be able to scratch herself. At 9:20 AM, V2 stated she visited R1 and asked R1 to show her if she could reach the areas that were observed to have scratch marks on 2/1/23. V2 stated she bathed R1 on 2/3/23 and saw no scratch marks red marks, or skin irritation on R1. V2 stated the night nurse on 2/8/23-2/9/23 stated R1 was scratching all night and the nurse called the physician for cream the AM of 2/9/23. V2 stated she was unaware of any creams R1 was provided prior to 2/9/23 for her itching. At 10:09 AM, V2 stated R1 told V2 she could reach those areas R1 stated she had been scratching and had caused scratch marks. On 2/9/23 at 9:34 AM, V14 (Sister) stated she previously provided R1 with a back scratcher and creams because R1 became so itchy recently. V14 stated the staff previously gave her a tube of cream to put on her skin when she started itching. V14 stated "I was just talking to her about the back scratcher. She just told me V2, and a nurse came in asking her about her scratch marks. You can't tell them anything because they deny it or downplay it. I told them not to do that to me. [R1] told them she could reach as far as the scratches are." Progress notes, dated 2/9/23, show, "Prior to resident scratching no skin issues noted. Resident noted to scratch skin at times this shift with dry brownish scratch marks noted to both anterior thigh, right chest and pinkish discoloration noted to right arm, with complaint of itching and per resident she scratches her skin."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11 Review of Bath/Shower Follow Up Question Report, printed 2/6/23, shows R1 received only 5 showers from 1/1/23 to 1/31/23 (showered on 1/6/23, 1/10/23, 1/13/23, 1/16/23, 1/20/23). The shower sheet shows R1 refused showers on 1/4/23, 1/25/23, and 2/1/23 all of which were documented as late entries by V9 (Restorative Nurse) on 2/2/23. On 2/6/34 at 3:50 PM, V9 (Restorative Nurse) stated the documentation entered on 2/2/23 on the Bath/Shower Follow Up Question report was not accurate and then provided hand-written shower sheets for R1 showing she provided R1 a shower on 1/16/23. V9 stated the hand-written shower sheets she provided were accurate documentation of showers she provided R1. V9 stated she filled out the shower sheet dated 1/20/23 for V12 (CNA/Scheduler) when V12 gave R1 a shower. V9 stated on 1/4/23 and 1/25/23 she offered R1 PM showers which she knew R1 did not prefer and R1 subsequently refused. V9 stated she only provided R1 one shower during January 2023 despite the documentation she recorded on 2/2/23 on the Bath/Shower Follow Up Question Report. On 2/6/23 at 9:40 AM, V12 (Scheduler/CNA) stated R1 only preferred her showers in the morning and all staff are aware of her preferences. V12 stated if you try to offer R1 showers in the afternoon/evening, she normally refuses. V12 stated the prior week was the second week in a row R1 had not received showers. V12 stated the last time she gave R1 a shower was on 1/20/23. V12 stated she was able to give R1 showers on 1/6/23, 1/10/23, 1/13/23, and 1/16/23 because they had more CNA staff. V12 stated the CNAs choose "Not Applicable" in	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12 the electronic record as a response when a resident's shower task appears during a day/shift that R1 was not scheduled for a shower. V12 stated residents are not offered showers when the response in the computer was marked "Not Applicable." Second floor facility shower list, dated 11/22/22, shows all residents are scheduled to receive two showers each week. Third floor facility shower list, dated 6/20/19, show all residents are scheduled to receive two showers each week. On 2/1/23 at 2:14 PM, V2 (Director of Nursing) stated staff were expected to check resident's incontinence briefs in their rooms every two hours if the residents were incontinent. 2. On 2/6/23 at 10:18 AM on the third floor, there was a strong smell of concentrated urine throughout each of the two hallways. R16 was a 95-year-old resident with multiple diagnosis including: Diabetes, Heart Failure, Hypertension, Protein Calorie Malnutrition, Gout, Dysphagia, and Muscle Weakness. Per R16's MDS (Minimum Data Assessment) dated December 27, 2022, R16 was dependent on staff for personal hygiene, transfers, position change, and is always incontinent of bowel and bladder. R16's care plan dated January 11, 2023, shows R16 required a two-person mechanical lift to transfer and R16's interventions included turning and repositioning R16 every two hours and as needed. R16 was assessed as cognitively impaired per the MDS assessment. Facility wound list, dated 2/2/23, shows R16 as having a healed wound to the left buttock and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 open Stage III wound to right buttock. R16 also has a previous Stage III pressure injury to the right heel that was documented as closed on October 25, 2022. R16's wound to the left buttock was noted as healed on January 24, 2023. Braden Scale, dated 2/1/23, shows R16 was at "mild risk" for development of a pressure injury. On 2/6/23, V13 (CNA) stated between 7:30 AM and 8:30 AM on 2/6/23, there was only one CNA working on the floor providing direct care for all 54 residents. At 8:30, a second CNA began working on the floor. On 2/6/23, R16 was observed on the third floor in the dining room or directly outside the dining room near the nursing station from 9:10 AM until 1:40 PM. R16 was noted sitting directly on the sling for the mechanical lift in an adult reclining chair. During this time, R16 was not checked for incontinence nor was she repositioned. At 3:20 PM, R16's wounds were observed with V2 (Director of Nursing RN) and V8 (Assistant Director of Nursing RN) and the area on the left buttocks was noted to be open. Both V2 and V8 confirmed that this area was now reopened and V8 stated he would notify the wound doctor. V17 (Wound Physician) was notified about the re-opened wound, was interviewed on February 7, 2023, at 1:15 PM, and stated that R16 should be repositioned at least every two hours to remove pressure. V17 also stated that since he is not in the facility all of the time that he assumed the staff would change R16's position at least every two hours. V17 stated that not providing position changes leads to new skin issues. 3. Face sheet, printed 2/1/23, shows R3's	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 14	S9999		

diagnoses included hemiplegia and hemiparesis following cerebral infarction, chronic respiratory failure with hypoxia, morbid obesity, and depression. MDS, dated 12/5/22, shows R3 was cognitively intact, required total assistance from staff for transfers, required the extensive assistance from two staff for bed mobility, dressing, toilet use, bathing and personal hygiene, and was always incontinent of bowel and bladder. Braden scale, dated 12/5/22, shows R3 was at mild risk for the development of a pressure ulcer.

On 2/1/23 at 2:29 PM, R3 stated during the day shifts she usually waits approximately 45 minutes for staff to answer her call light. R3 stated staff fail to turn her every two hours and fail to provide R3 showers. R3 stated she had not had a shower for weeks. R3 stated, "It makes me feel horrible." R3 stated front office staff had to help last time she was bathed because she needed so much cleaning.

On 2/6/23 at 9:40 AM, V12 (CNA) stated in early December 2022, R3 was seen by her Nurse Practitioner who told the facility to give R3 a shower because R3 was unclean, had foul odor, and R3's hair was matted. V12 stated she showered R3 at that time and had not given her a shower since.

On 2/6/23 at 11:48 AM, V20 (Nurse Practitioner) stated she did ask staff to give R3 a shower because R3's hair was not able to be combed out, R3 had an odor, and R3 had a denuded area under her breasts.

Review of facility Bath/Shower Follow Up Question report, printed 2/6/23, shows R3 received only 3 showers between 1/1/23 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 15 1/31/23 (showered on 1/20/23, 1/27/23, and 1/31/23). The report shows the staff marked "Not Applicable" on 1/3/23, 1/10/23, 1/17/23 and 1/24/23 indicating no shower was offered. Hand-written shower sheets provided by V9 (Restorative Nurse), showed she provided R3 showers on 1/20/23, 1/27/23, and 1/31/23. On 2/6/34 at 3:50 PM, V9 (Restorative Nurse) stated the documentation she entered on 2/2/23 on the Bath/Shower Follow Up Question report showing R3 was provided multiple showers by V9 (1/6/23, 1/13/23) was not accurate and provided hand-written shower sheets which accurately showed the showers she provided for R3. The shower sheets showed V9 only provided R3 showers on 1/20/23, 1/27/23, 1/27/23, and 1/31/23. On 2/6/23 at 9:40 AM, V12 (Scheduler/CNA) stated R3 did not receive showers on 1/6/23, 1/13/23, 1/17/23, 1/20/23 and 1/21/23. V12 stated the CNAs responded, "Not Applicable" in the computer when the task comes up in the computer and it is not the resident's shower/bath day. V12 stated no baths were provided to R3 on those days. ADL care plan, revised 2/6/23, shows R3 required two staff assistance with bed mobility, transfers, toileting, grooming and bathing. The revision shows, "Often declines ADL cares - showers, repositioning then says she was not offered care." Intervention, revised 2/6/23, shows, "Provide resident with a sponge bath when a full bath cannot be tolerated. If [R3] declines cares offer her a different time. Re-approach- re-attempt task." Alteration in skin integrity care plan, revised 1/6/22, shows R3 was at risk for an alteration in skin integrity and refuses to allow	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 16	S9999		

staff to provide incontinence care in a timely manner and to turn and reposition off a skin tear to thighs. Interventions include staff to provide toileting and incontinence care with care rounds and as needed as well as turn and reposition every two hours as needed. Transfer care plan, dated 12/13/22, shows R3 requires the use of a mechanical lift for transfers.

On 2/8/23 at 2:43 PM, V12 stated the care plan for R3 was inaccurate that R3 declined ADL cares including repositioning, incontinence care and showers. V12 stated she had worked with R3 every day for a couple of years and R3 never refused her offers of showers, incontinence care, or turning/repositioning.

On 2/8/23 at 12:24 PM, V1 (Administrator) stated V21 (Corporate Consultant) altered R3's care plan on 2/6/23. Attempts to reach V21 were unsuccessful.

4. Face sheet, printed 2/2/23, shows R10's diagnoses included pressure ulcer right heel, dementia, Alzheimer's disease, adult failure to thrive, restlessness and agitation, and legally blind. MDS, dated 12/27/22, shows R10 was severely cognitively impaired, was totally dependent on staff for bed mobility, transfers, dressing, toileting, required extensive assist from staff for bathing, eating, and personal hygiene, and was always incontinent of bowel and bladder. Braden scale, dated 12/26/22, shows R10 was at only mild risk for the development of pressure ulcers.

Impaired skin integrity care plan, revised on 2/21/22, shows R10 was admitted with an alteration in skin integrity / pressure injury and interventions included R10 was to receive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 17	S9999		

incontinence care with care rounds and as needed. Transfer care plan, initiated 12/29/22, shows R10 required the use of a mechanical lift for transfers and interventions included providing two staff assistance for transferring. Incontinence care plan, revised 12/29/22, shows R10 was incontinent related to dementia and interventions included provide assistance for toileting.

On 2/1/23 at 9:30 AM, R10 was sitting reclined in her reclining wheelchair just outside the third floor dining room doorway. R10 yelled, "I have to pee! What am I gonna do!?" V7 (RN-Registered Nurse) responded to R10 and stated, "Go ahead and pee. They will change your brief in a little bit." R10 responded to V7 and stated, "That's embarrassing! Oh Lord!" V7 then looked away from R10 and stated, "She's a [mechanical] lift." R10 continued to ask to go to the bathroom and V7 left R10's vicinity. At 9:33 AM, V7 stated R10 was very demented and incontinent.

R10 was observed sitting in her wheelchair on 2/6/23 from 9:47 AM-1:30 PM without being repositioned or having her incontinence brief checked/changed. R10 was noted with large amounts of facial hair, uncombed and matted hair, and strong body odor. R10's clothing was soiled with food and debris along with her chair.

5. Care plan, initiated 9/27/22, shows R4's diagnoses included dementia, cerebral infarction without residual deficits, muscle weakness, chronic obstructive pulmonary disease, non-pressure chronic ulcer of skin, chronic kidney disease, and diabetes. The ADL care plan, revised 9/27/22, shows R4 required assistance with transfer, bed mobility, hygiene, toileting and bathing. The care plan interventions included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 18 assisting R4 with ADLs and utilizing a mechanical lift for transfers. Skin integrity care plan, revised 9/27/22, shows R4 was at risk for alterations in skin integrity related to poor skin turgor, dementia, poor hygiene, dermatitis to scalp and feet, incontinence of bowels and bladders, and noncompliant with ADL care including turning, positioning, and incontinence care. The care plan shows R4 had chronic on and off redness to buttock and scrotum and a non-pressure wound to the right great toe and left second toe. Interventions included incontinence care with care rounds and as needed and turn and reposition as per schedule and as needed. Transfer care plan shows R4 required the use of a mechanical lift and two staff assisting R4 for transfers. Incontinence care plan shows R4 experienced bowel/bladder incontinence due to prostate enlargement and an inability to delay voiding. Interventions included checking R4 for incontinence. Repositioning care plan, revised 9/27/22, shows R4 required assistance from staff for bed mobility and was unable to turn/reposition himself in bed without physical assistance. Interventions included providing R4 weight bearing assistance as needed while sitting up, laying down, or turning side to side in bed. MDS, dated 12/15/22, shows R4 was severely cognitively impaired, required total assistance from staff for bathing, transfers and toileting, required extensive assistance from two staff for bed mobility, dressing, and required the extensive assistance of one staff for personal hygiene. The MDS shows R4 was always incontinent of bowel and bladder. Braden scale, dated 12/13/22, shows R4 was at mild risk for pressure ulcer development On 2/1/23 at 9:19 AM, R4 was sitting in the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 19 third-floor dining room slightly reclined in his wheelchair and finishing breakfast. On 2/1/23 during continuous observation between 9:19 AM and 12:19 AM, R4 sat in the same reclined position with no staff repositioning R4 and no staff checking/changing R4's incontinence brief. At 12:19 PM, R4 was taken to his room to have his incontinence brief checked/changed. On 2/6/23 R4 was again observed in his wheelchair from 9:15 AM until 1:36 PM and R4was not repositioned or checked for incontinence. R4 was noted with long jagged fingernails with a brownish substance underneath. R4 had food crumbs and debris on his clothing and face. R4 had dirty greasy hair, long facial hair, and strong body odor. At 1:36 PM, V13 (CNA) proceeded to provide personal care to R4. R4 was noted with saturated brief and hard dried fecal matter. R4's right buttock area was noted to be red and inflamed. V13 needed numerous wipes to clean the dried fecal matter from R4's buttock and anal area since the stool was dried. V13 stated that R4 will scratch his buttock and that is why R4 has fecal matter under his nails. V13 stated that this was the first time he had to change R4 since they only had 2 nurse aides on the floor. R4's skin assessment sheet dated February 7, 2023, documents that R4 has a pressure injury on the left buttock measuring 5.5 by 0.5 by 0.1 centimeters and another injury on the sacrum measuring 5.0 by 0.5 by 0.1 centimeters. 6. Face sheet, printed 2/1/23, shows R2's diagnoses included incontinence without sensory awareness, dementia, depression, and cervicalgia. MDS, dated 11/11/22, shows R2 was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 20	S9999		

cognitively intact, was totally dependent on staff for transfers, required the extensive assistance of two staff for bed mobility and toileting, required the extensive assistance of one staff for bathing, dressing and personal hygiene, and was always incontinent of bowel and bladder. Braden scale, dated 11/11/22, shows R2 was at mild risk for development of a pressure ulcer.

On 2/1/23 at 2:39 PM, R2 stated there were often only two CNA staff for the whole second floor of residents. R2 stated she sometimes waited 12-15 hours for her soiled briefs to be changed. R2 stated her last bed bath was 1/20/23 and before that she had not had a shower in a long time because there were not enough staff at the facility. R2 stated at times there is only one CNA working the entire second floor on a AM or PM shift. R2 stated the staff only reposition her when they change her incontinence brief. R2 stated the staff typically change her incontinence brief approximately three times a day - usually at 4:00 AM during the PM shift, at 10:00 AM after breakfast, and then at approximately 9:30 PM before she goes to sleep.

On 2/8/23 at 2:43 PM, V12 (CNA/Scheduler) stated R2 preferred her showers on the AM shift per her shower schedule which had been followed for years.

Review of Bath/Shower Follow Up Question Report, printed 2/6/23, shows R2 received only 4 showers from 1/1/23 to 1/31/23 (showered on 1/17/23, 1/24/23, 1/27/23, 1/31/23). The report shows on 1/6/23, 1/13/23, 1/20/23 and 1/21/23 the CNA responded, "Not Applicable" in the computer. Review of hand -written shower sheets, provided by V9 (Restorative Nurse), shows R2 received showers by V9 only on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 21 1/17/23, 1/24/23, 1/27/23, and 1/31/23. No hand-written shower sheets were provided for 1/3/23 and 1/10/23. On 2/6/34 at 3:50 PM, V9 (Restorative Nurse) stated the documentation entered on 2/2/23 on the Bath/Shower Follow Up Question report showing R2 was provided multiple showers by V9 (1/3/23, 1/10/23) was not accurate and provided hand-written shower sheets which accurately showed the showers she provided for R2. The shower sheets showed V9 provided R2 showers on 1/17/23, 1/24/23, 1/27/23, and 1/31/23. On 2/6/23 at 9:40 AM, V12 (Scheduler/CNA) stated R2 did not receive showers on 1/6/23, 1/13/23, 1/20/23 and 1/21/23 because the CNAs responded, "Not Applicable" in the computer. V12 stated facility CNAs mark Not Applicable on the bath/shower task when the task comes up in the computer and it is not the resident's shower/bath day. ADL Care Plan, revised 11/18/22, shows R2 required staff assistance with ADLs related to weakness and pain. Interventions included one staff assistance for bed baths, assist with ADLs as needed, check for skin changes during bathing, Intervention, revised 7/24/18, shows R2 prefers bathing after dinner between 8:00 PM and 9:00 PM. On 2/8/23 at 2:31 PM, V12 (Scheduler/CNA) stated R2 prefers showers in the AM which had been her shower schedule for years. 7. Care plan, revised 9/22/21, shows R7's diagnoses included dementia, bipolar disorder, psychotic disorder, depression, and anxiety. Care plan, revised 9/21/21, shows R7 had a	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 22 potential for impaired skin integrity and interventions included turning and repositioning every two hours as needed. MDS, dated 1/2/23, shows R7 was severely cognitively impaired, required the extensive assistance of staff for bathing, bed mobility, transfers, dressing, toileting, and personal hygiene, and was always incontinent of bowel and bladder. Braden scale, dated 9/30/22, shows R7 was at mild risk for the development of pressure ulcers. On 2/1/23 at 9:19 AM, R7 was sitting in her wheelchair finishing her breakfast in the third-floor main dining room. On 2/1/23, during continuous observation between 9:10 AM and 12:05 PM, R7 sat in her wheelchair without staff repositioning R7 or checking/changing R7's incontinence brief. At 2:05 PM, R7 was toileted by V5 (CNA). V5 stated he got R7 up from bed at approximately 8:00 AM and checked/changed R7's incontinence brief at that time. R7's incontinence brief had a very strong smell of urine. 8. Face sheet, printed 2/1/23, shows R9's diagnoses included dementia, anxiety, and depressive disorder. MDS, dated 12/2/22, shows R9 was severely cognitively impaired, was totally dependent on staff for bathing, required the extensive assistance of two staff for bed mobility and transfers, required the extensive assistance of one staff for dressing, eating, toileting and personal hygiene, and was always incontinent of bowel and bladder. Braden scale, dated 12/2/22, shows R9 was at mild risk for development of a pressure ulcer. On 2/1/23 at 9:24 AM, R9 was laying in her bed in her room on her back sleeping with a thick blanket covering her body from her toes to her	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 23	S9999		

neck. The room temperature was very warm. During continuous observation, R9 was laying in the same position without incontinence check/change or repositioning from 9:24 AM to 12:29 PM. As R9 laid in bed, R9's cheeks became more red and at 12:08 PM R9 pulled the blanket down from her chin to her chest.

On 2/1/23 at 12:16 PM, V18 (Assistant Administrator) stated R9 required assistance from staff to reposition in bed every two hours.

On 2/1/23 at 12:29 PM, V5 (CNA) changed her incontinence brief which had bowel movement in the brief. V5 stated he last changed / repositioned R9 at 8:00 AM that morning.

9. Face sheet, printed 2/2/23, shows R12's diagnoses included dementia and palliative care. MDS, dated 12/19/22, shows R12 was severely cognitively impaired, was totally dependent on staff for bathing, toileting, transfers, bed mobility, dressing, eating, and personal hygiene. The MDS shows R12 was always incontinent of bladder and bowel.

Skin integrity alteration care plan, revised 8/24/22, shows R12 had a history of pressure ulcers and interventions included incontinence care with care rounds and as needed as well as turning and repositioning every two hours and as needed. Transfer care plan, revised 7/6/22, shows R12 required the use of a mechanical lift for transfers and interventions included providing two staff assistance for transfers. ADL care plan, revised 7/6/22, shows R12's ADL interventions included 1-2 staff to assist R12 with her ADLs. Turning/Repositioning care plan, revised 7/6/22, shows R12 required assistance from staff for bed mobility and R12 could not reposition herself

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 24	S9999		

without physical assistance from staff due to dementia, impaired cognition, and weakness/deconditioning. Interventions included staff to provide weight bearing assistance as needed for resident while sitting up, laying down, or turning side to side in bed.

On 2/1/23 at 9:19 AM, R12 was sitting in her recliner wheelchair finishing breakfast in the main dining room of the third floor. On 2/1/23 during continuous observation between 9:29 AM and 12:01 PM, R12 sat in her wheelchair in the dining room and no staff repositioned R12 or checked/changed R12's incontinence brief.

On 2/1/23 at 12:55 PM, V6 (CNA) stated the last time she toileted R12 was approximately 7:45 AM before breakfast.

10. POS (Physician Order Sheet), as of 2/2/23, shows R11's diagnoses included quadriplegia. dementia, anxiety, and depression. MDS, dated 11/3/22, shows R11's cognition was severely compromised, R11 required was totally dependent on staff for transfers and bathing, R11 required the extensive assistance of two staff for bed mobility and toileting, R11 required the extensive assistance of one staff for personal hygiene, eating, and dressing, and R11 was always incontinent. Care plan, revised 5/10/22, shows R11 had a potential for skin integrity alteration and approaches included turn and reposition per schedule and as needed. Care plan, revised 8/10/22, shows R11 required a mechanical lift for transfers including the assistance of two staff.

On 2/1/22 at 9:19 AM, R11 was sitting in her wheelchair finishing breakfast in the third floor dining room in her wheelchair. On 2/1/22 during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 25 continuous observation between 9:19 AM - 11:44 AM, R11 remained in the same position in her wheelchair without staff repositioning R11 or checking/changing R11's incontinence brief. At 11:44 AM, R11 was removed from the dining room to have her incontinence brief checked/changed. On 2/1/23 at 12:52 PM, V5 (CNA) stated the last time R11 was repositioned or had her incontinence brief checked/changed was approximately 8:00 AM - 8:30 AM before R11 ate breakfast. 11. Care plan, revised 11/22/21, shows R5's diagnoses included dementia, muscle weakness, adult failure to thrive, and protein-calorie malnutrition. The care plan, revised 2/1/22, shows R5 had a history of pressure ulcers and interventions included turn and reposition as per schedule and as needed. Care plan, revised 11/6/22, shows R5 required two staff assistance and the use of a mechanical lift for transfers. MDS, dated 1/13/23, shows R5 was severely cognitively impaired, was totally dependent on staff for bathing, transfers, dressing, toileting use, and personal hygiene, required the extensive assistance of two staff for bed mobility, and was always incontinent of bowel and bladder. Braden scale, dated 1/13/23, shows R5 was at mild risk for the development of a pressure ulcer. On 2/1/23 at 9:19 AM, R5 was sitting in her wheelchair in the third floor main dining room finishing her breakfast. On 2/1/23 during continuous observations between 9:19 AM and 11:36 AM, R5 was not repositioned and R5's incontinence brief was not checked/changed by staff.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 26 On 2/1/23 at 12:45 PM, V6 (CNA) stated R5 was incontinent of bowel/bladder and she last toileted R5 at approximately 8-8:30 AM. 12. Face sheet, printed 2/1/23, shows R6's diagnoses included dementia and overactive bladder. MDS, dated 1/2/23, shows R6 was severely cognitively impaired, was totally dependent on staff for bathing, required the extensive assistance of two staff for transfers, required the extensive assistance from one staff for bed mobility, dressing, toileting, and personal hygiene, and was totally incontinent of bowel and bladder. Braden scale, dated 1/2/23, shows R6 was at mild risk for the development of a pressure ulcer. On 2/1/23 at 9:19 AM, R6 was sitting in her reclining wheelchair in the third-floor dining room finishing breakfast. On 2/1/23, during continuous observation between 9:19 AM and 11:54 AM, R6 sat in her wheelchair with no staff repositioning her and no check/change of her incontinence brief. On 2/1/23 at 11:54 AM, facility staff asked R6 if she wanted to be toileted. On 2/1/23 at 12:53 PM, V5 (CNA) stated R6 was last toileted before breakfast at approximately 8:00 AM. 13. Face sheet, printed 2/1/23, shows R8's diagnoses included dementia, and restlessness and agitation. MDS, dated 1/26/23, shows R8 was severely cognitively compromised, was totally dependent on staff for toileting, required the extensive assistance from staff for bathing, bed mobility, transfers, dressing, personal hygiene, and was always incontinent of bowel and bladder. Braden scale, dated 1/25/23, shows R8	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 27 was at moderate risk for the development of a pressure ulcer. On 2/2/23 at 9:37 AM, R8 was sitting at the nursing station in her wheelchair. At 11:55 AM, staff wheeled R8 into the dining room for lunch without checking/changing R8's incontinence brief or repositioning R8. At 12:18, R8 was toileted by V6 (CNA). On 2/2/23 at 12:13 PM, V6 (CNA) stated R8 was last changed at approximately 9:00 AM. 14. R19 is an 83-year-old resident with the following diagnosis: Dementia with Behaviors, Cognitive Communication Deficit, Agitation, Major Depression, and Hypertension. MDS, dated 1/1/23, shows R19 was totally dependent on staff for bathing, required the extensive assist of two staff for bed mobility and transfers, required the extensive assistance of one staff for hygiene, and toileting, required set up and supervision of meals, and was always incontinent of bowel and bladder. Care plan, revised 1/9/23, shows R19's diagnoses included dementia with behavioral disturbance, schizophrenia, cognitive communication deficit, major depression, anxiety, idiopathic peripheral autonomic neuropathy, and muscle weakness. The care plan, revised 12/30/21, shows R19 was at risk for alteration in skin integrity and interventions included avoid turning R19 to her back as much as possible, turn and reposition every two hours, and toileting assistance with care rounds. The care plan shows R19 is unable to turn and reposition herself in bed without physical assistance from staff.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 28 On 2/1/23, R19 was laying in her bed on her back asleep with her breakfast tray untouched sitting on her bedside table. On 2/1/23, during continuous observation between 9:28 AM and 11:57 PM, R19 laid on her back in her bed without any repositioning or incontinence brief check/changes. At 11:57 AM, V2 (Director of Nursing - DON) asked R19 if she needed her incontinence brief changed and R19 stated no. V2 stated R19 could turn and reposition herself in bed and did not need staff assistance to do so. On 2/6/23 at 9:48 AM, R19 was noted to be slouched down in bed and unable to reach her breakfast meal of: eggs, toast, orange juice and liquid nutritional supplement. The resident remained unable to reach her food until 10:05 AM and then refused to eat. Staff did not assist or set up R19's food for her to reach. 15. R17's care plan shows she had a diagnosis of dementia, cognitive communication deficit, overactive bladder. The care plan showed R17 had impaired cognitive functioning and required the use of a mechanical lift for transfers. ADL Care plan, initiated 2/1/23, shows R17 required ADL assistance with tasks as needed. Alteration in Skin Integrity care plan shows R17 was at risk for development of skin integrity alterations due to bowel/bladder incontinence, requiring extensive assistance with bed mobility and transfers, and a diagnoses of overactive bladder. Interventions include pericare after incontinence episodes. On 2/6/23 during continuous observation between 9:00 AM and 11:58 AM, R17 sat in her wheelchair and facility staff did not check/change R17's incontinence brief. At 10:10 AM, R17 was sitting	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 29 in her wheelchair at the nursing station with her husband next to her and yelled, "I have to have a BM (Bowel Movement)!" No staff responded to R17's comment. At 11:02 AM, R17 was taken to her room and transferred to her bed by V11 (CNA) and V8 (Assistant Director of Nursing). V11 stated he got up R17 from bed and last changed her brief at approximately 8:00 AM - 8:30 AM before breakfast. V11 and V8 did not check/change R17's incontinence brief at the time of the transfer to bed. During continuous observation from 11:15 AM when R17 was placed in bed to 11:58 AM, R17 laid in bed with no staff checking/changing her brief. At 11:58 AM, R17 yelled from her room, "Change my diaper!" V9 (Restorative Nurse) changed R17's incontinence brief and the brief had a large bowel movement in the brief and was saturated in urine. 16. Review of R14's care plan shows R14 required ADL assistance related to her dementia including toileting, bathing, transfers, bed mobility, and personal hygiene. R14's care plan shows R14 constantly fidgeted in her wheelchair and was able to put her legs up in the air causing friction to her sacral/coccyx area and interventions included pressure redistribution support on her wheelchair and toileting/incontinence assistance with care rounds- nursing to assist with incontinence care. On 2/6/23 during continuous observation from 9:05 AM to 11:25 AM, R14 sat in her wheelchair in the same position without her incontinence brief checked/changed. R14 was also noted to have a strong body odor, her clothing was full of food and debris and R14 had greasy unwashed hair. At 11:25 AM, V8 (Assistant Director of Nursing RN) changed R14's brief which was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 30 noted to be wet and had a strong odor of urine. 17. R15 is a 74-year-old resident with the following diagnosis: Hypertension, Dementia, Kidney Disease, Major Depression and Malignant Neoplasm. MDS, dated 11/17/22, shows R15 required extensive assistance from staff for dressing, toilet use, personal hygiene, dressing and bathing. R15 also required a two-person mechanical lift for transfers. R15's care plan revised 11/24/22 shows R15 was incontinent of bowel and bladder and interventions included provide assistance with toileting and peri care. R15's care plan also showed R15 required ADL assistance and R15 was at risk for skin alterations related to mobility issues and incontinence. On 2/6/23 R15 was observed on the third floor in the dining room or area outside the dining room near the nursing station from 9:08 AM until 1:20 PM, and was not repositioned and was not checked for incontinence. R15 was only moved from the dining room to the area near the nursing station after lunch while staff cleaned the dining room. R15 was noted to have heavy unshaven beard, dirty fingernails, food crumbs and debris all over his clothes and wheelchair. R15 was noted to have a strong body odor and his arm splint was noted to be heavily soiled. 18. R20 is a 67-year-old resident with the following diagnosis: Parkinson's Disease, Anemia, Ataxia, Anxiety Disorder, Muscle Weakness and Bipolar disorder. R20's MDS showed R20 required the extensive assistance from two staff for bed mobility and transfers and the extensive assistance from one staff for personal hygiene, toilet use, and bathing. R20 was observed during incontinence care on 2/6/23	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000459	A. BUILDING: _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VALLEY RIDGE REHAB & HCC	275 EAST ARMY TRAIL ROAD BLOOMINGDALE, IL 60108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 31 at 10:30 AM provided by V13 (CNA). V13 was noted to remove the soiled adult brief that was saturated with urine. A second adult brief was also noted layered under the first and this brief was also heavily saturated with urine. R20's turning pad was also noted to be stained yellow and dried. R20 was noted with dried and fresh stool that took 5 wipes to remove. V13 stated that this was the first time he had been in R20's room and that now they only had two nurse aides on the floor but earlier he was the only CNA on duty. R20 is a two-person transfer via mechanical lift and was changed in his bed. Abuse Policy, dated 9/2020, shows, "The facility affirms the right of our residents to be free from abuse, neglect .... This will be done by: ...3. Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; 4. Identifying occurrences and patterns of potential mistreatment ...." The policy shows, "Neglect is the failure of the facility, its employees or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress." The policy shows, "c. Random rounds will be made throughout facility assessing the safety of the facility environment .... E. On a regular basis, supervisors will monitor the ability of the staff to meet needs of residents; staff understanding of individual resident care needs .... " (B)	S9999		