Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ______ B. WING ______	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 300.610a) 300.1010i) 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures.	S9999	**Attachment A** Statement of **Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ______ B. WING ______	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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 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 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. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ______ B. WING ______	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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	S9999		

nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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 regulations are not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide direct supervision during a meal and failed to ensure that the incident was immediately reported to the nurse for one resident (R34) of 24 residents reviewed for accidents/incidents in a sample of 37. These failures resulted in R34 sustaining a second degree burn to the left forearm/left elbow and a burn of unspecified degree to the left breast area.

Findings include:

R34 is a 50 year old female that suffered a Cerebral Infarction in February 2021 which resulted in left sided weakness and paralysis. R34's medical record also documents the following pertinent diagnoses: Generalized Muscle Weakness, Lack of Coordination, Need for Assistance with Personal Care, Dysphagia, Muscle Wasting and Atrophy and Diabetes Mellitus.

A facility Incident Report documented that R34 experienced a Burn Incident on 5/23/21. The incident report dated 5/23/21 at 12:05pm was

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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	S9999		

authored by V6 (LPN-Licensed Practical Nurse) and documents: "This nurse was assisting (R34's) roommate with toileting in the bathroom when this nurse overheard (R34) inform therapist that she spilled her hot drink on her and burned herself. According to the patient, she grab(bed) her coffee from table and once it was on hand, it slipped and it spilled on her left arm and bed. She states feeling pain 5/10." Upon assessment, R34 had visible redness on left lateral arm and forearm. V6 applied a cold compress and obtained an order for Silvadene treatments to start twice a day after notifying V16 (Physician Assistant) of the burns.

On 6/8/21 at 10:35am, R34 recounted the incident and stated, "They brought my tray to me in my room and just left it there. The tea was very hot despite the creamer and the thickener. It was very hot. Hot enough to burn me. The mug slipped from my hand and the whole hot tea spilled on my left side. I already can't feel well on that side because of the stroke. They didn't supervise me. There was no supervision the day that it happened. Generally, it's (V11-Speech Therapist) that supervises me but she was not here that day or maybe she was with another resident. Generally, I was told that someone needs to always supervise me because I spill on myself during meals." R34 continued, "The CNA (Certified Nurse Assistant) should stay with me and they didn't. But they have many patients to take care of. If I was supervised, it wouldn't have happened. And then, the CNA didn't change me after I spilled the hot tea. She left me in the wet gown for almost an hour and a half." R34 stated, "This never should have happened. Now, despite trying to recover from the stroke and brain surgery, I now have to deal with more treatments and pain for these burns." R34 indicated that V7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ____ B. WING ____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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	S9999		

was aware that she spilled hot tea on herself and also knew that she was eating by herself.

The CNA was identified as V7.

On 6/9/21 at 2:07pm, V6 (LPN) stated as was documented in R34's incident report that, "(V7) came to tell me that (R34) spilled on herself. She did not tell me that it was a hot liquid. She just said, "I'll be back to her to change her but have to take care of another patient first." V6 indicated that V7 never reported to her that R34 was burned. V6 indicated that one hour later she was assisting R34's roommate to the bathroom and overheard R34 state that she spilled her drink and got burned. V6 stated, "Her gown was still wet from chest to belly. I thought back to when (V7) told me about a spill." V6 performed an assessment and found redness on R34's left arm/forearm and left breast. V6 stated, "(R34) is supposed to be direct supervision for meals. So, I'm thinking (V7) didn't stay with her and supervise her. (R34) cannot have hot drinks by herself." V6 indicated that the therapist offered to change R34's gown but requested help so V6 asked V7 to assist.

On 6/9/21 at 2:25pm, V7 (CNA) made a statement that was opposite R34 and V6's statement. V7 stated, "Another person brought the tray to her. I don't know what happened because I was taking care of another resident. I'm busy in another room. (R34) told me that she spilled on herself. I did not supervise her during lunch because it was delivered and no one told me."

R34's Physician Order Sheet (POS) documents an order dated 5/11/21 that reads: Pureed with nectar thick liquid. 1:1 assisted feeding with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ______ B. WING ______	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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		

supervision and feeding assist.

A sign above R34's bed reads: direct supervision-double swallow with puree: puree/nectar thick liquids. No talking while eating.

On 6/8/21 at 11:00am, V11 (ST-Speech Therapist) stated, "Right now (R34) is on a pureed diet with nectar thick liquids. I usually request direct supervision when they go from NPO (nothing by mouth) to a diet for safety reasons. She can't use left side. She holds everything with the right hand but does not have the best grip with cups and utensils." V11 further indicated that R34 requires supervision with hot drinks.

R34's ST notes dated 5/20/21 documents: "Requires moderate cues to aspiration precautions."

On 6/9/21 at 11:24am, V12 (OT-Occupational Therapist) indicated that R34 can self feed but requires a lot of cueing to complete a task. V12 stated, "Judgement wise - giving her hot drinks could be a safety issue." V12's OT notes dated 5/21/21 document: "Pt requires max verbal and tactile cueing for initiation, sequencing and task completion."

On 6/9/21 at 12:00pm, V5 (Dietary Manager) indicated that at the time of R34's burn incident, it was not the protocol of dietary staff to perform temperatures on the hot liquids before they were served. V5 indicated that the coffee or hot water would come straight from the machine to a pot and then to cups for service. V5 stated that once R34's incident occurred, he started temping the hot liquids and found that the hot liquids were 175 degrees Fahrenheit straight from the machine. V5

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ________ B. WING ________	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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 stated that the process was changed to where he performs temperatures before the hot liquids are served and that the coffee or hot water is allowed to cool off in an airpot before service. R34's progress notes dated 5/24/21 document that R34 developed redness with three blisters on her left forearm and a large blister to left breast. On 5/24/21 at 6:56am, R34's progress notes document that she was experiencing pain at the burn site and was administered Morphine 5 milligrams. It is documented that R34 continued to complain of pain in both burn sites and required pain medication. On 5/26/21, R34's left forearm burn site measured 4 cm (centimeter) length by 2.5 cm (width) by 0 cm (depth) and R34's left breast burn site measured 2.5 cm by 4 cm by 0 cm. R34's POS documents that Silvadene treatments to R34's left arm and left breast started daily on 5/24/21. On 5/27/21, the wound care team initiated care for R34's burns. R34's treatment was changed on 5/28/21 to Dakin's solution, Silvadene ointment and foam dressing every two days for both sites. R34's wound care documentation dated 5/27/21 reads: Burn of unspecified degree of chest wall-left breast and burn of second degree of left elbow-left forearm. On 5/27/21, R34's left breast burn measured 4 cm by 3 cm by 0.1 cm and the left forearm measured 3 cm by 7 cm by 0 cm. Both burn sites increased in size. On 6/9/21, during wound care, two scabbed areas were noted on R34's left breast area and a darker brown area noted on left forearm area. On 6/9/21 at 10:20am, V13 (Wound Care Nurse) stated to R34 while changing the dressing on her left breast, "There will be a possible debridement done next week to help healthy tissue come out.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ____ B. WING ____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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		

Continued From page 7

There will be pain. He will scrape the top layer of the scab to get to healthy tissue."

On 6/10/21 at 10:37am, V15 (Physician) stated, "We just assumed care for her in May. Definitely, she should have been supervised when taking meals. She was supervised during her meal, right?" V15 was told that R34 was not supervised during the meal at the time of the burn incident. V15 stated, "Someone should have been in there."

On 6/10/21 at 9:55am, V1 (Administrator) stated, "My expectation is that incidents get reported to the nurse right away."

On 6/9/21 and 6/10/21, the facility was asked to submit a policy regarding Supervision. There was no policy submitted.

(B)

2 of 3

300.690b)
300.690c)

Section 300.690 Incidents and Accidents

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ______ B. WING ______	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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 resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These regulations are not met as evidenced by: Based on interview and record review, the facility failed to report an incident that caused burn injuries within 24 hours and within seven days of the reportable injury to the State agency which affected one resident (R34) of 24 residents reviewed for incidents/accidents in a sample of 37. Findings include: R34 is a 50 year old female that suffered a Cerebral Infarction in February 2021 which resulted in left sided weakness and paralysis. R34's medical record also documents the following pertinent diagnoses: Generalized Muscle Weakness, Lack of Coordination, Need for Assistance with Personal Care, Dysphagia, Muscle Wasting and Atrophy and Diabetes Mellitus. A facility Incident Report documented that R34 experienced a Burn Incident on 5/23/21. The incident report dated 5/23/21 at 12:05pm was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ______ B. WING ______	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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		

authored by V6 (LPN-Licensed Practical Nurse) and documents: "This nurse was assisting (R34's) roommate with toileting in the bathroom when this nurse overheard (R34) inform therapist that she spilled her hot drink on her and burned herself. According to the patient, she grab(bed) her coffee from table and once it was on hand, it slipped and it spilled on her left arm and bed. She states feeling pain 5/10." Upon assessment, R34 noted slight redness on left lateral arm and forearm.

On 6/8/21 at 10:35am, R34 recounted the incident and stated, "They brought my tray to me in my room and just left it there. The tea was very hot despite the creamer and the thickener. It was very hot. Hot enough to burn me. The mug slipped from my hand and the whole hot tea spilled on my left side. I already can't feel well on that side because of the stroke. They didn't supervise me. There was no supervision th(at) day that it happened. Generally, it's (V11-Speech Therapist) that supervises me but she was not here that day or maybe she was with another resident. Generally, I was told that someone needs to always supervise me because I spill on myself during meals." R34 continued, "The CNA (Certified Nurse Assistant) should stay with me and they didn't. But they have many patients to take care of. If I was supervised, it wouldn't have happened. And then, the CNA didn't change me after I spilled the hot tea. She left me in the wet gown for almost an hour and a half." R34 stated, "This never should have happened. Now, despite trying to recover from the stroke and brain surgery, I now have to deal with more treatments and pain for these burns."

The CNA was identified as V7.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ______ B. WING ______	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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 R34's progress notes dated 5/24/21 document that R34 developed redness with three blisters on her left forearm and a large blister to left breast. R34 was experiencing pain at the burn site and was ordered/administered Morphine 5 milligrams as needed. On 5/26/21, R34's left forearm burn site measured 4 cm (centimeter) length by 2.5 cm (width) by 0 cm (depth) and R34's left breast burn site measured 2.5 cm by 4 cm by 0 cm. R34's POS documents that Silvadene treatments to R34's left arm and left breast started daily on 5/24/21. On 5/27/21, the wound care team initiated care for R34's burns. R34's treatment was changed on 5/28/21 to Dakin's solution, Silvadene ointment and foam dressing every two days for both sites. R34's wound care documentation dated 5/27/21 reads: Burn of unspecified degree of chest wall-left breast and burn of second degree of left elbow-left forearm. On 5/27/21, R34's left breast burn measured 4 cm by 3 cm by 0.1 cm and the left forearm measured 3 cm by 7 cm by 0 cm. Both burn sites increased in size. On 6/9/21 at 10:20am, V13 (Wound Care Nurse) stated to R34 while changing the dressing on her left breast, "There will be a possible debridement done next week to help healthy tissue come out. There will be pain. He will scrape the top layer of the scab to get to healthy tissue." On 6/9/21, two scabbed areas were noted on R34's left breast area and a darker brown area noted on left forearm area. On 6/9/21, V1 (Administrator) and V2 (DON-Director of Nursing) indicated that they were not aware that the incident had to be reported to the State agency and confirmed that R34's burn incident was not reported. On 6/9/21 at 3:15pm, V2 stated, "The incident	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ______ B. WING ______	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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 was not reported because I was told by my nurse consultant that since she is alert and could tell us how it happened, that it didn't need to be reported." On 6/9/21 at 3:20pm, V1 stated, "It wasn't reported because she didn't go to the hospital and didn't have any fractures." A facility policy dated 9/2020 and titled, "Incident/accident reports" documents: Procedure 12. The Director of Nursing, Assistant Director of Nursing or Nursing Supervisor must notify: a) The (State agency) of any serious incident or accident. "Serious" means any incident or accident that causes physical harm or injury to a resident. b) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, the facility shall notify the Department's toll-free complaint registry hotline. c. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven (7) days after the occurrence. (C) 3 of 3 Section 300.675 COVID-19 Training Requirements EMERGENCY 300.675a)1)3)A-G) 300.675c)1)A-J)3) a) Definitions. For the purposes of this Section,	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ___ B. WING ___	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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 following terms have the meanings ascribed in this subsection (a): 1) "CMMS Training" means CMMS Targeted COVID-19 Training for Frontline Nursing Home Staff and Management, available at https://QSEP.cms.gov. 3) "Management staff" means any facility staff who: A) Assign and direct nursing activities; B) Oversee comprehensive assessment of residents' medical needs and care planning; C) Recommend numbers and levels of nursing personnel; D) Plan nursing service budgeting; E) Develop standards of nursing practice; F) Supervise in-service education and skill training for all personnel; G) Participate in the screening of prospective residents and resident placement. c) Required Management Staff Training 1) All management staff employed by facilities shall complete the following portions of CMMS Training: A) Module 1: Hand Hygiene and PPE; B) Module 2: Screening and Surveillance; C) Module 3: Cleaning the Nursing	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ______ B. WING ______	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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 Home; D) Module 4: Cohorting; E) Module 5: Caring for Residents with Dementia in a Pandemic; F) Module 6: Infection Prevention and Control; G) Module 7: Emergency Preparedness and Surge Capacity; H) Module 8: Addressing Emotional Health of Residents and Staff; I) Module 9: Telehealth for Nursing Homes; and J) Module 10: Getting Your Vaccine Delivery System Ready. 3) Facilities shall ensure 100% of management staff have completed the CMMS Training by February 28, 2021. These regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 100% compliance of management staff for completion of the CMMS (Centers for Medicare and Medicaid Services) Targeted COVID -19 training designated as required for management staff by February 28, 2021. Findings include: On 06/08/2021 CMMS Targeted Covid-19 Training was checked for compliance. V1	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014757	A. BUILDING: ______ B. WING ______	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD DES PLAINES, IL 60016

(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 (Administrator) is not in compliance with the CMMS targeted COVID-19 training course. V1 completed the lesser course for frontline workers and not the management course that is required for his position as Administrator of the facility. V1 completed the frontline course on 03/09/2021. V1 stated he is aware he completed the wrong course and will retake the course for management. V1 stated he was unsure of the dates the course was supposed to be completed and will look it up. V1 submitted an E-mail titled in the subject field CMS (Centers for Medicare and Medicaid Services) COVID-19 Training/TNA (Temporary Nursing Assistant) rule change notification. Under CMS Targeted COVID-19 training states IDPH (Illinois Departement of Public Health) is adopting an emergency rulemaking extending the mandatory compliance dates. By January 31, 2021 all LTC (Long Term Care) facilities, as defined under the Nursing home care act, shall have achieved at least 50% completion of the CMS training by frontline clinical staff and management. By February 28, 2021 all frontline staff and management shall have completed the CMS training. However, the required training modules for frontline staff (five specific modules) and management (ten specific modules) will not change. (C)	S9999		