STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0042010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD , DES PLAINES, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Investigation of Facility Reported Incident of 11/24/25/IL2682332	S0000		12/18/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210c) 300.1210d)6) 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 300.1210 General Requirements for Nursing and Personal Care 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:	S9999		12/18/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0042010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	**1221 EAST GOLF ROAD , DES PLAINES, Illinois, 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) COMPLETION DATE
S9999	Continued from page 1 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to implement fall preventive measures for a resident who is a 2-person transfer assist due to limited mobility due to surgical site. This deficiency affects one (R1) of three residents reviewed for Falls prevention program. This failure resulted in R1 to have dislocation of the right hip prosthesis requiring hospitalization. R1 is an 83-year-old with the following diagnosis: periprosthetic fracture around internal prosthetic right hip joint, history of falling, essential hypertension, hyperlipidemia, myelodysplastic syndrome, anemia, orthostatic hypotension, personal history of transient ischemic attack and cerebral infarction without residual deficits, age-related osteoporosis without current pathological fracture, polymyalgia rheumatica, presence of right artificial hip joint. Facility Reported Incident dated 11/24/25 documents during the transfer from toilet to wheelchair, R1 experienced sudden weakness in his right leg and was lowered to the floor by the CNA (Certified Nurse Aide). Head to toe assessment completed and the resident denied pain at the time of the fall. R1 reassessed for pain and stated he has pain in the right hip. MD and daughter were notified. X-ray was completed which revealed dislocation of the right hip prosthesis. R1 was sent to the emergency room for further evaluation.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0042010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	1221 EAST GOLF ROAD , DES PLAINES, Illinois, 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) COMPLETION DATE
S9999	Continued from page 2 On 12/06/25 at 11:45 am, V2 (Director of Nursing) said that on 11/24/25 when incident occurred with transfer to toilet R1 should have been a 2-person transfer assist. V2 said that the certified nurse aide working with R1 during incident is no longer an employee at the facility for multiple reasons including resident safety. V2 said that R1 was transferred to hospital due to dislocation of right hip prosthesis and has not returned to facility. On 12/06/25 at 12:30 PM, V5 (Registered Nurse) stated that when incident with R1 occurred R1 was being transferred to the toilet by 1 staff assist (certified nurse aide). V5 said R1 is supposed to be a 2-person transfer assist due to R1 being a surgical patient and fall precautions needed to be in place. V5 said that the certified nurse aide called him to the room and V5 observed R1 in a sitting position on the floor. V5 assessed R1 with no change of Level of consciousness and no complaints of pain, V5 and the certified nurse aide assisted R1 back to bed using a gait belt. V5 said he notified the MD, family member and Director of Nursing. V5 said when R1 was reassessed for pain R1 said he was having pain to the right hip. V5 notified MD and received orders for x-rays of the right hip for R1 due to fall and complaint of pain. On 12/06/25 at 1:15pm, V6 (Restorative Nurse) said that R1 is a 2 person assist upon admission due to surgical site and having a wound vac, V6 said that she assessed the resident for transfer status assist upon admission and also refers to physical therapy for recommendation and if agreed then the transfer status is then updated in the residents chart and also in the resident point of care charting and updated in the transfer status binder located at the nurses station. On 12/06/25 at 2:00PM, V1 (Administrator) said that R1 had a fall in the facility and the fall was reported due to injury. V1 said that the certified nurse aide working with R1 during time of incident was suspended pending investigation and eventually was let go of the facility due to multiple factors. The Fall Risk Assessment dated 11/19/25 documents At risk for falls. GG Screener Assessment dated 11/19/25 documents Toileting Hygiene: Dependent transfer. Functional Abilities- Admission Assessment dated 11/21/25 documents Chair/bed to chair transfer: Dependent transfer. Toilet transfer: dependent transfer.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0042010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	**1221 EAST GOLF ROAD , DES PLAINES, Illinois, 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) COMPLETION DATE
S9999	Continued from page 3 Restorative Progress note dated 11/21/25 documents staff/patient education to use walker with 2-person assist to transfer using left side/good side for safety. Radiology Progress Note dated 11/25/25 documents Patient X-ray result was with hip dislocated. Physical Therapy Evaluation and Plan of Treatment dated 11/20/25 documents R1 is a Max assist out of bed and total dependence assist with transfers. The Care Plan dated 11/19/25 documents R1 is at high risk for falls d/t generalized muscle weakness, impaired mobility, gait, balance, decreased activity tolerance and medical diagnosis of right pre-prosthetic hip, myelodysplastic syndrome. Interventions in place include encourage appropriate use of walker, bed to chair transfer 2-person assist using rollator walker using good side/left side to transfer. The Care Plan dated 11/21/25 documents R1 has an ADL functional performance deficit due to generalized muscle weakness, impaired mobility, gait, balance, decreased activity tolerance and medical diagnosis of right pre-prosthetic hip, myelodysplastic syndrome. Interventions in place include bed to chair transfer 2-person assist using rollator walker using good side, left side to transfer. Facility Policy on Transfer revision date 2/10/2022 Definition: Transfer refers to activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record. Considerations: 2. Fractures- Follow physician orders regarding movement or weight bearing restrictions and any therapy recommendations when developing individualized programs. General transfer guidelines: 1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe transfers of residents.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0042010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	**1221 EAST GOLF ROAD , DES PLAINES, Illinois, 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) COMPLETION DATE
S9999	Continued from page 4 2. Manual lifting of resident's should be eliminated when feasible. 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual resident's needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include: a. Resident's preferences for assistance. b. Resident's mobility (degree of dependency) c. Residents size d. Weight-bearing ability e. Cognitive status f. Whether the resident is usually cooperative with staff g. The resident's goals for rehabilitation, including restoring or maintaining functional abilities. 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. General Transfer Procedures: 3. utilize assistive devices as needed: bedrails, walker, slide board, etc. 7. transfer toward the resident stronger side and place the chair/wheelchair at the resident's stronger side when possible. Facility Policy on Management of Falls revision date 8/2020 Policy: The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the residents plan of care in order to minimize the risks for fall incidents and/or injuries to the resident. Procedure: 1. Complete a Fall Risk Assessment upon admission, re-admission, with significant change, post-fall, quarterly, and annually.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0042010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN DES PLAINES REHAB & HC	**1221 EAST GOLF ROAD , DES PLAINES, Illinois, 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) COMPLETION DATE
S9999	Continued from page 5 3.Develop a plan of care to include goals and interventions which address resident's risk factors. Risk factors may include but are not limited to the following contributing diagnosis/disorders/diseases processes/ active infections/ other comorbidities, history of fall incidents, incontinence, medications (Narcotics, Antihypertensives, etc.), assistance required with ADL's, gait/transfer/balance issues, Behaviors, and /or cognitive status. 4. provide assistive devices for mobility, hearing and vision as appropriate for the resident. 5. Assess appropriateness for resident to participate in skilled therapy or restorative programming in order to maintain or improve physical function or resident. (A)	S9999		