STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145126	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Lincoln Rehab & H C Ctr	504 West Wellington Avenue Chicago, IL 60657

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on observation, interview and record review, the facility: 1. Failed to ensure Registered Dietician/Clinical Dietician's enteral feeding recommendation was implemented. 2. Failed to notify Nurse Practitioner (NP) or physician that enteral feeding recommendation was not carried out. 3. Failed to ensure that enteral feeding and flushing were administered as ordered by physician. These failures resulted in R1's significant / severe weight loss of 11.3lbs (pounds) = 10.7% x 30 days and elevated BUN (Blood Urea Nitrogen) level reviewed for improper nursing care in a sample of 3. The finding include: R1's health record documented admitted on 2/14/24 with diagnoses not limited to Unspecified dementia, severe, with other behavioral disturbance, Adult failure to thrive, Encounter for attention to gastrostomy, Type 2 diabetes mellitus with diabetic chronic kidney disease, Unspecified severe protein-calorie malnutrition, Chronic combined systolic (congestive) and diastolic (congestive) heart failure, Hypertensive heart and chronic kidney disease with heart failure, Diaper dermatitis, Schizoaffective disorder bipolar type, Pneumonia, Dysphagia oropharyngeal phase, Body mass index [bmi] 19.9 or less, Ocular pain left eye, Gastro-esophageal reflux disease without esophagitis, Personal history of COVID-19, Age-related osteoporosis without current pathological fracture, Restlessness and agitation, Peripheral vascular disease, Long term (current) use of insulin, Chronic kidney disease stage 2 (mild), Primary insomnia, Personal history of transient ischemic attack (tia), and cerebral infarction without residual deficits, Vitamin d deficiency, Iron deficiency anemia, Long term (current) use of oral hypoglycemic drugs, Unspecified psychosis not due to a substance or known physiological condition, Hyperlipidemia, Long term (current) use of anticoagulants, Post-traumatic stress disorder, Epilepsy, Paroxysmal atrial fibrillation, Aphasia. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	On 5/5/24 at 1:03pm Enteral feeding and flushing administration observation conducted with V3 (Registered Nurse / RN) and V5 (Certified Nursing Assistant / CNA). R1 sitting up in wheelchair, wearing abdominal binder, Gastrostomy tube (G-tube) site with dressing dry and clean. Observed V3 checked gastric residual then administered Fibersource HN 1.2 250ml bolus enteral feeding and flushed with 150ml water. At 3:18pm Interviewed V2 (Director of Nursing / DON) and V2 said nurses are expected to follow doctor's order in administering G-tube feeding and flushing. Nurses are expected to document or sign off on the MAR (Medication Administration Record) after administering g-tube feeding and flushing. If MAR was not signed or documented, task was not done, G-tube feeding and flushing was not administered. If G-tube feeding and flushing were not administered or were missed could potentially lead to weight loss or dehydration. On 5/6/24 at 8:02am interviewed V17 (Clinical Dietician / Registered Dietician), stated R1 had weight change in April, weight loss of 10% x 30 days, 5% and above considered as significant weight change x 30 days. Recommended increasing the tube feeding to elevate volume and concentration. V17 said Fibersource 1.2 1250ml per day was not adequate to meet R1's needs, recommended to increase enteral feeding to1800ml / day on 4/20/24. Recommendation was calculated based on R1's ideal body weight and R1 is underweight with history of malnutrition. V17 said was informed that his recommendation was not put through because the family (POA) needed to okay the recommendation. Stated that his goal for his recommendation was to meet R1's nutritional needs through enteral feeding. R1 is on pleasure feeding but not eating enough about 0-50% per staff documentation. If R1 continues to receive enteral feeding of Fibersource 1250ml/day will continue to lose weight due to not enough for his nutritional needs. He said during weight meeting, he was informed that R1 with issue of diarrhea. Fibersource will help with diarrhea. R1 significant weight loss is contributed with: 1. enteral feeding not meeting his nutritional needs. 2. Diarrhea - due to altered bowel function. 3. Loss of fluids due to his diarrhea. V17 said enteral water flushing order is 150ml 5x per day, total of 750ml per day. He said R1's fluid needs is 1900-2200ml/day. R1 is getting his hydration needs from enteral feeding of 1010ml /day, 120ml from medication flushing and 120ml from supplements. Total of 2000ml/day. V17 said R1's nutritional needs, calculated with his ideal body weight of 142lbs. Calorie intake 30-35kg came out to 1928-2249cal/day. Current order of enteral feeding (Fibersource 1.2 1250ml/day) provides 1500cal/day. R1's oral intake = 0-50%. V17 said if g-tube water flushes were missed could potentially elevate the BUN level and needs not being met as R1 with very poor oral intake. If enteral bolus feeding were missed or not given could contribute to significant weight loss, based on current regimen, anything missed would be detrimental. R1's hydration and nutritional needs is dependent to enteral feeding and flushing. At 9:19am Interviewed V18 (Nurse Practitioner / NP), stated he is aware of R1's significant weight loss of 10% for 30days and the recommendation to increase enteral feeding to 1800ml/day and was okay with it but was not aware that order was not in place at this time. If enteral feeding recommendation was not carried out, it would contribute to further significant weight loss, any missed enteral feeding can also contribute to weight loss. V18 said missed enteral water flushing could potentially elevate BUN level. Depending on how many times R1 missed his G-tube flushes will depend how elevated the BUN level would be. R1 is getting his hydration and nutritional needs through G-tube flushes and feeding so it is important to give G-tube feeding and flushing as ordered and recommended. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Alden Lincoln Rehab & H C Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 504 West Wellington Avenue Chicago, IL 60657	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Minimum Data Set (MDS) dated [DATE] showed R1's cognition was severely impaired. He needed total assistance or Dependent with eating, oral, toileting and personal hygiene, shower/bathe self; Substantial / maximal assistance with upper and lower body dressing; Partial / moderate assistance with chair/bed transfer. MDS showed R1's weight was 105lbs, had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months, not prescribed weight loss regimen and R1 with feeding tube. Reviewed R1's weight and documented in part: 4/17/2024 = 94.7 Lbs (pounds); 3/28/2024 = 105.0 Lbs; 3/21/2024 = 106.0 Lbs; 3/14/2024 = 105.0 Lbs; 3/12/2024 = 108.0 Lbs. R1's laboratory results reviewed and documented in part (BUN reference range = 7-23): 3/25/24: BUN = 36; 4/1/24: BUN = 29; 4/10/24: BUN = 40; 4/18/24: BUN = 34; 4/19/24: BUN = 28. R1's MAR (medication administration record) reviewed: - Enteral feed order five times a day flush feeding tube with 125ml H2O with each bolus feed - not signed as administered on 4/10/24 at 6am. - Enteral feed order five times a day flush feeding tube with 150ml H2O with each bolus feed - not signed as administered on 4/18/24 at 2pm. - Enteral feed order five times a day flush feeding tube with 175ml H2O with each bolus feed - not signed as administered on 4/11/24 at 10pm. - Enteral feed order five times a day tube feeding (BOLUS FEED): Fibersource HN 1.2 250ML 5X per day - not signed as administered on 4/10/24 at 6am, 4/18/24 at 2pm R1's POS (physician order sheet) reviewed with active order not limited to: - Enteral Feed five times a day flush feeding tube with 150ml with each bolus feeding. - Enteral Feed five times a day tube feeding (BOLUS FEED): Fibersource HN 1.2 250ml 5x per day 1, 250ml/daily. V17's Nutrition notes dated 4/20/2024 documented in part: Weight: 94.7, -5.0% change [10.7%, 11.3lbs] x 30d; -7.5% change [16.9%, 19.3] x 90d; -10.0% change [20.4%, 24.3] x 180d. 04/20/2024; BMI 15.3 reflects underweight for age. Diet: Pleasure Feeding diet, Mechanical Soft texture, thin consistency; Meal intakes 0-50%; wt. (weight) loss likely inadequate kcal intakes and/or inadequate Enteral infusion; Start EN (enteral nutrition) Fibersource HN 1.2 to infuse1800 mL/d @ 90 mL/h, continuous; Flush @ 145mL q6h, bolus. R1's monthly enteral assessment dated [DATE] documented in part: Dietary recommendations - Start EN (Enteral Nutrition) Fibersource HN 1.2 to infuse 1800ml/day at 90ml/hour, continuous via PEG (Percutaneous Endoscopic Gastrostomy); Flush at 145ml every 6hours, bolus via PEG. EN provides 2160kcal, 97g, 1454ml free water. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R1's electronic health record reviewed no documentation showed that dietary recommendation was carried out or implemented. No documentation indicated that Nurse Practitioner or Physician was notified that RD's enteral feeding recommendation was not implemented. Facility's enteral nutritional feeding policy dated 9/2020 documented in part: Verify MD (Medical Doctor) orders for feeding. Document on MAR (medication administration record) with initials verifying that feeding was running on that shift.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47304 Based on observation, interview and record review the facility failed to follow their policy and procedures to ensure signage outside of the resident's room indicating Enhanced Barrier Precaution (EBP) was posted; failed to ensure PPE (Personal Protective Equipment) was made available and accessible outside of the resident's room or nearby and failed to ensure proper PPE were worn by staff when providing high contact resident care activities to 1 (R1) resident. These failures have the potential for cross contamination to 29 residents residing on the 2nd floor as of census 5/5/24. The findings include: R1's health record documented admitted on 2/14/24 with diagnoses not limited to Unspecified dementia, severe, with other behavioral disturbance, Adult failure to thrive, Encounter for attention to gastrostomy, Type 2 diabetes mellitus with diabetic chronic kidney disease, Unspecified severe protein-calorie malnutrition, Chronic combined systolic (congestive) and diastolic (congestive) heart failure, Hypertensive heart and chronic kidney disease with heart failure, Diaper dermatitis, Schizoaffective disorder bipolar type, Pneumonia, Dysphagia oropharyngeal phase, Body mass index [bmi] 19.9 or less, Ocular pain left eye, Gastro-esophageal reflux disease without esophagitis, Personal history of COVID-19, Age-related osteoporosis without current pathological fracture, Restlessness and agitation, Peripheral vascular disease, Long term (current) use of insulin, Chronic kidney disease stage 2 (mild), Primary insomnia, Personal history of transient ischemic attack (tia), and cerebral infarction without residual deficits, Vitamin d deficiency, Iron deficiency anemia, Long term (current) use of oral hypoglycemic drugs, Unspecified psychosis not due to a substance or known physiological condition, Hyperlipidemia, Long term (current) use of anticoagulants, Post-traumatic stress disorder, Epilepsy, Paroxysmal atrial fibrillation, Aphasia. On 5/5/24 at 1:03pm Surveyor observed R1's room with no door signage indicating Enhanced Barrier Precautions (EBP). No Personal Protective Equipment (PPE) supplies (like gowns) were accessible to staff or made available near R1's room. Enteral feeding and flushing administration observation conducted with V3 (Registered Nurse / RN) assisted by V5 (Certified Nursing Assistant / CNA). V3 and V5 donned gloves, not wearing gown. R1 wearing abdominal binder, G-tube site with dressing dry and clean. Observed V3 checked gastric residual then administered Fibersource HN 1.2 250ml bolus enteral feeding and flushed with 150ml water. V3 (Registered Nurse / RN) stated there are 29 residents residing on the 2nd floor with 3 CNAs and 1 nurse working. At 3:18pm Interviewed V2 (Director of Nursing / DON), V2 stated resident with G-tube feeding would be under EBP (Enhance Barrier Precautions) and staff is expected to wear proper PPE (Personal Protective Equipment) such as gown and gloves when administering G-tube feeding and flushing or any other high contact care activities. There should be a signage posted by the door to identify that resident is on EBP. V2 said PPE supplies should be in the bin, set up by room entrance for easy access to staff when providing high contact care activities. Staff is expected to wear proper PPE to prevent spread of infection or cross contamination. Facility's enhanced barrier precautions (EBP) policy dated 12/14/23 documented in part: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- EBP involves gown and gloves use during high-contact resident care activities for residents with indwelling medical device. - High contact resident care activities include the following: Device care or use - feeding tube. - Residents that have indwelling medical devices, regardless of MDRO (Multi Drug Resistant Organism) status, will be on EBP. Some examples may include: Feeding tube. - Post CDC EBP sign outside of the resident's room. - Make PPE available and accessible outside of the resident's room.