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	10/31/2024

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 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44103

Based on observation, interview, and record review, the facility failed to determine and assess a resident to determine if self-administration of medications is appropriate, failed to obtain a physician's order for medication self-administration, failed to develop a person-centered care plan addressing self-administration of medications, failed to obtain physician orders for resident's medications, and failed to follow-up on the medication administration for 1 (R1) out of 3 residents reviewed.

Findings Include:

On 10/29/24 at 10:37 AM, R1 was sitting up in [R1's] bed alert and able to verbalize needs. R1 showed Surveyor multiple loose pills inside a small clear pouch on top of R1's bedside table. When Surveyor asked what those pills are, R1 answered, These are my 6:00 AM and 9:00 AM medications. I have here three pills of Sevelamer, one Losartan, one Eliquis, one antibiotic, two 25 mg of Metoprolol, and one renal vitamin. I have not taken these because I haven't eaten anything yet.

On 10/29/24 at 10:58 AM, Surveyor entered R1's room with V5 (Licensed Practical Nurse/LPN). V5 was about to administer three tablets of Sevelamer 800 mg to R1 that was scheduled at 11:00 AM when V5 saw the loose pills inside the clear pouch on top of R1's bedside table. V5 stated, You did not tell me that you did not take your 9AM meds yet. I did not give those to [R1] the night shift nurse did. Those are [R1's] 6AM and 9AM meds. [V7/Registered Nurse] was the night shift nurse. [V7] gave these to [R1] before [R1] went for dialysis. Maybe we should call the Doctor to change the timing of your medications. Surveyor and V5 also observed the following medications at R1's bedside on top of R1's nightstand:

- One bottle of Neuriva. R1 stated, I take two tablets of those a day.

- One bottle of Prevagen. R1 stated R1 takes one tablet once a day.

- One bottle of Areds. R1 stated R1 takes one tablet twice day.

- Levalbutirol inhaler. R1 stated R1 takes one puff every 4 hours.

- Wixela inhaler. R1 stated R1 takes one puff twice a day.

- Fluticasone inhaler. R1 stated R1 takes 2 puffs at nighttime.

(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 10/31/2024

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 12:45 PM, Surveyor reviewed R1's electronic health records. R1 was admitted on [DATE] with included diagnoses not limited to Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, and End Stage Renal Disease. R1's Minimum Data Set, dated dated dated [DATE] shows R1 is cognitively intact. R1's physician orders with active orders as of 10/29/24 shows no order for self-administration of medications. There were also no assessments or re-evaluations found in R1's records to determine if R1 is appropriate to self-administer R1's own medications. R1's care plan does not address if medication self-administration is appropriate for R1. R1's physician orders show medication orders for Apixaban 5 mg 1 tablet every 12 hours; Fluticasone-Salmeterol inhalation 1 inhale orally two times a day; Levalbuterol Inhalation 1 inhale orally via nebulizer every 4 hours; Losartan 12.5 mg one time a day; Metoprolol 50 mg one time a day every Monday, Wednesday, Friday, and Sunday; Renal Multivitamin 1 tablet one time a day; Sevelamer 800 mg 3 tablets three times a day; and Wixela Inhalation 1 inhale orally two times a day. There were no physician orders found for Neuriva, Prevagen, and Areds. On 10/29/24 at 3:13 PM, a phone interview was conducted with V7 (Registered Nurse). V7 stated [V7] never completed job orientation in the facility. V7 stated [V7] worked the 3rd floor night shift (10/28/24) until morning of 10/29/24. V7 stated it was V7's first time on the third floor and didn't know the residents there. V7 stated V7 did not know R1 was going to dialysis early in the morning. V7 stated, [R1] came up to me after 2:00 AM and asked me to give [R1] all [R1's] 9:00 AM medications. [R1] said [R1] is going to the dialysis and [R1] needed to take [R1's] meds with [R1]. [R1] directed me what medications [R1] wanted to take with [R1]. I checked the EMAR [Electronic Medication Administration Record]. I gave all of [R1's] 9:00 AM meds to [R1] in the clear pouch, and [R1] took the meds with [R1] to dialysis. [R1] told me [R1] would take them at 9:00 AM. On 10/30/24 at 10:04 AM, Surveyor reviewed R1's progress notes on 10/29/24. No documentation found if R1's missed morning medications on 10/29/24 were followed up with V8 (R1's Physician). R1's progress notes dated 10/29/24 at 10:43 AM written by V5 reads in part: During meds round, the nurse noticed that the patient still had the medication that the nurse from the night shift had given to him to take with him to dialysis. The patient was re-educated about the importance of taking the medication at the correct time. On 10/30/24 at 11:40 AM, inspected R1's medications inside 3rd floor team 1's medication cart with V9 (LPN). R1's inhalers and eye drops were not in the medication cart. V9 stated R1 keeps all [R1's] eye drops and inhalers at bedside and takes them on his own. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 1:05 PM, V2 (Director of Nursing) stated that nurses have to check from the resident's EMAR what medications they are administering to the residents. They have to wait until the resident takes the medications. They are not supposed to leave the resident's room without making sure that the resident took the meds. V2 stated that if residents are not monitored and made sure that the resident had taken their medications, then the resident could potentially take the medications with other medications that could double the dose. V2 stated that if the medications are refused or they miss a dose, nurses have to call the physician and they have to check the full vital signs to check if the resident is stable from missing medications and find out how many times it's occurred. V2 stated V2 expects the nurses to follow the physician orders for medication administration. V2 stated V2 is not aware of the facility's policy regarding self-administration of medications because there are no resident currently residing in the facility that is self-administering their own medications. V2 stated that if a resident would like to self-administer their own medications, then there should be an evaluation or assessment to show that the resident is eligible and is safe to administer their own medications. V2 stated that resident evaluation should be done prior to giving the permission to the resident to self-administer own medications. V2 stated that the nurses need to do a lot of resident teaching and observation that the resident is taking the medication correctly. V2 stated that the education and assessment should all be documented in the resident's chart and needs to be re-assessed quarterly to make sure that the residents who are self-administering medications still have the ability to do that. V2 stated that self-administration of medication should be ordered by the physician. V2 stated that R1 is not self-administering their own medications and the nurses should be providing R1's medications and making sure that R1 is taking [R1's] medications. V2 stated that R1 is not allowed to keep [R1's] own medications at bedside. V2 stated all residents' medications should be securely stored in the medication carts. V2 stated, As far as I know there is no one here that is self-administering their own medications. The facility's SELF-ADMINISTRATION OF MEDICATIONS policy dated 9/20 reads in part: Residents will not be permitted to administer or retain medications in their rooms unless so ordered by the attending physician, assessed for their cognitive, physical, and visual ability to self-medicate, and approved by the care planning team. The Self- Medication Training Program will consist of the following: resident request to self-medicate, self-medication assessment completed initially and quarterly, MD order to participate in the program, plan of care with quarterly documentation to the progress of the established goal, and completion of the self-medication daily flow sheet. The facility's MEDICATION ADMINISTRATION policy dated 9/20 reads in part: Drugs must be administered in accordance with the written orders of the attending physician.