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	05/24/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43351 Based on observation, interview, and record review, the facility failed to ensure the call device was placed within a resident ' s reach and failed to ensure staff inquired what a resident needed when responding to a call device. These failures affected 2 (R2 and R3) residents reviewed for call devices in the total sample of 5 residents. Findings include: On 05/23/2025 at 12:15pm, R2 ' s call device was behind the nightstand, not within her reach. V13 (Licensed Practice Nurse) checked the call device string and stated it is tangled. V13 untangled the call device string and clipped to R2 ' s left side. V13 stated placement of the call light should be within R2's reach. So, we can know when she needs assistance. On 05/23/2025 at 12:20pm, V14 (Certified Nursing Assistant) stated the last time I went to her room was an hour ago. I did not check for the placement of R2's call light. On 05/23/2025 at 12:31pm, the call device overhead light indicator on R3 ' s room was lit. On 05/23/2025 at 12:33pm, V14 went inside the room and informed R3 that staff are getting ready to serve lunch. V14 did not ask what R3 needed. The overhead call device indicator light was turned off and V14 exited R3 ' s room. This surveyor inquired if V14 asked R3 what kind of assistance R3 needed. V14 stated I did not ask R3 what he needs. On 05/23/2025 at 3:44pm, V2 (Director of Nursing) stated the purpose of call light is for the resident to be able to ask for assistance. My expectation is the call light should be placed within reach of the resident. I want them to be able to use it, have access to it. My expectation is to answer the call light immediately, within 2-3 minutes, and to ask the resident what he or she needs; what type of assistance he or she needs. On 05/23/2025 at 4:01pm, V2 stated if the resident rings the call light, they must be needing something, and we have to accommodate the need of the resident. R2 ' s (Active Order as of: 05/23/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) history of falling, hypertension, and age-related osteoporosis. (continued on next page)

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2 ' s (03/21/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 10. Indicating R2 ' s mental status as moderately impaired. R2 ' s (Target Date: 06/20/2025) care plan documented, in part at High RISK for falls related to HX (history) of fall incident in the community, repeated falls and History of repeated falls. She is modified independent with transfers, ambulation, and ADL, and she completes tasks on her own without calling for assistance. Interventions/Tasks: Promote placement of call light within reach. R3 ' s Admission Record documented that R3 ' s diagnoses (include but not limited to) hypertension, severe dementia and age-related cataract. R3 ' s (04/07/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 04. Indicating R3 ' s mental status as severely impaired. Section GG. Functional Abilities. GG0130. Self-Care. C. Toileting hygiene and I. Personal hygiene: 2 - substantial/maximal assistance. R3 ' s (05/23/2025) Fall Risk Assessment documented, in part Reason for Assessment: e. Post Fall. R3 ' s (Target Date: 07/06/2025) care plan documented, in part Focus: AT RISK for falls related to hx (history) of falling, use of Indwelling foley catheter, Bowel incontinence, poor balance, unsteady gait, impaired cognition, use of wheelchair and RW, poor vision, and Dx (diagnosis) of Hx of displaced apophyseal Fracture of Left femur, Dementia, BPH and HTN. has poor safety awareness and has impulsive behavior. The (03/2023) Certified Nursing Assistant Job description documented, in part Job Summary: Provides residents with daily nursing care in accordance with current federal, state, and local standards, guidelines and regulations, facility policies as may be directed by the Charge Nurse, Supervisor, Assistant Director Of Nursing, Director Of Nursing Or Administrator to ensure that the highest degree of quality care is maintained at all times. Essential Functions: P. Answer call lights promptly. AA. Keeps the nurse ' s call system within easy reach of the resident. The (09/2020) Use of Call light documented, in part Purpose: To respond promptly to resident ' s call for assistance. Procedure: 3. Answer all call lights in a prompt, calm and courteous manner; turn off the call light as soon as you enter the room. 4. Never make the resident feel you are too busy to give assistance; offer further assistance before you leave the room. 7. B sure call lights are placed within the resident reach at all times. The (08/2020) Fall Management Program documented, in part Policy: The facility is committed to minimizing resident falls and or injury so as to maximize each resident ' s physical, mental, and psychosocial well-being. While preventing all resident falls is not possible, it is the facility ' s policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies, and facilitate a safe environment. Procedure: 3. Educate staff members to check during room rounds the 4 P ' s. d. Personal needs. 5. b. At the time of admission, and in accordance with the plan of care. The resident will be oriented to use the nurse call device. The nurse call device will be placed within the resident ' s reach. c. Call lights are to be answered promptly.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43351 Based on interview and record review, the facility failed to develop a careplan for a resident ' s known behavior and failed to ensure fall interventions were implemented. These failures affected 2 (R1 and R3) residents reviewed for careplan in the total sample of 5 residents. Findings include: On 05/23/2025 at 2:25pm, V7 (Certified Nursing Assistant) stated I know (R1) ' s incident was after supper, on the second floor dining room, as I was wheeling her (R1) out and before I made a turn to the exit, out of the dining room, she grabbed the wheel of (R5) ' s wheelchair. Her (R1) left hand got caught on the wheel of (R5) ' s wheelchair and she lunged and fell . On 05/23/2025 at 2:45pm, V7 stated I am familiar with her (R1). When I first came in, the senior CNAs told me that she grabs on to things and to be careful. The first time I was assigned to her, I already noticed behaviors of grabbing onto things each time I wheel her out of the dining room to her bed, she will hold onto something like the rail. She grabs stuff all day long. If you have to toilet her and change her diaper, she would grab the table with her hands spread out. I think it should be care planned to prevent incidents that happened on that day (04/23/2025). On 05/23/2025 at 4;21pm, V6 (Licensed Practice Nurse) stated I am familiar with the resident (R1). I observed her grabbing onto things when we wheel her out of the dining room. When you wheel her, she would spread her arms and start grabbing whichever is closer to her like a chair or wheelchair. When she came to the second floor, she already exhibited the behavior of grabbing on things when she wheeled out. I think she had that behavior while she was on the 3rd floor. I don ' t know if she was care planned for that behavior. It could have helped if the behavior of grabbing on to things was care planned so interventions could be implemented. On 05/23/2025 at 3:11pm, V16 (Resident Care Coordinator) stated if a resident has a behavior of grabbing things like wheelchair and tables, it should be care planned so it can be addressed to prevent injury to the resident and to other residents. It should be care planned the moment they observe the resident exhibiting the behavior right there and then so the behavior could be addressed. On 05/23/2025 at 3:36pm, V8 (Memory Care Director) stated the behavior of grabbing onto things should be care planned when the behavior was first noted and to make sure staff is aware of the behavior. So, if it continues to occur, we can help prevent the behavior. It is a safety concern. We can help prevent the behavior and we can keep the resident safe. On 05/23/2025 at 3:49pm, V2 (Director Of Nursing) stated the behavior should be care planned when it was first noted. Basically, we want to be able to identify how the resident acts, and we will put in different interventions and monitor the effectiveness of the interventions. This surveyor showed V2 R1 ' s 4/24/2025 careplan which was initiated a day after the incident. V2 stated if care planned before the incident, we could have potentially prevented the incident. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 ' s (Printed: 05/23/2025) census list documented that R1 was moved from the third floor to the second floor on 11/20/2024. R1 ' s (Active Order as Of: 05/23/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) history of falling, hypertension, and dementia. R1 ' s (03/14/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 2. Indicating R1 ' s mental status as severely impaired. R1 ' s (Date Initiated: 04/24/2025) careplan documented, in part Focus: noted to continue to stand while in wheelchair and at dining room table and attempt to grab items while being transported in wheelchair. Goal: will be free from injury. Of note, care plan was initiated after the fall incident. R3 ' s (05/23/2025) Fall Risk Assessment documented, in part Reason for Assessment: e. Post Fall. R3 ' s (Target Date: 07/06/2025) care plan documented, in part Focus: AT RISK for falls related to hx (history) of falling, use of Indwelling foley catheter, Bowel incontinence, poor balance, unsteady gait, impaired cognition, use of wheelchair and RW, poor vision, and Dx (diagnosis) of Hx of displaced apophyseal Fracture of Left femur, Dementia, BPH and HTN. has poor safety awareness and has impulsive behavior. Intervention: Do not leave in bed while awake. On 05/23/2025 at 12:07pm, V13 (Licensed Practice Nurse) stated we have 2 nurses and 2 CNAs working this shift. On 05/23/2025 at 12:24pm, V15 (Certified Nursing Assistant) responded to R3 ' s call device. V15 went inside R3 ' s room. After responding to R3 ' s call device, V15 left R3 ' s room. On 05/23/2025 at 12:25pm, no staff was present in R3 ' s room. R3's stated I am okay, I am okay. This surveyor went by R3's door and requested for assistance. On 05/23/2025 at 12:27pm at the doorway of R3 ' s room, V15 came in and after a short interview, V15 left. On 05/23/2025 at 12:29pm by the nurse ' s station, inquiring who was assigned to R3. V13 stated she (V14 - CNA) stepped out for few minutes. On 05/23/2025 at 12:31pm, the call device overhead light indicator on R3's room was lit. On 05/23/2025 at 12:33pm, V14 went inside the room and informed R3 that staff are getting ready to serve lunch. The overhead call device indicator light turned off and V14 exited the room. On 05/23/2025 at 12:34pm, inside R3's room, no staff was present. R3 attempted to get out of the bed. This surveyor called V13 for assistance. On 05/23/2025 at 12:35pm, V13 went inside the room and stayed in the room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/2025 at 4:02pm, V2 (Director Of Nursing) stated I expected the care plan to address the need of the resident and implementing the interventions is the best way to keep our resident safe. On 05/23/2025 at 4:03pm, V2 (Director Of Nursing) stated we do encourage (R3) to stay in the dining room. If he is in the bed and awake, he tries to get out of the bed. At this time, this surveyor handed V2 R3 ' s careplan and informed V2 that R3 was in the room awake with no staff present in the room. V2 stated we are not following the intervention. This intervention is to prevent him from falling. R3 ' s Admission Record documented that R3 ' s diagnoses (include but not limited to) hypertension, severe dementia and age-related cataract. R3 ' s (04/07/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 04. Indicating R3 ' s mental status as severely impaired. Section GG. Functional Abilities. GG0130. Self-Care. C. Toileting hygiene and I. Personal hygiene: 2 - substantial/maximal assistance. R3 ' s (05/223/2025) Fall Risk Assessment documented, in part Reason for Assessment: e. Post Fall. R3 ' s (Target Date: 07/06/2025) care plan documented, in part Focus: AT RISK for falls related to hx (history) of falling, use of Indwelling foley catheter, Bowel incontinence, poor balance, unsteady gait, impaired cognition, use of wheelchair and RW, poor vision, and Dx (diagnosis) of Hx of displaced apophyseal Fracture of Left femur, Dementia, BPH and HTN. has poor safety awareness and has impulsive behavior. Intervention: Do not leave in bed while awake. The (05/24/2025) email correspondence with V1 (Administrator) documented, in part Behavior would constitute a change in residents plan of treatment, so expectation would be to update the care plan accordingly, to include a focus, goals, and intervention reflective of the behavior. Care plans should be updated routinely (initial, quarterly, annually, readmit, sig changes) and or if new behavior is observed. The reason is so that goals and interventions can be created to then be able to further assist with caring for resident. The (9/2016) Memory Care Director Job Description documented, in part Job Summary: The memory care director is directly responsible for the initial and continual development and monitoring of the holistic, therapeutic, present centered memory care program on the memory. The Memory Care Director will achieve and maintain the highest quality of life for each resident, either diagnosis or disease that causes dementia residing in or under the care of the facility. Essential Duties: L. Become knowledgeable of each individual resident ' s Behavioral care needs and preferences in detail to develop and ensure an appropriate person centered plan of care. The (11/2017) Comprehensive Care Plans documented, in part An individualized, person centered comprehensive care plan, including measurable objectives with timetables to meet the resident ' s physical, psychosocial and functional needs, is developed and implemented for each resident. Procedure: 1.) the interdisciplinary team will develop and implement a person centered, comprehensive plan of care. 2. The Interdisciplinary team includes b. A nurse and nurse ' s aide that have responsibility for the resident. 6.) the comprehensive person-centered care plan will b. Describe the services that are to be provided to attain or maintain the highest practical physical, mental and psychosocial well being.

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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. 43351 Based on interview and record review, the facility failed to institute interventions for a resident ' s known behavior to provide safety for the resident and other residents. This failure resulted in a resident falling and sustaining a closed fracture of the phalanx (small bone) of index finger and contusion of the head. This deficient practice affected 1 (R1) resident reviewed for quality of care in the total sample of 5 residents. Findings include: On 05/23/2025 at 2:25pm, V7 (Certified Nursing Assistant) stated I know (R1) ' s incident was after supper, on the second floor dining room, as I was wheeling her (R1) out and before I made a turn to the exit, out of the dining room, she grabbed the wheel of (R5) ' s wheelchair. Her (R1) left hand got caught on the wheel of (R5) ' s wheelchair and she lunged and fell . On 05/23/2025 at 2:45pm, V7 stated I am familiar with her (R1). When I first came in, the senior CNAs told me that she grabs on to things and to be careful. The first time I was assigned to her, I already noticed that behavior of grabbing onto things each time I wheel her out of the dining room to her bed, she will hold onto something like the rail. She grabs stuff all day long. If you have to toilet her and change her diaper, she would grab the table with her hands spread out. Whenever I am assigned to her, I always wheel her out of the dining room last, so the exit is clear; no chairs and no wheelchair because I know she likes to grab things when I wheel her out. On that evening, she (R1) was the first one to leave the dining room because she was sleepy, (R5) was still in the dining room by the exit. I did not move anyone. I just wheeled her out (R1). On 05/23/2025 at 4;21pm, V6 (Licensed Practice Nurse) stated I am familiar with the resident (R1). I observed her grabbing onto things when we wheeled her out of the dining room. When you wheel her, she would spread her arms and start grabbing whichever is closer to her like a chair or wheelchair. When she came to the second floor, she already exhibited the behavior of grabbing on things when she wheeled out. I think she had that behavior while she was on the 3rd floor. I don ' t know if she was care planned for that behavior. It could have helped if the behavior of grabbing on things was care planned so interventions could be implemented. If the CNA knew about this behavior, I expected I her to clear the path with nothing to grab on to and to wheel her to safety. My back was turned, and I did not see the fall. I heard a loud bang on the floor. I assessed her and there was swelling on her midline forehead about 1.5 inches x 1.5 inches, and she was also complaining of pain on her left hand second digit. On 05/23/2025 at 3:11pm, V16 (Resident Care Coordinator) stated if a resident has a behavior of grabbing things like wheelchair and tables, it should be care planned so it could be addressed to prevent injury to the resident and to other residents. It should be care planned the moment they observed the resident exhibiting the behavior right there and then so the behavior could be addressed. On 05/23/2025 at 3:36pm, V8 (Memory Care Director) stated the behavior of grabbing onto things should be care planned when the behavior was first noted and to make sure staff is aware of the behavior. So, if it continues to occur, we can help prevent the behavior. It is a safety concern. We can help prevent the behavior and we can keep the resident safe. (continued on next page)

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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 05/23/2025 at 3:49pm, V2 (Director Of Nursing) stated the behavior should be care planned when it was first noted. Basically, we want to be able to identify how the resident acts, and we will put in different interventions and the effectiveness of the interventions. This surveyor showed V2 R1's 4/24/2025 careplan which was initiated a day after the incident. V2 stated if care planned before the incident, we could have potentially prevented the incident. On 05/23/2025 at 3:53pm, V2 stated if the CNA has knowledge of the behavior, my expectation is to maintain the resident's safety, call for help to move other residents out of the way of this resident so the incident could have been prevented. R1 ' s (Printed: 05/23/2025) census list documented that R1 was moved from the third floor to the second floor on 11/20/2024. R1 ' s (Active Order as Of: 05/23/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) history of falling, hypertension, and dementia. R1 ' s (03/14/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 2. Indicating R1 ' s mental status as severely impaired. R1 ' s (04/23/2025) Pain management Evaluation documented, in part Reason for Evaluation: Post Occurrence. Location of Pain. Site: Left hand- swollen 2nd digit. Face - contusion hematoma forehead. Authored by: V6. R1 ' s (04/23/2024) Local Hospital Emergency Department Patient Visit Information documented, in part You were seen today for: Concussion without loss of consciousness, Contusion of head and Closed fracture of phalanx of index finger. R1 ' s (04/23/2025) Xray Report documented, in part Abnormal findings. Radiograph of the left hand. Findings: An avulsion fracture is seen at the base of the proximal phalanx of the index finger. R1 ' s (04/23/2025) CT (Computed Tomography) Scan documented, in part Findings: Soft tissue: there is a significant soft tissue swelling over the midline frontal calvarium. R1 ' s (Date Initiated: 04/24/2025) careplan documented, in part Focus: noted to continue to stand while in wheelchair and at dining room table and attempt to grab items while being transported in wheelchair. Goal: will be free from injury. Of note, care plan was initiated after the fall incident. The (05/24/2025) Email correspondence with V1 (Administrator) documented, in part Behavior would constitute a change in residents plan of treatment, so expectation would be to update the care plan accordingly to include a focus, goals, and intervention reflective of the behavior. Care plans should be updated routinely (initial, quarterly, annually, readmit, sig(significant) changes) and or if new behavior is observed. The reason is so that goals and interventions can be created to be able to further assist with caring for resident.