

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 06/21/2025
NAME OF PROVIDER OR SUPPLIER Alden Lincoln Rehab & H C Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interview and record review, the facility failed to ensure a resident's environment was free of accident hazard. This failure affected 1 (R1) resident reviewed for falls in the total sample of 4 residents.</p> <p>Findings include:</p> <p>Review of R1's and R4's census lists documented R1 and R4 were roommates beginning 11/20/2024.</p> <p>On 06/20/2025 at 10:57am, R1 was walking slowly from the activity/dining room to her room. R1 stated, I had fallen but I cannot tell how. I forgot already.</p> <p>On 06/20/2025 at 1:19pm, V7 (Licensed Practice Nurse) stated, I know (R1). She fell before and she has a left hip fracture. She is limping when she walks. Before the recent fall on 05/14/2025, she was allowed to walk in the unit without supervision. On 05/14/2025 at dinner time, (R4) was in the dining room but she (R1) was not. I (V7) did not see her (R1) in the dining room at that time, at 4:30pm. Then at around 4:50pm, I heard her screaming aray! in her room. Which translates as ouch!. I went to her room, and I observed her sitting on the floor, between her bed and her roommate's (R4) bed. She was wearing her crocs shoes or rubber shoes. I did not see how she fell, and she did not say what happened. She could have tripped on her roommate's floor mat. It was on the floor between their (R1 and R4) beds. Floor mats should be placed on the sides of the bed when residents are in bed. These should not be laid on the floor when residents are ambulating in the room because these gives the residents instability when they are walking. Floor mats are a tripping hazard. I assessed her and there was a 1-inch swelling on the right side of her head.</p> <p>On 06/20/2025 at 2:13pm, V2 (Director of Nursing) stated, Our fall interventions include floor mats so when a resident falls, it cushions the landing. Floor mats should be placed on the sides of the bed when the resident is on the bed because floor mats pose as tripping hazard. The floor mats should not be on the floor when a resident is ambulating in the room to protect the resident because it is a potential tripping hazard.</p> <p>R1's admission Record documented R1's Diagnoses: (include but not limited to) disorder of brain, history of falling, amnesia, and dementia.</p> <p>(continued on next page)</p>

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's (05/09/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 03. Indicating R1's mental status as severely impaired. Section GG. Functional Abilities&gt; GG0170. I. Walk 10 feet: 5 - Set up assistance. J. Walk 50 feet with two turns: 04 - Supervision assistance. K Walk 150: 04 - Supervision.</p> <p>R1's (05/14/2025) progress notes documented, in part Writer was alerted by resident's scream. On entry to the room, resident noted sitting on the floor, right side of her head on a chair nearby. Resident's head was lifted and noted swelling on the R (right) parietal side of the head, able to walk but complains of R hip pain. NP (Nurse Practitioner) ordered to send resident to hospital for evaluation and mgmt. (management). Authored by: V7 (Licensed Practice Nurse).</p> <p>R1's (05/14/2025) After Visit Summary indicated the following diagnostic exams were performed including CT of Cervical Spines without contrast; CT of chest, abdomen, and pelvis without contrast; and CT of head without contrast; x rays of Chest AP and PA views; XR of hips bilateral view and pelvis with no notes of injury.</p> <p>R1's (05/15/2025) Fall Risk Assessment documented, in part 0. Reason for Assessment. e. Post Fall.</p> <p>R1's (Initiated: 05/22/24) care plan documented, in part Focus: at risk for falls r/t (related to) impaired cognition, weakness, unsteady gait, reduced activity tolerance and DX (diagnoses) of dementia, Hx (history) of falling, amnesia, and left hip fracture. Goal: will be free from injury related to falls (initiated: 5/14/2025).</p> <p>R4's admission Record documented that R4's Diagnoses: (include but not limited to) history of falling, hypertension, and dementia.</p> <p>R4's (06/12/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 03. Indicating R4's mental status as severely impaired.</p> <p>R4's (Initiated: 08/09/2024) care plan documented, in part Focus: at high risk for falls. Intervention: Floor mats will be placed when (R4) is in bed.</p> <p>The (08/2020) Management of Falls documented, in part 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 resident's plan of care in order to minimize the risks for fall incidents and/or injuries to the resident.</p> <p>The (06/20/2025) Untitled Facility provided document indicated, in part Floor mats should be removed from the bedside and stored in a(n) appropriate place when the resident is not in bed. The purpose is to maintain resident safety.</p>		