

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 11/24/2025
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)		
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** Based on interview and record review, the facility failed to follow the provider's order and care plan intervention for one (R1) resident out of three reviewed for wound care treatments. Findings Include: R1's clinical records show an admission date of 4/10/25 with included diagnoses but not limited to non-pressure chronic ulcer of other part of right lower leg with fat layer exposed, chronic diastolic (congestive) heart failure, and lymphedema. R1's Minimum Data Set assessment dated [DATE] shows R1 is cognitively intact with BIMS (Brief Interview for Mental Status) of 15. R1's comprehensive care plan documents in part (date initiated on 4/11/25): [R1] has an actual skin alteration and at risk to develop pressure injury related to altered some ADL [Activities of Daily Living] function and decreased mobility. R1 has right leg-non pressure. Goal: Site(s) will not become infected through next review (date initiated 9/16/25; target date 10/13/25). Intervention reads in part: Treatment as ordered (date initiated 9/16/25). R1's right leg wound notes electronically signed by V11 (Wound Care Nurse Practitioner) with treatment recommendation on 9/22/25 reads in part: Daily and as needed clean with normal saline Calcium Alginate with silver foam dry dressing for 30 days. R1's Order Summary Report with active orders as of 11/23/25 reads in part: Calcium Alginate-Silver External Pad 4 (Calcium Alginate-Silver) Apply to right leg topically every day shift for skin condition cleanse with saline then apply Calcium Alginate with Silver and cover with foam or dry dressing (ordered 9/23/25). R1's September Treatment Administration Record (TAR) shows blank and unsigned on 9/23/25. R1's progress notes on 9/23/25 does not document R1's refusal to her wound treatment and no documentation related to the status of R1's right leg wound/treatment. On 11/23/25 at 10:27 AM, R1 stated that a wound doctor checked her right leg wound in September and put a dressing. R1 said that her right leg wound treatment was supposed to be done daily, but on 9/23/25, it was not done. R1 said, I don't know what happened that day, but it was not changed. I did not go out that day or refuse the wound care treatment. [V15 (Licensed Practical Nurse/LPN)] does my wound dressing. [V15] does it when she's here. [V15] was my nurse, but I don't know what happened that day. [V15] was probably got caught with something. I told [V10 (LPN)] that it was not changed in the morning, but he did not do it. [V10] was the second shift nurse. R1's right leg was noted wrapped with dressing. R1 refused for the dressing to be removed. On 11/23/25 at 1:29 PM, V15 (Licensed Practical Nurse) stated, that the nurses are doing the residents' wound treatments. V15 said, After I finish passing meds then I do my treatment. I follow the doctor's order. If the treatment is ordered once a day in the morning, the treatment should be done in the morning shift. From 7:00 AM to 3:30 PM. After I do the treatment, I sign the TAR that it's done. If I don't sign the TAR, it means I did not do it. I make sure I sign it off before I leave for the day at the end of my shift. [R1] prefers to do the wound treatment in the hospital. I can't remember what really happened in September. On 11/23/25 at 1:45 PM, a phone interview was conducted with V10 (Licensed Practical Nurse) and stated, I do wound treatments if it's assigned to me. I haven't done any wound treatment for [R1] because the treatment order is not assigned to me. I don't remember it being assigned maybe it was done the day before. I don't remember her [R1] asking me to do the wound treatment. On 11/23/25 at 12:10 PM, V2 (Director of Nursing) stated that the nurses are doing the residents' wound care treatments and V11 comes (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
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weekly to monitor the wounds and see if the treatments are appropriate. V2 said that the nurses change the dressing, they document that the dressing is changed and what they assess on the wound. In progress notes they will document. V2 said if the dressing is done, it should be documented in the TAR. It should be signed off. In the TAR it should be signed that it's done. V2 said if the resident refuses, it should also be documented in the progress notes. V2 said that if it's not signed off in the TAR it means, it's not done; and the documentation should also be part of the progress notes. On 11/23/25 at 1:52 PM, a phone interview was conducted with V11 (Wound Care Nurse Practitioner). V11 stated, I cannot really tell if [R1's] wound is getting worse. I don't have my notes with me. If there is a change in measurement and if it's getting bigger then I would say it's getting worse. I do my initial assessment and I do weekly follow up if I'm consulted. If I have a treatment recommendation I would include it in my wound notes. I talk to the nurse and I will send the process notes to the [V2] to make sure my recommendations are carried out. It's important that my wound treatment recommendations are followed because if it's not followed the wound will get worsen. The wound treatment order for [R1] is daily dressing so that the nurses can check and see the status of her wound. They can inform me if there is a change in the wound. If they don't follow the order, it can make the wound worse. It should be done everyday and when it's soaked it's done as needed. The facility's PREVENTION AND TREATMENT OF PRESSURE INJURY AND OTHER SKIN ALTERATIONS policy and procedure dated 3/2/21 documents in part: Implement preventative measures and appropriate treatment modalities for pressure injuries and/or skin alterations through individualized resident care plan. At least daily, staff should remain alert for potential changes in the skin condition during resident care. The facility's Staff Nurse (Registered Nurse/License Practical Nurse) Job Description documents in part: Prepare and administer medications and treatments if appropriate as ordered by the physician.		