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	02/26/2026

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to provide supervision during a shower. This failure resulted in one (R1) resident sustaining a fall with injury in a sample of eight reviewed for falls.Findings include:R1's face sheet dated 02/24/2026 documents in part that R1 was admitted on [DATE] with diagnosis of Multiple fractures of the pelvis, non-displaced fracture of posterior wall of right acetabulum, chronic diastolic heart failure, diabetes mellitus, atrial fibrillation, muscle weakness, poly osteoarthritis, major depressive disorder, malignant neoplasm prostate, cardiac defibrillator.R1's Minimum date set section C for brief mental status dated 1/16/2026 displays that R1 has a score of 14 which means R1 is cognitively intact; section GG Functional abilities dated 10/24/2026 documents in part that R1 required partial/moderate assistance for showers/bathes which means staff does less than half the effort, staff lifts, holds or supports trunk or limbs to assist R1 but provides less than half the effort.R1's progress note dated 01/07/2026 at 10:47 AM, documents in part that [R1 was found in right lying position in shower at approximately 1030 AM. Vital signs taken BP of 179/79. Patient able to answer questions and stated, I think I hit my head. Full body check done, no bruising, lacerations, swelling, or bleeding noted. Initial Neuro check completed with no deficits. Proper grip strength in all extremities, neuro orientation at baseline, PERRLA intact. Patient made remarks of 3/10 RLE pain at anterior thigh. Pain medication offered and denied, Cold pack denied. R1 assisted to wheelchair with assistance of CNA and R1 escorted back to room by CNA. R1 assisted into bed by staff, NP (V9) called with orders to send R1 to hospital due to being on multiple blood thinners. ambulance called immediately with ETA of 1115.Neuro checks completed per protocol at 1030, 1045, 1100, 1115, and 1145. Patient left facility at approximately 1150 escorted by two paramedics. Patient stable upon exit of facility.] Progress noted documented by V12 (Registered Nurse).R1's progress noted dated 01/07/2026 at 9:25 PM, documents in part that R1 was admitted to hospital with multiple fractures to right hip.R1's hospital records dated 01/07/2026 documents in part that; R1 sustained right acetabular/pubic rami fracture, displaced fracture right iliac bone with fractures roof and medial aspect right acetabulum, displaced fracture lateral right ischium, displaced fractures right superior and inferior pubic rami because of mechanical fall in shower from standing position. R1 is not a candidate for surgery at time of surgical consult.R1's care plan dated 1/13/2026 documents in part; R1 is noted to have limitations in range of motion related to presence of pain to Right hip due to fracture, decrease in physical activity, generalized muscle weakness and diagnosis of Major Depressive Disorder, 01/12/2026, R1 requires assist from staff to dress related to non-weight bearing status to right lower extremity due to Right hip fracture and poor balance.R1's physician order sheet documents in part: 01/13/2026 pain management/modalities hot/cold pack to right hip as needed; physical therapy to begin for four to six weeks. 02/04/2026 weight bearing status toe touch right lower extremity. 02/23/2026 Norco tablet 5-325 milligrams every 12 hours for pain to (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 0689 Level of Harm - Actual harm Residents Affected - Few	right hip.On 02/23/2026 at 12:18 PM, R1 stated on 01/07/2026 he was trying to take a shower, and I could not get my sock off my foot, V4 left the shower room and said she would be back. R1 stated he leaned over and fell on the floor. I do need help in the shower; staff normally stay with me in the shower in case I need help. When I fell no one was in shower room with me, I was in pain, and the nurse came and looked at me then sent me to the hospital. I was receiving pain medication for my pelvic fracture, but I have stopped taking it because the pain medication causes me to have constipation which is more painful. I still have pain now, but I just bear with the pain. R1 stated he normally can remove his socks in the shower room with staff present but these socks were too small and very tight, so it was hard to remove. R1 stated since I am no longer able to walk around with my rollator, and I must depend on staff more for my care. This makes me feel helpless. R1 stated the nurse met with him and would be giving him a stool softener that should give him some relief.On 02/23/2026 at 12: 29 PM, V3 (Certified nursing assistant (CNA) stated she is the CNA who takes care of R1 and that R1 requires extensive assistance for showers, two staff members are required to assist him and we use gait belt because of his restrictions. R1 does not do any of his care, staff does all care. R1 uses wheelchair now since he has fractures.On 02/24/2026 at 10:25 AM, V4 (CNA) stated at 10:25 am I was accompanying R1 to shower, and he was using his rollator that is when I saw the call light was going off and I went to answer the call light. I instructed R1 to wait for me, normally I go in and set R1 up in the shower room. R1 told me that he was standing up and trying to remove his sock and that's when he tumbled over. V4 stated I wanted him to wait next to shower room while I went to answer another call light, normally I would have his towels, soap and gowns set up for him. R1 is a supervision and R1 normally removes footies while staff is in there. V4 stated her understanding of supervision is if R1 needs some assistance staff would be present to assist for care needs, I don't think R1 would have fallen if someone was with him. V4 states R1 receives showers twice a week and normally she is supposed to tell the nurse before she enters the shower room with a resident so the nurse can be aware to respond to the shower room light so they can check the residents skin. V4 stated it slipped her mind to inform the nurse. V4 stated she could have asked another staff member to answer the light but she thought she could answer the light quickly then attend to R1 because normally he would wait for me.On 02/24/2026 at 12:05 PM, V12 (Registered Nurse) stated R1 was not to be left unattended by staff in shower room. V12 stated he was not made aware by certified nursing assistant (CNA) that R1 was going into the shower. The CNA came and informed me that R1 was lying on the shower room floor, I went and assessed R1. R1 stated he was in pain and I asked him if he wanted Tylenol or cold pack and R1 declined, he was not sure if he hit his head but R1 takes blood thinners, the day of the incident was the first time I ever worked with R1. V12 stated the CNA should have stayed with R1 and another staff member could have assisted and completed the other task she went to do, she could have asked myself or another aide to answer the call light to decrease the risk of R1 falling if she was present with him.On 02/24/2026 at 12:58 PM,V9 (Nurse Practitioner) stated he was informed on the date of the incident 01/07/2026 that R1 sustained an unwitnessed fall in the shower room and that R1 is on blood thinners and was uncertain if he his head or not. That is why he gave orders to have him evaluated at the hospital. V9 stated a staff member should have been with R1 in the shower room to break the fall and decrease R1 from slipping. V9 stated the fractures that R1 sustained, normally takes healing around eight weeks or more but R1 is being seen by Orthopedic clinic, R1 is a diabetic and that can slow down the healing process. R1 has been transferred to skilled unit for increased staff supervision related to his fractures, because R1 requires more assistance from staff at this timeOn 02/24/2026 at 1:35 PM, V2 (Director of Nursing) stated she is the person that does (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	restorative programs in the facility and prior to R1's fall on 01/07/2026, he was able by himself with the rollator but since the fall and fractures occurred R1 has restriction now of toe touch and is not ambulating and not using rollator. R1's transfer status: toe touch, gait belt and pivot avoiding touching that effected extremity. V2 stated staff offer oversight for showers, prior to the incident staff would alert R1 and he would gather his own things for the shower. Staff always offers help. Staff stay in shower room area if residents need assistance. Staff should assist R1 after shower to walk him back to room and make sure R1 has everything he needs and in case there is water on floor staff are present to assist to decrease risk of accidents. After the fall R1 was moved to skilled unit on the 3rd floor, for more therapy and increased supervision, R1 appears to be happier on the unit. Prior to incident R1 was completing active range of motion and no deficits were present and was using rollator.On 02/24/26 at 1:46pm, V2 (Director of Nursing) stated it is her expectation of the staff that resident's safety is always maintained to decrease risk of falls and injuries. Staff are required to make sure they have everything that is needed for showering of a resident prior to entering the shower room. Residents are encouraged to be independent but staff should not leave residents alone in the shower room who require supervision. V2 stated the shower room is designed with a separate area where staff can provide the resident with privacy but still be in the room close enough to assist the resident if help is needed. V2 stated the certified nursing assistant (CNA) should have asked someone else to answer the other light and proceed to assist R1 to decrease risk of fall and injury and the nurse should be informed by the CNA so they are aware of the residents who are going into the shower room and to be alert if the shower light rings so the nurse can come and complete a body assessment.On 02/25/26 at 11:19 AM, V10 (Physical therapist) stated R1 has multiple fractures and is currently toe touch weight bearing for the next six weeks, it is hard for R1 to adjust to this modified way of movement because he was used to moving with rollator independently but R1 tries his best. V10 stated prior to fall with fractures R1 was modified independent for transfers, mobility and using a rollator but now R1 is minimum contact guard assistance for transfers from bed to chair with use of mechanical lift do to R1's restrictions, healing takes times but R1 is progressing well.-Facility document presented by V2 titled falls has R1 listed as having a fall on 01/07/2026.-Facility policy dated 08/2020, titled Management of falls documents in part; The facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the residents plan of care to minimize the risks for fall incidents and/or injuries to the resident.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that nursing staff was in facility as assigned on their schedule; this failure resulted in residents having to receive medications and treatments with a delay. This failure effected four (R2, R6, R7, R8) out of eight residents reviewed for nursing services. Finding include:R2's face sheet dated 02/24/2026 documents in part that R2 was admitted on [DATE] with diagnosis of Diabetes mellitus, neuropathy, essential hypertension, urinary tract infection, peripheral vascular disease, human immunodeficiency virus, bipolar disorder, hyperlipidemia, sleep disorder, malignant neoplasm prostate.R2's Minimum date set section C for brief mental status dated 12/30/2025 displays that R2 has a score of 12 which means R2 is cognitively intact.R6's face sheet dated 02/25/2026 documents in part that R6 was admitted [DATE] with diagnosis of Chronic diastolic heart failure, tachycardia, major depressive disorder, insomnia, protein calorie malnutrition, anemia, palpitations.R6's Minimum date set section C for brief mental status dated 12/22/2025 displays that R6 has a score of 15 which means R6 is cognitively intact.R7's face sheet dated 02/25/2026 documents in part that R7 was admitted on [DATE] with diagnosis of Cervical spinal cord, asthma, benign prostatic hyperplasia, peripheral vascular disease, essential hypertension, diabetes mellitus, muscle spasms.R7's Minimum date set section C for brief mental status dated 02/09/2026 displays that R7 has a score of 15 which means R7 is cognitively intact.R8's face sheet dated 02/25/2026 documents in part that R8 was admitted on [DATE] with diagnosis of Diabetes mellitus, essential hypertension, benign prostatic hyperplasia, glaucoma, insomnia, long term use of insulin, back pain, hyperlipidemia, post-traumatic stress disorder.R8's Minimum date set section C for brief mental status dated 12/02/2025 displays that R8 has a score of 15 which means R8 is cognitively intact.On 02/25/2026 at 10:23 AM, V7 (Activity Director) stated after resident council all the concerns are either given to the administrator or the director of nursing to follow up with. V7 stated that the residents did express that there were no nurses on the night shift, either the resident did not see the nurse, or the resident could have been sleep when the nurse came by, but I do not have anything to do with staffing. Resident council meets monthly and if they have any concerns the residents inform me and then the concern is given to the appropriate department. The last time the residents informed me that they had concerns with there not being a nurse on the unit was a concern form written on [DATE], meeting.On 02/25/2026 at 10:35 AM, R7 stated he is the resident council vice president and there was one day that there was only one nurse in the facility running all three floors and other times the nurses come in late. R7 stated he cannot remember the exact dates.On 02/25/2026 at 10:49 AM, R8 stated that he is the resident council president. R8 stated few months ago there were some concerns with nurses not being on the unit at the start of night shift, but the concerns have been fixed since then. R8 stated he became the resident council president about a month ago and suggested if there was no nurse on the unit that a nurse from another unit should come downstairs and administer the medication. The reason I was concerned because I am a diabetic and received my insulin late on a few times in the past, it did not cause me to become sick because I know how to manage myself, but it could have resulted in a major concern if it continued to happen. R8 stated he spoke to the administrator and director of nursing; they both told me that they would take care of it. R8 stated when the concern of no nurse on the unit or nurses arriving late it was happening often. R8 stated he did not want it to happen again, so I addressed it for myself and the other residents. R8 stated since I brought the concern to their attention there has been a nurse present daily to pass medications and address the residents' concerns.On 02/25/2026 at 11:06 AM, R6 stated that he has concerns with there (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not being a nurse on his unit several times on night shift when he has come out to the nursing station to request for something, R6 stated normally he would just ignore it but it has happened so much that it has begun to frustrate him. R6 stated last week he needed pain medication and came to the nursing station around 11:30 PM and was informed that he would have to wait to be medicated because the night nurse had not arrived to facility yet. R6 stated he then went downstairs to another unit and informed a nurse that he was in pain and needed to be medicated, R6 stated the nurse from the first floor came upstairs with him and administered him his pain medication and informed him that the night nurse was running late and would be in soon. R6 stated he is not sure of the time that the nurse arrived because he went to bed after receiving his medication. R6 stated he informed the administrator and director of nursing of his concerns.On 02/25/2026 at 11:59 AM, V8 (Registered Nurse) stated she has worked on the first floor since December 2025. V8 stated she could not remember the date but last week on night shift around 11:40 PM, R6 came down to the first floor and informed me that there was no nurse on his unit and he needed pain medication. V8 stated she went upstairs and gave R6 his medication. R8 stated that the nurse for the third floor unit was running late and arrived close to 12:00 AM. V8 stated this was the first time that I experienced such a thing related to having to administer medication on another unit because a nurse was running late, and no residents have told me that they had concerns related to late medication administration or a nurse not being available during my shifts.V8 stated R6 is not her assigned resident but she was just helping out since the nurse was not in the facility.On 02/25/2026 at 12:58 PM, V1 (Administrator) stated that he was made aware of the concern on 10/27/2025, the issue was addressed about attendance and calling in late with nursing staff and informing nursing staff who to notify when they are running late. V1 stated I have noticed that there was a trend of the nurses running late and it was addressed immediately, and it has been improving lately. V1 stated the nurses run late less than an hour some 15-20 minutes to my knowledge. Nursing directors address the nurses and in-services were done. If nurses are running late or calling off, they would notify myself and nursing director. V1 stated the 9/29/2025 resident council concern were reviewed by checking the staffing schedule and for call ins and nothing reflected that there were no nurses on the shifts. I spoke with the residents who had the concerns and they said they eventually saw the nurse.On 02/25/2026 at 1:17PM, V2 (Director of Nursing) stated it was brought to my attention by the residents that staff were coming in late and not notifying the nursing directors. My expectation is that if a nurse is coming in late, they need to also call the facility to inform the staff. Also, the assistant administrator would call the facility to notify the building so if a resident needs something on another floor the staff are aware that they need to go to the unit and assist the resident with the need and or pass the medication until the nurse arrives. This doesn't happen much but is a concern that the facility is addressing on a constant basis by in servicing and educating the staff on attendance policies and disciplinary actions that can result in continued behavior. V2 stated V8 does not work on the unit R6 resides on but it is the expectation if a nurse is not available on the unit another nurse is to go and assist the resident with their medication needs. Reviewed facility resident council minutes dated September 29, 2025, documents in part; residents state there were no nurses on a couple of night shifts. Residents listed as attending the meeting were as follows R6, R7, R8 who had concerns with nurses not being available on night shift.Reviewed facility in service dated October 2025, topic documents in part : Attendance, call ins, lateness attached with a facility guideline titled absenteeism and tardiness standards.Reviewed facility concern form dated 10/27/2025 documents in part with R6 name on it , nature of concern: nurse is not coming on time causing R6 to receive his medications late.10/28/2025 V2(Director of Nursing) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented that she spoke with R6 regarding his medication administration concerns and that the nurses were educated.Reviewed R6's medication administration record which reflected that V8 completed pain assessment on 2/18/2026 and administered him medication .On 02/26/2026 at 2:01 PM, V1 stated the facility does not have a policy for staffing. The facility ensures that they meet the minimum staffing ratios.