STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145450	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Lakeland Rehab & Hcc	820 West Lawrence Chicago, IL 60640

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39779 Based on interview and record review the facility failed to obtain guardianship for a resident with no documented representative and could place the resident at risk of receiving services without a representative's consent. This failure affected 1 (R4) resident reviewed for guardianship and resident rights in a sample of 7. Findings Include: R4 was admitted to the facility on [DATE]. R4 has diagnosis not limited to Persistent Vegetative State, Dependence on Supplemental Oxygen, Tracheostomy, Dysphagia, Nontraumatic Subdural Hemorrhage, Encephalopathy, Essential (Primary) Hypertension, Gastrostomy, Chronic Respiratory Failure with Hypoxia, Peripheral Vascular Disease, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms and Obstructive and Reflux Uropathy. R4's MDS (Minimum Data Set) Section C - Cognitive Patterns document in part: Resident sis rarely/never understood. Cognitive Skills for Daily Decision Making: 3. Severely Impaired - never/rarely made decisions. R4 Electronic Medical Record documents R4 as the Resident Representative Receives Statement. Care Plan document in part: Focus: R4 has an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related/to) Decreased Functional Ability, Encephalopathy, Tracheostomy, Persistent Vegetative State, Dependence on Supplemental Oxygen, Chronic Respiratory Failure with Hypoxia Date Initiated: 12/12/22. Focus: R4 has not chosen any Advanced Directives at this time due to personal preference and also his inability to make decisions. Guardianship has been initiated. Date Initiated: 12/13/22. Focus: requires 1:1 activities due to: cognitive impairment, limited/no discernable response and/or preference, physical impairments Date Initiated: 12/12/22. Progress note dated 06/18/24 14:16 document in part: R4 left the facility via stretcher accompanied by 2 EMT (Emergency Medical Technician) to hospital. R/O (rule/out) possible head edema. Resident was alert and oriented x 0. MD (Medical Doctor) is aware of resident transfer to Emergency department. Progress note dated 06/19/24 08:17 document in part: Follow up with ER (emergency room) - resident is transferred (to another hospital) for swelling to head cranial flap. (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/24 at 04:06 PM V8 (Hospital Social Worker) stated the facility is allowing the physician to make decisions for R4. The facility did not go through the Illinois Health Care Surrogate Act to get R4 a guardian because R4 is not able to make decisions on his own. R4 is currently in the hospital and will not be sent back to the facility until a petition for guardianship if filed. On 06/25/24 at 12:54 PM V19 (Licensed Practical Nurse) stated R4 is still out at the hospital. On 06/18/24 R4 was sent to the hospital with swelling of the head cranial flap. The doctor was notified. No family was notified of R4 hospitalization . R4 does not have any family members on his contact. R4 is his own representative on his profile. When a resident cannot make their own decisions most likely they have a guardian. R4 is alert and oriented x 0-1, nonverbal, very cognitively impaired, opens his eyes but is unable to move and a total care. If a resident does not have any family or friends, they will have a state guardian. I haven't seen anyone visit R4. On 06/25/24 at 01:36 PM V9 (Social Service Director) stated if a resident doesn't have anyone to speak for them, we start the process of guardianship. We look through the resident records to see if there are any family or friends. If we cannot find any family or friends in the resident record the facility is responsible for them. Medical decisions are made by the medical director. The resident has to be deemed rather they are decisional or what is their capacity for being able to make decisions for themselves. If they are unable to make decisions and there is no family or friends, they should have a guardian. I am still looking to see if we can find someone in R4's paperwork. On 06/26/24 at 12:05 PM V3 (Director of Nursing) stated If a resident cannot make decisions and there is no family, they have to refer them to age options. On 06/26/24 at 12:48 V14 (Assistant Director of Nursing) stated If a resident is unable to make decisions social service is in charge of applying for guardianship. R4 did not have any family and was not able to make any decisions. R4 record said R4 is responsible for self. R4 is nonverbal and in that case the medical director would make decisions for the resident until a representative was found or the guardianship was applied for. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/24 at 03:42 PM V28 (Psychosocial Coordinator) stated if a resident is deemed non decisional, we would pursue guardianship as soon as the facility deem a potential need for a guardian. The resident would be evaluated by the physician to assess decisional capability, the facility completes a referral for guardianship, gather necessary documents and send it to the office of state guardian. Once reviewed they will indicate if they accept the nomination for guardianship or not. If they agree to act as the guardian and they accept, the attorney that represents the facility will file a petition for guardianship. We then get a court date, and a sheriff or processor will come out and serve the resident, let them know that a petition for guardianship was file and there is a court date that they have the right to appear. The court date depends on the situation. The court will appoint a guardian that will go to the facility to meet the resident, write a report concerning the resident limitations, needs and rather they support the petition for guardianship. They then go back to court and the judge will give their opinion based on what was presented and appoint a guardian. R4 was admitted to the facility in November 2022. I can't say that R4 is non decisional, it has to be a physician that diagnosis the resident. When the surveyor asked V28 would R4 diagnosis of persistent vegetative state care planned 12/12/22 and the fact that R4 has no representative create a need for R4 to have a guardian. V28 responded, that would lead me to say there is a potential for guardianship. I became aware of this situation today. The hospital had initiated guardianship and I can't speak to why a referral for guardianship had been sent to the office of the state guardian. If the facility feels they have a situation they are capable of submitting a referral for guardianship on their own. I spoke to the doctor, and she completed the physician report document used in court and based on the doctor's assessment the resident is non decisional and a guardian is required. Document titled RESIDENTS' RIGHTS for People in Long-Term Care Facilities undated document in part: As a long-term care resident in Illinois, you are guaranteed certain rights, protections, and privileges according to state and federal laws. Your rights to dignity and respect. Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis, condition, or payment source. Your rights to safety: Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your rights as a citizen and a facility resident: If a court of law has appointed a legal guardian for you, your guardian may exercise your rights for you. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Document titled Job Description Title: Social Service Director I. Job summary responsible for performing assigned social work duties and responsibilities within the facility. Plan, develop, organize, oversee, and run the overall operation of the social service department and accordance with current policies and procedures, federal, state, and local standards, guidelines, and regulations. See. Current knowledge of federal and state long term care LTC (Long Term Care) social service regulations and or ability to understand and interpret. D. Demonstrate skills and ability in working with and understanding the needs of the residents, families, other staff members and personnel from community agencies. IV. Essential Functions: C. Become knowledgeable of each individual residents' background, culture, life, history, disease, and medical care needs in detail to ensure an appropriate person-centered social service plan. E. Prepare and plan of care for treatment with the Interdisciplinary team (IDT) based on the Comprehensive Assessment for each resident. Contribute as an integral member of the IDT on a continual basis and at the Resident Care Plan conferences. This also involves documenting the social/emotional/mental needs related to the resident's illness/disability, adjustment to placement, cognitive, emotional/mental (mood), psychosocial functioning and the absence/presence of any behaviors (verbal/nonverbal) within the supportive network, and his/her response to the treatment/rehabilitation/need for placement according to each individual residents' case. Based upon these the SSD (Social Service Director) will make specific recommendations to assist in the residents' overall care and genuine well-being within the care plan for the best IDT approach. I. SSD must act as resident advocate, as well as a liaison between the resident and his/her family, the facility and community agencies. M. Conduct, oversee, and complete initial and all on-going assessments and MDS (Minimum Data Set), and care planning initiatives, including but not limited to social, medical, cognitive, physical, neuro-psychological, behavioral, communication abilities and spiritual needs (in conjunction with/at the lead of the Activity Department), amongst others as it relates to individual social service needs. Policy: Titled Residents' Rights revised 11/17 document in part: The facility will respect and uphold residents' rights. Titled Advance Directives revised 11/22 document in part: The Social Service Director and/or designee will assess, care plan, and implement Advanced Directives. 5. If the resident is deemed by a physician to lack decision-making abilities the pre-appointed agent, healthcare surrogate, or guardian will be involved in the decision-making for the resident. a. If resident does not have pre-existing advanced directives and lacks decision-making abilities, a healthcare surrogate decision making maker or guardianship may be pursued. 9. Staff will be trained on policy regarding Advanced Directive/Life Sustaining Treatment upon hire and annually.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110 Based on observation, interviews, and record reviews the facility failed to follow their wound prevention policy by failing to ensure pressure ulcer prevention measures were implemented and failing to place interventions in place timely for one of three residents (R1) reviewed for pressure ulcers, Findings include, R1's clinical record indicate in part: R1 was admitted on [DATE] with medical diagnosis include but not limited to chronic kidney disease, stage 4 (severe), type 2 diabetes mellitus, essential (primary) hypertension, heart failure, diverticulitis of intestine, weakness, polyarthritis, myalgia, obstructive and reflux uropathy, major depressive disorder, anxiety disorder, psychotic disorder with hallucinations due to known physiological condition, long term (current) use of insulin, personal history of transient ischemic attack (tia), and cerebral infarction. R1's Initial Nursing assessment dated [DATE]. Completed, signed, and locked on 2/19/24: -Left gluteal fold excoriation [No physician orders noted for excoriation] R1's Wound Admission assessment dated [DATE]: -Right heel Deep Tissue Injury [DTI] [No physician orders noted for DTI] R1's Physician/Practitioner Wound Care assessment dated [DATE]. -Left buttock stage [2] pressure ulcer Interventions: Air loss mattress. off-loading, wheelchair cushion, repositioning R1's Care Plan -L (left) buttock pressure injury (resolved 2/29/24) -Pressure reduction foam mattress or pressure redistribution support (low air or alternation air) in bed dated :3/1/2024 R1 Physician orders: Dated 2/28/24-Low air Loss Mattress [Pressure Ulcer noted on 2/15/24] (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dated 2/20/24- Skin Check Complete on every Monday and Thursday [Pressure Ulcer noted on 2/15/24] On 6/25/24 at 9:24 AM, V4 [Ombudsman] stated, The family member told me that R1 developed bed sores since she been here in the facility. I could not get any answers from nursing staff if R1 did in fact have bed sores. If R1 has bedsores, it's probably due to her not being repositioned every two hours. During my visits, I have not seen R1 soiled. I usually see her in a hospital gown. On 6/25/24 at 10:00 AM, observed R1 sitting up in her recliner chair, feeding herself lunch properly. R1 did not choke or cough during her lunch meal. R1 consumed 80% of her lunch. R1's call light was in reach. R1 did not have heel protector boots in place, slip free footies was on R1's feet. On 6/25/24 at 12:15 PM, R1 stated, I been okay here at this facility. I can feed myself and use my call light. I like my recliner chair, better than the regular wheelchair, it's more comfortable. The nurses must use a machine to put me in the recliner chair, because I cannot stand up. I have not stood up since early last year. The certified nurse assistants change me and help me turn in the bed. I do not have any bed sores. On 6/25/24 at 1:15 PM, surveyor observed V27 [Certified Nurse Assistant] provide peri care with R1's permission. No open areas noted on R1's peri area, or buttocks. Surveyor and V27 observed R1 did not have any heel protector boots in place. V27 stated, R1 had heel protector booties, they must be in the laundry. On 6/26/24 at 8:38 AM V12 [Wound Coordinator Nurse] stated, R1 was admitted on [DATE]. R1's initial wound care assessment dated [DATE], noted a right heel DTI [Deep Tissue Injury]. There were no measurements, treatment orders, interventions completed upon discovery and no further assessments completed of the right heel. I am not sure how the DTI on R1's right heel was overlooked. I started working here the second week of January, and my first month was training. On 6/26/24 at 8:50 AM, Surveyor, V12 and with permission of R1 observed R1's bilateral heels. R1's was resting in her recliner chair with no heel protector boots in place. R1's heels were normal in color. V12 stated, R1's heel protector boots must be in laundry. R1's right deep tissue injury has healed, I am not sure when, there is nothing documented. If R1 keep going without her heel protector boots, the deep tissue injury could come back. On 6/26/24, at 9:03 AM, V12 stated, On the initial admission assessment, there was excoriation noted on the left buttocks area. There was no treatment in place for the excoriation on the buttocks. On 2/15/24, R1 was noted with a stage 2 pressure ulcer to her left buttocks area measuring 1.5 x 1.5 x 0.1cm [centimeters]. V13 [Wound Care Nurse Practitioner] and I assessed the area. Wound treatment order for xeroform, silicone foam border dressing, three times per week and as needed. Offloading torso, repositioning every two hours, use of wedge pillow to assist with positioning, pain management, nutrition/protein supplement and air loss mattress. I placed the order for the air mattress on 2/28/24, but I am sure she had the air loss mattress placed on her bed prior to 2/28/24. During the assessment with V13, we did not observe or assess R1's bilateral heels. R1's pressure ulcer was avoidable. If R1's excoriation upon admission was assessed, and interventions put in place upon admission, the pressure ulcer potentially would not have occurred. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 9:25 AM V13 [Wound Care Nurse Practitioner] stated, R1's comorbidities history of stroke, weakness, poor mobility, and diabetes; along with staying in wheelchair, moving in regular bed without air loss mattress, incontinent and excessive moisture are potential reasons for R1's pressure ulcer. I completed my first wound assessment with R1 on 2/15/24 for left buttock pressure ulcer stage #2 measured 1.5 x 1.5 x 0.1 cm., I did not assess or was made aware about a DTI to her right heel. A DTI is a pressure ulcer that have not opened. I have seen R1 since she healed out on 2/29/24. According to R1's initial admission assessment, excoriation was noted on 2/12/24. Excoriation usually comes from excessive moisture due to incontinence. R1's pressure ulcer was avoidable, due to no wound interventions upon admission put in place timely to prevent the excoriation progressing to a stage 2 pressure ulcer. On 6/26/24 at 10:36 AM, V14 [Assistant Director of Nursing] stated, On 2/12/24, V15 [Registered Nurse] was R1's admitting nurse. I opened R1's initial admission assessment on 2/12/24. I did not complete R1's admission assessment. I am not sure who completed R1's admission assessment, but V16 [Former MDS Coordinator] signed and locked the assessment seven days later on 2/19/24. I do not know who completed the assessment, because once I opened the assessment any nurse could go into the assessment and make revisions, and or add to the assessment until the assessment is signed and locked. Usually, the nurse would complete the assessment and when wound care assessment the resident, they would include their findings. Then MDS would include their information. The assessment was opened on 2/12/24, signed and locked on 2/19/24, so I do not know who, or when wound care or MDS placed information in the assessment. I cannot explain or confirm why the initial assessment was completed seven days later. On 6/25/24 at 12:48 PM V3 [Director of Nursing] stated, V6 (Family Member) express a few weeks ago, that R1 would get a bed sore if she is not change and repositioned. I explained to V6 that R1 was kept clean, dry, and repositioned. V6 wants the facility to give R1 a regular wheelchair and use the recline wheelchair that therapy recommended for R1 safety. The admission protocol related to skin checks, is the nurse must complete a head-to-toe body assessment. The findings of the assessment are documented on the resident's admission assessment and or in the admitting nurse's note. Once the admission assessment was completed by the admitting nurse, the nurse should have sign, and locked the assessment. R1's initial admission assessment was open on 2/12/24, by V14 [Assistant Director of Nursing], and seven days later on 2/19/24, V16 [Former MDS Coordinator] completed the admission assessment, signed and locked the assessment, which is not protocol. On 2/12/24, the admitting nurse for R1 was V15 [Registered Nurse]. Once an assessment was open and unlocked, anyone could access R1's assessment and make revisions or add information until the assessment is signed and locked. I do not know why V14 opened the admission assessment which include a body assessment, was not completed until 2/19/24. If there is any abnormalities or skin alterations, the physician and family should be notified. The physician orders, treatments, and interventions should be in place and followed out by nursing staff. Certified nurse assistance should follow the plan of care and place heel protector boots in place, if not it could potentially cause a skin alteration. Policy documents in part: Prevention and Treatment of Pressure Injury and other Skin Alterations dated 3/2/21: -Identify residents at risk for developing pressure injuries. -Identify the presence of pressure injuries and other skin alterations (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Implement preventive measures and appropriate treatment modalities for pressure injuries or other skin alterations -Pressure injuries will be assessed weekly