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	01/10/2025

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

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 - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on interview, and record review the facility failed to follow their policy to ensure that call lights are answered in a timely manner to five (R4, R10, R17, R18, & R19) residents out of 7 residents reviewed for call light. Findings Include: R4's face sheet shows R4 is a [AGE] year-old male. R1's health record documented admitted d 10/26/23 with diagnoses not limited to paraplegia unspecified, neuromuscular dysfunction of bladder, muscle weakness, unspecified lack of coordination, pressure ulcer of sacral region stage 4, and pulmonary embolism with acute pulmonale. On 1/7/25 at 11:01 AM, R4 received up in motorized wheelchair clean and well groomed. R4 stated that R4 has been in the facility for sixteen months, and R4 stated that most of the times, R4's call light will be on for an hour before staff will respond. R4 stated that R4 sits on soiled linen for too long, and that afternoon (PM) shift does not respond to call lights. On 1/8/25 at 10:16 AM, V21(Certified Nursing Assistant/CNA) stated that all staff should answer call light as soon as possible to check if something is wrong with the resident. V21 stated that failure to answer call light could lead to fall or death. On 1/8/25 at 11:19 AM, V35 (Social Worker Director) stated that V35 has been in the facility for six months, and that everyone should answer the call light. V35 stated that when the call light is not answered, then the needs of the resident will not be met. On 1/8/25 at 12:43 PM, R10 stated that the 2nd and 3rd shift does not answer the call light. On 1/8/25 at 12:44 PM, R17 stated that the 2nd shift does not answer call light, and R17 sometimes scream for about an hour for help because staff do not answer the call light. R17 stated that R17 feels frustrated and irritated when the staff fails to answer call light for almost an hour. On 1/8/25 at 12:50 PM, R18 stated that staff do not answer call light on time, and that staff answer call light whenever staff want to answer. On 1/8/25 at 12:55 PM, R19 stated that R19 does not see the staff to answer the call light most of the time. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 10:52 AM, V2 (Director of Nursing) stated that it is V2's expectation that staff will answer call light in a timely manner between 2 to 3 minutes to provide for the need of the residents. V2 stated that when staff fails to respond timely to call light, the resident may be calling for an emergency which could potentially lead to harm, like fall and respiratory distress. Documents Reviewed: R4's Minimum Data Set, dated dated dated [DATE] shows R4 is cognitively intact. R4 functional assessment shows R1 is dependent for toileting, and transfer. Facility's Policy titled: 'call light use' dated 9/20 documents in part; To respond promptly to resident's call for assistance. Resident Council Meeting Minutes from 10/2024 to 12/2024. With concerns related to answering of call light. Grievance/Concern Forms from 08/2/2024 to 12/31/2024. With concerns related to answering of call lights.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on interview and record review the facility failed to follow their policy and procedure in notifying resident representative of a cognitively impaired resident prior to changing the resident's room. This failure affected one (R5) out of 5 residents sample reviewed for resident rights. Findings Include: R5's clinical records show an initial admitted [DATE] with included diagnoses but not limited to Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Aphasia, and Encounter for Attention to Cystostomy. R5's Minimum Data Set (MDS) dated [DATE] shows R5 has severely impaired cognition. R5's census list report printed on 1/07/25 shows R5 was transferred to a different room on the 4th floor on 12/17/24 and then to a different room on the 3rd floor on 12/18/24. A review of R5's electronic health records and progress notes dated 12/01/24 to 12/25/24 show no documentation that R5's representative was notified of R5's room changes. On 1/07/25 at 12:24 PM, V2 (Director of Nursing) stated that it's the facility's policy to notify the resident or their responsible party of any room changes, and notification of room changes should be documented in the resident's chart. V2 stated that if it's no documented, it's not done. On 1/07/25 at 12:58 PM V19 (Admissions Director) stated that V19 suggested the room change for R5 on 12/17/24. V19 stated [V19] instructed V16 (Licensed Practical Nurse/LPN) that R5 needs to be transferred to the 4th floor. V19 stated [V19] is not sure who notified R5's family of the room change. On 1/07/25 at 1:10 PM, V11 (Infection Control Preventionist/Licensed Practical Nurse) stated that V19 suggested to move R5 to the 4th floor with R10 but when [V11] found out that R5 was not a match with R10, [V11] decided to immediately move R5 out of R10's room and transferred R5 to the 3rd floor. V11 stated that the nurse in charge was supposed to notify the family of the room changes. On 1/07/25 at 1:23 PM, V16 (Licensed Practical Nurse) stated that [V16] worked morning shift on 12/17/24. V16 stated that V19 told V16 that R5 needed to be transferred to the 4th floor. V16 stated, I don't remember if I notify the family of the room change. If I did, I would document. On 1/07/25 at 1:42 PM, V16 came back to this surveyor and stated that [V16] just remembered that [V16] was not the nurse assigned to R5 during the room change. V16 stated, I was not R5's nurse at that time. I got a call from [V19] that [R5] needed to be moved to [4th floor] because they needed a bed so I relay the message to [V24 Registered Nurse]. On 1/07/25 at 1:49 PM V24 (Registered Nurse) stated, [V19] told me that they were moving [R5] to the fourth floor because they needed a bed for my admission. I don't know which room number [R5] went to. I think I saw them wheeled [R5] up with all [R5's] belongings. I did not notify the family because I thought that admissions will notify the family because usually it's management to notify family of room changes. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/07/25 at 3:32 PM, V18 (Licensed Practical Nurse) stated that V18 received R5 on the 4th floor on 12/17/24 and R5 was transferred to a different room on 12/18/24. V18 stated [V18] does not know who notify the family of the room changes. The facility's RESDIENT/FAMILY NOTICE REGARDING ROOM/ROOMMATE CHANGE policy dated 11/17 documents in part: Resident/Representative shall be given notice when a room change is necessary. Prior to changing a resident's room (in non-emergency situations) or introducing a new roommate, resident, or the resident's representative when applicable, will be notified by a facility designee.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on observation, interview, and record review the facility failed to obtain a physician's order for splint use and to develop a compressive care plan for one (R1) resident out of two residents reviewed for splint use. Findings Include: R1's face sheet shows R1 is a [AGE] year-old male. Minimum Data Set, dated dated dated [DATE] shows R1 is cognitively severely impaired with functional limitation in range of motion in all extremities. R1's health record documented admitted d 05/17/24 with diagnoses not limited to anoxic brain damage, chronic respiratory failure with hypoxia, dysphagia following cerebral infarction, chronic kidney disease with heart failure, encounter for attention to tracheostomy, poisoning by heroin, chronic obstructive pulmonary disease, ventilator associated pneumonia, encounter for attention to gastrostomy, unspecified dementia, and sepsis unspecified organism. On 1/7/25 at 10:30 AM, R1 received up in recliner chair in the day room, alert and not verbal. On 1/8/25 at 9:36 AM, R1 received in bed, and right-hand resting splint in place. On 1/9/25 at 9:21 AM, R1 received in bed, awake with splint on right hand. On 1/7/25 at 11:28 AM, V13 (Restorative Nurse) stated that V13 has been in the facility since September 2024. V13 stated that R1 has limitation to right hand and R1 is using a resting hand splint. V13 stated that according to the facility's policy, and V43 (Restorative Nurse Consultant) there should be a physician's order for splint. V13 stated that applying splint on R1 without a physician's order is a potential for injury to the affected site. On 1/9/25 at 9:30 AM, V46 (Registered Nurse/RN) stated that V46 has been in the facility since 1997, and that V46 is familiar with R1. V46 stated that R1 has splint on R1's right hand most of the time. On 1/9/25 at 10:34 AM, V49 (MDS/Care Plan Coordinator) stated that V49 has been in the facility for one year, and the purpose of the care plan is to describe the goals and intervention needed for the resident to attain wellness. V49 stated that care plan should be personalized and individualized, and splint should be care planed by the restorative department. V49 stated that the potential problem of not having a care plan could lead to improper application, duration, frequency, and care of the resident. On 1/9/25 at 10:52 AM, V2 (Director of Nursing) stated that V2 has been in this facility for over a year, and that there should be a physician order and individualized care plan for splint to ensure appropriate care is provided to the resident. V4, and V47 (CNAs) both stated that R1 wears right hand splint. Documents Reviewed: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Physician Order Sheet (POS) with active orders as of 01/07/25 shows no order for resting hand splint. R1's care plan completion dated 12/2/24 revealed no documentation indicating that R1 is using a resting hand splint. R1's splint daily task schedule titled: Documentation Survey Report dated from 10/1/24 to 1/7/25 documents in part, apply right hand splint. Facility's Policy titled: Splint or Brace Assistance dated 3/10/22, documents in part: These sessions are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record. Facility's policy titled: Restorative Nursing Program dated 3/10/22 documents in part: A plan of care will be developed as indicated to accomplish the goals. Facility's policy titled: Comprehensive Care Plans dated 11/2017 documents in part, an individualized, person-centered comprehensive care plan, including measurable objectives with timetables to meet resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview and record review, the facility failed to ensure enhanced barrier precaution signage were posted on residents' (R6, R7, R8) doors and failed to ensure proper personal protective equipment (PPE) were used during high contact resident care activities for 4 residents (R1, R6, R7, R15). These failures have the potential to affect all 65 residents residing on the third-floor unit. The facility also failed to ensure a resident (R5) with MDRO (Multidrug-Resistant Organism) was appropriately cohorted in a room with another resident. This failure affected 1 (R10) out of 1 resident in a sample of 14 residents reviewed for infection control. Findings Include: 1) On 1/07/25 at approximately 9:41 AM, Surveyor and V3 (Certified Nursing Assistant/CNA) entered R6's room. R6's door/room had no transmission-based precaution signage. R6's enteral feeding as running. R6 was non-verbal. Surveyor asked V3 to assist in checking R6's gastrostomy tube (G-tube) site. V3 did not wear an isolation gown when V3 showed Surveyor R6's G-tube site. V3 stated not sure if R6 was on isolation precaution because there was no signage posted on the door or in R6's room. On 1/07/25 at 9:50 AM, Surveyor and V4 (CNA) entered R7's room. R7's door/room had no transmission-based precaution signage. R7's enteral feeding was running. R7 was non-verbal. Surveyor asked V4 to assist in checking R7's G-tube site. V4 did not wear an isolation gown when V4 showed Surveyor R7's G-tube site. V4 stated R7 is not on isolation precaution because there was no signage on the door. On 1/07/25 at 9:54 AM, Surveyor and V4 entered R8's room. R8 was noted sleeping in bed with indwelling urinary catheter hanging on the side of R8's bed. R8's door/room had no transmission-based precaution signage. V4 stated R8 has a urinary catheter and not on isolation precaution because there was no signage on the door. V4 stated if a resident is on isolation there would be a signage posted on the door what type of isolation the resident is on. On 1/07/25 at 10:17 AM, R15 was noted lying on a geriatric chair in the dining room. R15 was non-verbal and noted R15's enteral feeding was running. R15 was noted with tracheostomy. Surveyor observed V28 (Agency CNA) providing hygiene care to R15. V28 was observed cleaning R15's face with a washcloth and adjusting R15's gown. V28 was not wearing isolation gown. V28 stated R15 is not sure if R15 is on isolation precaution because it's V28's first time taking care of R15. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/07/2025 at 12:04 PM, interviewed V11 (Infection Control Preventionist/Licensed Practical Nurse) and stated V11 oversees the Infection Control Program in the facility. V11 stated that residents with enteral feedings, wounds, urinary catheters, tracheostomy and on ventilation are placed on Enhanced Barrier Precaution (EBP) and the purpose of EBP is to protect both resident and staff from each other. V11 stated that staff going in and out of the rooms are supposed to wear gloves and isolation gown anytime they are doing direct contact not limited to changing the resident, providing personal hygiene care, moving up, emptying foley, dressing changes, bathing, and incontinence care. Any direct contact with the resident. V11 stated that it's important to wear proper PPE to prevent the spread of whatever organism the resident may have or whatever a staff may have come in encounter with for protective measures. V11 stated that residents on EBP are supposed to have a signage posted on their doors with the resident's bed number to let the staff and visitors know what proper PPE to wear inside the room. V11 stated that the staff are supposed to wear PPE during direct care contact even if they are just touching the gown of the resident because that is a direct contact. V11 stated staff are supposed to change and use brand new gown and gloves with each resident. R6's clinical records show an initial admitted [DATE] with included diagnoses but not limited to Stage 4 Sacral Pressure Ulcer, Encounter for Attention to Tracheostomy, and Encounter for Attention to Gastrostomy. R6's Minimum Data Set (MDS) dated [DATE] shows R6 has severely impaired with cognition. R6's physician orders read in part: EBP FOR CANDIDA AURIS (AXILLA/GROIN); CRAB (URINE); CRE (RECTAL); KPC (RECTAL) AND VIM (ordered 9/1/24). EBP For Chronic Wound (ordered 4/22/24). EBP For Tracheostomy/Ventilator (ordered 4/19/24). EBP For Device Care or Use of Urinary Catheter (Ordered 4/19/24). EBP For Device Care or Use of Feeding Tube (Ordered 4/19/24). R6's care plan documents in part: R6 has MDRO: EBP For Chronic Wound; EBP For Device Care or Use of Feeding Tube; EBP For Device Care or Use of Urinary Catheter; EBP For Tracheostomy/Ventilator (date Initiated 7/14/23). Interventions include: Enhanced Barrier Precautions will be implemented during high contact resident care activities and post appropriate Enhanced Barrier Precautions signage outside of the room for staff and visitors. R7's clinical records show an initial admitted [DATE] with included diagnoses but not limited to Encounter for Attention to Tracheostomy and Encounter for Attention to Gastrostomy. R7's MDS dated [DATE] shows R7 has severely impaired with cognition. R7's physician orders read in part: EBP FOR CANDIDA AURIS (AXILLA/GROIN); CRAB (URINE), EBP For Device Care or Use of Feeding Tube, EBP For Device Care or Use of Central Line/IV, For Device Care or Use of Urinary Catheter, and EBP For Tracheostomy/Ventilator (ordered 1/3/25). R7's care plan documents in part: R7 has MDRO: EBP CANDIDA AURIS AND CRAB RECTAL (date initiated 10/11/23). Interventions include: Enhanced Barrier Precautions will be implemented during high contact resident care activities and post appropriate Enhanced Barrier Precautions signage outside of the room for staff and visitors. R8's clinical records show an initial admitted [DATE] with included diagnoses but not limited to Stage 4 Right Buttock Pressure Ulcer. R8's MDS dated [DATE] shows R8 is cognitively intact. R8's physician orders read in part: EBP FOR CHRONIC WOUNDS (ordered 5/13/24) and EBP FOR CANDIDA AURIS (ordered 12/20/22). R8's care plan documents in part: R8 has MDRO: history of Candida Auris (date initiated 06/02/23). Interventions include: Enhanced Barrier Precautions will be implemented during high contact resident care activities and post appropriate Enhanced Barrier Precautions signage outside of the room for staff and visitors. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15's clinical records show an initial admitted [DATE] with included diagnoses but not limited to Encounter for Attention to Tracheostomy and Encounter for Attention to Gastrostomy. R15's MDS dated [DATE] shows R15 is on vegetative state and is dependent on staff assistance with activities of daily living (ADL) care. R15's physician orders read in part: EBP For Device Care or Use of Urinary Catheter, EBP For Chronic Wound, EBP For Device Care or Use of Feeding Tube, and EBP for Tracheostomy/Ventilator (ordered 7/11/24). R15's care plan documents in part: R15 has potential for complications secondary to tracheostomy (date initiated 11/29/22). Intervention includes: Enhanced Barrier Precautions will be implemented during high contact resident care activities. The facility's ENHANCED BARRIER PRECAUTIONS policy dated 12/24 documents in part: Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) in nursing homes. As well as to prevent multi-drug resistant organism acquisition of those with an increased risk of acquiring MDROs including residents with a chronic wound or an indwelling medical device. EBP involves gown and gloves use during high-contact resident care activities for residents known to be infected or colonized with MDROs when contact precautions do not otherwise apply. As well as residents with a chronic wound and/or indwelling medical device. High-Contact Resident Care Activities include the following: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and Wound care. Post the CDC (Centers for Disease Control and Prevention) EBP sign outside of the resident's room. Gown and gloves use prior to the high-contact care activity (change PPE before caring for another resident). 2) R5's clinical records show an initial admitted [DATE] with included diagnoses but not limited to Resistance to Other Specified Beta Lactam Antibiotics and Encounter for Attention to Cystostomy. R5's MDS dated [DATE] shows R5 has severely impaired cognition. R5's physician orders read in part: EBP FOR CANDIDA AURIS (AXILLA/GROIN); CRE (RECTAL) KPC (RECTAL); VIM (AXILLA/GROIN) AND NDM1 (ordered 9/01/24). EBP For Chronic Wound (Ordered 8/02/24). EBP For Device Care or Use of Urinary Catheter (orders 1/29/23). R5's care plan shows R5 has history of MDRO: KPC and VIM rectal, candida auris and crab rectal (date initiated 6/05/23). R5's census list report printed on 1/07/25 shows R5 was transferred to a four-bedroom room on the 4th floor with R10 on 12/17/24. R10's clinical records show an initial admitted [DATE]. R10's census list report printed on 1/07/25 shows R10 is in a four-bedroom room on the 4th floor since 9/7/24. R10's clinical records show R10 has no infection or history of infection with organisms similar to R5. R10's physician orders read in part: EBP for Device Care or Use of Urinary Catheter (ordered 4/17/24). R10's MDS dated [DATE] shows R10 is cognitively intact. On 1/07/2025 at 12:04 PM, interviewed V11 (Infection Control Preventionist/Licensed Practical Nurse) and stated that the facility cohorts residents in the same room depending on what type of organisms the residents have. V11 stated that a resident with KPC organism is not supposed to be cohorting with a resident who has no history of KPC. V11 stated, We do not cohort residents with someone who has no active or history of MDRO. Because they are contagious we try to keep those people with the same type of organisms so we don't make an outbreak. We consult with the DPH (Department of Public Health) guidelines for the type of organisms the residents have. [R5] has Candida Auris in axilla/groin, CRE rectal, KPC rectal, VIM on axilla/groin. [R10] has no history of MDRO. The type of isolation and the type of organisms should be indicated in the physician orders. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/07/2025 at 12:58 PM, interviewed V19 (Admissions Director) and stated that on 12/17/24, V19 made a suggestion that [R5] can move to R10's room because there was a resident coming in from the hospital and the facility needed a bed with ventilator. V19 stated, We needed a bed in the third floor. The hospital didn't tell us ahead of time that this resident is coming in so I called [V16 Licensed Practical Nurse] that [R5] needs to be transferred to [R10's room]. V19 stated that [V19] did not check if R5 has organism. V19 stated that when V11 found out about the room change, V11 said that R5 can't be in the room with R10. V19 stated, It was a big panic at first because we didn't have any more ventilator room. [V11] instructed the staff to move [R5] to a different room. On 1/07/2025 at 1:10 PM, V11 stated that V19 suggested to move R5 with R10 but when V11 found out that R5 was not a match with R10, V11 decided to immediately move R5 out of R10's room. On 1/07/2025 at 3:32 PM, interviewed V18 (Licensed Practical Nurse) and stated that V18 was the nurse on the 4th floor on 12/17/24. V18 stated that R5 was transferred to R10's room around 4:00 PM on 12/17/24. V18 stated that [V18] called V2 (Director of Nursing) and stated that there was a mixed up with the room and told [V18] that [R5] was not supposed to be in the room with R10. V18 stated that V18 worked the double and when V18 left early morning on 12/18/24, R5 was still in R10's room. On 1/09/25 at 9:19 AM, interviewed R10 regarding the room change with R5 on 12/17/24. R10 stated [R10] remembers that staff moved someone in [R10's] room in December but does not know the resident's name. R10 stated that the resident stayed in the room with R10 overnight and was moved out the next day. The facility's Antimicrobial Resistance, Mechanisms of Resistance, and MDRO Classification Explained guidelines (no date) document in part: Cohorting Hierarchy: 1 High priority- these organisms and mechanisms should be matched when cohorting: Candida Auris and Pan-resistant organisms of any kind. 2 Priority- these organisms and mechanisms should be matched when cohorting: CRE-VIM, CRAB-KPC or CRAB-VIM. 3 Lower priority- these organisms/mechanisms of resistance are endemic to Chicago and may be cohorted together, if needed: CRE-KPC. 47304 F880 Based on interview and record review, the facility failed to follow their policy and procedures to (a) ensure linens and clothing worn were placed in plastic bags and send to laundry for 1 (R13) resident with scabies; (b) contact physician for treatment for the R13's roommate; (c) inform the local health department and IDPH of suspected or confirmed scabies. The facility also failed to develop comprehensive care plan for 1 (R13) resident with suspected / confirmed scabies. These failures affected 2 (R13 and R16) out of 14 residents reviewed for infection control. The findings include: R13's admission record showed admitted on 12/12/2019 with diagnoses not limited to Unspecified atrial fibrillation, Type 2 diabetes mellitus with ketoacidosis, Hypertensive chronic kidney disease, Chronic kidney disease, Anemia, Hypothyroidism, Dementia in other diseases classified elsewhere, Gastro-esophageal reflux disease, Unspecified psychosis, Benign prostatic hyperplasia, anxiety disorder. (continued on next page)

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	01/10/2025

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's admission record showed admitted on 7/23/2019 with diagnoses not limited to Chronic obstructive pulmonary disease, Hypertensive heart disease without heart failure, Atherosclerotic heart disease of native coronary artery, Cardiac arrhythmia, Chronic pulmonary embolism, Chronic pain syndrome, Schizoaffective disorder bipolar type, Peripheral vascular disease, Supraventricular tachycardia, Gastro-esophageal reflux disease without esophagitis, Chronic pulmonary edema, Iron deficiency anemia, , Irritable bowel syndrome, Acquired absence of right leg below knee, Other recurrent depressive disorders On 1/8/25 at 1:04PM V2 (DIRECTOR OF NURSING / DON) stated if there is a suspected or confirmed scabies in the facility, should be reported to IDPH (Illinois Department of Public Health). She said R13 with scabies and was not reported to State Agency. At 3:17PM V27 (REGISTERED NURSE / RN) stated has been working in the facility for about [AGE] years and regularly working on the 4th floor. Stated has been working with R13 who has scabies. MD (Medical Doctor) was informed and R13 was transferred to another room by himself and placed under contact isolation. She said scabies treatment was provided as prescribed by physician and saw R13 the following day, he was still wearing the same clothes and bed sheets / linens were not stripped / removed. V27 said did not do proper protocol for scabies. She said when she saw R13 using the same clothes, she was very annoyed as R13 was just reinfecting himself. V27 said R16 was the roommate of R13 before he was transferred for contact isolation for scabies. She said if bed linens were not removed after treatment was provided, it could possibly cause cross contamination if another resident or staff came across the soiled bedsheet or clothes. On 1/9/25 At 10:35am V49 (MDS and CP coordinator) stated care plan should be individualized and personalized and developed by IDT (interdisciplinary team) that would include goals and interventions. Resident with suspected or confirmed scabies should have a plan of care in place so staff would know how to care the resident such as isolation precautions and resident's needs. At 10:43am V2 (DON) stated if there is a suspected / confirmed scabies, staff is expected to pack all resident' belongings, linens and clothing that resident used and send to laundry for washing to prevent re-exposure to the organism after being treated and prevent cross contamination. She said R13 was placed on contact isolation for scabies, he had a roommate (R16). Stated staff are expected to assess R16 due to exposure and belongings will be treated as well. V2 said staff is expected to inform R16's MD to notify about the scabies case, R16 should have prophylaxis treatment and should be documented in resident's records. V2 said care plan should be individualized and personalized according to resident's needs, status, or condition to provide appropriate care for the residents, and it would help staff to care for the residents. V2 said resident with scabies should have a plan of care. MDS (Minimum Data Set) dated 10/14/2024 showed R13's cognition was moderately impaired. He needed set up or clean up assistance with eating, oral hygiene; Supervision or touching assistance with toileting and personal hygiene, shower / bathe self, upper and lower body dressing, chair / bed, and toilet transfer. R13's POS (physician order sheet) dated 1/8/24 with active order not limited to: Isolation: Contact PRECAUTIONS: R/T suspected scabies. Order date 12/23/24. V29's (NP / Nurse Practitioner) notes for R13 dated 12/19/24 documented in part: SCABIES: Pruritic pimple like rash to upper and lower extremities per R13 rash is worsening. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurses Note dated 12/23/2024 documented in part: NP (Nurse Practitioner) made aware of worsening state of Rashes on R13's entire body. R13 takes a shower 12 hours after Elimite cream is applied but is noted with his same clothes, thereby re-infecting himself. R13's care plan reviewed; no care plan found for scabies. R16 MDS dated [DATE] showed cognition was intact. He needed Supervision or touching assistance with toileting and personal hygiene, shower / bathe self, toilet transfer. Reviewed R16's progress notes from 12/4/24 to 1/5/25, no documentation found that physician / NP was notified regarding roommate's suspected / confirmed scabies. No prophylaxis treatment documented that was provided to R16. R16's POS (Physician order sheet), TAR (treatment administration record), MAR (medication administration record) reviewed, did not reflect treatment order for scabies. Facility's scabies policy and procedure dated 9/2020 documented in part: If resident has a roommate, contact the residents' physician for treatment for the roommate regardless symptoms. Bedding and clothing worn or used next to skin anytime during the 3days before treatment should be machine washed using hot water and dried using hot dryer cycles or be dry cleaned. The facility shall inform the local health department and IDPH of suspected or confirmed scabies. Strip bed and place in plastic bag for laundry. Place all washable clothing from closet, in plastic bags and send to laundry. Facility's Comprehensive care plan policy dated 11/2017 documented in part: The interdisciplinary team will develop and implement a person centered, comprehensive plan of care. Care plans are comprised of focus statements, goals and interventions. Assessment of the resident is ongoing and care plans are revised based on the resident condition. 49486 Findings Include: R1's face sheet shows R1 is a [AGE] year-old male. Minimum Data Set, dated dated dated [DATE] shows R1 is cognitively severely impaired. R1's health record documented admitted d 05/17/24 with diagnoses not limited to anoxic brain damage, chronic respiratory failure with hypoxia, dysphagia following cerebral infarction, chronic kidney disease with heart failure, encounter for attention to tracheostomy, poisoning by heroin, chronic obstructive pulmonary disease, ventilator associated pneumonia, encounter for attention to gastrostomy, unspecified dementia, and sepsis unspecified organism. On 1/7/25 at 11:47 AM, V11 (Infection Preventionist) stated that the facility place residents on Enhanced Barrier Precautions (EBP) for any skin opening to protect both the residents and staff. V11 stated that staff must wear gown and gloves when providing contact care like; tracheostomy care, and when administering medication through the gastrostomy tube (GT) to prevent the spread of the organism the resident may have. On 1/8/25 at 9:54 AM, V32 (Licensed Practical Nurse/LPN) stated that V32 has been in this facility for ten years, and V32 is familiar with R1. V32 stated that R1 is on EBP isolation, and V32 wears PPE to provide contact care to R1, R14 (R1's roommate) and other residents with EBP signage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 10:03 AM, Surveyor observed V45 (Registered Nurse/RN) and V48 (RN) providing contact care to R1 without wearing PPE. V48 stated that V48 is administering medication to R1 through R1's GT. V45 stated that V45 and V48 should have donned gown and gloves before proving contact care to R1 to prevent spread of infection. On 1/9/25 at 10:52 AM, V2 (Director of Nursing) stated that it is V2's expectation that staff will don the appropriate PPE when providing care like administering medication through the GT to prevent infection. V4, V8, V36, and V46 all stated that they wear PPE to prevent the spread of infection. Documents Reviewed: R1's Physician Order Sheet (POS) with active orders as of 01/07/25 shows an order for EBP for device care or use of feeding tube. R1's EBP signage outside the door, documents in part: Providers and staff must also wear gloves and gown for high-contact resident care such as feeding tube. Facility's policy on infection prevention control dated 9/20/24. Resident Council Meeting Minutes from 10/2024 to 12/2024. Grievance/Concern Forms from 08/2/2024 to 12/31/2024.