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	01/30/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 50728 Based on interview and record review, the facility failed to ensure R1 was free from neglect by failing to ensure R1 received needed antibiotics to treat R1's infections. This failure contributed to R1 being sent to the hospital for management of sepsis. This failure affected 1 resident (R1) reviewed for neglect. Findings include: R1's discharge paperwork from the hospital (dated 1/8/2025) documents, .Instructions from your doctor: Finish antibiotics --> vancomycin 1.25 g every 12 hours, metronidazole 500 mg every 8 hours, and cefepime 2 g every 8 hours for 6 more days until 1/12/2025 . R1's medication administration record documents that R1 received cefipeme on 1/9/2025 and 1/10/2025. No documentation was provided that R1 received vancomycin or metronidazole. R1's physician orders do not indicate that R1 received vancomycin or metronidazole or that the orders were transcribed to the facility's physician orders. R1's progress notes by V20 (Agency Registered Nurse) affirm that medications were reviewed and reconciled with R1's attending physician's nurse practitioner and that there were no changes to R1's medications. On 1/24/2025 at 11:38 AM, V2 (Director of Nursing) reviewed R1's discharge documentation from the hospital and confirmed R1 was supposed to receive vancomycin 1.5 grams every 2 hours, metronidazole 500 mg every 8 hours, and cefepime 2 grams every 8 hours until 1/12/2025. V2 reviewed R1's electronic health record and confirmed there was no documentation that the orders for metronidazole/vancomycin were transcribed to the facility's records or that the metronidazole/vancomycin was administered. V2 was not made aware of the medication error. V2 explained that the admitting nurse is supposed to transcribe the orders into the facility's system upon readmission and then the clinical support nurse is supposed to complete an audit of the chart to ensure all orders were transcribed. V2 could not give a reason why the metronidazole and vancomycin were not given. V2 stated that if antibiotics are not given, a resident's health status could get worse or develop a serious infection. V2 affirmed that it is the facility's expectation that all orders are transcribed accurately and are carried out. (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 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/24/2025 at 2:39 PM, V5 (Consultant Pharmacist) affirmed that V5 is the consultant pharmacist for the facility. V5 reviewed R1's hospital records and affirmed that R1 should have been administered vancomycin, metronidazole and cefepime. V5 reviewed the cultures provided in the hospital paperwork and stated, Cefepime would not have had enough coverage to effectively treat all of what grew in (R1's) cultures. V5 affirmed that the pharmacy was not made aware of the vancomycin or metronidazole order and stated that the orders were not in the pharmacy's system. V5 confirmed that the vancomycin and metronidazole were not dispensed to the facility for R1. V5 stated that not treating infections with the appropriate antibiotics can cause an infection to a worsen or cause sepsis. On 1/25/2025 at 10:45 AM, V6 (Physician) affirmed that V6 is the attending physician for R1. V6 reviewed R1's vital signs and progress notes from 1/11/2025. V6 stated that R1 met sepsis criteria. V6 stated that V6 was not made aware of the medication error or any changes to V6's medication by V6's nurse practitioner. R1's cultures were reviewed with V6 and V6 affirmed that cefepime was not enough to cover all the bacteria identified within the culture. V6 stated that the lack of antibiotic administration, certainly could have contributed to (R1) developing sepsis, I mean, (R1) clearly needed the medication. On 1/25/2025 at 11:02 AM, V1 (Administrator) affirmed that V1 was the abuse prevention coordinator for the facility. Surveyor inquired the definition of neglect and V1 replied, I would have to google it to give you the definition, I don't want to give you something wrong. V1 explained that medication reconciliation is the responsibility of the admission floor nurse. After, the clinical support nurse (CSN) reviews for accuracy. V1 stated, that is the role of the CSN, (V12) is basically a QA (quality assurance) nurse. V1 stated, I wouldn't say sepsis is a life-threatening condition but that would be more of a question for a clinician. On 1/27/2025 at 9:41 AM, V12 (Clinical Support Nurse, Licensed Practical Nurse) affirmed that V12 completes quality assurance audits on all new admissions or readmissions to the facility. V12 stated that V12 completed an audit on R1's chart when R1 was readmitted to the facility. V12 reviewed R1's discharge records and affirmed that R1 had orders for vancomycin, metronidazole and cefepime. V12 reviewed R1's orders and affirmed that the orders were not transcribed to R1's medical record. V12 stated that V12 did not catch (the medication errors). I must have missed it. On 1/27/2025 at 1:29 PM, V20 (Agency Registered Nurse) stated that V20 has picked up shifts on 2 occasions at the facility but couldn't recall if V20 had worked on 1/8/2025 when R1 was readmitted . V20 stated, go look in the chart, and see if I worked. You see my notes? Then clearly I worked. V20 stated that V20 recalled getting an admission on one of the shifts. V20 explained that V20 transcribed the orders and called the nurse practitioner, and no orders were changed from the discharge paperwork. Surveyor reviewed the discharge paperwork with V20 and V20 affirmed that those orders for metronidazole and vancomycin should have been transcribed. Surveyor asked where V20 transcribed the orders to and V20 replied the physician orders in (electronic health record). Surveyor reviewed the orders with V20 that were transcribed and no orders for vancomycin and metronidazole were noted. Surveyor inquired why V20 did not transcribe the orders into the system and V20 stated, check the miscellaneous tab, they discontinued them (INCONGRUENT STATEMENT). Surveyor asked who discontinued the orders and V20 could not say, and stated, the facility must have gotten rid of my fax. V20 could not give any more information about the incident. The miscellaneous tab was reviewed and no relevant information was noted. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/27/2025 at 1:38 PM, surveyor requested documentation of the fax from V20 from V2 and V4 (Nurse Consultant). V2 stated, there is no fax and V4 stated, no (V20's) story isn't right. (R1) should have gotten the meds and didn't. It's a medication error and we are working on fixing it. Record review of R1's progress notes documents in part that R1 was stabilized and transferred back to the faility on 1/8/2025. On 1/11/2025 at 1:05 AM, a telehealth visit was completed by V19 (Physician). R1's vital signs were: temperature 100.4, heart rate 135 beats per minute, respiratory rate 22 breaths per minute, blood pressure 87/55, oxygen saturation 55% on trach collar. V19 documented in part R1 is a patient with hypotension and sepsis and the facility will (transfer) to the emergency department for rapid evaluation and management of sepsis with low blood pressure. R1 was transferred to the hospital at 2:30 AM and was subsequently admitted . On 1/29/2025 at 5:02 AM, V24 (Licensed Practical Nurse) affirmed V24 was caring for R1 on 1/11/2025. V24 explained that R1 was having difficulty breathing and V24 obtained R1's vital signs. R1 had increased respirations, heart rate, a fever which were signs of sepsis. V24 called the telehealth physician and completed a telehealth appointment with V19 (Physician). V19 told V24 that V19 was concerned with septic shock so V24 called EMS and R1 was sent to the hospital. V19 stated that V19 was unaware of any antibiotics that were missed during admission. V19 stated that sepsis is a life-threatening condition. On 1/29/2025 at 11:59 AM, V19 (Physician) reviewed V19's charting and affirmed V19 was the physician that treated R1 on 1/11/2025 via telehealth. V19 stated that R1's vital signs were indicative of sepsis because R1 was being treated for an infection. V19 recalled being concerned with the low blood pressure as that is a sign of septic shock. V19 ordered R1 to be sent to the hospital for evaluation and management of sepsis. V19 was unaware that R1 was ordered vancomycin and metronidazole and did not receive them. V19 stated if the antibiotics were ordered, they were ordered for a reason; people should get the medication that a physician orders. V19 affirmed that sepsis and septic shock is life-threating. Facility policy titled, ABUSE POLICY (For Illinois Facilities) (Dated 9/20) documents in part, .This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion . This facility therefore prohibits mistreatment, neglect or abuse of its residents .the facility is committed to protecting our residents from abuse by anyone including by not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends or other individuals . Neglect is the failure of the facility, its employees or service providers to provide goods and services needed to avoid physical harm, pain, mental anguish or emotional distress .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on observation, interview and record review, the facility failed to ensure oral care is being provided to residents on the ventilator unit in a manner that meets professional standards; failed to administer oral care in accordance to facility policy. This failure affects 1 resident (R2) and all 36 residents that reside on the ventilator unit. Findings include: Record review of R2's Minimum Data Set, dated dated dated (11/7/2024) documents in part that R2 is dependent on facility staff for oral care. On 1/24/25 at 10:00 AM, surveyor observed R2 with thick, beige secretions covering R2's lips and teeth. V8 (Agency Certified Nursing Assistant) observed R2 and stated that R2 was in need of oral care but that V8 provided it earlier today. On 1/24/25 at 10:03 AM, V9 (Licensed Practical Nurse) entered the room and observed R2. V9 affirmed that R2 needed oral care and addressed V8 stating, I (V9) told you earlier that he needed oral care, why didn't you do it? V8 replied, I (V8) did it earlier, (R2) is just having a lot of secretions. V9 stated, I'll do it (oral care). V9 donned gloves and wrapped a washcloth around V9's index finger. V9 then proceed to wipe R2's lips and teeth with the dry washcloth. V9 stated that poor oral care can cause infections. Record review of R1's Minimum Data Set, dated dated dated [DATE] documents in part that R1 is dependent on staff for oral care and utilizes invasive ventilation. Record review of activity of daily living documentation for oral care for R1 for January 2025, documents that R1 did not recieve oral care on 1/8/2024 and only recieved oral care one time daily for the duration of R1's admissions to the facility. Surveyor requested oral care documentation from 12/2024 for R1 and no documentation was recieved prior to the end of the survey. Record review of R3's Minimum Data Set, dated dated dated , 11/28/2024 documents in part that R3 is dependent on staff for completing oral care and that R3 uses invasive ventilation. Record review of R3's oral care documentation for 1/2025 documents in part 10 days when R3 only recieved oral care one time per day. Surveyor requested oral care documentation from 12/2024 for R3 and no documentation was recieved prior to the end of the survey. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy titled ORAL CARE FOR THE UNCONSIOUS RESIDENT (dated 6/2019) documents in part, Equipment: 1. Tongue depressor. 2. Lemon and glycerin swabs. 3. Applicators. 4. Mouthwash 5. Suction machine with connection tubing 6. Irrigation syringe. 7. Resident's toothbrush or disposable toothbrush. 8. Toothpaste or powder. 9. Petroleum jelly. PROCEDURE: 1. Check resident care plan for special instructions 2. Place resident on the side with face extending over edge of pillow (facing you). 3. Place towel and emesis basin under mouth. 4. Hold mouth open with tongue depressor if necessary. 5. Moisten applicators with mouthwash and cleanse inside of mouth. Change applicators frequently and discard properly. 6. Inspect inside of mouth and gums for irritation and open areas. 7. If teeth are present, brush teeth with small amount of toothpaste or powder (with disposable toothbrush). Brush tongue gently. 8. Rinse resident's mouth with warm water of diluted mouthwash in an irrigation syringe, while suctioning to remove irrigating fluids. 9. If necessary, use lemon and glycerin swab to lubricate mouth; apply petroleum jelly to lips. NOTE: Dentures are usually not placed in an unconscious resident's mouth. 10. Repeat as often as necessary to keep mouth and lips clean and moist. The policy excludes a minimum neccisary amount of oral care to be completed outside of as often as necessary. On 1/24/2025 at 10:56 AM, V2 (Director of Nursing) affirmed that ORAL CARE FOR THE UNCONSIOUS RESIDENT policy is the vent unit's policy for oral care. V2 stated that the facility standard for oral care is that it is to be provided at least twice daily or as needed. V2 reviewed the policy and stated, no, it should say at least twice a day. V2 stated that if residents undergoing ventilator therapy do not get adequate oral care, it can cause pneumonia. V2 stated that staff should be using the appropriate equipment to complete oral care, not washcloths. On 1/24/2025 at 1:28 PM, V7 (Medical Director) stated that poor oral care can cause pneumonia. V7 said that the general standard is that oral care is provided two times a day for patients and as needed. On 1/31/2025 at 11:31 AM, V2 (Director of Nursing) stated that V2 could not find documentation of oral care for R1, R2 and R3 in December of 2024. V2 stated that if there is no documentation, it could mean it was not completed, or that we do not have any documentation to prove it was completed. Documenation for oral care given to R1, R2, and R3 for 12/2024 was not recieved prior to the exit of the surey.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50728 Based on observation interview and record review, the facility failed to ensure nebulizer tubing was changed per facility policy. This failure has the potential to affect 1 resident (R12) sampled for respiratory care. Findings include: Record review of R12's Minimum Data Set (dated 12/23/2024) documents in part that R12 is unable to speak, is rarely/never understood, is cognitively impaired, is dependent on staff for activities of daily living, and utilizes a ventilator. On 1/27/2025 at 11:44 AM, R12 was observed lying in bed with nebulizer tubing attached to R12's tracheostomy site. V10 (Resident Care Coordinator, Licensed Practical Nurse) observed the nebulizer tubing for R12 and affirmed it was dated 1/15/2025. V10 stated the nebulizer tubing should be changed weekly to prevent infection. Record review of R12's progress notes for 1/29/2025 document that R12 was diagnosed with a urinary tract infection, pneumonia, and sepsis. Record review of facility policy titled, RESPIRATORY EQUIPMENT CHANGE PROCEDURE (10/2018) documents in part, .4. Nebulizer set-ups for bronchodilator therapy: changed every 7 days and PRN.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50728 Based on interview and record review, the facility failed to ensure agency staff had adequate competency, training and the skills necessary to care for the facility's residents. This failure has the potential to affect all residents that reside within the facility. Findings include: Record review of active resident census documents that 162 residents reside within the facility. On 1/27/2025 at 1:29 PM, V20 (Agency Registered Nurse) stated that V20 has picked up shifts on 2 occasions at the facility but couldn't recall if V20 had worked on 1/8/2025 when R1 was readmitted . V20 stated, go look in the chart, and see if I worked. You see my notes? Then clearly I worked. V20 stated that V20 recalled getting an admission on one of the shifts. V20 explained that V20 transcribed the orders and called the nurse practitioner, and no orders were changed from the discharge paperwork. Surveyor reviewed the discharge paperwork with V20 and V20 affirmed that those orders for metronidazole and vancomycin should have been transcribed. Surveyor asked where V20 transcribed the orders to and V20 replied the physician orders in (electronic health record). Surveyor reviewed the orders with V20 that were transcribed and no orders for vancomycin and metronidazole were noted. Surveyor inquired why V20 did not transcribe the orders into the system and V20 stated, check the miscellaneous tab, they discontinued them (INCONGRUENT STATEMENT). V20 affirmed that V20 documented the change on a fax and not within the electronic health record. Surveyor asked who discontinued the orders and V20 could not say, and stated, the facility must have gotten rid of my fax. V20 could not give any more information about the incident. Surveyor inquired what type of training was given to V20 by the facility and V20 stated, I (V20) work agency so we (agency nurses) don't get training. We get a brief orientation of the facility of like where stuff is and who to call in an emergency, but no formal training. V20 denied any training on the admissions process/policy or documentation. On 1/27/2025 at 1:40 PM, surveyor requested documentation from V2 (Director of Nursing) regarding any training provided to V20 prior to working. V2 stated that this is usually done by the agency and that the facility does not have a formal procedure for educating/evaluating competency of agency nurses prior to starting their shift. On 1/29/2025 at 11:53 AM, V2 affirmed that the facility utilizes agency to fill staffing needs. V2 stated that the agency had no training documents for V20. V2 explained that that facility does not have any documentation that V20 was competent on how to complete an admission. V2 affirmed that there is a resource binder on the floor for agency staff to use should they have questions on things, like an admission. V2 stated there is no documentation that V20 was aware of the contents of the resource binder or reviewed the resource binder. Record review of job description titled Staff Nurse (dated 1/2015) documents in part, .Job Summary Responsible to provide direct nursing care to the customer, and to supervise the day-to-day nursing activities performed by the nursing assistants . Qualifications . C. Must be knowledgeable of nursing and medical practices and procedures . Essential Functions . Perform routine charting duties as required . responsible for completion of admission, discharge and transfer processes . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of Facility Assessment Tool (reviewed 7/31/24) documents in part, . 3.4 Describe staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. *See Training/Education & Competencies tab . Training/Educations & Competencies tab was not provided during the survey.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 50728 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors. This failure contributed to R1 developing sepsis and requiring hospitalization . These failures affected 2 residents (R1, R3) reviewed for medication errors. Findings include: 1) R1's discharge paperwork from the hospital (dated 1/8/2025) documents, .Instructions from your doctor: Finish antibiotics --> vancomycin 1.25 g every 12 hours, metronidazole 500 mg every 8 hours, and cefepime 2 g every 8 hours for 6 more days until 1/12/2025 . R1's medication administration record documents that R1 received cefipeme on 1/9/2025 and 1/10/2025. No documentation was provided that R1 received vancomycin or metronidazole. R1's physician orders do not indicate that R1 received vancomycin or metronidazole or that the orders were transcribed to the facility's physician orders. R1's progress notes by V20 (Agency Registered Nurse) affirm that medications were reviewed and reconciled with R1's attending physician's nurse practitioner and that there were no changes to R1's medications. On 1/24/2025 at 11:38 AM, V2 (Director of Nursing) reviewed R1's discharge documentation from the hospital and confirmed R1 was supposed to receive vancomycin 1.5 grams every 2 hours, metronidazole 500 mg every 8 hours, and cefepime 2 grams every 8 hours until 1/12/2025. V2 reviewed R1's electronic health record and confirmed there was no documentation that the orders for metronidazole/vancomycin were transcribed to the facility's records or that the metronidazole/vancomycin was administered. V2 was not made aware of the medication error. V2 explained that the admitting nurse is supposed to transcribe the orders into the facility's system upon readmission and then the clinical support nurse is supposed to complete an audit of the chart to ensure all orders were transcribed. V2 could not give a reason why the metronidazole and vancomycin were not given. V2 stated that if antibiotics are not given, a resident's health status could get worse or develop a serious infection. V2 affirmed that it is the facility's expectation that all orders are transcribed accurately and are carried out. On 1/24/2025 at 2:39 PM, V5 (Consultant Pharmacist) affirmed that V5 is the consultant pharmacist for the facility. V5 reviewed R1's hospital records and affirmed that R1 should have been administered vancomycin, metronidazole and cefepime. V5 reviewed the cultures provided in the hospital paperwork and stated, Cefepime would not have had enough coverage to effectively treat all of what grew in (R1's) cultures. V5 affirmed that the pharmacy was not made aware of the vancomycin or metronidazole order and stated that the orders were not in the pharmacy's system. V5 confirmed that the vancomycin and metronidazole were not dispensed to the facility for R1. V5 stated that not treating infections with the appropriate antibiotics can cause an infection to worsen or cause sepsis. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 1/25/2025 at 10:45 AM, V6 (Physician) affirmed that V6 is the attending physician for R1. V6 reviewed R1's vital signs and progress notes from 1/11/2025. V6 stated that R1 met sepsis criteria. V6 stated that V6 was not made aware of the medication error or any changes to V6's medication by V6's nurse practitioner. R1's cultures were reviewed with V6 and V6 affirmed that cefepime was not enough to cover all the bacteria identified within the culture. V6 stated that the lack of antibiotic administration, certainly could have contributed to (R1) developing sepsis, I mean, (R1) clearly needed the medication. On 1/27/2025 at 9:41 AM, V12 (Clinical Support Nurse, Licensed Practical Nurse) affirmed that V12 completes quality assurance audits on all new admissions or readmissions to the facility. V12 stated that V12 completed an audit on R1's chart when R1 was readmitted to the facility. V12 reviewed R1's discharge records and affirmed that R1 had orders for vancomycin, metronidazole and cefepime. V12 reviewed R1's orders and affirmed that the orders were not transcribed to R1's medical record. V12 stated that V12 did not catch (the medication errors). I must have missed it. On 1/27/2025 at 1:29 PM, V20 (Agency Registered Nurse) stated that V20 has picked up shifts on 2 occasions at the facility but couldn't recall if V20 had worked on 1/8/2025 when R1 was readmitted . V20 stated, go look in the chart, and see if I worked. You see my notes? Then clearly I worked. V20 stated that V20 recalled getting an admission on one of the shifts. V20 explained that V20 transcribed the orders and called the nurse practitioner, and no orders were changed from the discharge paperwork. Surveyor reviewed the discharge paperwork with V20 and V20 affirmed that those orders for metronidazole and vancomycin should have been transcribed. Surveyor asked where V20 transcribed the orders to and V20 replied the physician orders in (electronic health record). Surveyor reviewed the orders with V20 that were transcribed and no orders for vancomycin and metronidazole were noted. Surveyor inquired why V20 did not transcribe the orders into the system and V20 stated, check the miscellaneous tab, they discontinued them (INCONGRUENT STATEMENT). Surveyor asked who discontinued the orders and V20 could not say, and stated, the facility must have gotten rid of my fax. V20 could not give any more information about the incident. The miscellaneous tab was reviewed and no relevant information was noted. On 1/27/2025 at 1:38 PM, surveyor requested documentation of the fax from V20 from V2 and V4 (Nurse Consultant). V2 stated, there is no fax and V4 stated, no (V20's) story isn't right. (R1) should have gotten the meds and didn't. It's a medication error and we are working on fixing it. No fax was provided before the end of the survey related to medication errors. Record review of R1's progress notes documents in part that R1 was stabilized and transferred back to the hospital on 1/8/2025. On 1/11/2025 at 1:05 AM, a telehealth visit was completed by V19 (Physician). R1's vital signs were: temperature 100.4, heart rate 135 beats per minute, respiratory rate 22 breaths per minute, blood pressure 87/55, oxygen saturation 55% on trach collar. V19 documented in part R1 is a patient with hypotension and sepsis and the facility will (transfer) to the emergency department for rapid evaluation and management of sepsis with low blood pressure. R1 was transferred to the hospital at 2:30 AM and was subsequently admitted . (continued on next page)

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	145450	A. Building B. Wing	01/30/2025

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Alden Lakeland Rehab & Hcc	820 West Lawrence Chicago, IL 60640

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 1/29/2025 at 5:02 AM, V24 (Licensed Practical Nurse) affirmed V24 was caring for R1 on 1/11/2025. V24 explained that R1 was having difficulty breathing and V24 obtained R1's vital signs. R1 had increased respirations, heart rate, a fever which were signs of sepsis. V24 called the telehealth physician and completed a telehealth appointment with V19 (Physician). V19 told V24 that V19 was concerned with septic shock so V24 called EMS and R1 was sent to the hospital. V19 stated that V19 was unaware of any antibiotics that were missed during admission. V19 stated that sepsis is a life-threatening condition. On 1/29/2025 at 11:59 AM, V19 (Physician) reviewed V19's charting and affirmed V19 was the physician that treated R1 on 1/11/2025 via telehealth. V19 stated that R1's vital signs were indicative of sepsis because R1 was being treated for an infection. V19 recalled being concerned with the low blood pressure as that is a sign of septic shock. V19 ordered R1 to be sent to the hospital for evaluation and management of sepsis. V19 was unaware that R1 was ordered vancomycin and metronidazole and did not receive them. V19 stated if the antibiotics were ordered, they were ordered for a reason; people should get the medication that a physician orders. V19 affirmed that sepsis and septic shock is life-threating. 2) Record review of R3's patient transfer summary signed by R3's hospital physician documents in part an order for micafungin 100 mg every 24 hours via IV. R3's hospital records Instructions from your doctor documents in part instructions to administer micafungin 100 mg every 24 hours until 1/5/2025 for candidiasis (yeast infection). Record review of R3's physician orders and medication administration record, documents in part that R3 had an order for and received micafungin 50 mg IV every 24 hours until 1/5/2025. Record review of R3's progress notes does not indicate that medication reconciliation occurred with R3's physician. No documentation was received by the end of the survey that indicates that the order for micafungin was changed by a provider. On 1/25/25 at 10:52 AM, V2 (Director of Nursing) reviewed R3's medical record, including but not limited to physician orders, progress notes, medication administration record and hospital discharge paperwork. V2 affirmed that R3 received 50 mg of micafungin. V2 stated that R3 should have received 100 mg. V2 affirmed that the incorrect dose of micafungin was administered and could not give a reason for the medication error. On 1/27/2025 at 9:41 AM, V12 (Clinical Support Nurse, Licensed Practical Nurse) affirmed that V12 completes quality assurance audits on all new admissions or readmissions to the facility. V12 stated that V12 completed an audit on R3's chart when R3 was readmitted to the facility. V12 reviewed R3's discharge records and affirmed that R10 had orders for micafungin 100 mg. V12 reviewed R3's orders and affirmed that R3 had 50 mg transcribed instead of 100 mg. V12 reviewed R3's medical record and could not find documentation to warrant a different dose. V12 stated, I guess I missed this (medication) during my audit too. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Facility policy titled Re-admissions dated 6/2022, documents in part, Policy/Purpose: Medications for residents readmitted to the facility are verified and initiated on a timely basis . 2. The facility nurse will clarify and confirm all admission orders (or any changes, additions or deletions from previous POS (Physician Order Sheet)) with the attending physician .4. If the resident was discharged for longer than 24 hours, or other time as determined by facility policy, a new set of physician orders are prepared at readmission .

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on interview and record review, the facility failed to complete an accurate facility assessment that includes staffing information that identifies staffing needs per shift/unit; identifies respiratory therapists within the staffing plan; identifies the contracts to staff respiratory therapy staff. This failure has the potential to affect all residents that reside within the facility. Findings include: Record review of active resident census documents that 162 residents reside within the facility. Record review of facility assessment dated [DATE], documents in part the following: 1) The number of residents the facility is licensed to care for broken down by floor/unit, however only floors are specified. The ventilator unit is not identified. 2) Respiratory therapists are not identified as a staff member needed to care for the facility's population. 3) Staffing plan lists total number of FTE (full-time employees) needed for the facility. The staffing plan does not indicate how many staff and what kind of staff are needed per unit or per shift. The ventilator unit is not mentioned within the staffing plan. 4) Staffing contract is not identified for respiratory therapist staffing. On 1/28/2025 at 10:50 AM, V18 (Director of Respiratory) stated that V18 is a registered respiratory therapist and is contracted out of the therapy services provider to oversee the respiratory therapy program within the facility. V18 stated that the facility has a large ventilator program (36 residents) that require the needs of registered respiratory therapists to manage the resident's airways. V18 stated that the facility contracts another medical staffing agency to staff the ventilator unit. V18 explained that the staffing needs are identified by V18 and the staffing in the ventilator unit is 1 respiratory therapist to every 16 airways so the facility always has at least 2 respiratory therapists on site at all times. Additionally, the facility has CLIA certification needs to be able to run in-house arterial blood gasses by respiratory therapists and V18 oversees the program with a physician. Respiratory therapists need certain educational requirements to be able to complete arterial blood gas labs, which V18 supervises. Educational competency is also overseen by V18 and V14 (Respiratory Manager) who completes competencies for respiratory therapists and nursing staff. V18 stated that the competencies are completed annually and whenever new equipment is in use for the facility. On 1/28/2024 at 11:48 AM, V1 (Administrator) stated that the facility assessments are completed yearly by the facility. V1 stated We (the facility) is not required to break down our staffing needs in our facility assessment. It has listed our full-time needs. We always staff 2 respiratory therapists, and that staffing pattern is given to us by V18 who is from a consultant company. V1 affirmed that the facility's respiratory therapists are all staffed by a contracted staffing company. On 1/30/2025 at 11:58 AM, surveyor requested the facility's policy for completing the facility assessment. V1 stated, We (the facility) do not have a facility assessment policy, we use our facility assessment tool. We are only required to complete the assessment yearly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on observation interview and record review, the facility failed to ensure foley catheter tubing was off the floor; failed to follow the infection prevention policy and complete data collection/surveillance related to infections. This failure has the potential to affect all residents that reside within the facility. Findings include: Record review of active resident census documents that 162 residents reside within the facility. On 1/24/2025 at 12:51 PM, V3 (Infection Preventionist, Licensed Practical Nurse) affirmed that V3 is the infection preventionist for the facility. V3 provided a copy of the facility's infection control log. Surveyor completed review of infection control log with V3 and noted that the infection control log was missing R1's cases of pneumonia, types of pathogens were not being tracked, symptoms were not being tracked, and mapping of infections was not completed. V3 stated, I (V3) do not have to track all that (pathogens, symptoms, mapping). I only have to track antibiotics. If someone is one an antibiotic, it flags for me in the system and I make an infection control case. It's really any anti-infective medication, such as antifungals too. Surveyor inquired about how infections that are not treated with an anti-infective agent (such as certain viral infections) are tracked, and V3 replied, No, you don't need to track anything unless it has an anti-infective medication prescribed to treat it. On 1/24/2025 at 1:49 PM, V2 (Director of Nursing) stated that infection symptoms, pathogens and mapping should be completed as a part of the infection control program for infection surveillance. V2 affirmed if this is not completed, outbreaks of infections could occur. V2 explained that this process was being completed by the prior assistant director of nursing but that they left in November. V2 stated that V4 (Registered Nurse Consultant) was overseeing V3's work and training V3 since November when V3 started. On 1/24/2025 at 4:47 PM, V4 (Registered Nurse Consultant) affirmed that V4 is from the corporate team that governs the facility. V4 stated that V3 resigned earlier on 1/24/2025 and affirmed that V4 would be the facility's infection preventionist until a replacement was found. V4 stated that V4 was supervising V3's work and training V3. V4 showed the surveyor the infection control program module that creates the infection log on V4's laptop and affirmed that V3 was completing it in the system. V4 stated that the log V3 provided was not accurate. Surveyor asked V4 to show the pathogens being tracked in the module for January 2024 and the organism section for each infection control case was blank, indicating pathogens were not being tracked. Copies of the infection control module that showed the missing organism in the module were requested during survey and not received prior to the end of survey. V4 was unsure how the modules could be marked complete if the organism section was blank, stating, there must be a glitch. V4 reviewed R1's electronic health record and affirmed no infection control assessments were completed related to R1's cases of pneumonia/sepsis. Surveyor requested to see any infection control surveillance/mapping documentation and V4 stated that the mapping was completed in V3's office and that V4 would provide it to surveyor the following morning. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/24/2025 at 5:02 PM, surveyor observed V4 walk into V1 (administrator) office and asked V2 for the infection control binder. V2 stated, I told you already, we couldn't find any binder. We checked the office. The mapping was not completed. On 1/25/2025, at 10:47 AM, V4 provided infection control logs for January 2025, December 2024, and November 2024 and stated that those were the infection control logs that pulled correctly. V4 affirmed that tracking of organisms was occurring. V4 also provided infection surveillance mapping and stated that V4 completed them after the surveyor left on 1/24/2025. Record review of infection control logs provided by V4 on 1/25/2025 do not document universal tracking of organisms, signs/symptoms or a summary/analysis of infection control tracking or trending. Record review of facility policy titled, INFECTION PREVENTION AND CONTROL PROGRAM MANUAL (dated 2020) documents in part, .Elements of surveillance system include: - Standardized definitions and listings of the symptoms of infections based upon national standards of practice . - Use of monitoring tools such as surveys and data collection templates, walking rounds throughout the healthcare facility; - Identification of residents at risk for infection; - Identification of processes or outcomes selected for surveillance; - Statistical analysis of data that can uncover an outbreak . DATA COLLECTION: 1. The unit charge nurses will identify residents with symptoms or identified infections and complete the Criteria for Infection Report Forms for the respective type of infection: a. Urinary Tract Infection b. Respiratory Tract Infection c. Gastrointestinal Tract Infection d. Skin, Soft Tissue and Mucosal Infection 2. The Infection Preventionist will ensure data collection to complete a comprehensive Monthly Infection Control Log for surveillance activities on: a. The infection site b. Pathogen c. Signs and Symptoms d. Resident Location e. Summary and Analysis of number of residents/staff with infections. 3. The Infection Preventionist or designee will be alerted to identify any necessary interventions in order to identify trends or clusters for action. 4. The Infection Preventionist will keep an updated map of infections to identify any clusters or trends . Record review of R12's Minimum Data Set (dated 12/23/2024) documents in part that R12 is unable to speak, is rarely/never understood, is cognitively impaired, is depended on staff for activities of daily living, and utilizes a ventilator and catheter. On 1/27/2025 at 11:44 AM, R12 was observed lying in bed with nebulizer tubing attached to R12's tracheostomy site. Additionally, R12's foley catheter tubing was lying on the floor. V10 (Resident Care Coordinator, Licensed Practical Nurse) entered room and observed the foley catheter tubing and stated, that should be in a basin, it should not be touching the floor. V10 affirmed that foley catheter tubing touching the floor can cause infection. Record review of R12's progress notes for 1/29/2025 document that R12 was diagnosed with a urinary tract infection, pneumonia, and sepsis. Record review of R14's Minimum Data Set, dated dated dated [DATE] documents that R14 is in a persistent vegetative state with no discernable consciousness, is dependent on staff for activities of daily living and utilizes an indwelling catheter. On 1/27/2025 at 12:19 AM, R14 was observed lying in bed with R14's catheter tubing on the floor. V10 observed the tubing and stated that the tubing should not be lying on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of facility policies titled, CATHETER CARE and INDWELLING FOLEY CATHETER (dated 9/2020) do not instruct where catheter tubing should be placed to prevent infection. No other policy related to foley catheters was submitted for review prior to the end of the survey.