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	04/15/2026

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 0686 Level of Harm - 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** Based on review of records and interviews the facility failed to provide preventive treatment for 1 out of 3 residents (R6) reviewed for wound and/or pressure ulcer prevention and treatment.These failures affected 1 resident (R6) who sustained a wound in the facility on the sacral/tailbone that became infected.Findings include:R6 a [AGE] year-old resident initially admitted in the facility on 01/13/2026 with diagnosis of cerebral infarction, anoxic brain damage, morbid obesity due to excess calories, diabetes mellitus among others.On 03/24/2026 at 09:40 AM, V28 (Family of R6) stated that facility failed to communicate to him the status of R6's wound. V28 said he was informed by the hospital that R6 had a Golf ball-size pressure ulcer a month after R6 was admitted in the facility. Currently, R6 is still in the hospital being treated for her wound.Per initial admission assessment clinical notes by V41 (Registered Nurse) dated 01/13/2026 documents that R6 skin assessment was done. R6 has intact skin, and no wounds. Clinical notes of V42 (Wound Nurse/Licensed Practical Nurse) dated 01/14/2026 documents that R6 skin were intact with MASD (Moisture-Associated Skin Damage) on the sacrum.R6's care plan intervention dated 01/27/2026 documents R6 needs barrier cream to areas exposed to moisture/incontinence. Review of R6 treatment administration records (TAR) for January 2026 does not document any treatment on the sacrum for MASD (Moisture-Associated Skin Damage). After eighteen (18) days without documented physician orders and treatment administration record of sacral MASD (Moisture-Associated Skin Damage) treatment, V43 (Registered Nurse) clinical notes dated 01/31/2026 documents: V12 (Medical Doctor) informed of MASD (Moisture-Associated Skin Damage) to sacral ad left buttock, V12 ordered Zinc Oxide cream to affected area every shift each incontinent care and to notify wound care team and wound consult. On 03/26/2026 at 10:49 AM V43 (Registered Nurse) stated that on 01/31/2026, R6's sacral wound has slight opening irritation on the skin. Zinc Oxide cream protects and dries the skin to help protect the skin. R6 was not seen by V27 (Advance Practice Nurse for Wound) until 02/17/2026 seventeen (17) days after V12 physician ordered for wound consultation.V27 (Advance Practice Nurse for Wound) notes and assessment dated [DATE] documents that R6 sacral wound worsen from previous wound area from 0 (skin intact) to 10 centimeters by 15 centimeters by 0.1 centimeter (length by width by depth). Per V27's notes first evaluation R6 previously had MASD (Moisture-Associated Skin Damage) to sacrum. Upon V27 examination, sacral MASD (Moisture-Associated Skin Damage) worsened. V27 ordered culture and sensitivity to rule out localized infection. And to refer to Infection Disease (ID) for culture and sensitivity results. V27 instructions was to perform the following test: Please refer to Infectious Disease specialist for Culture and Sensitivity sacral ulcer.On 03/25/2026 at 01:34 PM, V42 (Wound Nurse/Licensed Practical Nurse) stated that upon admission R6 skin was intact with MASD (Moisture-Associated Skin Damage). V42 reviewed R6 clinical records, upon knowing that R6 had MASD (Moisture-Associated Skin Damage) without physician order for treatment. V42 stated that there should have been an order for Zinc Oxide cream twice a day. V42 stated that Daikins solution (ordered on 02/17/2026), is used to treat open wounds to fight bacteria and to clean the area of the wound. While Zinc Oxide cream is only used if wound is not deep and no rawness. V42 stated that based on R6's culture and sensitivity result her (R6) sacral wound got infected. V42 stated that the (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 0686 Level of Harm - Actual harm Residents Affected - Few	expectation is for wound staff to address skin concerns as early as possible to prevent wound issues. It could help if it was addressed from the very beginning. Review of R6 treatment administration records (TAR) for February 2026 documents that on 02/17/2026 Dakins (1/2 strength) Solution 0.2-0.25 % was added as a new treatment.Per R6's census history, R6 was discharged on 02/18/2026. Clinical notes dated 02/18/2026 by V29 (Registered Nurse) documents that R6 was transferred to the hospital with elevated temperature or fever, Complete Blood Count blood results noted that [NAME] Blood Cell (WBC) results 18.5 which was high. Reference Range from 3.6 to 11.2. WBC elevates when there is infection. On 02/20/2026 facility received R6's culture and sensitivity result that documents R6 tested positive for wound infection.Per V29 (Registered Nurse) clinical notes dated 02/19/2026 during R6 transferred to the hospital documents R6 were admitted for sepsis and sacral region pressure ulcer evaluation.Centers for Disease Control (CDC) on 03/26/2026 defines Sepsis as follows:Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.Anyone can get an infection, and almost any infection can lead to sepsis.Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency. Sepsis happens when an infection you already have triggers a chain reaction throughout your body.Without fast treatment, sepsis can quickly lead to tissue damage, organ failure, and death.Prevention and Treatment of Pressure Injury and other Skin Alteration dated 03/02/2021:Policy is to implement preventive measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and review of records, the facility failed to maintain safe transfers procedure and checking of equipment in accordance with their policy for 2 out of 3 residents (R8, R17) reviewed for mechanical lift (Hoyer) transfers.These failures resulted in two (2) residents (R8, R17) sustained multiple fall accidents during transfers with Hoyer lift.Findings include: R8 is [AGE] year-old resident in the facility. R8 initially admitted on [DATE] with medical diagnosis that includes diabetes mellitus with foot ulcer, anxiety disorder, depression, acquired absence of left leg below knee. On 03/24/2026 at 01:01 PM, R8 was seen in his room verbally able to express thoughts well and within topic. R8 stated that two (2) times he had a problem with Hoyer lift. First, during Christmas facility staff tried to get R8 back from shower to his bed. Hoyer lift tilt forward and it dropped to me. R8 explained that the handle where sling was attached hit his head. According to R8 facility staff told him that he was unconscious for a few seconds. Second incident was again after shower, facility staff transferred him from shower table to Geri chair. The strap of the sling attached to the Hoyer lift broke and R8 dropped on the floor. R8 stated that he was brought to the hospital, but no major injury was sustained. R8 stated that shower bed cannot fit the area inside the room that facility staff need to transfer him from shower table to Hoyer lift on the hallway. R8 said, I felt sore because of the fall. Now I will never let them transfer with Hoyer lift again. After the second accident, no way! V44 (Registered Nurse) clinical notes dated 12/25/2025 documents that Hoyer lift fell and hit R8 on the forehead. R8 did not respond for ten (10) seconds. V13 (Licensed Practical Nurse) clinical notes dated 01/29/2026 documents that R8 was being transferred from the Hoyer lift to bed when the strap of the sling broke hitting R8 head on the frame of the lift. On 03/24/2026 at 01:29 PM, V45 (Registered Nurse) inspected Hoyer lifts that were available on the floor where R8 is located. V45 said, Some Hoyer lifts do not work, some of them don't work. It hits and misses sometimes. Sometimes they don't work. There are two (2) Hoyer lifts, one did not work, the other was able to move arm that attaches the sling upwards. V45 was asked if all rooms can accommodate Hoyer lift to fit? V45 said, Some rooms are too small that shower bed cannot fit in R8's room. On 03/24/2026 at 01:50 PM with V30 (Maintenance Director/Building Manager) measurements were done on shower table as follows: 76 inches (length), 31 inches (width) and 34 inches (height). At R8's room measurements were done area on the side of the bed are as follows: 74 inches length short of 2 inches and measurement from side of the bed to wall is 30 inches that has no room for a person to maneuver with 31 inches wide for the bed. On 03/25/2026 at 10:55 AM, V13 (Licensed Practical Nurse) stated that R8 was transferred on the right in front of his doorway by placing a sling via Hoyer lift going into his room. V13 stated she cannot remember a lot of details. V13 stated that what she remembered was that assessment was done, 911 was called and R8 was sent to the hospital. On 03/25/2026 at 11:37 AM, V21 (Certified Nursing Assistant) stated that he was helping to transferred R8 in both incidents (12/25/2025 and 01/29/2026). First, with V47 (Certified Nursing (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant) during Christmas day when Hoyer lift tilt and hits the head of R8. Second with V22 (Certified Nursing Assistant) when the sling broke. R8 hit the floor at the entrance of his room. V21 stated that R8 was transferred via Hoyer lift from the hallway near the door to the bed. V21 stated that it would be easy if R8 was smaller. Per weight record, R8 weighs 384.6 LBS on 12/23/2025 and 385.0 LBS on 01/06/2026. On 03/25/2026 at 12:35 PM, V25 (Restorative Nurse/Licensed Practical Nurse) stated that sling for Hoyer lift needs to be checked that without a tear, not crunchy. If they are we need to replace it. Hoyer lift cannot be used for transportation because it can swing and may tip. It can be turned or moved near the bed but not a distance from hallway to bed. Hoyer lift can be moved but it is not recommended due to safety issue. On 04/02/2026 12:09 PM, R17 stated that he was dropped out of the hoyer in the facility. the hoyer sling tore. The incident happened on 10/15/2025. R17 stated he was on the second floor. R17 was then sent to the hospital. On 10/15/2025, he was hoyered out of his bed. and as they were starting to lower him, the lower strap tore free from the sling and R17 landed on the wheelchair. R17 was then lowered to the floor and manually placed back in bed. They ordered x-ray. X-ray came and took it that day. X-ray showed no fracture. R17 was then transferred to the hospital and when he came back, he was transferred to the fourth floor. R17 stated that two CNAs were helping him when using the hoyer lift. On 04/02/2026 at 12:10 PM, V13 (Licensed Practical Nurse) stated that they round on residents every hour to an hour and a half. V13 stated that R17 had a fall in the facility. R17 was going from the bed to wheelchair. V13 stated that the sling tore and R17 said he slipped out of the sling to the wheelchair and the CNA lowered him to the floor. The CNA was assisting R17. When it happened, the CNA called V13 to the room. V13 stated that R17 was not sent out because after assessment he did not have any pain or neurological deficit. On 04/02/2026 at 12:16 PM, V8 (Certified Nursing Assistant) stated that he is familiar with R17. V8 stated that she was transferring R17 from the bed to his wheelchair using a hoyer lift. V8 stated that while R17 was up on the hoyer lift, the sling ripped and R17 slipped out of the sling into his chair and onto the floor. V8 stated that two people are expected to use the hoyer lift together when transferring residents. R17's fall investigation on 10/15/2025 documents in part: On 10/15/2025, 2 CNAs were transferring the resident via hoyer lift when the hoyer sling strap ripped and tore apart from the sling while the resident was hovering above the wheelchair. Root Cause Analysis: Sling harness torn. Per facility policy, hoyer lift sling needs to be checked for rips, tears, or abnormal wear prior to use. If noted, take out of circulation immediately and notify DON or designee. Total Mechanical Lift policy and procedure dated 01/14/2021: The purpose of this policy is to lift, transfer and move a resident from one surface to another. Under procedure, facility staff needs to check the sling for rips, tears or abnormal wear prior to use; if noted, take out of circulation immediately, and notify Director of Nursing. Position as close as possible to the device you will be transferring resident to.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of records and observations, the facility's failures on respiratory care for 8 out of 11 residents (R7, R21, R22, R23, R24, R26, R28 and R16) are as follows:Facility failed to monitor one (1) resident (R7) with tracheostomy receiving oxygen at twenty (20) liters per minute via tracheostomy to be free from extubating/dislodging.Facility failed to ensure assigned healthcare professionals were screened, evaluated for competency to take care of residents with tracheostomy.Facility failed to report to State agency and investigate unusual occurrence resulted to death of one (1) resident (R7) due to dislodged tracheostomy in establishing parameters to prevent potential reoccurrence.Facility failed to ensure that initial assessments are made to tracheostomy residents to determine acuity and different levels of care.Facility failed to ensure that tracheostomy equipment is functional and/or readily available for reinsertion in case of dislodge for six (6) residents (R21, R22, R23, R24, R26 and R28) per their policy.Failed to follow doctor's order to perform and complete tracheostomy care and suctioning for one resident (R16).These failures resulted in 1 resident (R7) dislodged of tracheostomy being found unresponsive, pulseless, and apneic and was pronounced dead by paramedic. Failures have the potential to affect six (6) residents (R21, R22, R23, R24, R26 and R28) respiratory needs. Due to lack of equipment or equipment not functional as intended. Failures affected one (1) resident (R16) that sustained respiratory infection. These failures have the potential to affect all twenty (29) residents receiving tracheostomy care in the facility.Findings include: This was identified as an immediate jeopardy which began on [DATE] at 05:31 PM when R7 was pronounced dead after dislodging tracheostomy being found unresponsive, pulseless, and apneic by paramedics. V1 (Administrator) was informed of immediate jeopardy, and a template was presented on [DATE] at 11:40 AM. On [DATE] an acceptable removal plan was received after revision from the original plan submitted on [DATE]. On [DATE] the surveyor confirmed by observation, interview, and record review to confirm that the removal plan was initiated, and the immediacy was removed on [DATE]. However, the non-compliance remains at level two because additional time is needed to evaluate the implementation and effectiveness of in-services training. R7 subject of the complaint expired on [DATE]. R7 was [AGE] year-old resident in the facility with medical diagnosis of toxic encephalopathy, respiratory failure with tracheostomy collar, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Prior to admission to the facility, R7 was in the hospital for ventilator support due to lethargy and worsening hypoxia requiring intubation for airway protection and ICU (Intensive Care Unit) admission. Hospital records documents that on [DATE] due to inability to wean from ventilator, R7 had a tracheotomy peg placed. R7 was admitted in the facility on [DATE] with physician order to receive high flow oxygen of twenty (20) liters per minute via tracheostomy collar. On [DATE] at 09:45 AM, V10 (Family of R7) stated that facility staff (V10 cannot remember specific name) told her that they (facility staff) were able to resuscitate R7. Upon arrival in the facility, somebody approached her and said, I'm sorry for your loss. V10 stated that R7 was completely (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	swollen and unrecognizable. V10 stated that according to facility staff, R6 pulled out his tracheostomy. V10 emailed picture of R7's death certificate and multiple photos. Clinical notes of V9 (Licensed Practical Nurse) dated [DATE] are as follows: At 03:30 PM, R7 observed V9 with oxygen tubing connected to tracheostomy tubing in his finger. No intervention was documented to prevent tracheostomy from dislodging on V9's clinical notes. At 04:45 PM, V11 (Respiratory Therapist) found the resident with a dislodged tracheostomy tube. At 04:46 PM Cardiopulmonary Resuscitation (CPR) was performed to R7. At 04:47 PM 911 was called. At 04:55 PM 911 arrived and took over Cardiopulmonary Resuscitation (CPR). Paramedics informed facility that R7's time of death at 05:31 PM. On [DATE] at 02:52 PM, V9 (Licensed Practical Nurse) stated that R7 was alert but non-verbal, she saw R7's finger near tracheostomy tube and R7 was redirected and repositioned. Per R7's assessments and care plan, R7 cognition was impaired due to toxic encephalopathy, R7 rarely or never understood for any redirection. V9 stated that she heard an alarm and saw Respiratory Therapist and another nurse (V9 did not give any names when asked) trying to reinsert tracheostomy. According to V9 that was the time she knew that R7's tracheostomy was dislodged. V9 stated that she was not sure that R7 was assigned to her the day R7 expired. V9 stated that she does not know how much oxygen R7 is needed. V9 stated, I do not know off hand how much oxygen R7 needed. I don't know because, I mean the oxygen is always there. V9 was informed that an increase of FiO2 was ordered the day when R7 expired based on ABG (Arterial Blood Gas) result. V9 replied, ABG result? Increase of FiO2? If the doctor gave the new order, then maybe he (R7) was not saturating good. V9 stated facility did not provide any respiratory training for her. V9 stated that she does not have certificate or any training for tracheostomy care or specific to tracheostomy care. Here? I did not get any respiratory care class. V9 stated that there was no respiratory assessment for residents with tracheostomy. V9 stated, I don't know any assessment something needs to be done with that, because how would we know what to do. On [DATE] at 12:58 PM, after request from Human Resources, V35 (Human Resources/Business Manager) provided all records of V9 (Licensed Practical Nurse and V37 (Licensed Practical Nurse) during hiring. Both V9 and V37 nursing skills competency evaluation requirements for nursing positions were not done. V9 (Licensed Practical Nurse) assigned to R7 on [DATE] was not evaluated for competency during hiring on [DATE]. V3 (Director of Nursing) reviewed V9's employment records in full as follows: Under job description it covers, job summary, qualifications, physical requirements, essential functions signed by V9 and dated [DATE]. No Administrator signature or date. Registered Nurse / Licensed Practical Nurse Orientation that covers nursing skills or procedures, everything was not done. V9 just signed and dated [DATE]. Medication Pass Guidelines and Tips, Insulin Pen, Disinfecting Blood Glucose Monitoring Machine, (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Hand Hygiene, Intravenous Piggyback Competency, Validation of Qualitative Fit Test Procedure, Accessed and Reviewed Policies and Procedures on FTP Sites, Isolation and Personal Protective Equipment all evaluations were not done, V9 just signed and dated all evaluation forms. Per nursing schedule from [DATE] to [DATE], V37 was assigned to work on ventilator unit on [DATE], [DATE], [DATE] and [DATE] at 07:00 PM to 07:00 AM twelve (12) hour shift. On [DATE] at 10:49 AM, V43 (Registered Nurse) stated, Before they had RTs (Respiratory Therapists) assigned to all tracheostomy residents. Now they have cut down on RTs. This happened about last year like 4 to 5 months ago. On [DATE] at 01:24 PM, V3 (Director of Nursing) stated that it was V9 (Licensed Practical Nurse) who first knew that tracheostomy was dislodged. V3 stated that onboarding evaluation during hiring is basically to see if nurses need more training in a particular area. When asked about V9 tracheostomy or respiratory care training. V3 replied, There are no trach care or respiratory care training. Review of R7's clinical notes of the incident on [DATE] are as follows: V11 (Respiratory Therapist) clinical notes dated [DATE] documents at approximately 04:45 PM. V11 reinserted tracheostomy into R7. R7 with pulse and on labored breathing. In contrast with V9 (Licensed Practical Nurse) clinical notes with the same date [DATE]. Cardiopulmonary Resuscitation (CPR) was performed at 04:46 PM. Which was a minute after R7 reinserted tracheostomy into R7. According to V11, R6 with pulse and labored breathing. At 04:47 PM paramedics (911) were called. At 04:55 PM paramedics (911) arrived and took over CPR. Change in condition assessment dated [DATE] also documents that nurse was informed by RT (Respiratory Therapist) that tracheostomy was dislodged, reinserted R7 with breathing and pulse. CPR was performed. Paramedics (911) report dated [DATE] documents the following: Team was dispatched on [DATE] at 04:47:24 PM arrived at scene at [DATE] 05:52:37 PM, R7 was found unresponsive, pulseless, and apneic by ambulance crew members. Tracheostomy tube reportedly dislodged, nursing home staff attempting to reinsert. Crew arrived to find patient in asystole, CPR initiated immediately. Initial assessment revealed facial and tongue swelling. Intubation with laryngoscope was not attempted due to facial and tongue swelling. Patient received five rounds of Epinephrine, remained in asystole and PEA (Pulseless Electrical Activity) throughout resuscitation efforts. Hospital Emergency Department was contacted, and permission was granted to terminate resuscitation efforts in the field. R7 final acuity report: Dead with Resuscitation Efforts. R7's Death Certificate time of death documents 05:31 PM certified by V12 (Medical Doctor) primary care physician of R7 in the facility. On [DATE] at 01:24 PM, V3 (Director of Nursing) stated CPR will be performed only when there has no pulse, because the purpose is to resuscitate. Which is supported by facility's policy on Cardiopulmonary Resuscitation (CPR) dated 04/2025. It documents that facility does provide CPR to residents per American Heart Association guidelines. Guidelines instruct healthcare personnel to initiate CPR if there are no response and no breathing and do not definitely feel a pulse within 10 seconds. On [DATE] after request to V3 (Director of Nursing) for incident report and full investigation of unusual occurrence reported by facility to the State agency related to the death of R7 after (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	tracheostomy was dislodged. At 12:28 PM, V36 (Nurse Consultant) stated that facility did not report R7's death to the State. V36 stated No incident report or investigation, it was just a medical case. Do we need to report all the residents that died in the facility? V36 was made aware that R7 expired after tracheostomy dislodging which is not expected outcome of a resident's condition or disease process. Per Incident / Accident Reports policy dated 09/2020, facility is required to report all accident or incident where there is injury or potential to result in injury. An accident refers to any unexpected or unintentional incident, which may result in injury or illness to a resident. Policy requires reporting to State agency (IDPH) among others. More stringent reporting is required when death occurred due to accident or incident. It requires facility to call State Regional Office or to call IDPH hotline and verify that requirement for reporting was met. On [DATE] at 11:04 AM, V3 (Director of Nursing) stated that incident report to State agency needs to be done when it resulted death, any injury that resulted to stitches, sutures or any fracture, unexplained injury like bruises. Facility will investigate anything that can be done differently in order not to repeat similar incidents. V3 said, purpose of investigation is to prevent that if there is something that can be done differently. On [DATE] at 11:25 AM, V11 (Respiratory Therapist) stated he was able to reinsert tracheostomy, that R7 had vital signs after reinsertion of his tracheostomy. V11 stated that a person receiving twenty (20) liters per minute is a high flow oxygen. It means extra flow to keep airway open or keep lungs open. Per physician order, R7 was instructed to receive 20 liters per minute oxygen via tracheostomy collar. V11 denies that R7 has swelling on his face. V11 stated that there was no subcutaneous emphysema or facial swelling. V11 stated that he did not document any of these details including R7's vital signs or appearance during the incident because he forgot. According to an Article on Subcutaneous Emphysema Following Open Tracheostomy During Tracheostomy Mask Ventilation dated [DATE] from National Library of Medicine a government website by American Journal of Case Report. Tracheostomy is a surgical procedure that is done by creating an ostomy in the anterior wall of the trachea to facilitate airway access and ventilation. It is indicated for acute respiratory failure after prolonged intubation, upper airway obstruction, difficult airway, and extensive secretions. Early perioperative complications include bleeding, pneumothorax/pneumomediastinum from a false tract, sub-cutaneous emphysema, esophageal perforation, and tracheal ring fractures. Subcutaneous emphysema is rare but carries a high risk of morbidity and mortality, especially if progressed to pneumothorax and pneumomediastinum. It results from tight closure of tissues around the tracheostomy tube or tears in the posterior tracheal wall. On [DATE], via email V10 (Family of R7) provided photos of R7 that compare photos taken on [DATE] (R7's day of initial admission) from [DATE] (day R7 expired with dislodged tracheostomy). Per R7's photos it was clear that R7 has substantial swellings on his face and body. On [DATE] at 08:17 AM, V11 (Respiratory Therapist) after requesting writer to call. V11 changed his statement and stated that R7 had swelling, I saw it was swelling, if paramedic noted that they cannot intubate the swelling affected around the trach. It means there was substantial swelling. V11 stated that he was the first person who saw R7 with dislodged tracheostomy. V11 stated that before dislodging he saw the resident (R7) three (3) to four (4) hours ago. V11 stated that Respiratory Therapist (RT) was in charge of residents with tracheostomy and ventilator. Nurses are in charge of residents with tracheostomy without ventilator. (continued on next page)

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	145450	A. Building B. Wing	04/15/2026

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 03:11 PM, V11 (Respiratory Therapist) again changed his statement and stated that he had a hard time getting tracheostomy in. I was not able to totally insert it in. But when I suction, I did not get any resistance. It was not all the way in, or it was not totally inserted. I don't know if it was totally in. V11 stated first insertion of tracheostomy was not successful because he was trying to place a larger tracheostomy or tube. When he went to grab a smaller tube, he was able to insert but not sure if it was totally in. V11 stated that ABG (Arterial Blood Gas) let us know if patient breathing appropriately. When FiO2 increases after ABG results it means patients need additional oxygen. When it increased from 26% to 30% percent, it means patients need 30% FiO2 to have receive the right oxygen. On [DATE] the day when R7 expired after tracheostomy was dislodged. Facility received R7's ABG result, V12 (Medical Doctor) ordered to increase R7's FiO2 from 26% to 30%. On [DATE] at 11:08 AM, V19 (Respiratory Therapist) stated that physician standard order is to titrate oxygen down. If FiO2 was increased that means the patient needs more oxygen. V19 stated that she was not sure if R7 was taken care of the nurse or RT. V19 then said, Based on the progress notes the nurses was assigned to the patient. It is accurate to say that not all patients are assigned to Respiratory Therapist. V19 stated that Respiratory Therapist does not do CPR. It is the nurse that performs CPR. On [DATE] reviews on respiratory equipment availability for tracheostomy residents are as follows: At 01:31 PM with V39 (Registered Nurse) R21 during tracheostomy care pulse oximeter connected to R21's finger did not work. It did not show result on monitor/screen. V21 tried to reposition equipment attached to R21's finger but did not show any oxygen saturation results. V39 stated that it was defective and does not work. V21 performed suctioning three (3) times without oxygen saturation information. With V39 and V4 (Assistant Director of Nursing) R22 was seen with tracheostomy. V4 stated that R22 currently receiving high flow oxygen twenty (20) liters per minute via Airvo machine. V39 stated that she thought Airvo machine was a ventilator. V39 checked Airvo machine to confirm settings that R22 is receiving 20 liters per minute. V39 stated that the machine was off. V4 stated that it was possible that CNA (Certified Nursing Assistant) turned it off during bedside care. In the same room, R23 screen/monitor does not show oxygen saturation result. R23 has ventilator connected via tracheostomy collar. With V40 (Registered Nurse) and V4 (Assistant Director of Nursing) at the bedside of R24. V40 stated that R24 receives 35 liters per minute high flow oxygen via Airvo. V40 stated that R24 does not have pulse oximeter machine connected to a monitor like other residents with vital signs equipment. V40 stated that she has a portable pulse oximeter and takes R24's oxygen saturation from time to time. V4 and V40 were asked with 35 liters per minute high flow oxygen via Airvo machine does R24 tolerate room air in case tracheostomy accidentally dislodge? V4 and V40 did not reply to the question. V40 stated, I get what you mean, but did not elaborate. On [DATE] at 02:41 PM with V3 (Director of Nursing), inside R24's room, V3 cannot locate pulse oximeter inside room. On [DATE] at 01:08 PM with V14 (Licensed Practical Nurse) stated that she was assigned to respiratory unit. Respiratory equipment on the bedside was reviewed for residents that have tracheostomy with V14. The following residents do not have complete supplies per Reinsertion of Tracheostomy Tube with Accidental Extubation policy or equipment does not work: R26 was seen without spare tracheostomy tube, sterile 4 X 4 and tape. R27 without sterile 4 X4 and tape. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R28 pulse oximeter disconnected does not read on the screen/monitor. V14 stated that it may be due to room deep cleaning or when R28 took shower. V14 was asked when was pulse oximeter disconnected? V14 replied It's been a while. R23 without spare tracheostomy, sterile 4 X 4 and tape. Policy on Reinsertion of Tracheostomy Tube with Accidental Extubation dated 09/2020 documents the following equipment needed: Gloves, Tracheostomy Tube, Ambu Bag, Sterile 4 X 4s, Tape, Sterile K-Y Jelly or Sterile Saline and Pulse Oximeter. On [DATE] at 01:24 PM, V3 (Director of Nursing) stated that residents that are found at risk of dislodging tracheostomy cannot be left alone. Residents need to be sent out to hospital for observation when they cannot be redirected or ask doctor for mitten/restraint. V3 said, If the resident is touching trach, I will not leave the resident, if not redirected send resident out for observation, or asked for restraint we can call doctor for mitten. V3 stated when the tracheostomy tube is dislodged, it may result in low oxygen or desaturation, confusion, altered mental status, or death. Per V3 (Director of Nursing) facility follows physician order currently there is no initial assessment specific for residents with tracheostomy to determine acuity of care. R7's plan of care was to obtain oxygen saturation by physician order. Under physician order R7 to monitor continuous pulse oximeter reading to check for oxygen saturation. Per oxygen saturation summary history under vital signs there was no documentation for [DATE], the day R7 expired. Medication Administration Record (MAR) for [DATE] have a single documentation at the morning shift of R7's oxygen saturation. Clinical notes did not document any vital signs on [DATE] when R7 expired. On [DATE] at 01:40 PM, V12 (Medical Doctor) stated that in general residents with tracheostomy are not breathing on their own. Generally, every patient with trach, they are not breathing on their own. They cannot breathe on their own. Soft tissue swelling that's a very high possibility due to dislodge of trach, Swelling can occur post manipulation of airway. V12 stated that R7 does not have any swelling during her initial assessment the day after R7 was admitted . Per list provided by facility dated [DATE]: There are twenty-nine (29) residents on tracheostomy in the facility. On [DATE] at 11:37 AM, V34 (Registered Nurse) stated that she is familiar with R16. V34 stated that R16 had a trach that was usually suctioned by the respiratory therapist. V34 stated that R16 did not have pneumonia when he was initially admitted on [DATE]th. V34 stated that 16 had an order to change his trach dressing every shift and as needed. V34 stated that R16 had an order to suction every 4 hours and as needed. V34 stated that there was an incident one time when R16's family was upset because R16 was not taken care off properly. V34 stated that she passed medications, and then changed his trach collar, inner canula. V34 stated that the family was worried because R16's trach gauze had mucus on it. V34 stated that it is expected of her to perform trach dressing change and change inner canula according to doctor's orders to reduce the risk of the resident collecting mucus in his trache which can lead to pneumonia if kept clean. On [DATE] at 12:47 PM, V2 (Director of Nursing/Infection Preventionist) stated that he is the current infection preventionist with the consultant. V2 stated that nurses and staff are expected to follow doctor's orders full and completely. The nurses are expected to document according to the order that (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	the nurses complete. V2 stated that if it is not documented, that means it is not done. V2 stated that the purpose of doing trachea care is to clear the airway from mucus. V2 stated that if trachea care is not done, that leads to accumulation of mucus. V2 stated that an accumulation of mucus leads to difficulty breathing. V2 stated that nurses are expected to change the inner cannula for a trachea. V2 stated that the purpose of changing inner cannula is to limit the growth of bacteria and reduce the cause of infection. V2 stated that if inner canula is not changed, it increases the risk of that resident acquiring infection. V2 stated that the trachea and vent patients are very prone to infection. V2 stated that if nurses follow doctor's orders to perform trachea care and change inner cannula that reduces the risk of contracting pneumonia. V2 stated that he sees R16's chart. V2 stated that R16 missed trachea care on [DATE], [DATE] and [DATE]. V2 stated that R16 missed changing inner canula on [DATE]. This can increase R16's risk of contracting pneumonia. V2 stated that R16 was initially admitted to the facility on [DATE] without any infection. V2 stated that R16 was sent back to the hospital on [DATE] for difficulty breathing and infection. V2 stated that R16 was readmitted back in the facility on [DATE]. V2 stated that R16 had labs drawn on [DATE] which shows a white blood count of 18.3 which means infection. On [DATE] at 1:11 PM, V18 (Medical Doctor) stated that she has patients here in this facility. V18 stated that she oversees patients in the vent unit. V18 stated that any respiratory order is put in by the pulmonologist. V18 stated that trach care and inner cannula change is put in to prevent infections and maintain airway. V18 stated that if these tasks are not done then that can increase the risk of infection. V18 stated that he is familiar with R16. V18 stated that R16 was initially admitted in the facility in December. V18 stated that he was sent out on [DATE] for desaturation and was admitted back in the facility on 1/19. R16's treatment administration record for 12/2025 documents in part: Order for changing inner cannula was daily. R16 had missing treatment administration signatures on [DATE] and [DATE]. Order for trach care and collar was scheduled for every shift and as needed. R16 had missing treatment administration for trach collar care on [DATE], [DATE], and [DATE]. Order for cleaning inner cannula was every shift and as needed. Missing treatment administration for cleaning inner cannula on [DATE], [DATE] and [DATE]. Order for suctioning trach was every 4 hours and as needed. R16 had missing trach suctioning on [DATE] at 8:00 PM, [DATE] for midnight and 04:00 AM, [DATE] for 8:00 AM, 12:00 PM and 04:00 PM, [DATE] for 8:00 AM and 12:00 PM, and [DATE] for 8:00 AM, 12:00 PM and 04:00 PM. R16's progress notes on [DATE] by nurse on duty documents in part: R16 noted with a O2 sat that continues to fluctuate between 88-92. Respiratory therapist informed, treatments given as ordered. All tubing and inner cannular changed. Suctioned as ordered and prn but O2sat continues to be fall between 88-92 after bagging. V18 phoned and left message. Waiting for return call. R16's progress notes on [DATE] by V34 documents in part: 915:AM R16 wife is here this am. She asked writer to come into the bedroom to see that R16 had a runny nose and a stream of saliva on the side of his mouth. Writer said she will get it. Writer obtained a wet warm towel, cleaned his face and nose and replaced his bib around his neck. As writer returned to her task that she was doing, R16's wife came back to the writer with the phone. She had R16's sister on the phone, who began to yell and scream about other concerns she had. Then she said she was going to call the director of nursing (DON) to complain about the care. She was very angry and rude, so writer responded that the (DON) was the right person to talk to. V18 was in the room with the wife. V18 examined R16 about his condition and her concerns. Family still was not satisfied with the update she received. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R16's hospital record on [DATE] documents in part (pg 75): R16's chest x-ray with superimposed pneumonitis. tachycardic and tachypneic upon arrival. leukocytosis present on admission white blood count of 16.28. Infectious disease is consulted for evaluation and treatment of sepsis. R16's hospital record on [DATE] documents in part (pg 117): Tracheal cultures on [DATE] results in serratia marcescens. Group G strep. Chest x-ray with super imposed pneumonitis. Overall source may be related to pneumonia with dyspnea/hypoxia. On [DATE], the surveyor made observations, conducted interviews and received documents to confirm the following removal plan was initiated: R7 expired on [DATE] at the facility. There are twenty-nine (29) residents on tracheostomy in the facility on [DATE]. Policies, procedures and practices for assessing and monitoring residents receiving Oxygen via tracheostomy tubes, including preparation for and management of medical emergencies were reviewed. Education for staff that were directly involved in this alleged failure (V9 and V11) was reviewed. Education that was conducted by the facility for Nurses Competency was reviewed. Education that was conducted by the facility for Respiratory Therapists was reviewed. Schedules of both nurses and RT assigned on the respiratory unit were reviewed to ensure they received facility-approved training and demonstrated competency using the Nurse Respiratory Unit and Tracheostomy Tube Competency Tools. Facility's respiratory unit was reviewed with Director of Nursing to ensure all respiratory equipment per policies were available. Quality Assurance Audit tools for monitoring residents who receive Oxygen via tracheostomy tubes to ensure emergency equipment is available at the bedside according to the Equipment Back-Up for Ventilator Unit and Reinsertion of Tracheostomy Tube with Accidental Extubation were reviewed. Facility's audits of 5 residents and 5 staff members three times a week for four weeks, then weekly for four weeks, then monthly x 3 months, and then randomly was reviewed. The QAPI committee on emergency equipment to be available at the bedside were reviewed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to ensure medication was administered per doctor order as scheduled. This failure affected 2 residents (R1 and R5) of 2 residents reviewed for scheduled medication administration. On 3/24/2026 at 10:58 AM, the surveyor reviewed R1's administration record dated 2/1/2026 to 2/28/2026 and found R1 did not receive his scheduled baclofen 5 mg (milligram) dose or pregabalin 10 mg (milligram) scheduled on 2/25/2026 at 2:00 PM. The surveyor observed R5's medication administration record dated 3/1/2026 to 3/31/2026 documents a missing dose of gabapentin capsule 300 mg (milligram) on 3/16/2026 at 6:00 AM, give 1 capsule by mouth every 8 hours related to Polyneuropathy with an active order date of 1/6/2026 at 4:24 PM. On 3/24/2026 at 11:46 AM, V13 (Licensed Practical Nurse) stated you should document a progress note if the medication is not given; if a medication is administered the electronic health record system will enter a check mark in the box on the date and time the medication has been given; a empty box next to the date and time of a scheduled medication means the medication was not given because it has been reordered and the nurse is waiting for pharmacy to bring the medication; and V13 verified with the surveyor the medication baclofen 5 mg (milligrams) and Pregabalin 10 mg (milligrams) administration box dated 2/25/2026 was blank. On 3/24/2026 at 12:42 PM, V15 (Licensed Practical Nurse) stated if the box designated on a specific scheduled date and time next to a medication on the medication administration record is empty, it means the medication was not given or the resident refused the medication; if the medication is not given or is refused, the family and the doctor is called and a progress note is entered in the residents chart; and V15 verified with the surveyor the medication baclofen 5 mg (milligrams) and Pregabalin 10 mg (milligrams) administration box dated 2/25/2026 was blank.On 3/24/2026 at 2:46 pm, V3 (Director of Nursing) stated he (V3) would investigate if a resident complained a nurse was on duty but had not punched in and the nurse went to lunch instead of administering a residents request for pain medication; when a medication is administered a green check mark with the nurses' initials displays in the box next to the medication in the electronic health record; a blank box by a medication is an indication of a missed medication dose, if the medication is scheduled; the policy regarding missed medication is to investigate why it was missed but all prescribed medication is suppose to be administered as schedule according to the doctor's orders unless it is refused and the reason a medication dose is missed should be documented in the progress notes. V3 verified R1's baclofen and pregabalin were missed doses on 2/25/2026 at 2 PM. On 3/36/2026 at 8:30 AM, surveyor conducted a medication pass observation of 21 opportunities on R18, R19, and R20 with no errors with V32 (Licensed Practical Nurse).Facility's policy titled Medication Administration dated 9/2020 documents drugs must be administered in accordance with the written orders of the attending physician.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of records and interviews, the facility failed to accurately document resident who expired due to dislodged tracheostomy for 1 out of 6 residents (R7) reviewed for resident records. These failures affected 1 resident (R7) in determination of accurate and complete documentation of incident that may help in preventing occurrent of similar incidents.Findings include: R7 was [AGE] year-old resident in the facility with medical diagnosis of toxic encephalopathy, respiratory failure with tracheostomy collar, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Prior to admission to the facility, R7 was in the hospital for ventilator support due to lethargy and worsening hypoxia requiring intubation for airway protection and ICU (Intensive Care Unit) admission. On [DATE] due to inability to wean from ventilator, R7 had a tracheotomy collar was placed. R7 was admitted in the facility on [DATE] with physician order to receive high flow oxygen of twenty (20) liters per minute via tracheostomy collar. Clinical notes of V9 (Licensed Practical Nurse) dated [DATE] are as follows:At 03:30 PM, R7 observed V9 with oxygen tubing connected to tracheostomy tubing in his finger. No intervention was documented to prevent tracheostomy from dislodging on V9's clinical notes.At 04:45 PM, V11 (Respiratory Therapist) found the resident with a dislodged tracheostomy tube.At 04:46 PM Cardiopulmonary Resuscitation (CPR) was performed to R7.At 04:47 PM 911 was called.At 04:55 PM 911 arrived and took over Cardiopulmonary Resuscitation (CPR).Paramedics informed facility that R7's time of death at 05:31 PM. Review of R7's clinical notes of the incident on [DATE] are as follows: V11 (Respiratory Therapist) clinical notes dated [DATE] documents at approximately 04:45 PM. V11 reinserted tracheostomy into R7. R7 with pulse and on labored breathing. In contrast with V9 (Licensed Practical Nurse) clinical notes with the same date [DATE]. Cardiopulmonary Resuscitation (CPR) was performed at 04:46 PM. Which was a minute after R7 reinserted tracheostomy into R7. According to V11, R6 with pulse and labored breathing. At 04:47 PM paramedics (911) were called. At 04:55 PM paramedics (911) arrived and took over CPR. Paramedics (911) report dated [DATE] documents the following: Team was dispatched on [DATE] at 04:47:24 PM arrived at scene at [DATE] 05:52:37 PM, R7 was found unresponsive, pulseless, and apneic by ambulance crew members. Tracheostomy tube reportedly dislodged, nursing home staff attempting to reinsert. Crew arrived to find patient in asystole, CPR initiated immediately. Initial assessment revealed facial and tongue swelling. Intubation with laryngoscope was not attempted due to facial and tongue swelling. Patient received five rounds of Epinephrine, remained in asystole and PEA (Pulseless Electrical Activity) throughout resuscitation efforts. Hospital Emergency Department was contacted, and permission was granted to terminate resuscitation efforts in the field. R7 final acuity report: Dead with Resuscitation Efforts. R7's Death Certificate time of death documents 05:31 PM certified by V12 (Medical Doctor) primary care physician of R7 in the facility. On [DATE] at 01:24 PM, V3 (Director of Nursing) stated CPR will be performed only when there has no pulse, because the purpose is to resuscitate. Which is supported by facility's policy on Cardiopulmonary Resuscitation (CPR) dated 04/2025. It documents that facility does provide CPR to residents per American Heart Association guidelines. Guidelines instruct healthcare personnel to initiate CPR if there are no response and no breathing and do not definitely feel a pulse within 10 seconds. On [DATE] at 11:25 AM, V11 (Respiratory Therapist) stated he was able to reinsert tracheostomy, that R7 had vital signs after reinsertion of his tracheostomy. V11 stated that a person receiving twenty (20) liters per minute is a high flow oxygen. It means extra flow to keep airway open or keep lungs open. Per physician order, R7 was instructed to receive 20 liters per minute oxygen via tracheostomy collar. V11 denies that R7 has swelling on his face. V11 stated that there was no subcutaneous emphysema or facial swelling. V11 stated that he did not document any of these details including R7's vital signs or appearance during the incident because he forgot. According to an Article on Subcutaneous (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Emphysema Following Open Tracheostomy During Tracheostomy Mask Ventilation dated [DATE] from National Library of Medicine a government website by American Journal of Case Report. Tracheostomy is a surgical procedure that is done by creating an ostomy in the anterior wall of the trachea to facilitate airway access and ventilation. It is indicated for acute respiratory failure after prolonged intubation, upper airway obstruction, difficult airway, and extensive secretions. Early perioperative complications include bleeding, pneumothorax/pneumomediastinum from a false tract, sub-cutaneous emphysema, esophageal perforation, and tracheal ring fractures. Subcutaneous emphysema is rare but carries a high risk of morbidity and mortality, especially if progressed to pneumothorax and pneumomediastinum. It results from tight closure of tissues around the tracheostomy tube or tears in the posterior tracheal wall. On [DATE], via email V10 (Family of R7) provided photos of R7 that compare photos taken on [DATE] (R7's day of initial admission) from [DATE] (day R7 expired with dislodged tracheostomy). Per R7's photos it was clear that R7 has substantial swellings on his face and body. On [DATE] at 08:17 AM, V11 (Respiratory Therapist) after requesting writer to call. V11 changed his statement and stated that R7 had swelling, I saw it was swelling, if paramedic noted that they cannot intubate the swelling affected around the trach. It means there was substantial swelling. V11 stated that he was the first person who saw R7 with dislodged tracheostomy. On [DATE] at 01:24 PM, V3 (Director of Nursing) stated that it was V9 (Licensed Practical Nurse) who first knew that tracheostomy was dislodged. On [DATE] at 03:11 PM, V11 (Respiratory Therapist) again changed his statement and stated that he had a hard time getting tracheostomy in. I was not able to totally insert it in. But when I suction, I did not get any resistance. It was not all the way in, or it was not totally inserted. I don't know if it was totally in. V11 stated first insertion of tracheostomy was not successful because he was trying to place a larger tracheostomy or tube. When he went to grab a smaller tube, he was able to insert but not sure if it was totally in. On [DATE] at 10:59 AM, V36 (Nurse Consultant) stated that V9 (LPN) did not perform CPR (cardiopulmonary resuscitation) although it was written in the clinical notes that she performed CPR. V36 said, You know it is not always true what they chart. V9 stated that R7 was still in labored breathing when paramedics arrived. V36 was informed that there are many inconsistencies with facility's notes compared to paramedics 911 report. V36 stated, How will I know, I was not here when it happened.

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	04/15/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews and record reviews, the facility failed to provide each of their residents will access to a call light. This applies to 6 residents (R1, R2, R10, R12, R13 and R14) in the sample of 6 reviewed for call light access.Findings include: R1's Face Sheet documents R1's diagnosis of spinal stenosis, intervertebral disc degeneration, lumbar region with discogenic back pain and lower extremity pain, essential (primary) hypertension, and type 2 diabetes mellitus with hyperglycemia. R1's last quarterly Minimum Data Sheet (MDS) documents a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact with little to no impairment. R2's Face Sheet documents R2's diagnosis of R2's of diabetes, unsteadiness of feet, pedestrian foot injury, and cervical spinal cord syndrome. R2's last quarterly Minimum Data Sheet (MDS) documents a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact with little to no impairment. R10's Face Sheet documents diagnosis of chronic obstructive pulmonary disease, hypertension, anoxic brain damage, polyneuropathy, and heart failure. R10's last quarterly Minimum Data Sheet (MDS) documents a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact with little to no impairment. R12's Face Sheet documents diagnosis of chronic kidney disease. Dementia, history of falling, hypertension, and cardiac murmur. R12's last quarterly Minimum Data Sheet (MDS) documents a Brief Interview for Mental Status (BIMS) score of 13 indicating cognitively intact with little to no impairment. On 3/24/2026 at 11:05 AM, R1 who resides in bed C stated R10 who resides in bed B share the same call light which was located on the wall between the beds of R1 and R10. There was one yellow string attached to the call light switch. The yellow string was long, hidden and not assessable to R1 or R10 unless they knelt and removed the string from behind the nightstand. R1 said R1 rarely used the call light because R1 was independent and able to walk to the nurse's station if R1 needed assistance. However, R1 said R10 needed the call because R10 was less ambulatory than himself. R1 said R1 shared the same yellow call string when R2 stayed in bed B when R2 was a resident. R1 added R1 has resided in the facility since 2024 and has always shared the same one call light string as the resident in bed B. During this conversation, R10 said R10 could not reach the call light and would like to have access to it in case of an emergency. R10 said R10 walked with a cane, and it takes R10 a long time to get to nurse's station. On 3/24/2026 from 11:15 AM, R11 stated that they only have two call lights in their room and residents in beds B and C must share the call light string. R11 who sleeps in bed A and has their own light stated that residents in beds B and C were not as mobile as R11 so they need access to call light. The yellow call light string was not in reach for R12 and R12 was not able to answer the surveyor's questions as indicated by R12's gaze. R13 said that R13 shares a call light with the resident in bed C: R14. R13 said that a call light would be useful because R13 sometimes cannot get to the nurse's station.V5, V6 and V8 (Certified Nursing Assistants/CNAs) interviewed consecutively on 3/24/2026 from 2:35 PM to 3:20 PM stated they were not aware of R2 not being able to move around the room there were three wheelchairs in the room. They said R2 did not voice concerns about not having a call light. V13 (Licensed Practical Nurse) and V16 (Social Worker) interviewed consecutively on 3/24/2026 from 1:50 PM to 2:24 PM stated they were not aware that R2 had problems moving around in R2's room because there were too many wheelchairs in R2's room. They said they did not realize that R2 complained of R2's room having only one call light. On 3/24/2026 at 2:18 PM, V17 (Registered Nurse) stated that R2 never voiced any wheelchair or call light complaints to V17. On 3/24/2026 at 2:33 PM, V3 (Director of Nursing) stated that it is expected for every resident to have their own call light regardless of their mobility status. V3 said totally independent residents should have as much access to call light as dependent residents. On 3/25/2026 at 11:50 AM, V30 (Maintenance Director) stated V30 was not aware of residents having only one yellow string attached to their call light switch. V30 stated that both residents in beds B and C (of 3-resident rooms) should have access to their own call light string to activate the call light. On 3/25/2026 at 3:02 PM, V1 (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Administrator) stated they are expected to follow their call light policy and ensure that call lights are in reach for each resident in the room regardless of their mobility status. Review of the facility's Call Light, Use of policy dated 09/2020 documents Be sure call lights are placed within resident reach at all times.