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	05/05/2026

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	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed the facility failed to follow one resident's (R10) plan of care while on trials to be weaned off mechanical ventilation and failed to monitor R10's pulse oximetry alarm was on. The alarm is used to alert staff when R10's oxygen saturation drops below 92%. Subsequently, on [DATE] R10 was observed unresponsive, pulse less and breathless due to staff not monitoring and supervising a resident that depended on mechanical ventilation to sustain his life. Additionally, the facility failed to ensure pulse oximetry alarms and displays function properly for 3 (R11, R12, and R16) residents in a sample of 4 residents reviewed.This was identified as an Immediate Jeopardy. This Immediate Jeopardy began on [DATE].The Administrator (V1) and the Director of Nursing (DON) (V2) were notified of Immediate Jeopardy and a template was presented on [DATE] at 10:46am.On [DATE] an acceptable removal plan was received after revision from the original plan submitted on [DATE] at 4:41pm; [DATE] at 6:11pm; and on [DATE] at 8:20am: and [DATE] at 12:43pm.On [DATE] and [DATE] the surveyor confirmed by observation, interview, and record review 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.R10's medical diagnoses include but are not limited to chronic respiratory failure, dependence on respirator, tracheostomy, heart failure, atrial fibrillation, and essential hypertension. R10's Minimum Data Set (MDS) dated [DATE] indicates R10's cognition is severely impaired. R10's admission date to the facility is [DATE] and date of death at the facility is [DATE]. R10's physician order with start date of [DATE] documents in part, Trach: Aerosol trach collar FIO2 (Fraction of Inspired Oxygen) 50 % (percent) during the day as tolerated. R10's physician order start date [DATE] documents in part, Vent settings: Mode AC (Assist Control), rate 16, TV (Tidal Volume) 450, PEEP (Positive End Expiratory Pressure) 5, FIO2 40% at bedtime or if resident unable to tolerate trach collar trial. R10's physician order start dated [DATE] documents in part, 1:1 (one to one) with a sitter at all times. R10's respiratory progress note dated [DATE] at 9:45am documents in part, Placed on 40% trach collar for the day per order RR (respirations) 20 HR (heartrate) 84 SaO2 (arterial oxygen saturation) 94% no distress noted will continue to monitor. On [DATE] at 1:28pm surveyor made observations with V15 (Licensed Practical Nurse/LPN). Surveyor observed R11's pulse oximetry connected to R11's finger but no oxygen saturation observed on the monitor and monitor blinking with no sound. Surveyor observed V15 trying to troubleshoot the monitor. R11's monitor had no sound. V15 then observed removing R12's pulse oximetry to check the alarm. R12's pulse oximetry was removed by V15, R12 monitor had visual blinking but no alarm sounded.On [DATE] at 1:28pm V15 (LPN) stated that she doesn't know why the residents' monitors are not sounding. V15 stated that when the resident's oxygen is down or the sensor is removed, the alarm should sound.On [DATE] at 10:31am made observations with V23 (LPN). Observed R15's pulse oximeter sensor on the floor, R15's monitor alarm flashing, no alarm sound heard. V23 (LPN) stated that R15 probably removed the pulse oximeter herself, but the alarm should still sound. Observed R16's pulse oximeter on R16's finger, R16's monitor not showing an oxygen saturation and alarm observed flashing with no sound. V23 stated that she does not know what R16's oxygen saturation is (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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V14 stated that after rounding on all 16 of the residents that V14 was assigned to, V14 did not go back to check on R10, instead V14 sat down to chart. V14 stated that R10 was always busy with his hands and R10 would pull on and remove his tubes. V14 stated that R10 did not have a sitter at the bedside when V14 removed R10 from the ventilator and placed R10 on trach collar trials. V14 stated that he does not communicate with the nursing staff to inform them when he is removing a resident from the ventilator and placing the resident on trach collar trials. V14 stated that when a resident is placed on trach collar trials, they place the resident on continuous pulse oximetry. V14 stated that the pulse oximetry should alarm when the resident's oxygen saturation drops below 90. V14 stated that the facility's pulse oximetry's are pretty beat up and worn out. V14 stated that the staff sometimes pull the pulse oximetry off the resident when rendering care and don't replace them. V14 stated that he did not hear R10's pulse oximetry alarming at the time of R10' code and is unsure if R10 had the pulse oximetry on. V14 stated that the nursing staff take the pulse oximetry off when caring for the residents and replacing it when done is not important to them. On [DATE] at 3:50pm V19 (Registered Nurse/RN) stated that she found R10 unresponsive while doing her regular rounds. V19 stated that R10 did not have a pulse when she found him. V19 stated that R10 did not have any alarms sounding at the time that she found him unresponsive. V19 stated that sometimes the alarm settings are off or paused. V19 stated that sometimes families, CNA's or housekeeping go into resident rooms and turn the alarms off. V19 stated that R4 did not have a sitter the day that R10 coded. On [DATE] at 5:07pm V20 (Pulmonologist) stated R10 has only been able to tolerate 2 to 3 hours of weaning. V20 stated that R10 should have had continuous pulse oximetry while R10 was on trach collar. V20 stated that without continuous pulse oximetry monitoring, the staff would not know if R10 became hypoxic. V20 stated that it is not safe practice to have a resident like R10 off the ventilator without monitoring the resident's pulse oximetry and the alarm should be loud enough for the staff to hear and respond to it. On [DATE] at 5:20pm V2 (Director of Nursing/DON) stated that if a resident's pulse oximetry is not working properly, the nurse and the respiratory therapist should trouble shoot the alarms. V2 stated that when the alarms are not working properly, the staff should round on the residents more frequently. V2 stated that R10 should have had a pulse oximetry on, and it should have been alarming at the time that R1 was found unresponsive. V2 stated that he was unaware that R10 still had an active order for a 1:1 sitter. V2 stated that if R10 had an order for a sitter then he should have had a sitter at the time that R10 was found to be unresponsive. On [DATE] at 10:15am V14 (RT) stated that R10 was not actively weaning and was just to be taken off the ventilator during the day and placed back on the ventilator during the night. V14 stated that because R10 was not being weaned, R10 only required a routine check form respiratory and V14's plan was to check on R10 during his next set of rounds in 3 to 4 hours. V14 stated that he signed the wean form, acknowledging he removed R10 from the ventilator. V14 stated that R10's wean log form had previous documentation that R10 was taken off the ventilator on 3 other days already. On [DATE] at 1:36pm V20 (Pulmonologist) stated that R10 was actively weaning. V20 stated that R10's order should 100% be considered a weaning order. V20 stated that if the resident's order documents as tolerated, it is considered a weaning order. V20 stated that as tolerated is not added to the orders of residents that have successfully weaned from the ventilator. V20 stated that R10 should not have been strictly off the ventilator during the day and (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that R10 has only been tolerating a couple of hours of weaning. R10's wean log dated [DATE] documents in part, Start time: 07:30am. Stop time 10am. Decreased SPO2 (Peripheral Capillary Oxygen Saturation). R10's wean log dated [DATE] documents in part, Start time: 09:45am. Stop time: 11:45am. On [DATE] at 12:11pm V26 (Director of Respiratory) stated that all respiratory therapist know that if as tolerated is seen on an order, the as tolerated is the wean order. V26 stated that the facility does not have specific timing for rounding on residents being weaned, but the expectation is for staff to round on them more frequently because the resident is being weaned. V26 stated that when a resident is being weaned, the resident should be placed on the monitor to monitor their oxygen saturations. V16 stated that the monitor should alarm if the resident is having a change of condition. On [DATE] at 11:06am V24 (RT) stated that if a resident has an order to be on trach collar during the day and ventilator at night, the respiratory therapist should fill out the weaning form. V24 stated that the weaning form is how the staff know how the residents are tolerating being off the ventilator. V24 stated that resident's that are being weaned have to be on continuous pulse oximetry which monitors the residents' oxygen and heart rate. V24 stated that the pulse oximeter would alarm if the residents oxygen saturation dropped below 92%. V24 stated that the alarm lets the staff know that something is wrong and to check on the resident. R10's record review of care plans initiated on [DATE], no care plan found for R10's respiratory needs. On [DATE] at 12:22pm V2 (Director of Nursing/DON) stated that residents should have a baseline care plan upon admission. V2 stated that the baseline care plans are for the staff to understand the residents' basic needs. V2 stated that breathing is a basic need. V2 stated that the resident's pulse oximetry machine should alarm if it is in use and the resident either takes it off or if the resident desaturates. V2 stated that if the alarm is not sounding, then the staff won't know when to respond to a resident in distress. V2 stated that if a resident is in distress and not attended to, the resident could die. V2 stated that he was made aware by his staff on [DATE] after the IDPH surveyor left the unit that the resident's pulse oximeter alarms were not making sounds. V2 stated that he went to the unit and was able to troubleshoot and fix the monitors so that the alarms can be heard. On [DATE] at 3:16pm V2 stated that it is confirmed that R10 did not have a 1:1 sitter at the time that R10 died in the facility. V2 stated that the facility does not accommodate 1:1 sitters but there was an active physician's order then the order should have been followed. V2 stated that he is not sure why the nurse documented that R10 had a sitter the day that R10 died, but the nurse should not have documented what is not true. R10's progress note dated [DATE] at 12:50pm documents in part, patient to have a sitter 1:1 at all times d/t (due to) pulling on tubes, extubation, danger to self/others. On [DATE] at 1:56pm V2 (DON) stated that he was not aware that R10 had an order for 1:1 monitoring. V2 stated that the nurses are aware that the facility does not do 1:1 monitoring and if he was aware that R10 had an order for 1:1 monitoring, he would have instructed the nurse to get an order to send R10 to the hospital. V2 stated that the 1:1 monitoring order was active and should have been followed. V2 stated that a doctor's order creates necessity. Facility's undated job description titled Respiratory Therapist documents in part, Job Summary: To provide respiratory patient care, including but not limited to, ventilator management and weaning, airway management, bronchodilator therapy and diagnostic testing. Facility's untitled and undated manufacture's guidelines for the resident pulse oximeter monitors documents in part, 1. Purpose and Safety: Alarms: Monitor will alert for abnormal readings. Always respond promptly. 7. Alarms and Alerts: Test alarms periodically to ensure audio/visual alerts function. Facility's policy titled Ventilator Weaning dated 07/2025 documents in part, Purpose: Residents will be periodically evaluated for their continued need of a mechanical ventilator. Procedure: 1. Each resident will be evaluated on an ongoing basis for appropriateness of weaning from ventilator. 3. Continuous pulse oximeter may be required. 5. Staff will wean according to physician orders/weaning protocol. 10. Weaning will be logged on a weaning log sheet. Equipment: 1. Continuous pulse oximeter. Facility's policy titled Pulse Oximeter (Continuous) documents in part, Policy: To monitor residents for oxygen saturation. Procedure: Residents on mechanical ventilation, supplemental oxygen and artificial (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on-site with Heart Med representatives to review alarm settings (Heart Med owns and supplies the machines to the facility for temporary use).On [DATE], Heart Med representatives reviewed each unit's alarm settings and made modifications when indicated.Alarms at highest volumeAlarm blast interval at shortest setting (8 seconds)Alarm to sound if probe becomes disconnected from residentNight mode reduced volume feature disabled Alarm mute time limited to 60 secondsHeart Med representatives visit the facility monthly for preventative maintenance and additionally as requested. Heart Med representatives will also visit to evaluate any issues identified by the facility upon request. Documentation of service(s) provided is available upon request. On [DATE], education listed below (including details as listed in #1 of this removal plan) was started by the DON, ADON, Nurse Consultant and/or Director of Respiratory Care with nursing and respiratory staff who work on the ventilator unit. Education was initiated with nursing and respiratory staff members who were working and will continue to be conducted prior to the start of the next shift for each nursing and respiratory staff member on an ongoing basis until all nurses, CNAs (Certified Nursing Assistants) and RTs (Respiratory Therapists) scheduled to work have been educated and demonstrate understanding of the education through written quizzes and/or return demonstration of competency. The Director of Nursing and Director of Respiratory Care will be responsible for monitoring compliance with this process. Licensed Nurses will be educated on:Ventilator WeaningVentilator Weaning policyMonitoring residents on ventilator weaning trialsDocumentation during ventilator weaning trialsCommunicating with the IDT when residents are on ventilator weaning trialsIdentification of residents on ventilator weaning trialsMonitoring Pulse OximetryPulse Oximetry (Continuous Pulse Oximetry) policyMonitoring pulse oximetry alarms to ensure functional and volumes audibleManaging a patient with orders for 1:1 supervisionCNAs will be educated on:Ventilator WeaningVentilator Weaning policyMonitoring residents on ventilator weaning trialsIdentification of residents on ventilator weaning trialsMonitoring Pulse OximetryPulse Oximetry (Continuous Pulse Oximetry) policyMonitoring pulse oximetry alarms to ensure functional and volumes audibleManaging a patient with orders for 1:1 supervision RTs will be educated on:Ventilator WeaningVentilator Weaning policyMonitoring residents on ventilator weaning trialsDocumentation using the ventilator weaning form and EMR (Electronic Medical Record) during ventilator weaning trials Communicating with the IDT when residents are on ventilator weaning trialsIdentification of residents on ventilator weaning trialsMonitoring Pulse OximetryPulse Oximetry (Continuous Pulse Oximetry) policyMonitoring pulse oximetry alarms to ensure functional and volumes audibleManaging a patient with orders for 1:1 supervisionMonitoring, Audits, QAPI, and Facility Assessment F695Medical records of newly admitted and readmitted residents, including those with ventilator support, ventilator weaning and/or trach collar trials, and trach collars, are reviewed within 24 hours by a Clinical Support Nurse (CSN). Each resident's PCC records are reviewed to ensure admission orders are entered into PCC according to the orders written by each resident's physician. Additional documentation is reviewed to ensure assessments have been completed based on each resident's individual needs. The DON or their designee oversees this auditing process and ensures corrective actions are taken when indicated.A Quality Assurance (QA) audit tool was developed on [DATE] to monitor facility compliance with management of residents on ventilator weaning and/or trach collar trials. The audit reviews confirmation of the following: residents listed on PCC Dashboard, RT communication during daily IDT standup meetings, updating of nurses by RTs when changes between ventilators and trach collars are made, monitoring of vital signs and/or end tidal CO2 completed as ordered and documentation in both PCC progress note and paper weaning log. Each resident, both newly admitted and long-term care care, on ventilator weaning and/or trach collar trials will be reviewed. The audits started on [DATE]. The audits will be done daily for two weeks, then three times weekly for two weeks, followed by weekly audits for four weeks and monthly audits x 3. Audits will be done by the Director of Nursing and Director of Respiratory Services or their designees until compliance is maintained. The results of the QA

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	05/05/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was stored at safe temperatures, failed to maintain required temperature logs, and failed to discard potentially hazardous food stored above safe temperature ranges. This failure has the potential to affect 135 residents on an oral diet out of 172 residents in the facility.On 4/17/2026 at 9:36 AM, V4 (CNA) stated that while serving dinner on a unknown date, R4 brought to V4's attention a carton of milk appeared clumpy even though it was not expired; V8 (Licensed Practical Nurse) instructed her (V4) to remove all milk cartons from resident trays and notify dietary staff; and an unknown dietary staff member came and got the milk from the floor.On 4/17/2026 at 2:03 PM, V8 (Licensed Practical Nurse) stated R4 informed her (V8) his milk had curbs and lumps in it; removed the milk from R4 and informed other residents to return all milk to staff; dietary was notified and the milk was discarded by dietary; don't remember if the date on the milk carton was expired; the incident happened about two weeks ago; dietary does not serve leftover food; and no other clumpy milk has been served on the unit. On 4/17/2026 at 2:11 PM, R4 stated he (R4) was served milk that was curdy and spoiled for the first time. On 4/17/2026 at 1:16 PM, surveyor observed the refrigerator cooler temperature thermometer reading at 45 degrees; parmesan cheese with a manufacturer date stamped 3/10/2026 and a date written with a black marker dated 4/15/2026; deli ham with an expiration date of 4/11; leftover turkey with an expiration date of 4/15/2026 and no use by date; five 10 pound packages of ground beef in which V10 (Dietary Supervisor) obtained a temperature of 49 degrees. On 4/17/2026 at 1:23 PM, V10 (Dietary Supervisor) stated all refrigerated food should have an open date and expiration date; obtained and verified temperatures of the milk at 48 degrees, deli turkey has an expiration date of 4/11/2026; and ground beef temperature was 49 degrees Fahrenheit; bottle of Italian salad dressing was dated 3/4/2026; if there is no open or use by date the food should be tossed; cold foods should be held at 40 degrees to prevent bacterial growth; foods held above 41 degrees Fahrenheit can cause residents to become sick. On 4/18/2026 at 9:06 AM, V22 (Dietary Cook) verified with surveyor all of the following: the walkˆin freezer temperature measured 34 F on the internal thermometer, while the external thermometer read 42 F, placing frozen foods above the 0 degree Fahrenheit safe frozen temperature range; the refrigerator temperature measured 38 F and the outside refrigerator thermometer temperature reading was 53 F, exceeding the required maximum of 41 F indicating inconsistent internal temperature regulation; reviewed of the freezer temperature tracking log on 4/18/2026 showed no temperature entry completed for the date of 4/18/2026; two 10 pound rolls of ground beef measured 51 degrees Fahrenheit and 50.4 degrees Fahrenheit on the second shelf from the floor in a plastic container labeled with prepared dated of 4/15/2026 and a use by date of 4/21/2026. On 4/18/2026 at 9:16 AM, V22 (Dietary Cook) stated the cold foods should be held at 41 degrees Fahrenheit to preserve the food and prevent residents from getting sick. V22 stated foods not held a safe temperature can cause residents to have diarrhea, vomiting, and death. On 4/18/2026 at 9:46 AM, V10 (Dietary Supervisor) verified with the surveyor that the ground beef internal temperature reading was 49.9 F, above the safe limit of 41 F.On 4/18/2026 at 9:56 AM, V10 (Dietary Supervisor) stated the ground beef was placed in the refrigerator on 4/15/2026 and intended for use by 4/21/2026; the meat should be held at 41 degrees, but sometimes the staff leaves the refrigerator open. V22 stated I have never had an inspector ask me about the temperature being 49 degrees. If you want me to discard it, I will. V22 state the purpose of maintaining proper temperatures is to avoid any spoilage but stated he was not 100% sure at what temperature spoilage begins and planned to keep the meat until I talk to corporate.On 4/18/2026 at 10:04 AM, V22 (Dietary Supervisor) verified with surveyor the following: At 10:04 AM, pork sausage from the freezer internal temperature measured 23 F with a thermometer and was not frozen. At 10:06 AM, charbroiled Salisbury patties dated 4/15/2026 internal temperature measured 24.3 F with a thermometer and was not frozen. At 10:07 AM, vegan (continued on next page)

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	145450	A. Building B. Wing	05/05/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	homestyle chicken tenders' internal temperature measured 30.9 F with a thermometer and was not frozen.On 4/18/2026 at 4:56 PM, surveyor reviewed work order invoice for the walk-in freezer with a diagnosis of low on refrigerant and leak test system found lead on the suction port and the walk-in cooler diagnosis with an evaporator coil fully iced up and drain line clogged.V1 (Administrator) stated he does not have a policy for refrigerator, freezer, and cooler tracking logs. Facility's policy titled Labeling and Dating dated 7/24 documents, in part, ready to eat time/temperature control for safety foods may be stored in the refrigerator held at 41 degrees Fahrenheit for 7 days and the purpose is to reduce the risk of food borne illness.Facility's policy titled Refrigerator Unit Temperatures dated 2/17 and 8/18 documents, in part, Refrigerators and Freezers will be maintained at the correct temperature to reduce the risk of food borne illness.