STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005193	A. BUILDING: _____ B. WING _____	C 01/30/2025

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ALDEN LAKELAND REHAB & HCC	820 WEST LAWRENCE CHICAGO, IL 60640

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S 000	Initial Comments Complaint Investigation: 2580366/IL184448	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240e) 300.3240g) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999		

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S9999	Continued From page 1	S9999		

well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis.

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act)

d) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the

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S9999	Continued From page 2	S9999		

facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.

This requirement is NOT met as evidenced by:

Based on interview and record review, the facility failed to ensure R1 was free from neglect and failed 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

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S9999	Continued From page 3	S9999		

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.

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S9999	Continued From page 4	S9999		

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

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S9999	Continued From page 5	S9999		

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

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S9999	Continued From page 6	S9999		

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."

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

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S9999	Continued From page 7	S9999		

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,

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S9999	Continued From page 8 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 ..." (A)	S9999		