

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017319		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2026	
NAME OF PROVIDER OR SUPPLIER ALDEN LAKELAND REHAB & HCC				STREET ADDRESS, CITY, STATE, ZIP CODE 820 WEST LAWRENCE , CHICAGO, Illinois, 60640			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments Complaint Investigation: 2680387/2712191 2680184/2709120 25812884/2705243		S0000			02/06/2026	
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210a) 300.1210b) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest		S9999			02/13/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017319		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2026	
NAME OF PROVIDER OR SUPPLIER ALDEN LAKELAND REHAB & HCC				STREET ADDRESS, CITY, STATE, ZIP CODE 820 WEST LAWRENCE , CHICAGO, Illinois, 60640			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 1 practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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. These regulations were not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide ADL (Activity of Daily Living) care to residents who are dependent on staff assistance with ADLs for two (R4, R5) out of four residents reviewed for incontinence care. This failure resulted in R4 experiencing pain, feeling humiliated and crying. Finding include, R4's clinical indicates the following in part: lack of coordination, systemic inflammatory response syndrome, cauda equina syndrome, primary generalized osteoarthritis, and major depressive disorder. R4's minimum data set [MDS] Brief Interview Mental Status Score [15] indicates R4 is cognitively intact. R4's MDS section [GG] indicates R4 is dependent on toileting hygiene, bed mobility and requires extensive assistance from staff. R4's Care plan in part: R4 has a self-care performance deficit due to weakness, impaired balance, lack of coordination, activity intolerance, incontinence related to generalized weakness, and cauda equina syndrome. R5's clinical record indicates the following in part; R5's medical diagnosis of spinal stenosis, weakness, gastrostomy, pressure ulcer wound on sacral area, polyosteoarthritis. R5's minimum data set [MDS] Brief Interview Mental Status Score [5] indicates R5 is moderately cognitively impaired. R5's MDS section [GG] indicates R5 is dependent on toileting hygiene, bed mobility and requires extensive assistance from staff.		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017319		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2026	
NAME OF PROVIDER OR SUPPLIER ALDEN LAKELAND REHAB & HCC				STREET ADDRESS, CITY, STATE, ZIP CODE 820 WEST LAWRENCE , CHICAGO, Illinois, 60640			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
S9999	Continued from page 2 R5's Care plan in part: R5 has a ADL self-care performance deficit due to weakness, impaired balance, lack of coordination, activity intolerance, incontinence related sepsis, seizures, depression, bilateral osteoarthritis of knee and spinal stenosis. On 1/27/26 during facility tour at 9:00AM, across from the nursing station surveyor observed a room with R4 resting in bed, alert and oriented x3. Surveyor noted a strong odor of feces. R4 stated, "I'm doing alright. After breakfast I had a bowel movement, and I need to be changed I just turned on the call light. The staffing is terrible. I always wait a long time sometimes for hours before I get changed and cleaned up. I use my urinal. I just need assistant when I have a bowel movement." On 1/27/26 at 9:05 AM, Surveyor exited the room with R4's call light sounding and observed V9 [Licensed Practical Nurse] in the same hallway two doors down from R4's room at the medication cart. Along with V7 [Certified Nurse Assistant] walking past R4's room three times between 9:06AM to 9:20AM. V9 nor V7 entered R4's room. On 1/27/26 at 9:22AM, surveyor asked V9 if she was the nurse for R4, and who was the certified nurse assistant for R4. V9 stated, "I am the nurse for R4, and V8 [Certified Nurse Assistant] is assigned to R4's room. V8 was sent out on a medical appointment with a resident, she left around 8:30AM. I am not sure what time V8 will return. V7 and V37 [Certified Nurse Assistant] are the other aids and will cover and provide care to V8's assigned residents." On 1/27/26 at 10:00AM, Surveyor observed V7 entered R4's room, turned off the call light and exited the room. On 1/27/26 at 10:15AM, surveyor entered R4's room, R4 stated while crying tears, "V7 answered my call light, V7 said she was busy with another resident, but will come help me in a few minutes. Please don't make them clean me, I want you to see how long it really takes them to clean me up. This makes me feel like a dog, lying here in my own feces while but buttocks is itching and burning." Surveyor conducted surveillance of R4's room on 1/27/26 from 9:00 AM to 11:50 AM. V7 did not return back to R4's room. R4 turned back on his call light at 11:45	S9999					

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017319		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2026	
NAME OF PROVIDER OR SUPPLIER ALDEN LAKELAND REHAB & HCC				STREET ADDRESS, CITY, STATE, ZIP CODE 820 WEST LAWRENCE , CHICAGO, Illinois, 60640			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
S9999	Continued from page 3 AM, V37 [Certified Nurse Assistant] answered the call light. V37 exited R4's room at 11:50AM, and V37 returned with supplies and initiated ADL incontinence care to R4 three hours later [9:00AM to 12:00PM R4 was soiled with feces]. On 1/27/26 at 12:24PM, V7 [Certified Nurse Assistant] stated, "I answered R4's light he reported he needed to be cleaned up after having a bowel movement, I did tell him I would be back, but I forgot. I was so busy with my own assigned residents. There are only two of us on this floor with approximately forty or more residents that need assistance. I am not sure why they sent V8 out on a medical appointment. Staffing has been an issue working short for over two months." On 1/27/26 at 10:20AM, during surveillance of R4's room, a couple rooms down from R4's room, surveyor heard someone yelling out for help. R5 was in bed, stated, "I am wet and need help. I been wet a long time." Surveyor turned on R5's call light. 10:22AM. V9 [Licensed Practical Nurse] turned off the call light and came out the room and went back to the nursing station. At 11:10AM, surveyor asked R5 was she still wet. R5 stated, "Yes, I am still wet. The lady said she will be back." On 1/27/26 at 11:30 AM, surveyor asked V9 what did R5 requested, when she answered the call light. V9 stated, "R5 needs to be cleaned up. I told one of the aides, I don't remember which one. I have an admission coming and need to get report. Staffing has been an issue for a while; we work together to do the best we can. Someone will help R5 soon as possible." On 1/27/29 at 11:58 AM, V8 [Certified Nurse Assistant] returned back to unit from escorting a resident to medical appointment. At 12:15PM, surveyor asked V8 if she could provide ADL incontinence care to R5. V8 stated, "I was sent out to go with a resident to their medical appointment. There are other aides that could have gone instead of me. There are restorative certified nurse assistants, and a wound care certified nurse assistant. They are not assigned to residents." V8 went to R5's room and provided care. R5 was wet from 10:22AM to 12:15PM [two hours]. On 1/27/26 R17, said the staffing is not sufficient and they have to wait a long time for assistance. They all said the facility needs more certified nurse assistants.	S9999					

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0017319		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2026	
NAME OF PROVIDER OR SUPPLIER ALDEN LAKELAND REHAB & HCC				STREET ADDRESS, CITY, STATE, ZIP CODE 820 WEST LAWRENCE , CHICAGO, Illinois, 60640			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 4 On 1/27/26 at 3:05 PM V3 [Acting Director of Nursing/Nurse Consultant] stated, "I became the acting director of nursing on 1/13/26. I was not made aware V8 [Certified Nurse Assistant] was sent out on a medical appointment. I rather had sent another certified nurse assistant such as restorative, or wound care aide. My expectation related to ADL incontinence care is that care is provided as soon as possible. For a resident to wait three hours for assistance is not acceptable. If a resident is left wet or soiled for two to three hours, it could potentially cause infection, skin breakdown, pain or feelings of sadness and/or dignity issues. Policy in part: Certified Nurse Assistant Job Description: Provide residents with daily nursing care in accordance with current federal, state and local standards, guidelines, and regulations. Provide ADL assistants to a specific number of residents and or directed by nursing staff. 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. (B)			S9999			