

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 02/11/2026	
NAME OF PROVIDER OR SUPPLIER ALDEN LAKELAND REHAB & HCC				STREET ADDRESS, CITY, STATE, ZIP CODE 820 WEST LAWRENCE , CHICAGO, Illinois, 60640			
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S0000	Initial Comments Complaint Investigation 2681310/2731154, 25811032/2665282		S0000			02/24/2026	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 300.3240c) 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 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		S9999			02/24/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 personal care needs of the resident. 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect 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) 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. These requirements are not met as evidenced by: Based on interviews and record review, the facility failed to ensure that a resident (R1) remains free from verbal abuse/assault from another resident (R3) and failed to follow their abuse policy. These failures caused psychosocial harm as evidenced by R1 feeling sad, nervous, scared, wanting to isolate self from community and not always feeling safe in facility's common areas due to R3's continuous verbal abuse/assault and despite R1's multiple notifications to various staff members. These failures affected one resident (R1) out of 3 residents (R1, R3 and R6) reviewed for verbal abuse/assault. Findings include: On 2/10/2026 at 10:34 AM, R1 stated, R3 is being verbally abusive/assaulting towards R1 and calling R1 names, such as "stupid n-word", "stupid pedophile", "nasty and disgusting" and other racial names and slurs and R3 would yell out false accusations about R1 such	S9999					

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S9999	Continued from page 2 as R1 using the system, not taking care of own children, falsely pretending to be sick to use state funding. R1 also said that R3 knows which room R1 resides on R1 and R3's floor, and on multiple occasions, R3 would pass by R1's room and sit in the wheelchair in front of R1's room, screaming and cursing at R1 and showing R1 offensive finger gestures. R1 stated that R3's verbal abuse towards R1 is ongoing and continuous and has been occurring for about a year. R1 stated that R1 told multiple staff members on different occasions throughout a year and feels that the facility is not doing anything to prevent R3's verbally abusing R1. R1 stated that R1 used to be more social and outgoing and would participate in group activities, speak with other residents and walk around the facility's common areas before R3's verbal abuse. R1 said that now R1 feels sad, nervous, scared and wanting to isolate self and stay in R1's room, to avoid contact with R3. R1 stated that R1 does not know why R3 is verbally abusing R1, because R1 never talks with R3, R1 always avoids and ignores R3. R1 also said that when talking to staff members about R1's concerns, the staff told R1 to ignore R3, not to look or talk with R3 and to avoid R3 as much as possible. R1 said that R1 enjoyed eating food at the dining room with other residents, but now R1 eats in R1's room and does not go out of room much and if R1 does go out of room, R1 makes sure that nurses are around. On 2/10/2026 at 10:50AM, V4 (Registered Nurse/RN) stated that V4 is aware of R1's concerns with R3 and that R1 talked with V4 about R3's verbal abuse on 2/2/2026. V4 stated that R1 told V4 that R3 continues to call R1 names and racial slurs and cursing at R1. V4 said that R1 told V4 that R3 would pass R1's room and sits in wheelchair in front of the door and curse at R1 and showed R1 inappropriate finger gestures. V4 stated that R1 told V4 that verbal abuse from R3 is an ongoing issue. V4 also said that once, (not sure of date), R1 was sitting in the dining room and R3 rolled up in the wheelchair towards R1 and called R1 the "n-word" and V4 heard it. V4 told the supervisor at that time. V4 said that the supervisor notified, does not work at the facility anymore. V4 affirmed that on 2/2/2026, V4 went to V1's (Administrator) office and V14's (Social Services Director) to report R1's concerns and that V4 documented it in R1's chart. V4 stated that V1 told V4 that V1 is aware of the issues between R1 and R3 and that V1 is working on the investigation. V4 stated that after V4 notified V1 and V14 on 2/2/2026, nobody spoke to V4 about those concerns. V4 stated, that in October 2025 (not sure of the exact date, but the same day that R3 was sent out to hospital) V4 observed R3 screaming and yelling at R1, and R3 calling R1 the "n-word". V4			S9999			

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S9999	Continued from page 3 stated that R3 had to be sent out to hospital due to R3's verbally abusive behavior. V4 stated that R1 used to be more social and would go to activities and that now, V4 noticed that R1 mainly stays in R1's room, eats in the room, and is more isolated. V4 stated that when there is a conflict between residents, facility staff tries to separate residents to make sure they are comfortable and that R1 was told to avoid conflict. V4 stated that R3 knows where R1's room is located. On 2/10/2026 at 11:12 AM V12 (Licensed Practical Nurse/LPN) stated that R3 is known to have abusive behavior, and that V12 saw R3 few months ago (10/10/2025) yelling and screaming at residents when passed by R3's room. V12 also stated that the same day, V12 heard R3 calling R1 the "N-word" once when R1 was at the nurse's station and R3 was passing by. V12 said that R1 told V12 that R1 never did anything to R3 to start behaviors and that R1 does not understand why suddenly R3 started calling R1 names. V12 stated that V12 noticed social isolation in R1 and that he does not come out of room as much as before. V12 also said that R1 eats in R1's room and before R3's verbally abusive remarks, R1 used to eat in the dining room. On 2/10/2026 at 11:35 AM, V4 (Registered Nurse/RN) and V12 (LPN) said that both heard R3 say the "n- word" in the past to R1 multiple times and that V4 and V12 redirected R3 and mentioned R3's behaviors to the supervisors at that time and that R3 was moved to a different room, but R3 still knows where R1 resides. The nurses also said that R3 usually eats in R3's room and does not come out, but both saw R3 wheeling around in the wheelchair in hallways and around R1's room. On 2/10/2026 at 11:54 AM R3 said that R3 knows R1 and that R3 did call R1 names a while ago (not sure when) but not the "n-word". R3 said, that R3 thinks that R1 is revolting and repulsive and that R3 called R1 "nasty man". R3 said that R1 does not talk with R3 and that R3 knows which room R1 resides. On 2/10/2026 at 12:07 PM, V16 (Certified Nursing Assistant/CNA) stated, that R3 has verbally abusive behaviors and that V16 heard R3 cursing, and yelling at R6, which used to be R3's roommate and other residents that would pass R3's room, but not sure of date. On 2/10/2026 at 12:10 PM, R6 said that R3 was R6's former roommate and that on daily basis R3 was calling R6 names and it was not nice. R6 said, that R3 would say "nasty" things, to R6 but is not sure or recalls the exact words used. R6 said that R3 was not a nice person. R6 said that R6 did not feel verbally abused,	S9999					

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S9999	Continued from page 4 but R6 is relieved and happy that the facility moved R6 out of R3's room. On 2/10/2026 at 12:14 PM, V9 (CNA), stated that R3 has a behavior where R3 would scream, yell and calls others with names and racial slurs and that R3 had to be sent out to hospital for behaviors evaluation because R3 was verbally abusive. On 2/10/2026 at 12:59 PM V14 (Social Service Director) said, that R3 has history of being verbally abusive and it is part of R3's diagnosis. V14 said that R1 mentioned to V14 a few months ago that R3 is calling R1 names. When V14 spoke to R1, R1 told V14 that R1 was at the nurse's station and that R3 called R1 the n-word. V14 thinks that R1 reported it to V14 sometimes before December but is not sure of date and that V14 notified V1 (Administrator). V14 said that V14 remembers a nurse (not sure which one and what date) mentioned to V14 that R3 was in the wheelchair sitting in the front of R1's room thinks it was about 2 weeks ago. V14 said that R1 did not like R3's behaviors and that R1 does not understand the reason R3 calls R1 names. V14 stated that V14 told R1 to ignore R3 and to walk away from R3 when R1 sees R3 anywhere in the facility. V14 said that R3 knows where R1's room is and that maybe R3 should have been moved to another floor away from R1, but R3 is still on the same floor as R1. V14 stated that V14 could not prevent R3's behavior, that it is hard to control what R3 will say. V14 stated that V14 cannot control R3, that all V14 could do is to educate R3 and speaks with s therapist. V14 said that R1 did not express feelings about R3's calling R1 names to V14. V14 is aware of incident in October 2025 with R3 calling R1 names and racial slurs and that it was reported. V14 stated that any abuse incident should be reported to abuse coordinator (V1 Administrator) and that documentation should be in resident's progress notes. V14 stated that V14 is not aware of R1 not going to activities. On 2/10/2025 at 1:49 PM, V14 (Social Services Director) stated that V14 spoke to R1 about 2 weeks ago and that V14 does not have documentation in R1's progress notes about the conversation and that V14 does not remember details. V14 stated that V14 told R1 "If you see (R3), try to walk the other way" and that R1 would reply, "I (R1) do. I don't even talk to (R3)." On 2/10/2026 at 1:55 PM, V1 (Administrator) stated that V1 is the abuse coordinator and that V1 is responsible for investigating incidents, keeping residents safe, protecting residents, submitting reports to state agencies, educating staff and that residents should be			S9999			

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S9999	Continued from page 5 informed about abuse. V1 stated that V1 is aware of only the incident reported on 10/11/2025 between R1 and R3 and that V1 does not remember exact details or who reported it to V1. V1 said that supposedly R3 was saying racial comments to R1 in the hallway. V1 said that V1 spoke to R1 and that R1 denied the allegations and that R1 said that nobody is verbally abusing R1. V1 stated that a week ago, (2/2/2026), V1 spoke to a nurse, (does not remember which nurse) and that the nurse asked V1 if V1 was aware of R3 calling R1 racially derogatory names, but the nurse did not report a new allegation and V1 assumed that the nurse was referring to the past incident between R1 and R3 (10/10/2025). V1 stated that V1 did not start a new investigation and told the nurse that the situation was previously investigated. V1 affirmed that V1 did not speak to R1 or R3 about the new allegations and V1 did not report it to the state agency. V1 stated that it is possible that verbal abuse between same residents could happen more than once and that V1 should report to state agency a new allegation of verbal abuse when the nurse came talk with V1 last week. V1 said that V1 should not assumed and should talk with R1 and R3. V1 stated that V1 speaks to R1 frequently and that R1 did not say anything about being verbally abused. V1 then stated that V1 did not ask R1 specifically about R3 and that R1 had hesitated with answers. V1 stated that R3 should have been moved to another unit, to benefit R1's concerns of verbal abuse, but V1 was not aware of repeated behaviors. V1 said that R1 told V1 that R1 feels safe. On 2/10/2026 at 3:20 PM observed R1 in R1's room, laying on the bed, watching TV. R1 stated that after the incident on 10/10/2025, nobody talked with R1 about what happened and that R1 did not receive follow up information or investigation conclusion information. R1 said, that V1(Administrator), did not ask R1 about R3's continuous behaviors of verbal abuse towards R1 and that V1 barely speaks to R1. R1 said that R1 did not deny allegations of incident in October and did not say to V1 that incident did not happen. R1 does not recall anybody asking R1 if R1 feels safe, in the facility. R1 stated that R1 feels safe only in R1's room, but not in the facility's common areas, because R3 might be there and would start calling R1 names again. R1 said that V14 (Social Services Director) told R1 to go another way of R3, ignore and avoid R3. R1 also stated that CNAs asked R1 why R1 is not coming out of the room as much? R1 stated that R1 used to enjoy movie nights and socializing with other residents, but now R1 barely speaks to any of residents and does not go to movie nights and that if R1 sees nurses around, then maybe R1 will go out of room for a moment to try to socialize		S9999				

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S9999	Continued from page 6 with other residents On 2/10/2026 at 3:40 PM, V4 affirmed that V4 heard R3 saying the n-word to R1 in the dining room and that R1 came to V4 on 2/2/2026 and reported all concerns ("n-word" calling, sitting in front of R1's room and showing R1 middle finger) to V4 and that V4 went to V1's (Administrator) office and notified V1. V4 said that V1 told V4 that V1 is already investigating and looking into the situation. V4 stated that nobody spoke to V4 about those concerns later or gave V4 any information about investigation. On 2/10/2026 at 3:59 PM, V1 (Administrator). stated, that if V1 is given an allegation, V1 should report it as soon as possible, and that the incident should be reported within 2 hours of allegation if harm, otherwise it is ok to report within 24 hours. V1 said, while looking at the 10/10/2025 incident report, that V1 believes the incident happened on 10/10/2025, but V1 reported incident to state agency on 10/11/2025 and said that V1 is not sure why they did not report on the 10th and that V1 is confused about the details. V1 stated that when the nurse notified V1 on 2/2/2026, V1 did not report the new allegations to state agency. V1 stated that V1 did not ask R1 about R3 verbally abusing R1 and that V1 noticed that when speaking with R1 in the past, R1 was hesitating with answers. R1's Admission Record documents, in part, diagnoses of Encounter for orthopedic aftercare; Spinal Stenosis; Intervertebral disc degeneration, Lumbar region; Primary Hypertension; Unspecified Asthma; Type 2 Diabetes Mellitus; Morbid Obesity; Hyperlipidemia; Insomnia; Venous insufficiency; non-pressure chronic ulcer of left calf; Radiculopathy, lumbar region; Lumbago with sciatica; Nicotine Dependence; Arthrodesis status and Vitamin D deficiency. R1's Minimum Data Sheets (MDS) (11/11/2025) in section C for Cognitive Patterns showed the Brief Interview for Mental Status (BIMS) score of 15 which showed intact cognition. R1's progress note (2/2/2026 at 7:53 AM), documented by V4 (RN) showed in part, that R1 verbalized concerns to V4 about another female resident making false accusations about R1 and continuing to approach R1 despite R1's expressing discomfort and that R1 notified social services. V4 documented that V4 notified social services and director of nursing. There is no documentation of concerns being reported to the state agency nor the facility investigating allegations. Interviews further showed that R1 was voicing concerns	S9999					

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S9999	Continued from page 7 about R3's being verbally abusive towards R1. R1's Census List (2/10/2026) showed in part that R1 was in the same room (Room 215 C) since 8/27/2025. R1's Abuse Risk Assessment (8/12/2025), documented by V14 (Social Services Director) showed in part that R1 answered all questions "no" and is not at risk for abuse. There is no later dated abuse risk assessment in R1's medical records. R1's Care Plan (Initiated on 8/29/2023) showed in part that the staff should monitor R1 for changes in activity level and adjust encouragement and types of activities offered. Reviewed R1's complete current care plan (8/28/2023-2/10/2026) which showed in part that there is no focus on R1 being verbally abused or being at risk for verbal abuse. R3's Admission Record documents, in part, diagnoses of End stage renal disease; Dependence on Renal Dialysis; Sequelae of Cerebral Infarction; Chronic Kidney Disease; Cerebral palsy; Major Depressive disorder; Mixed Anxiety disorders; Post-Traumatic stress disorder; Attention-Deficit Hyperactivity disorder; Anemia; Hypotension; and Hydrocephalus. R3's Minimum Data Sheets (MDS) (1/13/2026) in section C for Cognitive Patterns showed the Brief Interview for Mental Status (BIMS) score of 15 which showed intact cognition. Functional Abilities for Mobility Devices is a manual wheelchair. R3's progress note (10/10/2025 at 5:34 PM) documented by V14 (Social Services Director), showed in part that V14 was alerted by staff on 10/10/2025 that R3 was being verbally abusive and making racial slurs towards another resident. V14 documented that R3 was transferred out to hospital on 10/10/2025 at 4:00 PM. R3' Petition for Involuntary/Judicial Admission (10/10/2025 at 3:30 PM) filled out by V14 (Social Services Director), showed in part that R3 demonstrated increased agitation, mood lability and aggression and that R3 was making threats unprovoked, racial comments using racial slurs to those walking by R3's room and making discriminating comments towards men. R3's Census List (2/10/2026) showed in part that R3 was on hospital leave from 10/10/2025 at 4:31pm and returned to the same room on 10/10/2025 at 9:25 pm.	S9999					

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S9999	Continued from page 8 R6's Admission Record documents, in part, diagnoses of Hemiplegia and Hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side; Dysphagia; Cerebral edema; Essential Primary Hypertension; Type 2 Diabetes Mellitus; Unspecified Dementia, mild, without Behavioral Disturbance; Psychotic Disturbance; Spondylosis; Lack of Coordination; Contracture of muscle; Encephalopathy; Solitary Pulmonary nodule; Anorexia; Major Depressive Disorder; Anxiety; Overactive Bladder; History of Falling; Presence of Artificial Knee Joint; R6's Minimum Data Sheets (MDS) (12/3/2025) in section C for Cognitive Patterns showed the Brief Interview for Mental Status (BIMS) score of 7 which showed impaired cognition. Facility's booklet titled "Residents' Rights for People in Long-term Care Facilities" (3/17) showed in part that resident has the right to safety and good care and that resident must not be abused by anyone – physically, verbally, mentally, financially or sexually. Facility's document titled "Abuse Policy (For Illinois Facilities)" (3/25), showed in part that the facility supports the rights of the residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Document showed in part, that the facility must report suspicion of crime and that the facility prohibits abuse of its residents and attempted to establish a resident sensitive and safe environment. Policy also showed in part that the purpose is to ensure facility incidents of occurrences of abuse and this should be performed by establishing resident sensitive environment and prevention of mistreatment; Identifying incidences and patterns of potential mistreatment; Protecting residents involved in possible abuse incidents; Implementing systems to inspect all reports and accusations of mistreatment and perform necessary changes to prevent future incidents; Filing precise and timely investigative reports. The policy showed in part that the facility is committed to residents' protection from abuse by other residents, facility staff or other individuals at the facility. The document classifies verbal abuse as "the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of their age, ability to comprehend or disability". The document classifies in part, that mental abuse includes humiliation, harassment and that it could occur through either verbal or nonverbal contact, that could	S9999					

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NAME OF PROVIDER OR SUPPLIER ALDEN LAKELAND REHAB & HCC				STREET ADDRESS, CITY, STATE, ZIP CODE 820 WEST LAWRENCE , CHICAGO, Illinois, 60640			
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S9999	Continued from page 9 potentially cause resident to experience humiliation, intimidation, fear and shame. Facility's document titled "Abuse Prevention Program (For Illinois Facilities)" (3/25) showed in part that during employee orientation, the facility would include topics such as Sensitivity of resident rights and needs; Staff's obligation to prevent and report abuse; Assessment, Prevention and management of aggressive resident's reactions; Types of abuse and Reporting of suspicion of crime. Document showed in part that the facility should prevent abuse by establishing secure environment and that the residents' concerns should be recorded, reviewed and responded to by using the facility's grievances and that the residents should be informed of the procedure and the staff should assess and identify residents that could be vulnerable to abuse or having behaviors that could cause a conflict. Document showed in part, that the employees should immediately report any incident that is observed, heard about or suspected of to the supervisor or the administrator and the designee staff should initiate investigation. Document showed in part, that to prevent abuse during investigation, the facility should remove from contact a resident that is alleged to abuse another resident and evaluate resident's condition to determine the most preferable therapy, care approaches and placement with consideration on their safety and safety of other residents at the facility. (B)	S9999					