

Illinois Department of Public 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 04/15/2026	
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: 2682776/2798963 2682575/2791760 2682154/2749159			S0000			04/28/2026
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.610a) 300.1210a) 300.1210b) 300.1210d)5) 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 practicable level of independent functioning, and provide for discharge			S9999			05/01/2026

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 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. 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These regulations were not met as evidenced by: 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 65-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.			S9999			05/01/2026

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S9999	Continued from page 2 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 02/17/2026 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			S9999			05/01/2026

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S9999	Continued from page 3 (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 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 White 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:			S9999			05/01/2026

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S9999	Continued from page 4 Policy is to implement preventive measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan. (A) Statement of Licensure Violations: (2 of 2) 300.610a) 300.690(a) 300.690(b) 300.690(c) 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 300.690 - Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident.	S9999				05/01/2026	

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S9999	Continued from page 5 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 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 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.	S9999				05/01/2026	

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S9999	Continued from page 6 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: R7 subject of the complaint expired on 01/19/2026. R7 was 65-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 11/03/2025 due to inability to wean from ventilator, R7 had a tracheotomy peg placed. R7 was admitted in the facility on 01/13/2026 with physician order to receive high flow oxygen of twenty (20) liters per minute via tracheostomy collar. On 03/24/2026 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 swollen and unrecognizable. V10 stated that according to facility staff, R7 pulled out his tracheostomy. V10 emailed picture of R7's death certificate and multiple photos. Clinical notes of V9 (Licensed Practical Nurse) dated 01/19/2026 are as follows: At 03:30 PM, V9 observed R7 with oxygen tubing connected to tracheostomy tubing in his finger. No			S9999			05/01/2026

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S9999	Continued from page 7 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 03/25/2026 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 03/26/2026 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 01/19/2026 was not			S9999			05/01/2026

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S9999	Continued from page 8 evaluated for competency during hiring on 10/09/2025. 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 10/09/2025. 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 10/09/2025. Medication Pass Guidelines and Tips, Insulin Pen, Disinfecting Blood Glucose Monitoring Machine, 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 03/23/2026 to 03/30/2026, V37 was assigned to work on ventilator unit on 03/26/2026, 03/27/2026, 03/28/2026 and 03/29/2026 at 07:00 PM to 07:00 AM twelve (12) hour shift. On 03/26/2026 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 3/26/2026 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 01/19/2026 are as follows: V11 (Respiratory Therapist) clinical notes dated 01/19/2026 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 01/19/2026. Cardiopulmonary Resuscitation (CPR) was performed at 04:46 PM. Which was a minute after V11 reinserted tracheostomy into R7. According to V11, R7 with			S9999			05/01/2026

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S9999	Continued from page 9 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 01/19/2026 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 01/19/2026 documents the following: Team was dispatched on 01/19/2026 at 04:47:24 PM arrived at scene at 01/19/2026 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 03/26/2026 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 03/26/2026 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 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.			S9999			05/01/2026

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S9999	Continued from page 10 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 04/10/2026 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 03/27/2026 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 09/06/2022 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			S9999			05/01/2026

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S9999	Continued from page 11 tissues around the tracheostomy tube or tears in the posterior tracheal wall. On 03/25/2026, via email V10 (Family of R7) provided photos of R7 that compare photos taken on 01/13/2026 (R7's day of initial admission) from 01/19/2026 (day R7 expired with dislodged tracheostomy). Per R7's photos it was clear that R7 has substantial swellings on his face and body. On 03/31/2026 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. On 04/01/2026 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 01/19/2026 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 3/25/2026 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.			S9999			05/01/2026

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S9999	Continued from page 12 On 03/27/2026 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. V39 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. V39 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 04/14/2026 at 02:41 PM with V3 (Director of Nursing), inside R24's room, V3 cannot locate pulse oximeter inside room. On 04/02/2026 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 X 4 and tape.			S9999			05/01/2026

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S9999	Continued from page 13 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 03/26/2026 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 01/19/2026, the day R7 expired. Medication Administration Record (MAR) for January 2026 have a single documentation at the morning shift of R7's oxygen saturation. Clinical notes did not document any vital signs on 01/19/2026 when R7 expired. On 03/31/2026 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 03/23/2026: There are twenty-nine (29) residents on tracheostomy in			S9999			05/01/2026

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S9999	Continued from page 14 the facility. On 03/26/2026 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 December 12th. V34 stated that R16 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 03/27/2026 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 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 12/18/2025, 12/23/2025 and 12/30/2025. V2 stated that R16 missed changing inner canula on 12/24/2025. This can increase R16's risk of contracting pneumonia. V2 stated that R16 was initially admitted to the facility on 12/22/2025 without any infection. V2 stated that R16 was sent back to the hospital on 1/9/2026 for difficulty breathing and infection. V2 stated that R16 was readmitted back in the facility on 01/20/2026. V2			S9999			05/01/2026

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S9999	Continued from page 15 stated that R16 had labs drawn on 1/20/2026 which shows a white blood count of 18.3 which means infection. On 03/31/2026 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 1/9/2026 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 12/23/2025 and 12/30/2025. Order for trach care and collar was scheduled for every shift and as needed. R16 had missing treatment administration for trach collar care on 12/18/2025, 12/23/2025, and 12/30/2025. Order for cleaning inner cannula was every shift and as needed. Missing treatment administration for cleaning inner cannula on 12/18/2025, 12/23/2025 and 12/30/2025. Order for suctioning trach was every 4 hours and as needed. R16 had missing trach suctioning on 12/18/2025 at 8:00 PM, 12/19/2025 for midnight and 04:00 AM, 12/23/2025 for 8:00 AM, 12:00 PM and 04:00 PM, 12/24/2025 for 8:00 AM and 12:00 PM, and 12/30/2025 for 8:00 AM, 12:00 PM and 04:00 PM. R16's progress notes on 01/09/2026 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 01/21/2026 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			S9999			05/01/2026

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S9999	Continued from page 16 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 (Medical Director) 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. R16's hospital record on 1/9/2026 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 1/9/2026 documents in part (pg 117): Tracheal cultures on 01/09/2026 results in serratia marcescens. Group G strep. Chest x-ray with super imposed pneumonitis. Overall source may be related to pneumonia with dyspnea/hypoxia. (AA)	S9999				05/01/2026	