STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dupage Care Center	400 N County Farm Rd Wheaton, IL 60187

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409 Based on observation, interview, and record review, the facility failed to place call lights within reach of residents. This applies to 3 of 3 residents (R145, R168, R155) reviewed for accommodation of needs in a sample of 37. The findings include: 1. On August 20, 2024 at 12:46 PM, R145 was brought back to her room with the assistance of V24 (CNA/Certified Nurse Assistant). V24 wheeled R145 towards the foot of the bed and left the resident in her wheelchair at the foot of the bed. R145's call light was lying across the center of the bed, out of reach of the resident. When asked, R145 said she needed to press the call light to ask for help. R145 tried to propel herself to reach the call light but was not able to reach her call light. R145 asked R168 to reach for her call light, and R168 was not able to reach the call light. At 12:54 PM, R145 was still attempting to reach for her call light but was unable to. R145's face sheet showed R145 was admitted with diagnoses including repeated falls, wedge compression fracture, cerebral ischemia, generalized anxiety disorder, age-related osteoporosis, and weakness. R145's POS (Physician Order Set) showed R145 was on Fall Precaution. R145's MDS (Minimum Data Set) dated July 5, 2024 showed R145 had moderate cognitive impairment. R145 needed substantial assistance from staff for toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. R145's July 9, 2024 care plan showed she had an ADL (Activities of Daily Living) self-care performance deficit [related to] limited physical mobility, gait and balance impairments from dementia .with an intervention to Encourage the resident to use call button to call for assistance. R145's care plan also showed R145 was at high risk for falls [related to] cognitive impairment, musculoskeletal impairment from recent multiple fracture [status post] orthopedic surgery; psychotropic drug use; [history] of repeated falls, with an intervention to Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. 2. On August 20, 2024 at 12:42 PM, R168 was sitting in her wheelchair with the tray table in front of her. R168's call light was on the bed but out of reach of the resident. At 12:46 PM, R145 asked R168 to reach for her call light, and neither resident was able to access their call lights. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER: Dupage Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 400 N County Farm Rd Wheaton, IL 60187	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R168's face sheet showed she was admitted to the facility with diagnoses including hypertension, osteoarthritis, depression, and dementia. R168's MDS dated [DATE] showed R168 had severe cognitive impairment. R168 required moderate assistance from staff for personal hygiene, substantial assistance for toileting hygiene, shower/bathing, upper and lower body dressing, and was dependent on staff for putting on/taking off footwear. R168's care plan dated May 18, 2023 showed Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. On August 22, 2024 at 1:01 PM, V33 (CNA) said the call light should be within reach to the resident. V33 said he clips it to their clothes or blankets, and it be in a place where they can press it. On August 22, 2024 at 1:04 PM, V34 (CNA) said the call lights should be within reach as well as within sight to the resident, and he usually clips the call light onto them. On August 22, 2024 at 1:09 PM, V25 (CNA) said the call light needs to go near the resident so they could reach it. On August 22, 2024 at 1:11 PM, V26 (RN/Registered Nurse) said the call lights should be in a place the resident could reach. On August 22, 2024 at 1:16 PM, V35 (RN) said the call light should be where the resident could reach, and some of the residents even tell the staff where to place the call light. V35 said the staff should clip it on top of the sheets within reach of the resident. On August 22, 2024 at 9:39 AM, V2 (DON/Director of Nursing) said the call light should be within the resident's reach for those who can move their hands. V2 said the call light should be clipped on their clothes or the sheets in a place that is accessible to the resident. V2 said the staff do call light assessments as needed and if there is a change in condition. V2 said the call light should still be within reach if the resident is alert but not oriented. The facility's Call Light Protocol reviewed February 2021 showed A working call light is to remain within reach of the resident at all times when they are in their room; if they are in bed, a wheelchair, a geri chair, the toilet or a commode. 41384 3. On 8/20/24 at 1:42 PM, R155 was observed in her wheelchair leaning to her right side with her right arm hanging over the right armrest and she was crying. R155 said that her right arm was caught and when she tried to move it, it would cause her pain. The surveyor asked her if she could use her call light to call for help and she said no. R155's call light was observed at the head of the right side of the bed tied around the top bedrails and R155 was in her wheelchair on the left side of the bed behind the foot of the bed. The surveyor put the call light on so staff could come and assist R155. V14 (nurse) came in and had to remove the adapted device on R155's armrest to release R155's trapped arm. On 8/21/24 V14 (Nurse) said that on 8/20/24 at 1:42 PM, when she came to assist R155, R155's arm was trapped in her wheelchair and her call light was out of reach. (continued on next page)

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	145050	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dupage Care Center	400 N County Farm Rd Wheaton, IL 60187

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 10:46 AM, V21 (R155's husband) said that on 8/20/24, he had visited his wife from 10:45 am - 12:50pm and her call light was out of reach the whole time as it is every day. V21 said that R155's call light was tied to the bedrail at the top of the bed as it is every day and he did not move it.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on interview and record review the facility failed to report allegations of verbal abuse within 24 hours. This applies to 1 of 2 residents (R141) reviewed for abuse in a sample of 37. Findings include: R141 admitted to the facility on [DATE] with diagnoses that includes paraplegia, neuralgia, cramp / spasm, diverticulosis, hypertension, depression, anxiety, and insomnia. R141's MDS (Minimum Data Set) dated 7/17/24 shows he is cognitively intact with a BIMS (Brief Interview for Mental Status Score) of 15. On 8/20/24 at 11:48 AM, R141 stated V40, CNA (Certified Nurse Aide) verbally abused him by saying he was a bother and no other CNAs wanted to work with him. R141 stated, V2 DON (Director of Nursing) and V5 Social Services Manager were aware of his allegations from the previous week. On 8/20/24 at 12:10 PM, V5 stated she spoke to R141 on 8/17/24 regarding removing V40 CNA from his care team. V5 stated R141 did not like the way V40 positioned him in the wheelchair. V5 stated she did not ask R141 details as to why he no longer wanted to receive care from V40. V5 stated she informed R141 she was aware a service recovery (attempt by the facility to find a resolution for a dissatisfied resident) had been initiated by V6 Social Worker in the previous week. On 8/20/24 at 12:20 PM, V6 Social Worker stated she had spoken with R141 the previous week regarding V40 being mouthy and not placing him in his wheelchair correctly. V6 stated she did not ask R141 what he meant by V40 was mouthy. V6 stated she could not recall specific details of her conversation with R141. V6 stated on 8/19/24 V5 Social Services Manager informed her R141 claimed V40 was being abusive. On 8/20/24 at 3:48 PM, V2 DON (Director of Nursing) stated R141 left her a voice mail over the weekend accusing V40 of verbal abuse. V2 stated she reviewed the message on Monday 8/19/24. V2 stated V5 followed up with R141 regarding his allegation of abuse. V2 stated R141 had a service recovery regarding the care he received from V40 CNA the prior week. V2 did not know details regarding the service recovery. V2 stated staff doing a service recovery will ask the resident what their specific concerns are and attempt to address them. On 8/21/24 at 2:45 PM, R141 stated he had spoken to V6 Social Worker regarding his allegations against V40 the prior week. On 8/21/24 at 10:17 AM, V5 Social Services Manager stated she spoke to R141 on Saturday 8/17/24 while manager on duty. V5 stated R141 told her he no longer wanted V40 to provide his care. V5 stated R141 informed her V40 places him in his wheelchair in an uncomfortable position and told him he was a bother. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 9:34 AM, V40 CNA stated he was informed on Monday 8/12/24 that R141 complained and no longer wanted him to provide his care. V40 stated on Monday 8/19/24, V39 ADON (Assistant Director of Nursing) informed him of R141's allegations of abuse and suspended him. On 08/22/24 11:37 AM, V4 Assistant Administrator / Abuse Coordinator stated anyone in leadership can file a report for an abuse allegation including on the weekend as there is a manager on duty. V4 stated abuse allegations are to be submitted to the department of health within two hours. V4 stated verbal and mental abuse is a gray area. We file a report based on the allegations. We try to get details of a concern and if we can't get to the bottom of the concern within 2 hours, we file the report with the state. It is better for us to over report allegations rather than under report. R141 makes a lot of false allegations, and it has been a challenge for us. V4 stated the word bother isn't a word that is necessarily a trigger, but it is the perception of the individual. If someone says they are being abused, it should be reported. The voicemail V2 DON received on 8/19/24 is what triggered us to file the report of abuse. The facility service recovery report submitted by V6 Social Services states R141 expressed frustration with his CNA on the morning of Sunday 8/11/24. Immediate follow up / action take was to provide active listening and apologize to R141. Nursing to follow up as appropriate. A facility provided document dated 8/13/24 from V6 Social Services interview with R141 states V40 told him you're starting to bother me. An email dated 8/16/24 from V8 Head Nurse to V6 Social Services stated CNA was reeducated on customer service and removed from resident's care list. The initial report was submitted to IDPH (Illinois Department of Health) on 8/19/24. The facility policy Resident Abuse & Theft Prevention dated 10/2023 states the Administrator, abuse prevention coordinator or designee will be notified immediately of any reports of alleged mistreatment, neglect or abuse. The Administrator, Abuse Prevention Coordinator, Nursing Administration or designee will immediately send an initial report to IDPH.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observations, interviews, and record reviews, the facility failed to properly monitor, assess and treat a resident who is at risk for potential pressure ulcers. The facility also failed to properly monitor, and assess 1 resident who is unable to reposition themselves. This applies to 2 of 2 residents (R104 and R155) reviewed for quality of care. Findings include: 1. R104 is a [AGE] year old female admitted to the facility on [DATE] with diagnosis including chronic kidney disease stage 3, type 2 diabetes, unspecified mental disorder, schizoaffective disorder, urinary tract infection, E coli, altered mental status, ataxic gait, difficult in walking, history of falls, pressure ulcer of sacral region stage 3, pressure ulcers of left buttock unstageable, metabolic encephalopathy, depression, cognitive communication deficit, hyperlipidemia, muscle spasms, acquired absence of digestive tract, artificial right hip and anxiety. On 8/20/24 at 11:31 AM, R104 was observed in her bed on her back and again at 12:10 PM she was observed on her back when V17 (Wound Nurse) and V18 (Wound Doctor) came into the room to provide wound care to R104's stage 3 pressure ulcer to her coccyx wound. R104's dressing to her coccyx wound was found with brown substance on it, and an area on R104's left buttock was found with redness and the skin was blistered in some areas. The doctor assessed the area and said that it was a new open wound 3cm X 3cm caused by incontinence of urine and stool. V17 then cleaned both wounds and applied the medicated ointment as prescribed by the doctor. On 08/22/24 at 11:30 AM, V2 DON (Director of Nursing) said that her expectation is that staff provide incontinent care every 2 hours and as needed to prevent skin breakdown. V17 said that R104's wound to her left buttocks is a MASD (moisture associated skin damage) from incontinences of urine and feces. V17 said that he expects the nursing staff to change the residents and keep them dry. V17 said that he provided wound care to R104 coccyx wound on 8/19/24 and the wound to R104's left buttock was present and look the same as it did on 8/20/24. R104's electronic record did not show any record of a wound to R104's left buttock on 8/19/24. R104's 8/20/24 skin/wound note showed wound assessed and measured. Treatment done on sites. No complaints of pain made. New treatment order made and carried out. R104's 6/4/24 order showed coccyx - cleanse with normal saline, pat dry period apply calcium alginate and cover with gauze island dressing daily and PRN everyday shift for wound care. R104's 5/2/2024 order showed nurse to evaluate residence wounds for treatments. R104's 8/6/24 MDS (Minimum Data Set) shows that R104 is dependent for toileting hygiene, and she is totally dependent on staff to roll from left to right. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R104's 8/6/24 care plan showed that R104 has an ADL self-care performance deficit related to activity intolerance, limited mobility, limited range of motion, and poor endurance secondary to multiple medical chronic diagnosis such as kidney disease, diabetes mellitus, lipidemia, tachycardia, ataxia, and behaviors related to schizoaffective disorder and anxiety. R104's interventions included toileting hygiene physically dependent check and change large brief. R104's 5/24/24 care plan showed she has a potential for pressure ulcer development related to impaired mobility, activity intolerance, secondary to diagnoses of diabetes mellitus 2, anxiety, schizoaffective disorder, depressive type, muscle spasms, and incontinence. The goal is that the resident will have intact skin free of redness, blisters, or discolorations. The interventions or tasks include apply skin protectant after incontinent episodes, follow facility policy protocols for prevention or treatment of skin breakdowns, monitor nutritional status, provide assistance to turn or reposition at least every two hours more often as needed or requested, monitor bed pressure relieving air mattress, and monitor-skin observation. R104's 7/26/24 care plan also showed a returned status post hospitalization for hydronephrosis, UTI (urinary tract infection), with pressure ulcer to the coccyx stage 3 (5/7/24). The goals included the resident's pressure ulcer will show signs of healing and remain free of infection. the interventions and tasks include administer treatments as ordered and monitor for effectiveness, assess, record, and monitor wound healing, daily measure length width and depth where possible. Assess and document status of wound perimeter wound bed and healing progress. Report improvements and declines to medical doctor. Avoid positioning the resident on her back, monitor nutritional status, and monitor - skin observations. R104's 8/20/2024 wound evaluation & management summary showed Site 7 etiology (Quality) moisture associated skin damage. Duration - greater than 1 days, wound size 3 x 3 x 0.1 centimeters, surface area 9. 0 centimeters. cluster wound open ulceration area of 4.50 centimeters, & skin 50%. Additional wound detail - patient has new irritation to left inferior buttock with overlapping area from previous pressure site. patient is at high risk for skin breakdown due to previous wound site and this skin integrity is weakened from scar tissue as well as urinary and fecal incontinence. Dressing treatment plan - zinc ointment apply once daily as needed for 30 days. Recommendations reposition per facility protocol, & offload wound. R104's 8/20/24 skin & Wound Evaluation MASD (moisture associated skin damage) acquired in-house, left gluteus 9.0cm X 3.0cm x 3.0cm Erythema: Redness of skin - may be intense bright red to dark red or purple, additional care: incontinence management, moisture barrier, moisture control, turning repositioning program, education of off-loading and repositioning. 2. R155 is an [AGE] year old female admitted to the facility on [DATE] with diagnoses including cerebral ischemia, vascular dementia, depression, panic disorder, essential hypertension, difficulty walking, arteriosclerotic heart disease, lower back pain, and a history of falling. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 1:42 PM, R155 was observed in her wheelchair leaning to her right side with her right arm hanging over the right armrest and she was crying. R155 said that her right arm was caught and when she tried to move it, it would cause her pain. R155's wheelchair had a large bolster on her right arm rest and a lateral support to the right upper back of the wheelchair. There was an open area on the right side of the wheelchair where the 2 adaptive pieces did not meet. This opening is where R155's right arm had fallen through, and she was unable to get her arm back out. The surveyor asked her if she could use her call light to call for help and she said no. R155's call light was observed at the head of the right side of her bed tied around the top bedrails and R155 was in her wheelchair on the left side of the bed behind the foot of the bed. The call light was out of reach. The surveyor turned R155's call light on and V14 (Nurse) came to assist R155 to get her arm out. V14 attempted to bring R155's arm back over the armrest but was unable to. R155 continued to cry out in pain when she would move her arm. V14 then was observed removing the right bolster/adaptive device from R155's wheelchair so that she could get R155's arm released. On 8/21/24, V14 said that R155's arm was trapped because of the bolster on her wheelchair. V14 said that she saw that R155 could not call for help because her call light was out of reach. On 8/21/24 at 10:46 AM V21 (R155's husband) said that on 8/20/24 he visited his wife from 10:45 am until 12:50 pm. V21 said that during that time R155's call light was tied to the bedrails at the top of the bed as it is every day, and he did not move it. V21 said that the call light is never in R155's reach and he visits her every day. V21 said that his wife's arm is trapped in her wheelchair every day and it causes her pain when she tries to move it out. V21 said that the staff are aware of this because they move her arm out of being trapped every day to put the sling for the mechanical lift on her so that they can toilet her. V21 said that this has been like this for a year ever since they put the bolster on her armrest. V21 said that it causes her pain, and it is every day. On 08/22/24 at 09:15 AM, V44 (Manager of Rehabilitation Services) said that R155's has diagnoses of dementia, history of falls, and weakness and that is what causes R155 to lean. V44 said that on 7/10/2023 R155 was given a high back wheelchair with a bolster on the right armrest, and on 5/2024, R155 had increase weakness and leaning, and the facility added the right lateral support to her wheelchair. V44 said that since R155 has had the increased leaning she has been unable to reposition herself. V44 said that when R155 comes down for services at physical rehab she is leaning, and they have to reposition her. V44 said that she had not received any reports that R155's arm was being caught between the cushion on the armrest and the lateral support on her wheelchair. On 08/22/24 at 11:51 AM, V2 (DON) said that her expectations are that call lights are within reach, resident are being closely observed and frequent rounding if needed. V2 said that she expects the staff to report if a patient is falling through the adaptive devises. V2 said that this should be done so the patient can be comfortable, without pain, and free to move. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R155's electronic health record showed on 1/25/24 R155's cognition is severely impaired, and she needs substantial to maximal assistance for eating, toileting, sitting to standing, and personal hygiene. R155's 4/24/21 physician order showed she is on fall precaution every shift. R155's 5/13/24 care plan showed ADL self-care deficit related to impaired mobility, cognitive deficit, generalize weakness related to a diagnosis of dementia, and a history of falls. Interventions include monitor document and report as needed any changes, any self-care deficit declines in function, encourage to use bell to call for assistance. R155's 1/23/2024 care plan showed a risk for falls related to impaired mobility, cognitive deficit, generalized weakness related to dementia and history of falls. The interventions included anticipate and meet the residents needs, be sure that the resident's call light is within reach and encourage the resident to use it for assistance as needed, the resident needs to be in a safe environment. R155's Wheel Chair System - Patient Evaluation information showed that on 7/10/2023 a high back chair with foam and a bolster to the right side was given to R155, and on 5/2/2024 a lateral support was added to the right side of the wheelchair due to increased lean.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409 Based on observation, interview, and record review, the facility failed to safely transfer residents using a gait belt. This applies to 2 of 2 residents (R68, R191) reviewed for mobility in a sample of 37. The findings include: 1. On August 21, 2024 at 2:11 PM, V25 (CNA/Certified Nurse Assistant) and V41 (Restorative Aide) assisted R68 from a lying to a sitting position. V25 applies a gait belt around R68's waist and then V25 and V41 assists R68 into a standing position, with V25 pulling R68 up by her pants. At 2:11 PM, V25 pulled R68 further back into her wheelchair using her pants instead of the gait belt. R68's face sheet showed she was admitted to the facility with diagnoses including dysphagia, gastrostomy status, failure to thrive, cognitive communication deficit, osteoporosis, and a history of falling. R68's MDS (Minimum Data Set) dated August 14, 2024 showed R68 had severe cognitive impairments and was dependent on staff to transfer from lying to sitting on side of bed, sit to stand, and bed to chair transfers. R68's care plan revised on August 7, 2024 showed Resident will require 2 [Gait Belt] total dependent assist from staff. 2. On August 21, 2024 at 11:47 AM, R191 was being assisted into the wheelchair by V31 (CNA). R191 was sitting at the edge of her bed and V31 applied the gait belt around her and brought the wheelchair close to R191. V31 then pulled and pivoted R191 using her pants into the wheelchair. At 11:51 AM, R191 was taken to the bathroom, and V31 used R191's pants to pull her up instead of the gait belt and placed her on the toilet. At 11:55 AM, V31 pivoted R191 with one hand on the gait belt and the other hand on her pants. R191 face sheet showed she was admitted with diagnoses including abnormalities of gait and mobility and repeated falls. R191's MDS dated [DATE] showed R191 had moderate cognitive impairment. R191 required substantial assistance for sitting to stand, bed to chair transfers, and toilet transfers. R191's care plan dated April 1, 2024 showed The resident has an ADL (Activities of Daily Living self-care performance deficit [related to] cognitive deficit and mobility impairment .with an intervention including bed to chair 1 person assist to Give her time to participate in holding the side rails and let her pull herself to stand and pivot to the chair. On August 21, 2024 at 2:40 PM, V25 (CNA) said the staff should use a gait belt to transfer residents for safety. V25 said staff need to make sure it was placed tightly and then the resident should be pulled up by the gait belt, not by their pants. On August 22, 2024 at 1:04 PM, V34 (CNA) said the residents should be transferred using a gait belt and they should not be pulled by their pants. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dupage Care Center	400 N County Farm Rd Wheaton, IL 60187

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On August 22, 2024 at 1:16 PM, V35 (RN/Registered Nurse) said the staff should be transferring the resident using a gait belt and should not be pulling them by their pants. V35 said the gait belt was in place to use and pulling them by their pants could hurt them. On August 22, 2024 at 12:56 PM, V32 (Physical Therapy Program Manager) said ideally, the staff should only be holding the resident by the gait belt and should not be pulling them by their pants. On August 22, 2024 at 9:39 AM, V2 (DON/Director of Nursing) said the staff should use the gait belt to lift and transfer the residents. The facility's Transfer-Gait Belt Policy reviewed August 2023 showed Place your hands toward the back of the resident and grasp the belt by inserting your thumbs downward. Fingers are to be curled under belt and next to thumbs. The belt is to be snug enough to allow your hands only enough space to grasp the belt.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review, the facility failed to offer hydration fluids for a resident at risk for dehydration. This applies to 1 of 2 residents (R30) reviewed for hydration in the sample of 37. Findings include: R30's EMR (Electronic Medical Record) showed R30 had multiple diagnoses including recurrent urinary tract infections, a disorder of the kidney and ureter, neuromuscular dysfunction bladder, urinary retention, constipation, and parkinsonism. R30's MDS (Minimum Data Set) dated 5/09/2024 showed she was cognitively intact. R30's MDS continued to show she was dependent on facility staff for assistance with feeding including drinking liquids. On 8/20/2024 at 10:57 AM, R30 was in bed and said she was not getting enough water. R30 said she was having urinary discomfort and was waiting for her urine results. R30 had no water at the bedside but had a tub of thickener mixing powder. On 8/21/2024 at 11:30 AM, R30 was in bed with no water at the bedside. At 12:30 PM, R30 said she wanted to have water to drink. R30 said she was fed lunch and drank one cup of milk but did not have water. R30 did not have water at the bedside. On 8/22/2024 at 9:50 AM, R30 said she was still not receiving enough drinking water and wanted more. R30 said she only receives a small cup of lemon-thickened water with her medications. R30 said she would like to be given more lemon-thickened water throughout the day. R30 did not have water at the bedside. On 8/22/2024 at 9:53 AM, V13 (Head Unit Nurse) said staff should be offering fluids to residents between meals. V13 said residents who are in their rooms should have a water pitcher at the bedside. V13 said for those with thickened liquids they have available premade thickened liquid drinks. V13 said R30 had frequent recurrent urinary tract infections and needed more fluids. V13 said they would place lemon-thickened water at R30's bedside and offer her more fluids. On 8/22/2024 at 11:12 AM, V12 (Assistive Director of Nursing/ADON) said all residents who can drink oral fluids should be offered fluids because they are all at risk for dehydration. V12 said R30 should have been offered fluids and staff should assist her because of her swallowing precautions. R30's Care Plan dated 8/22/2024 showed multiple focus problems including a potential nutritional problem and an actual impaired urinary elimination problem. R30's care plan showed multiple interventions including Offer preferred foods/fluids within diet recommendation when possible and Encourage fluids during the day to promote prompted voiding response. R30's Annual Nutritional assessment dated [DATE] said R30's diet included moderately honey thick liquids. R30's assessment showed R30's estimated fluid needs were 2050-2100 milliliters and should be encouraged to consume moderately honey-thick liquids. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's urinalysis lab result dated 8/20/2024 showed an abnormal urine result. The facility's policy titled Hydration Plan with a revised date of 3/2024 said Purpose: To provide residents with adequate water and fluids throughout the day to maintain proper hydration. Policy: It is the policy of DPCC to maintain resident's health at the highest level. The procedure contained in the policy will ensure that all residents will have access to ample water and liquids to maintain the proper levels of hydration required .Procedure: A. 1. The Nurses will: Offer residents/patients a full glass of water with the medication pass .Monitor residents that are acutely ill that require increased hydration due to possible elevated temperatures or infections that demand more fluids to improve their conditions .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46409 Based on observation, interview, and record review, the facility failed to change, date, and label a feed tubing for an enteral feed for a resident with a gastrostomy tube (G-tube). This applies to 1 of 1 (R68) resident reviewed for gastrostomy tubes in a sample of 37. The findings include: On August 20, 2024 at 11:23 am, R68 was connected to her feeding via the gastrostomy tube and was receiving it at a rate of 50 milliliters per hour. R68's bottle of formula was dated August 19, 2024 at 4 PM and the tubing was dated August 15, 2024 at 9:53 PM. On August 21, 2024 at 11:32 AM, R68's feed tubing was not labeled or dated. On August 22, 2024 at 11:34 AM, V26 (RN/Registered Nurse) said the G-tube pump tubing was changed whenever a bottle was opened. V26 said the tubing should not be used for more than 24 hours. V26 also said the tubing needed to be dated and labeled. On August 22, 2024 at 1:16 PM, V35 (RN) said when the staff start a feeding, all the equipment needs to be brand new. V35 said the tubing and bottle need to be changed every 24 hours, or more frequently, depending on when the bag is changed. V35 said the tubing should also be dated. On August 22, 2024 at 9:39 AM, V2 (DON/Director of Nursing) said the gastrostomy feed tubing should be dated, but said for changing the tubing, she would need to double check the policy for when the tubing should be changed. As of August 23, 2024 at 3:30 PM, V2 was unable to provide a policy regarding when the tube feeding tubing should be changed. R68's face sheet showed she was admitted to the facility with diagnoses including gastrostomy status. R68's MDS (Minimum Data Set) dated August 14, 2024 showed R68 had severe cognitive impairment and was dependent on staff for eating. R68's POS (Physician Order Sheet) showed Enteral Feed Order Check tube placement before initiation of formula, medication administration, and flushing tube. The Manufacturer Guidelines for Ready-To-Hang Prefilled Enteral Feeding Containers provided by the facility, dated 2010, showed Proper identification and dating are essential for patient safety. Use formula, container, and tubing for 24 hours, or up to 48 hours after initial spike, when clean technique and only one new feeding set are used.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on interview and record review the facility failed to provide documentation of monthly medication reviews and obtain a documented physician response to pharmacy recommendations. This applies to 1 of 5 residents (R141) reviewed for unnecessary mediations in a sample of 37. Findings include: R141 admitted to the facility on [DATE] with diagnoses that includes paraplegia, neuralgia, cramp / spasm, diverticulosis, hypertension, depression, anxiety, and insomnia. R141's MDS (Minimum Data Set) dated 7/17/24 shows he is cognitively intact with a BIMS (Brief Interview for Mental Status Score) of 15. On 8/21/24 at 3:47 PM, V7 Pharmacy Manager stated he did not have documentation of the medication review done on 3/16/24 or 6/24/24. Pharmacy recommendations made on 11/27/23 did not have a physician response. On 8/22/24 at 9:53 AM, V7 Pharmacy Manager stated pharmacy recommendations are sent to the units for the physician to address when they round. Nursing is responsible for following up with the physician to address our recommendation. We do not have a policy to address the time frame in which the physician should respond to our recommendations. Pharmacy will send a follow up by the next review if we have not had a physician response. The pharmacy recommendation on 11/27/23 for Citalopram Hydrobromide continue at a reduced dose: maximum dose in the elderly (those over [AGE] years) is 20mg per product labeling due to the risk of QT prolongation. Please consider a dose reduction to 20mg if possible. V7 Pharmacy Manager stated a prolonged QT can cause arrhythmias in the heart if R141 has risk factors. The physician response provided by V43 Psychiatrist on 12/4/23 states not followed by me. Please refer to V42 PCP (Primary Care Physician). V7 Pharmacy Manager did not provide documentation of V42 PCP response to recommendations from 11/27/23 or documentation of pharmacy follow up with V42 PCP regarding recommendations. On 8/22/24 at 1:14 PM, V2 DON (Director of Nursing) stated the pharmacy delivers the monthly medication review to the head nurse or the charge nurse who should present it to the physician for review. V2 DON stated policy directing the time frame in which a physician should address pharmacy recommendations. V2 DON stated the physician or nurse practitioner make their rounds in the facility daily. V2 stated her expectation is that if the physician has not made rounds or addressed the pharmacy recommendations the nurse should contact him within a week. R141's current physician's orders show an increase of Citalopram Hydrobromide from 30MG (Milligrams) daily to Citalopram Hydrobromide 20MG twice daily. The facility provided policy Prescribing of Medications dated 8/2022 states if there is a question regarding an order, the pharmacist may contact the physician directly for clarification and, if necessary, may write a clarification on the patient's medical record. All current residents will undergo a monthly drug regimen review. Completion of review will be documented by the pharmacy manager or designee.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48944 Based on observation, interview, and record review, the facility failed to date and discard as indicated insulin vials when opened. The facility failed to store medications in their original packaging until they were administered. This applies to 8 of 8 residents reviewed (R104, R96, R160, R197, R75, R121, R146, R73) for medication storage in the sample of 37. Findings include: 1. On 8/20/2024 at 3:40 PM, V9 (RN/Registered Nurse) was asked to check the fourth floor's medication room for medication storage. V9 said R73's opened and filled Levemir insulin vial was not dated with the open date. V9 said R146's opened and filled Fiasp insulin vial was not dated with the open date. V9 said R121's opened and filled Lantus insulin vial was not dated with the open date. V9 said R75's opened and filled Fiasp and Glargine insulin vials were not dated with the open dates. V9 said insulin vials should be dated when they are opened for proper medication storage. On 8/20/2024 at 4:40 PM, V11's (Licensed Practical Nurse/LPN) medication cart was checked for medication storage. V11 said R197's opened and filled Lantus insulin vial package said do not use after 8/12/2024. V11 said R160's opened and filled Humalog insulin vial package said do not use after 8/12/2024 and opened and filled Lantus insulin vial package said do not use after 8/18/2024. V11 said insulin vials should be discarded after the indicated do not use after date and new insulin vials should be obtained. 2. On 8/20/2024 at 4:07 PM, V10's (RN) medication cart was checked for medication storage. V10's cart had 9 pills that were loose in a clear medication cup. V10 said she removed R104's scheduled 5 PM and 9 PM medications from their packages and poured them into a medication cup. V10's cart had another 5 pills that were loose in a clear medication cup and another medication cup with a loose white powdery substance. V10 said she removed R96's scheduled 9 PM medications and Miralax powder dose. V10 said she should have not removed R104 and R96's medications from their packages before their scheduled administration times and should have not stored them in the medication cart. On 8/20/2024 at 5:00 PM, V12 (Assistive Director of Nursing/ADON) said nurses are expected to label insulin vials once opened and discard them accordingly to ensure safe medication storage and administration. V12 continued to say medications should be prepared when scheduled, administered once prepared, and not be stored in the medication carts once removed from their packages to ensure safe medication storage and administration. The facility's policy titled Medication Administration with a revised date 10/2023 said Purpose: The purpose of this policy is to assure that all medications are administered safely .Standard of Practice 8. Medications will be destroyed or disposed of in accordance with facility policy and regulatory guidelines .Procedure 6. a. Check multi-dose vials for dates: When it was first opened, and what is the last date it may be used. b. If label does not contain these 2 dates, return medication to pharmacy .Storage of Medications 1. Medications are stored in manufacturer's containers until repackaged by pharmacy .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906 Based on observation, interview, and record review, the facility failed to properly label/date/seal/store items, remove expired items, and perform hand hygiene while in the facility kitchen. This applies to all residents that receive oral nutrition and foods prepared in the facility kitchen. Findings include: The facility's Long-Term Care Facility Application for Medicare and Medicaid (Form CMS-Centers for Medicare and Medicaid Services-671) dated [DATE] documents that the total census was 211 residents. On [DATE] at 1:16 PM, V39 (ADON/Assistant Director of Nursing) said there are 6 NPO (Nothing by Mouth) residents; all other residents eat from the facility kitchen. On [DATE] starting at 10:19 AM, V23 (Chef) was observed pureeing lunch items. After V23 pureed the chicken, she removed her gloves, pulled the garbage can out from under the counter with her bare left hand (while touching the rim of the garbage can) and threw away her gloves with her right hand. V23 then put on a new pair of gloves and did not wash her hands after touching the garbage can. V23 then put some of the roast beef and gravy into the blender to puree it. After V23 pureed the first batch of roast beef, she scooped out the rest of the not yet pureed roast beef with her gloved left hand and moved it into another silver container. V23 then grabbed a spoon, and with her gloved left hand she pulled down her face mask to taste test the consistency of the roast beef from the spoon in her right hand. After taste testing the roast beef consistency, V23 then pulled her mask back up over her nose and mouth with her gloved left hand and proceeded to puree the rest of the roast beef. V23 then poured the rest of the pureed roast beef into the silver container and covered it in plastic wrap while using her same gloved hands to touch the blender, the plastic wrap, and the steamer door handle. V23 did not wash her hands throughout the process of pureeing the chicken and roast beef after touching the garbage can and her face mask. On [DATE] starting at 10:40 AM, the facility kitchen was toured in the presence of V22 (Dietary Manager). The following was found: In the dry storage: 1. A large undated and unsealed bag labeled crispy onions. 2. A large undated and unsealed bag labeled croutons. In Cooler #2: 3. A 4 ounce package of sliced roast beef deli meat with a use by date of [DATE] and a handwritten date of [DATE]. V22 (Dietary Manager) said he was not sure why the kitchen staff wrote [DATE] on the package and he would find out when the roast beef was served. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:16AM, V22 said the roast beef was served to residents on [DATE]. V22 said the roast beef was labeled with the wrong date. On [DATE] at 12:43 PM, V22 said all food items in the kitchen should be labeled, dated, and sealed to keep the food fresh and safe to feed the residents. V22 said unsealed items are a concern because they can become contaminated by environmental contaminants. V22 said deli meat is safe in the refrigerator for 7 days, and if the package is unopened, the deli meat should be thrown away on the use by date. V22 said the unopened roast beef deli meat should have been discarded on [DATE]. V22 said it is a concern to have deli meat improperly dated because of the risk of serving it to the resident past the use by date with the potential to make the residents ill. V22 said the kitchen staff should wash their hands with soap and water after touching the garbage can to prevent food contamination. V22 said the kitchen staff should wash their hands with soap and water after touching their face mask to prevent cross contamination. V22 said staff should never touch the food with their gloved hands and should always use a utensil to prevent food contamination. The facility's policy titled Hand Hygiene last reviewed on ,d+[DATE] states, Purpose: To provide guidelines for hand hygiene and prevention of infections. To promote compliance with regulatory guidelines for hand hygiene. Policy: All healthcare workers and visitors will follow facility guidelines for hand hygiene .Procedure: Traditional soap and water method. Hand hygiene is the single most effective procedure for reducing the spread of infectious organisms and cross-contamination .Following is a list of some situations that require hand hygiene: Before & After: .Eating/handling food (hand wash with soap & water) . After: .Handling soiled equipment or utensils . Removing gloves or aprons The above lists do not include all opportunities to wash your hands, Remember to follow the hand hygiene guidelines anytime you question if contact with a source of contamination did occur. The facility's policy titled Labeling, Dating, and Storage of Food Items last reviewed ,d+[DATE] states, Purpose: To ensure food is labeled, dated, and stored properly. Policy: Dining staff will label, date, and store food items properly per standard sanitation procedures. Procedure: .2. All food items will be labeled with a receiving date that correlated with the month and day received. 3 .a. Any package opened for food production will be labeled with an open date and sealed airtight prior to it being placed back into food storage locations .5. All food storage areas will be monitored regularly to discard any outdated food items from inventory stock.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409 Based on observation, interview, and record review, the facility failed to use appropriate PPE (Personal Protective Equipment) for a resident on EBP (Enhanced Barrier Precautions) and failed to do proper hand hygiene to prevent the spread of infection. This applies to 5 of 5 residents (R68, R41, R155, R364, R365) reviewed for infection control in a sample of 37. The findings include: 1. On 8/20/24 at 11:23 AM, V27 (CNA/Certified Nurse Assistant) was providing personal hygiene and incontinence care for R68. R68 was on EBP due to having a G-Tube (Gastrostomy Tube). V27 applied a gown and gloves and provided incontinence care to R68, who had stool and urine in her disposable brief. V27 wiped the urine and stool off R68, then took a new incontinence brief and applied it under R68. V27 did not change her gloves or perform hand hygiene when going from the dirty brief to the clean brief. At 11:48 AM, V27 left R68's room without removing the PPE to throw the dirty linen bag in a container in the hallway. At 11:49 AM, V27 returned to the room and applied new PPE and entered R68's room, and then left the room again with all the PPE on. V27 returned with the same PPE on, washed her hands, and assisted V28 (CNA) with personal care for R68. On 8/21/24 at 1:48 PM, V25 (CNA) was providing personal hygiene and incontinence care to R68. V25 was not wearing a gown during personal care for R68. R68 had a soiled incontinence brief, and V25 provided incontinence care, and when going from dirty to clean, did not change her gloves or perform hand hygiene. On 8/21/24 at 2:40 PM, V25 said R68 was on EBP, and she should have worn the gown, gloves, and a mask when providing care. On 8/21/24 at 2:19 PM, V29 (RN/Registered Nurse) said R68 was on EBP due to having a G-Tube and so the staff needed to wear a gown and gloves for high contact activities. On 8/22/24 at 1:01 PM, V33 (CNA) said the staff should wear a mask, gown and gloves when giving care to a resident in EBP. V33 said the used PPE needed to be removed when you are about to leave the room. On 8/22/24 at 1:16 PM, V35 (RN) said when providing care for residents under EBP, staff need to wear a gown and gloves before entering the room, and before leaving the room, all the PPE needed to be removed, and hands needed to be washed. On 8/22/24 at 9:39 AM, V2 (DON/Director of Nursing) said if a resident is on EBP and the staff are providing care, the staff needed to wear a gown and gloves. V2 said the PPE should not be worn outside the rooms, and should be taken off while in the room, and handwashing needed to be performed. R68's face sheet showed she was admitted to the facility with diagnoses including gastrostomy status. R68's MDS (Minimum Data Set) dated August 14, 2024 showed R68 had severe cognitive impairment and was dependent on staff for all activities of daily living. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Enhanced Barrier Precautions policy dated August 2023 showed EBP as a routine approach to infection control is based on the recognition that Standard Precautions, which requires the use of gown and glove in situations of expected exposure to blood, body fluids, skin breakdown, or mucous membranes, often have not been successfully implemented in nursing home settings. Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (Multi-Drug Resistant Organisms) to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. EBP should be maintained for the entire resident's stay or until 1) Wound(s) have healed; 2) Indwelling medical devices are no longer present. In addition to following Standard Precautions gowns and gloves should be worn during the following: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs, or assisting with toileting, Device care or use, and Wound care. 41384 2. On 8/20/24 at 1:53 PM, V15 and V16 CNAs (Certified Nurses' Assistants) were providing incontinence care for R155. V15 and V16 with gloved hands, used a mechanical lift to assist R155 to a standing position and transport her to the toilet. They then lowered R155's pants and removed her soiled brief. R155's brief was soiled with stool and urine. V15 with gloved hands wiped R155's buttocks 5 times with the same wet towel and did not turn or fold the towel as he attempted to clean her buttocks of stool. After V15 was done cleaning R155's buttocks, he left the bathroom with his dirty gloved hands and opened R155's bedroom door, left the room, returned back to the room with plastic bags. V15 then put the soiled brief and towels in the bags, attached a clean brief and pulled R155's pants back up and then used the mechanical lift control to bring R155 back to her wheelchair. After getting R155 in her wheelchair V15 then untied R155's call light from her bedrails, moved R155's wheelchair closer to her call light and then took the plastic bags out of the room, all while still wearing his dirty gloves. V15 then put the plastic bags in 2 different containers in the hall and then removed his gloves and threw the dirty gloves in one of the containers in the hall and then cleaned his hands using the hands sanitizer on the wall next to the container. On 8/22/24 at 11:19 AM, V2 (DON) said that it is her expectation that during incontinent care staff will change their gloves and clean their hands when going from a dirty area to a clean area. It is her expectations that staff will wipe from front to back and after wiping fold the towel before wiping again. V2 said that this is to be done to prevent infections, UTIs (urinary tract infections), and cross contamination for infection control. 46380 3. On 8/20/2024 at 10:41 AM, V36 (CNA-Certified Nurse Assistant) was providing bladder and bowel incontinence care to R41. After V36 cleaned R41's feces, V36 did not change her gloves and continued to apply a fresh incontinent brief. With the same soiled glove, V36 continued to assist R41 with putting on clothes. Using the same soiled gloves, she combed and flatten R41's hair. When V36 was done assisting R41 with grooming, V36 took off her gloves and did not perform hand hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER: Dupage Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 400 N County Farm Rd Wheaton, IL 60187	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R41's MDS (Minimum Data Sheet) documents a BIMS (Brief Interview for Mental Status) of 6 which means R41 had severe cognitive impairment. R41 is also dependent on staff for toileting, personal hygiene, and upper and lower body dressing. R41 is always incontinent of bowel and bladder. R41's care plan dated 3/28/2024 documents that she is at risk for infection with intervention to educate resident/representative on techniques to prevent infection, such as handwashing, adequate rest, nutrition, and avoidance of crowds. 4. On 8/21/2024 at 9:13 AM, with bare hands, V37 (CNA) was observed inside R364's room tying a garbage bag with soiled incontinent pad . V37 took the garbage out of R364's room. In the hallway, V37 proceeded to double bag the garbage and put the garbage in a bin. Without performing hand hygiene, V37 proceeded to go inside R364's room and took out her meal tray, opened the meal cart which was in front of the nurse's station and put the meal tray inside the cart. R364's face sheet documents diagnosis of ESBL (Extended Spectrum Beta Lactamase) resistance in urine. R364 was on contact isolation. MDS dated [DATE] documents R364 is frequently incontinent of bowel and bladder and is dependent on staff for personal hygiene. R364's care plan did not address what staff should do to prevent infection. 5. On 8/21/2024 at 9:40 AM, R365 was observed being wheeled into the therapy room. On 8/22/2024 at 10:33 AM, R365 said she goes out to therapy early in the morning every day. She said she does not wash her hands before heading out with therapist. She said staff does not help her wash her hands before she goes to therapy. She said maybe staff thinks her hands are clean. R365's face sheet documents diagnosis of enterocolitis due to CDIFF (Clostridium Difficile) and is currently on contact isolation. R365's MDS dated [DATE] documents her BIMS score is 15 which means that she has intact cognitive functions. She is occasionally incontinent of bowel and bladder and needs partial or moderate assistance with toileting hygiene and personal hygiene. On 8/22/2024 at 10:58 AM, V32 (Therapy Program Manager) said R365 goes to the gym for therapy daily. On 8/22/2024 at 11:10 AM, V12 (ADON-Assistant Director of Nursing) said residents on contact isolation are permitted to go out of their rooms as long as incontinent care is rendered before going out of the room and residents wash their hands before going out of the room. R365's care plan did not address what staff should do to prevent infection. On 8/22/2024 at 1:14 PM, V38 (IP-Infection Preventionist) said she expects staff to perform hand hygiene before going inside a resident's room and before coming out of the room and in between providing care for patients. She said there are five steps staff needs to follow for hand hygiene. Steps are hand hygiene, put on gloves, do task, remove gloves, hand hygiene. She said hand hygiene can either be washing hands with soap and water or applying hand sanitizer. She said during peri care, staff should change gloves from dirty to clean and clean to dirty because it puts resident on higher risk for infection. She said when proper hand washing is not done on a resident with CDIFF before going out of room, there is a good chance of the CDIFF spore to spread. She said if proper handwashing is not done when needed during care, bacteria might spread to other residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dupage Care Center	400 N County Farm Rd Wheaton, IL 60187

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's Contact Isolation Policy dated 7/2002 and reviewed 9/2023 states the following: .Policy: .Contact Isolation is an isolation category designed to prevent transmission of highly contagious or virulent infections that may be spread by direct contact. These precautions are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions are needed to interrupt transmission in the facility. Procedure .3. Hand washing is indicated before and after resident contact. Hand hygiene should be performed after glove removal before leaving the resident's environment. Use an antimicrobial agent or waterless antiseptic. Facility's Hand Hygiene Policy dated 5/11/2010 and reviewed on 3/2024 states the following: . Hand hygiene is the single most effective procedure for reducing the spread of infectious organisms and cross contamination. Following is a list of some situations that require hand hygiene.Upon and after coming in contact with resident's intact skin . before moving from work on a soiled body site to a clean body site of the same resident . after handling soiled or used linens, dressings, bedpans, catheters, and urinals.After emptying garbage cans, waste baskets.