

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/11/2025
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interview and record review, the facility failed to provide residents their meal trays with others seated at the same table. This applies to 6 of 9 residents (R25, R62, R116, R153, R161, and R165) observed for dining in the sample of 35. The findings include: On September 8, 2025, at 12:09 PM during lunch meal observation on the first floor, 1 (one) North dining room, several residents were noted eating their meal when others on the same table had not received their meal tray. R160 was fed by V9 CNA (Certified Nursing Assistant) and had almost finished her meal, whereas R161 and R25 who were seated at the same table and had not received their meal trays. On a separate table in the same dining room, R68 was eating her lunch and R165 and R116 who were seated at the same table were looking on. On inquiry why R25, R116, R161, and R165 did not get their trays at the same time as other residents on the same table, V10 (Certified Nursing Restorative Aide) stated that these residents' trays are on the second cart, and it has not yet arrived. On September 8, 2025, at 12:29 PM, on another table, R90 was fed by V11 (CNA). R153 and R62 who were seated at the same table were looking at R90 being fed. When asked if she had finished eating, R62 stated that she has not received her tray. On September 8, 2025, at 12:32 PM, when R68 received her tray from the second cart, R90 had finished his meal. On September 10, 2025, at 10:51 AM, V12 (Food Service Manager) stated that the first cart should be delivered to the 1 North unit at 11:25 AM and the second cart delivered at 11:57 AM. V12 stated that the kitchen sends the second cart later so that the residents eating at the second seating can get hot food. V12 stated that the nursing communicates with the dietary via email on which residents to put in the first cart so that the residents can eat together. On September 10, 2025, at 11:59 AM, V2 (Director of Nursing) stated that her expectation is that the residents seated at the same table should be served together. V2 added that this is because How would you feel if the other person is eating when you are not. V2 stated that the nursing staff has to coordinate with V12 to change the meal trays that are placed in the first cart. Facility policy titled Tray Delivery Schedule (revised May 2025) included-Purpose: To communicate a tray delivery schedule aiding interdepartmental planning. Procedure: 1 North 11:25 [AM], 11:57 [AM]. Facility Census Roster showed that R25, R62, R68, R90, R116, R153, R160, R161, and R165 resided in the 1 North unit.		

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
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to change a wound dressing as ordered by the physician and the facility failed to prepare medications per facility policy. This applies to 4 of 35 residents (R134, R165, R177, R195) reviewed for quality of care in the sample of 35. The findings include:1. R134's EMR (Electronic Medical Record) states R134 is 93 years-old who has multiple medical diagnoses including unspecified open wound, right lower leg, initial encounter. On September 8, 2025, at 11:25 AM, R134 was in her bedroom sitting on her wheelchair. R134's right leg was covered with elastic bandage which was stained with red and brown color discharges on the lateral area of her right leg. V23 (4th Floor Head Nurse) stated R134 has venous stasis ulcer on her right leg. On September 9, 2025, at 10:51 AM, V21 (Wound Care Nurse) rendered wound care to R134 venous stasis ulcer in the right leg. R134's Unna Boot dressing was stained with new and old dry discharge which overflowed to the elastic bandage. The stain size was about 5 centimeter (cm) in length by 5 cm in width 5 on the elastic bandage. R134 stated that it was last changed on Sunday (September 7). On September 9, 2025, at 11:00 AM, as V21 was changing the dressing, V21 said the wound was a venous stasis ulcer, they change the dressing every Tuesday, Thursday, and Saturday and as needed when the dressing is soiled like this. V21 said the wound has sero-sanguinous discharges. V21 cleansed the wound with normal saline, wrapped the leg with Unna boot and secured with elastic wrap bandage. V21 also stated that he changed the dressing on Sunday because the dressing from Saturday was very soiled. R134's POS (Physician Order Summary) report shows: Right lateral leg wound- cleanse with NS (normal saline), apply Unna boot secure with elastic wrap three times a week, every Tuesday, Thursday, Saturday, and as needed for wound care. R134's care plan shows R134 has Venous Stasis Ulcers of the right lower extremity related to venous insufficiency, chronic kidney disease (CKD), and Obesity. The same care plan shows multiple interventions including administration of treatment as ordered. On September 10, 2025, at 12:21 PM, V2 (Director of Nursing/DON) stated that a wound can't be left with a soiled dressing. If the discharge was already seeping out, then the dressing should be change. 2. R165's EMR (Electronic medical record) showed R165 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder and vascular dementia unspecified severity with anxiety. 3. R177's EMR showed R177 was admitted to the facility August 15, 2025, with diagnoses mild protein calorie mild nutrition, depression unspecified and chronic kidney disease. 4. R195's EMR showed R195 was admitted to the facility September 14, 2017, with diagnoses Cerebral Palsy, Parkinsons disease without dyskinesia, without mention of fluctuations, Unspecified abnormality of gait and mobility, and unspecified mental disorder due to known psychological condition (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On September 10, 2025, at 1:40 PM, V16 (RN, Registered Nurse) V16 was preparing medications in the medication room. V16 proceeded to pull out a medication cup and placed it on the top of the medication cart. V16 then opened a drawer pulled a package of medication for a resident and poured the medication into a medication cup and wrote R165's last name on the cup. V16 threw the package in the garbage. V16 opened another drawer pulled out another package of medication opened it, poured it into another medication cup and wrote R177's name on the outside. She then threw the package in the garbage. V16 went to another drawer for a different resident and pulled out the medication package and poured the contents in the medication cup into a different cup writing R195's last name on the cup discarding the package in the garbage. V16 took all three cups and placed them in an empty drawer and put them to the side. V16 was asked the names of the residents and what medications were poured in the medication cups. R165 was administered Depakote 125mg tab, order to be given one time a day. R177 was administered Magnesium Oxide 400mg tablet, order to be given one time a day. R195 was administered baclofen 10mg tablet, Carbidopa Levodopa 25-100mg tablet, and Gabapentin capsule 300mg, order to be given three times day. On September 10, 2025 at 2:45 PM, V2 (DON/ Director of Nursing) stated her expectation for a medication pass was that the nurse takes the medication cart to the resident's room, the nurse is to check the EMAR (Electronic Medication Administration Record), pull the medications out of the drawer, check the five rights of medication administration, check any parameters (ex. blood pressure, pulse) and give the medication. V2 said she does not recommend the nurses prepare multiple resident's medications at the same time because there be some confusion. V2 said the nurses are not to pre-pour the medications. The facility provided their policy titled Medication Administration with a revision date July 2024, showed Preparation of medication.2. Tablets/capsules a) Tear open individual packets and place directly into soufflé cup at time of administration. Pre-pouring is a practice that puts patient at risk for med error that may cause actual harm. Pre-pouring is not allowed.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to provide a device or equipment for a resident with a limited range of motion to prevent potential further decrease in the range of motion (ROM). This applies to 1 of 8 residents (R9) reviewed for range of motion in the sample of 35. The findings include: R9's Face sheet shows that R9 is 75 years-old who has multiple medical diagnoses which include hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, aphasia following cerebral infarction, vascular dementia without behavioral disturbance, and weakness. MDS (Minimum Data Set) dated July 25, 2025, shows that R9 is cognitively impaired and totally dependent on staff for ADL (activities of daily living) care. On September 8, 9, and 10, from 9:30 AM through 1:30 PM, R9 was observed multiple times. R9 was in bed and non-verbal. R9's left hand noted in one position, it was slightly closed with the index and middle fingers in straight position while the ring and other fingers were bent to the joints. There was no splint or palm protector on her hand. V23 (4th Floor Head Nurse) stated that R9 is confused and requires total assistance with activities of daily living care. On September 10, 2025, at 11:33 AM, V20 (Physical Therapist/PT) assessed R9. V20 said that R9 has locked-in syndrome related to CVA (Cerebrovascular Accident). V20 tested the range of motion of R9's left fingers and stated that the metacarpal phalanges (MCT) were within normal limits, her wrist and thumb were good, the index and middle fingers were good but slightly stiff because of the dystonia, while the fourth and pinky fingers has tightness. V20 also said that R9 may benefit from a palm protector or a carrot, to open the hand and fingers and prevent skin irritation. Restorative notes dated September 10, 2025, at 12:26 PM shows: Resident assessed by PT for hand contracture management with new recommendation of Left-hand protector to be applied at bedtime for 6 hours daily, perform PROM before and after application. noted and carried out. Granddaughter updated (1st contact person) left message to voice mail. Physician Order summary (POS) report dated September 10/2025 shows: Palm protector on the Left hand for 6 hours Apply at bedtime for Left hand Perform PROM before and after application for contracture management and remove per schedule.		

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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. Based on observation, interview, and record review, the facility failed to implement feeding interventions to ensure safety for a resident (R173) while eating meals. This applies to 1 (R173) of 35 of residents reviewed for accidents and supervision in the sample of 35. The findings include: R173's electronic medical record showed R173 has diagnoses that include dementia, anxiety, retention of urine, depression, cochlear implants, and dysphagia, oropharyngeal phase. R173 Minimum Data Set showed R173 to be severely cognitively impaired and dependent on staff for eating and all activities of daily living (ADL). R173's care plan dated February 11, 2025, showed that R173 has a need for hands on feeding assistance. R173 ADL care plan dated 2/26/2024 showed that R173 required purple swallow assistance- pureed diet with thick liquids, and standard swallow precaution as follows: eat only when alert, sit upright, small sips/bites, eat drink slowly. On September 8, 2025, at 11:40 AM, R173 was observed sleeping in the dining room. On September 8, 2025, at 12:37 pm observed still sleeping then V19 (Registered Nurse/RN) wheeled R173 to table and at 12:40 PM began feeding resident a pureed diet. R212 had to constantly tell R173 to wake up, open eyes, and swallow. Spoons of food put in resident's mouth were just sitting in R173 mouth as R173 stopped swallowing and working food through her mouth. Food streamed out of resident's mouth at these times and resident pocketed food. V19 kept telling resident to wake up, swallow, and to open her mouth. At times R173 head slumps to the side and V19 tells R173 to wake up and rubs R173. R173's eyes were closed, and she did not speak during the feeding. V19 stated R173 is always sleepy, but sometimes she is alert. On September 9, 2025, at 12:35, V22 (Certified Nursing Rehab Assistant) was feeding R173. On September 9, 2025, at 1:02 PM, V22 stated that R173 is always sleepy and sometimes they can't get R173 out the bed because R173 is so sleepy. On September 10, 2025, at 9:19 AM, V8 (Speech Language Pathologist) stated R173 doesn't take a spoon of food well. V8 stated R173 is always sleepy and never opens her eyes. V8 stated when feeding R173 the resident should stay alert. V8 stated food can remain in R173's mouth and there is a risk of aspiration if she is fed while not awake and alert. V8 stated Purple Swallow is a program the facility has implemented to identify those residents who are a high aspiration risk and R173 is on the Purple Swallow program. On September 10, 2025, at 9:30 AM V7, (Medical Director) stated he was not aware resident was sleeping a lot. V7 stated the staff told him that R173 is a quiet person. V7 stated it is basic nursing care knowledge not to feed someone who is sleeping for risk of aspiration. On September 10, 2025, at 2:50 PM, V2 (Director of Nursing) stated that staff should not feed R173 if she is sleeping. R173's diet meal tickets alert staff that she is on the Purple Swallow program. R173's Tasks ADL Log showed the following: Purple Swallow-Diet Mechanical solids/nectar thick liquids. Individual Instruction-no straws. Double swallow. Swallow support level: Assistance. Standard Swallow Precautions: eat only when alert, sit upright, small sips/bites, eat drink slowly.		

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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** Based on interview and record review, the facility failed to put nutrition interventions in place in a timely manner for a resident with significant weight loss. This applies to 1 of 5 residents (R14) reviewed for nutrition in the sample of 35. The findings include: The EMR (Electronic Medical Record) showed R14 was admitted to the facility on [DATE], with multiple diagnoses including sequelae of cerebral infarction, vascular dementia, and chronic obstructive pulmonary disease. R14's MDS (Minimum Data Set) dated June 13, 2025, showed R14 had severe cognitive impairment. The MDS continued to show R14 did not have a behavior of refusing care. R14's nutrition care plan dated September 26, 2023, showed [R14] has potential nutritional problem related to vascular dementia, depression, anxiety may affect meal intakes. Diagnoses sequelae of cerebral infarction, hypertension. Diagnosis chronic obstructive pulmonary disease. Diagnosis hypothyroidism. The care plan continued to show multiple interventions dated September 26, 2023, including Monitor weight per facility protocol and record. Notify physician, registered dietician of significant weight changes, sudden weight loss. The care plan showed an intervention dated August 27, 2025, for Provide and serve supplements as ordered: super cereal with breakfast, super potatoes with lunch and super pudding with dinner daily. R14's EMR showed the following weights: July 2, 2025, at 11:59 PM, 172 pounds; July 5, 2025, at 12:52 AM, 172 pounds; August 2, 2025, at 12:01 PM, 154.9 pounds; August 2, 2025, at 3:46 PM, 154.9 pounds and; September 5, 2025, 2:59 PM, 154 pounds. R14's weights showed R14 experienced a significant weight loss of 9.94% (percent) in one month from July 2, 2025, to August 2, 2025. A Nutrition/Dietary note dated August 27, 2025, at 9:52 AM, by V14 (DTR/Dietetic Technician Registered) showed Nutrition High Risk Note: [R14] had an August weight completed, a re-weigh was requested, no re-weigh available at this time. Using her recorded August weight of 154.9 pounds, this is noted to be a 9.9% weight loss in one month, a 9.9% weight loss in three months, and a 9.9% weight loss in 6 months; prior to the August recorded weight, her weight had been stable from January to July. Will add super cereal to breakfast, super potatoes to lunch, and super pudding to dinner daily for additional calorie intakes. Will review with September weight. She continues on the pureed diet texture for impaired swallowing and chewing abilities, continues with no straws. She is now fed by staff during meals. On September 10, 2025, at 10:42 AM, V14 said a resident's monthly weight should be obtained by the fifth of the month. V14 said if a resident's monthly weight showed a significant weight loss, then V14 asks for a reweigh to be obtained for the resident. V14 said she requested R14 be reweighed when R14's August weight showed a significant weight loss. V14 said she did not get a reweigh for R14 so on August 27, 2025, V14 implemented fortified foods as a nutritional intervention for R14's weight loss. V14 said she notified V24 (Registered Dietician) about R14's significant weight loss this week when V24 returned after being off of work from August 26, 2025, until September 8, 2025. On September 10, 2025, at 1:28 PM, V2 (DON/Director of Nursing) said if a resident's monthly weight shows a significant weight loss, then the resident should be reweighed. V2 said R14's EMR showed R14 was reweighed on August 2, 2025, and the reweigh showed R14's significant weight loss was an accurate weight. V2 said interventions to prevent R14 from experiencing further weight loss should have been implemented sooner than 25 days after the reweigh was obtained. The facility's policy titled Heights and Weights dated July 2025, showed Purpose: To provide objective data to assist in the assessment of resident nutrition status. Policy: it is the policy of [the facility] that admission weights and heights will be documented for all new residents. Subsequently, weights will be documented monthly, and heights measured annually, unless ordered at different intervals by the physician. Scope/Eligibility: All clinical staff and residents. Procedure: . 5. 5. Significant weight change of greater than 5% times 30 days, greater than 7.5% times 60 days, and greater than 10% times 180 days will be reviewed and assessed by the Clinical Nutrition Staff. Individualized intervention will be provided as needed. Physician order as needed. The Dietician will review each month.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to follow physician order for medication administration. There were 25 medication opportunities with 2 errors, resulting to 7.69% error rate. This applies to 2 of the 8 residents (R9, R13) reviewed for medication administration in the sample of 35. The finding include: 1. On September 9, 2025, at 9:44 AM, V17 (Nurse) administered multiple medications to R13 including Esomeprazole via gastric tube (g-tube). The Esomeprazole cup remained with decent amount of medication residuals after V17 completed the medication administration. R13's Medication Administration Record (MAR) dated September 2025 shows to give Esomeprazole 20 mg via g-tube once daily for GERD (gastroesophageal reflux disease). 2. On September 9, 2025, at 1:39 PM, V18 (Nurse) administered Rifampin oral suspension to R9. The thick Rifampin liquid suspension was mixed with water when V18 administered it to R9 via g-tube. However, V18 did not give the full dose of this antibiotic because there were still residues of this medication left from the medicine cup. R9's MAR dated September 2025, shows Rifampin Oral Suspension 10 mg/ml (milligrams per milliliter) to administer 60 ml (600 mg) via g-tube one time only for prophylaxis. On September 10, 2025, at 12:15 PM V2 (Director of Nursing/DON) stated that when the nurses administer medication, it is expected that they will follow physician orders, and the 5 rights principles of medication administration such as the right time, dose, patient, medication, and route.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a resident with a pneumococcal vaccine. This applies to 1 of 5 residents (R34) reviewed for immunizations in the sample of 35. The findings include: The EMR (Electronic Medical Record) showed R34 was a [AGE] year-old resident admitted to the facility on [DATE], with multiple diagnoses including dementia, type 2 diabetes mellitus, chronic kidney disease, and ventricular tachycardia. R34's Pneumococcal Vaccine Consent/Declination Form showed on June 23, 2025, R34's POA (Power of Attorney) consented for R34 to receive the pneumococcal vaccine. R34's Immunization Report dated September 10, 2025, showed R34 did not receive the pneumococcal vaccine until September 9, 2025. On September 10, 2025, at 1:17 PM, V2 (DON/Director of Nursing) said R34 received the vaccine on September 9, 2025, after V5 (ADON/Assistant Director of Nursing) started compiling the requested vaccination information, V5 saw R34 did not receive the pneumococcal vaccine so the facility administered the vaccine at that time. V2 said R34 should have received the vaccine sooner since the consent was obtained in June 2025. The facility's policy titled Pneumococcal Immunization Program reviewed July 2025, showed Purpose: The purpose of this policy is to provide guidelines for the initial administration, series updating, monitoring, documentation, data collection and analysis of pneumococcal vaccines used to prevent and reduce the incidence of pneumonia. Policy: Prior to or upon admission to facility documentation is to be provided about the resident's pneumonia vaccination status i.e. which vaccine received and date received. Determination of which vaccine is to be administered as well as any series requirement, will be based on the information provided. Pneumococcal vaccine is provided to residents as part of the facility immunization program. A physician's order is required. All residents are offered the pneumococcal vaccine and on a recurring basis when revaccination is needed based on resident prior vaccination status CDC (Centers for Disease Control and Prevention), clinical criteria and the physician's recommendations.		