

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2025
NAME OF PROVIDER OR SUPPLIER Wynscape Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 2180 Manchester Road 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 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. Based on observation, interview, and record review, the facility failed to remove expired medications. This applies to 6 of 6 residents (R5, R6, R14, R24, R25, R43) reviewed for medication storage in a sample of 18. The findings include: On 8/21/25 at 9:18 AM, the medication storage room had the following items: R25's Metoprolol Tartrate 50 MG (Milligrams) expired 12/31/24 with 30 pills remaining in the box., and R25's Flecainide Acetate 50 MG expired 3/11/25 with 30 pills remaining in the box. R25's face sheet showed she was admitted to the facility with diagnoses including cerebral infarction, paroxysmal atrial fibrillation, and cerebrovascular disease. R24's Phenazopyridine 100 MG expired 2/4/25 with 15 pills remaining in the box. R24's face sheet showed she was admitted to the facility with diagnoses including pain in left leg and generalized pain. R24's POS (Physician Order Sheet) showed an order for phenazopyridine 100 mg starting 2/3/24 as needed three times daily. On 8/21/25 at 9:23 AM, V3 (ADON/Assistant Director of Nursing) said the drawers in the medication room are for extra medications and they were checked once a week. V3 said the expired medication should be returned to the pharmacy to be destroyed. On 8/21/25 at 9:50 AM, a medication cart was checked and had the following items: R6's Novolog Insulin pen without a clear opened on date or expired on date. R6's face sheet showed she was admitted to the facility with diagnoses including type 2 diabetes mellitus. R43's Benzonatate 200 MG expired 1/4/25 with 10 pills remaining in the box. R43's face sheet showed he was admitted to the facility with diagnoses including congestive heart failure, hypothyroidism, and dementia. R14's Ondansetron HCl (hydrochloride) 4 MG with four tablets expired on 3/1/25 mixed in the same box with three tablets expired 2/2024. R14's face sheet showed she was admitted to the facility with diagnoses including congestive heart failure, dizziness and giddiness, and gastroesophageal reflux disease. R5's Hydralazine 50 MG expired on 4/11/24 with 33 pills remaining in the box, and R5's Gabapentin 100 MG with 42 pills dated 10/19/24 and three pills dated 2/23/24. R5's face sheet showed she was admitted to the facility with diagnoses including hypertensive heart disease, heart failure, low back pain, osteoarthritis, and hypertension. On 8/20/25 at 1:18 PM, V5 (RN/Registered Nurse) said she was unable to tell what the date was on R6's Novolog Insulin pen. V5 said they need to know the correct date because the pen was only valid for 28 days. On 8/21/25 at 10:04 AM, V2 (DON/Director of Nursing) showed Novolog insulin pens should be labeled with the initials of the staff who opened it, the opened-on date, and the expires-on date. On 8/21/25 at 1:55 PM, V8 (LPN/Licensed Practical Nurse) said there should not be expired medication in the cart. V8 said the medications with various expiration dates should not be mixed within the same box as they have different lot numbers, and it would be difficult to track if there was a recall. V8 said the staff should not be storing expired medication in the medication cart or the storage room. V8 said the pharmacy comes to the facility every afternoon and the expired medication should be returned to the pharmacy. V8 said there was a potential to give expired medication to residents if it was stored in the medication cart. The facility's Medication Labeling and Storage policy dated 2/2023 showed If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145213	If continuation sheet Page 1 of 4

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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 administer medications as ordered. There were 35 opportunities with 3 errors resulting in an 8.57% error rate. This applies to 2 of 3 residents (R38 and R6) observed in medication pass. The findings include: 1. On 8/20/25 at 8:22 AM, V6 (RN/Registered Nurse) was observed for medication pass for R38. At 8:37 AM, V6 took R38 his Breyna inhaler to him. V6 put the inhaler in R38's mouth and administered one puff of the inhaler and held it there for 10 seconds prior to removing the inhaler. V6 did not instruct R38 to take water, swish, and spit the water after administration of the inhaler. V6 also did not administer R38's Metformin 850 MG (Milligrams). R38's face sheet showed he was admitted to the facility with diagnoses including Type 2 diabetes mellitus and wheezing. R38's POS (Physician Order Sheet) showed an order for Symbicort 160-mcg-4.5 mcg/actuation aerosol (Breyna inhaler) dated 8/12/25. R38's Breyna medication packaging showed to rinse and spit after administration of Breyna inhaler. R38's POS also showed an order for pioglitazone 15 MG/Metformin 850 MG two times daily starting 7/31/25. On 8/20/25 at 2:44 PM, R38's medication cart was reviewed and showed a box for pioglitazone with a highlighted section showing to Take along with Metformin 850 MG. R38's medication cart did not have a box of Metformin HCL (Hydrochloride) 850 MG tablets. On 8/20/25 at 3:22 PM, V6 said she thought the pioglitazone was combined with the metformin and thought she had administered the combination medication. On 8/20/25 at 3:18 PM, V3 (ADON/Assistant Director of Nursing) said she found R38's Metformin 850 MG tablets in the medication room. At 3:23 PM, V3 said the staff probably put the medication in the medication storage room because they thought it was two boxes of the same medication. The FDA (Food and Drug Administration) label for Breyna showed it should be administered as 2 inhalations twice daily (morning and evening, approximately 12 hours apart), every day by the orally inhaled route only. After inhalation, the patient should rinse the mouth with water without swallowing. 2. On 8/20/25 at 8:51 AM, V6 prepared R6's Novolin insulin pen. V6 cleaned the tip of the pen, attached the needle, and primed the pen with one unit of insulin. V6 then clicked the pen to 5 units of insulin and administered it to the resident. R6's face sheet showed she was admitted to the facility with diagnoses including Type 2 diabetes mellitus. R6's POS showed an order for Novolog flexpen U (Unit)-100 insulin aspart 100 unit/mL (Milliliter) subcutaneous (5 units) insulin Pen starting 8/16/25. On 8/20/25 at 1:18 PM, V5 (RN) said when administering medications, you had to follow the order in the computer. V5 said for insulin pens, it needed to be primed with two units prior to administering the dose. V5 also said after administering Breyna, the nurse should offer water to the resident to have them rinse their mouth and spit out the water. On 8/21/25 at 1:55 PM, V8 (LPN/Licensed Practical Nurse) said insulin pens needed to be primed with at least two units of insulin and to make sure to see the insulin shoot out. V8 said this was done to make sure there were no bubbles in the needle to ensure the resident received the correct dose. V8 also said after administration of the Breyna inhaler, the resident should rinse the mouth and spit the water out to prevent thrush. V8 said the order for pioglitazone with metformin were two separate pills and not a combination drug. On 8/21/25 at 9:42 AM, V2 (DON/Director of Nursing) said the insulin pens needed to be primed with five to 10 units of insulin to ensure removal of the bubbles. V2 said one unit of insulin was not sufficient to remove any bubbles. V2 also said after the use of the Breyna inhaler, the nurse had to offer the resident water to swish and spit as it could cause candida in the mouth. The facility's Administering Medications policy revised 4/2019 showed Medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control practices to prevent the spread of infection. This applies to 2 of 2 residents (R35, R27) reviewed for infection control in a sample of 18. The findings include: 1. On 8/19/25 at 11:56 AM, V4 (Scheduler) was passing lunch trays. R35's room was on contact isolation with signage on the door frame and an isolation cart with PPE (Personal Protective Equipment) including gowns, gloves, and face masks outside the room door. At 11:56 AM, V4 pulled the tray cart in front of R35's room, pulled R35's meal tray out of the cart, and entered R35's room without performing hand hygiene or wearing any PPE. V4 set R35's tray on the bedside table, moved her belongings around, and rolled the tray table in front of R35. R35 requested creamer from V4 and V4 left the room without performing hand hygiene and went to find creamer. Upon return at 11:59 AM, V4 entered R35's room again without performing hand hygiene or applying any of the appropriate PPE prior to re-entering R35's room. V4 handed R35 the creamer and removed the lid of her tray. On 8/21/25 at 1:51 PM, V4 said for contact isolation rooms, the staff need to wear gowns and gloves. V4 said prior to entering the room, the staff need to use gel to clean hands and apply PPE, and before exiting the room, to remove the PPE and wash hands. On 8/21/25 at 1:55 PM, V8 (LPN/Licensed Practical Nurse) said for contact isolation residents, you have to wash hands, wear gown, gloves before entering the room. V8 said even just to pass the meal trays, all the PPE should be worn. V8 said the PPE was worn to protect the staff and to prevent the spreading of whatever disease the resident had. On 8/21/25 at 9:42 AM, V2 (DON/Director of Nursing) said for residents with contact isolation, the signage needs to be placed outside the room door with an isolation bin. V2 said prior to entering the room, the staff need to wear gowns and gloves as it was strict isolation, and everything needed to be worn. R35's face sheet showed she was admitted to the facility with diagnoses including congestive heart failure, cognitive communication, and urinary tract infection. R35's POS (Physician Order Sheet) dated August 21, 2025 shows an order for Isolation- Contact Precautions Notes: For ESBL (Extended-spectrum beta-lactamase) in urine. R35's care plan dated August 21, 2025 showed Problem: [R35] has an infection- UTI (Urinary Tract Infection) (ESBL in urine) with interventions including Infection precautions per physician order. Use PPE, gown, and gloves at all times. Maintain contact isolation precautions at all times. Placed isolation signage outside [resident] door. Educated resident and family regarding contact isolation precautions and use of PPE. The facility's Contact Precautions policy revised 3/12/25 showed In addition to wearing gloves as outlined under Standard Precautions, clean, nonsterile gloves will be worn when providing direct care (changing clothing, toileting, bathing, dressing changes, etc.) to residents with MDROs (Multi Drug Resistant Organisms). Gloves should also be worn when handling items potentially contaminated by MDROs. This may include items such as bedside tables, over-bed tables, bed rails, bathroom fixtures, television and bed controls, suction, and oxygen tubing. Wearing gloves is not a substitute for hand washing. Gloves will be removed and discarded before leaving the resident's room, hands will immediately be washed with soap and water or an alcohol based hand rub will be used. Gowns should also be worn when body contact with environmental surfaces and items in the room that may be contaminated is anticipated. The gown will be removed and appropriately discarded before leaving the room. After gown removal, staff should ensure that clothing does not contact potentially contaminated (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environmental surfaces to avoid transfer of microorganisms to other residents or environments. 2. On 08/20/2025 at 11:51 AM, V10 CNA (Certified Nursing Assistant) put on PPE of face shield, gown and gloves in addition to the surgical mask he was already wearing. V10 CNA went into R35's contact isolation room, assisted her to reposition items on her over bed table, and delivered her meal tray. V10 removed all the PPE he was wearing and stepped out of R35's room without performing hand hygiene. V10 removed a new surgical mask from the PPE cart, re-entered R35's room and applied the surgical mask, exited R35's room, and used hand sanitizer. V10 CNA then moved the meal cart down the hall to deliver R27's meal tray. V10 put on a gown, face shield and gloves. V10 did not perform any hand hygiene. V10 assisted R27 in positioning the overbed table and delivered the meal tray. V10 removed his PPE except for the surgical mask and did not perform any hand hygiene. V10 moved the meal cart further down the hall. V10 stated he is required to perform hand hygiene before and after removing PPE. V10 stated he had missed opportunities for hand hygiene during the meal delivery. V10 did not say why it was important to do hand hygiene before and after removing PPE. On 08/21/2025 at 1:15 PM, V2 DON (Director of Nursing) stated R35 is on Contact isolation for ESBL (Extended Spectrum Beta Lactamases) in her Urine. V2 stated R27 is on Enhanced Barrier Precautions related to a wound she has. V2 DON stated staff entering and exiting resident's room should perform hand hygiene before and after care and before and after applying and removing PPE. Touching the clean PPE cart with soiled hands is an infection control issue and contaminates the clean PPE and increases the spread of infections.		