

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER West Suburban Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 311 Edgewater Drive Bloomington, IL 60108	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from abuse for one of 35 residents (R146) reviewed for abuse in the sample of 35.</p> <p>The findings include:</p> <p>R146's Admission Record dated October 28, 2024 shows she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, dementia, adult failure to thrive, history of falling, weakness, difficulty in walking, and depression.</p> <p>On October 28, 2024 at 9:23 AM, R146 was observed in bed. R146 had a large lemon sized bump to her right forehead. The right side of R146's face was discolored from bruising. R146 was not able to reposition herself in bed and was nonverbal.</p> <p>R146's Care Plan initiated on July 4, 2024 shows R146 has poor sitting balance can cannot maintain and upright position when she is in a wheel chair. R146's Care Plan initiated on August 24, 2022 shows R146 requires an extensive assist of one person for bed mobility and is non ambulatory.</p> <p>R146's Fall Incident Report dated October 14, 2024 entered by V19 RN (Registered Nurse) shows, This nurse at the nursing station heard a loud thud sound in the hallway and immediately checked all the rooms. While entering [R146's room] observed bed B [R72] sitting on [R146's] bed. R72 said, 'It's my bed, I push her away.' Observed [R146] laying on the floor on her right side. Upon assessment observed a big bump golf size on the right forehead without external bleeding. A statement entered by V19 on this same document shows R72 said, I pushed her [R146] and she fell . It's my bed.</p> <p>R146's Physician Progress Note dated October 16, 2024 shows R146 experienced a traumatic fall on October 14, 2024 close to midnight and was brought to the local emergency room . Per nurse report, R146's roommate [R72] was confused and demonstrated aggressive behavior, pulling R146 out of bed which caused the fall.</p> <p>R146's local hospital records dated October 15, 2024 at 3:14 AM shows R146 had a large softball sized hematoma to her forehead. R146's Cat-scan results showed, Scalp hematoma superficial to the right frontal bone. Possibility of a small focus of subarachnoid hemorrhage along the left frontal lobe cannot be excluded. Scalp hematoma and subcutaneous emphysema is noted superficial to the right frontal bone.</p> <p>(continued on next page)</p>

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: 145333	If continuation sheet Page 1 of 13

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On October 30, 2024 at 10:56 AM, V18 CNA (Certified Nursing Assistant) said she saw V19 RN running to R146's room. V18 said she went into R146's room and saw R146 on the floor and saw R72 sitting in R146's bed. V18 said R146 did not say anything and R72 kept saying, she's in my bed. V18 said that prior to this incident, R146 was quiet and doesn't move around much. V18 said R146 could be resistive to care at times. V18 said that R72 can get agitated at times and her agitation is unpredictable. V18 said that R72 has never refused care but has been combative to staff before.</p> <p>On October 30, 2024 at 11:03 AM, V19 RN said he was at the nurses' station when he heard a loud thud. V19 said he checked all the rooms and saw R146 on the floor and her roommate (R72) was sitting on R146's bed. V19 said that R146 was laying on her right side with her head down on the ground. V19 said there were no fall mats under R146. V19 said he asked R72 what happened and R72 told him that R146 was in R72's bed so R72 moved R146 out of R72's bed. V19 said that R146 was in the correct bed and R72 was confused.</p> <p>R146's Nursing Progress Note dated October 15, 2024 at 5:49 AM shows, R146 came back from the emergency room at 4:30 AM. R146 had a softball size traumatic hematoma to the forehead, purple in color running down to her right eye.</p> <p>R72's Admission Record dated October 29, 2024 shows R72 was admitted to the facility on [DATE] with diagnoses including alcohol use unspecified with alcohol induced persisting dementia, bipolar disorder, history of falling, alcohol dependence with alcohol induced persisting amnesic disorder, alcoholic liver disease, anxiety disorder, major depressive disorder, and paranoid personality disorder.</p> <p>R72's Care Plan dated July 7, 2024 shows frequent rounding when in room .</p> <p>R72's Mood/Behavior note dated January 26, 2024 shows she was on daily monitoring due to behavioral issues of being delusional, paranoia, and hallucinations with aggression, agitation, and anxiety. Noted also with episodes of combativeness when redirected.</p> <p>R72's Screening Assessment for Indicators of Aggressive and/or Harmful Behavior dated July 15, 2024 shows general awareness, insight, judgement, reasoning, memory, concentration and orientation is a significant problem for R72. It shows R72 has a history or recent episode of aggressive/agitated behavior and/or noncompliance with medications, treatment regimen, and resisting care. It also shows R72 has a history of criminal behavior.</p> <p>The facility's Memory Care policy not dated shows, [Name of Unit] is a secured neighborhood and a program specifically designed to provide a safe and home-like environment that promotes independence and socialization. Our Social Services and clinical teams will continue to observe all residents. This will foster further assessment opportunities to ensure proper placement and services are provided.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117</p> <p>Based on observation, interview, and record review the facility failed to clarify orders following a missed appointment for a residents treatment of rheumatoid arthritis. This applies to 1 of 35 residents (R58) reviewed for quality of care in the sample of 35.</p> <p>The findings include:</p> <p>R58's face sheet shows she is a [AGE] year old female admitted on [DATE] with diagnosis including rheumatoid arthritis, COPD, anxiety, major depressive disorder and low back pain.</p> <p>On 10/28/24 at 9:30 AM, R58 was observed lying in bed. R58 said she was not doing well. R58 has Rheumatoid Arthritis (RA) and has pain in her hands, shoulder, and arms and she is not receiving treatment for her RA. R58 was taking injections and steroids for her RA. R58 missed her appointment in September due to transportation not showing up and she is supposed to have another appointment in November. R58 is receiving hydrocodone (pain medication) but still having pain.</p> <p>On 10/29/24 at 11:21 AM, V15 (RN-Registered Nurse) said R58 is alert and oriented, she requests pain medication for generalized pain and arthritic pain. R58 does not have steroid medication ordered.</p> <p>On 10/29/24 at 11:34 AM, V14 (Licensed Practical Nurse-LPN) said she was R58's nurse on 9/5/24 when she received new orders for her corticosteroid medication (treatment for RA). R58's physician ordered to increase her steroid medication to a tapering dose and made an appointment for her to follow up with her Rheumatologist. After the tapering dose was completed, the order was to see if V22 (Physician) was okay to increase her steroid dose from 5 mg (milligrams) to 10 mg daily. V14 did not know R58 missed her appointment because she is not the regular nurse. R58's steroid medication should have been clarified after her appointment was missed.</p> <p>On 10/29/24 at 12:33 PM, V2 (Director of Nursing) said R58 had an appointment to see V22 (Physician). Transportation did not show up and she missed her appointment. It was re-scheduled for November. V14 who took the order from V21 (Physician Assistant) is a float nurse and would not know if she made it to her appointment. Nursing should have followed up to clarify the order regarding the prednisone.</p> <p>R58's nurses note dated 9/5/24 documents received new orders from V21 (Physician Assistant) Rheumatologist appointment scheduled 09/13/2024. Start Prednisone (steroid) 60 mg X 3 days, Prednisone 50 mg X 3 days, Prednisone 40 mg X 3 days. Prednisone 30 mg X 3 days, Prednisone 20 mg X 3 days, Prednisone 10 mg X 3 days (Please inform V22 (Physician) about this order and see if he is okay with daily Prednisone 10 mg (increased from 5 mg per V21).</p> <p>V21's Progress note dated 9/5/24 documents (R58) has pain in right shoulder and right sided sciatic pain . Prednisone taper dose and follow up made with V22 on 9/13/24 .plan rheumatoid arthritis acetaminophen and hydrocodone as needed Prednisone taper as below:</p> <p>Prednisone 60 mg x 3 days</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prednisone 50 mg x 3 days</p> <p>Prednisone 40 mg x 3 days</p> <p>Prednisone 30 mg x 3 days</p> <p>Prednisone 20 mg x 3 days</p> <p>Prednisone 10 mg daily.</p> <p>R58's Physician Orders dated October 2024 did not show orders for Prednisone until 10/30/24.</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>40798</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 35 residents (R118) reviewed for vision aids received a pair of corrective eyeglasses, as prescribed, in the sample of 35.</p> <p>The findings include:</p> <p>On 10/28/24 at 10:39 AM, R118 said she saw the eye doctor and needs glasses, but she has not gotten them. R118 was not wearing eyeglasses.</p> <p>On 10/29/24 at 12:51 PM, V20, Social Services, said R118 saw the eye doctor on 6/17/24 and she has a prescription for eyeglasses. V20 said he has not given R118 a pair of glasses; they probably have not come in yet. V20 said they should follow up with the eye doctor to check on the status.</p> <p>On 10/30/24 at 10:53 AM, R118 said she still wants her eyeglasses, but she was never given the option to order glasses and she had an eye exam in June. R118 said no one has ever followed up with her, so she is not sure if her glasses were ordered.</p> <p>R118's Patient Encounter with the Doctor of Optometry dated 6/10/24 shows R118 received a prescription for eyeglasses.</p> <p>R118's current care plan provided by the facility shows, The resident is alert & oriented & able to express her needs, desires, & opinion.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117</p> <p>Based on observation, interview, and record review the facility failed to ensure a protective dressing was in place for a resident with stage 3 sacral pressure ulcer. This applies to 1 of 9 residents (R152) reviewed for pressure ulcers in the sample of 35.</p> <p>The findings include:</p> <p>R152's face sheet shows he is a [AGE] year old male with diagnoses including orthopedic aftercare following surgical amputation, acquired absence of right leg above knee amputee, type 2 diabetes, PVD (peripheral vascular disease), end stage renal disease, dependence on renal dialysis, and hypertensive heart disease.</p> <p>On 10/28/24 at 9:49 AM, R152 was observed lying in bed, his oatmeal spilled over his bedsheets. R152 has a right leg amputation and a gauze dressing to his left foot. V17 (Certified Nursing Assistant-CNA) came in to the room to provide assistance. V17 pulled down R152 incontinent brief, an open area was observed to R152's sacrum without a dressing in place.</p> <p>R152's Braden Scale for Predicting Pressure Sore Risk shows he is a low risk for developing pressure.</p> <p>R152's Physician Progress note dated 10/24/24 documents a stage 3 sacral pressure measuring 0.5 cm (centimeters) x 0.5 cm x 0.1 cm with treatment orders including to cleanse with normal saline, apply triad cream (medicated cream), oil emulsion and foam dressing daily.</p> <p>On 10/29/24 at 12:24 PM, V13 (Wound Nurse) said R152 has a stage 3 sacral pressure wound and if the dressing comes off, staff should notify nursing. Nursing should re-apply the dressing. No one told me yesterday that R152's dressing was not on. She has in-serviced the staff about notifying nursing and nursing to re-apply treatment dressings when they fall off.</p> <p>The facility's undated Guidelines for Prevention/Treatment of Pressure Injuries states, It is the intent of the facility to recognize the following information and to act on it is such a way as to practice evidenced-based recommendations for the prevention/treatment of pressure injuries to the resides who reside in the facility.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506</p> <p>Based on observations, interview, and record review, the facility failed to have smoking precautions in place and failed to have fall prevention interventions in place for two of 35 residents (R30, R152) reviewed for safety and supervision in the sample of 35.</p> <p>The findings include:</p> <p>35119</p> <p>1. On 10/28/24 at 10:09 AM, R30 was up in her electric wheelchair. R30's left arm was in a splint and resting on her upper abdominal area. R30 said she goes outside to smoke. R30 said staff pass out the cigarettes at the door before you go out. R30 had cigarette ashes on lap, a burn hole in towel that was around her shoulders and cigarette ash on towel by her neck. R30 said staff light the cigarettes and she is able to use her right hand only to smoke.</p> <p>On 10/28/24 at 01:41 PM, R30 was outside smoking out on the patio. R30 had a cigarette in her mouth while talking to other residents and this surveyor. R30 did not have an apron on, only a bath blanket on her lap.</p> <p>On 10/29/24 at 09:40 AM, R30 was outside smoking with an apron in place. R30 said she calls the apron her party dress. R30 had cigarette ashes on chest above apron. R30 said she has to wear it because she drops ashes on herself, but sometimes they forget to put it on her, and she doesn't remind them.</p> <p>On 10/29/24 at 09:42 AM, V12 Activity Aid said activity monitors the am smoking session. V12 said there is a list of residents who need aprons for safety. V12 said the activity person should make sure everyone on the list has their aprons on.</p> <p>R30's Smoking Evaluation dated 9/30/24 shows R30, ability to independently hold and handle smoking product- No, Ability to dispose of ashes in the ashtray and extinguish cigarette- No, [R30] requires a smoking apron to smoke.</p> <p>R30's Care Plan shows I require a smoking apron to safely smoke due to my need for assistance while smoking my cigarette.</p> <p>The facility's Residents who are active smokers list dated 10/14/24 shows R30, Must wear smoking apron.</p> <p>The facility's Smoking Policy dated 6/10/23 shows, Residents will be assessed for safe smoking behavior prior to smoking at the facility. Based on the results of the smoking assessment education will be documented for the resident, their representative as well as any appropriate staff. The care plan and CNA assignment sheets will be reflective of the resident's needs as far as safe smoking.</p> <p>34117</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. R152's face sheet shows he is a [AGE] year-old male with diagnoses including orthopedic aftercare following surgical amputation, acquired absence of right leg above knee amputee, type 2 diabetes, PVD (peripheral vascular disease), end stage renal disease, dependence on renal dialysis, hypertensive heart disease.</p> <p>On 10/28/24 at 9:49 AM, R152 was observed lying in bed, his oatmeal spilled over his bed sheets. R152 pressed his call light for assistance. R152 said it takes a while for staff to answer his call light. At 9:58 AM, this surveyor looked outside of R152's room, his call light was not alarming. R152 pressed his call light again and the light did not alarm outside of his room. This surveyor pressed the call light from bed 1, it alarmed outside. V17 (Certified Nursing Assistant-CNA) entered the room and was notified R152's call light was not working. She said she will put in the book about his call light is not working.</p> <p>On 10/29/24 at 12:28 PM, R152 was lying in bed, he said no one has come to fix his call light. R152 pressed the call light button, and it did not alarm. At 1:00 PM, this surveyor notified V2 (DON) about R152's call light not alarming. V2 went to the nurses station and pulled the maintenance book. V2 said R152's call light was not written in the book for repair. R152 definitely needs his call light for staff assistance.</p> <p>R152's current care plan shows he is at risk for falls related to general weakness with interventions to place my call light within reach. His care plan shows he has self-care deficit and it total dependent on staff for transfers, extensive assist with bed mobility, and toileting.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to ensure a urinary catheter collection bag and tubing was positioned in a manner to prevent infection for 2 of 5 residents (R30 and R49) reviewed for urinary catheters in the sample of 35.</p> <p>The findings include:</p> <p>1. On 10/28/24 at 09:58 AM, R30 was up in her electric wheelchair by the nurses station. R30's urinary catheter collection bag was hung on back of chair even with bladder. The catheter tubing went down from the resident and then back up into the collection bag. There was yellow cloudy urine in downward area of the tubing, unable to go up into the collection bag. R30 said she has had a perpetual urinary tract infection for years.</p> <p>R30's Care Plan shows R30 is at risk for complications related to suprapubic catheter use related to urogenic bladder with intervention of monitor position of drainage bag and keep below waist to ensure proper drainage.</p> <p>2. On 10/28/24 at 11:52 AM, R49 was propelling himself in his wheelchair down the hallway towards his room. R49's urinary catheter tubing was dragging on the floor. Bloody urine was observed in the tubing.</p> <p>On 10/28/24 at 12:12 PM, R49 was in room sitting in his wheelchair. R49's urinary catheter tubing was resting on the floor under the wheelchair. Bloody urine remained visible in the tubing.</p> <p>On 10/28/24 at 12:26 PM, R49 was in the dining room, sitting in his wheelchair. R49's urinary catheter tubing was resting on the ground under his wheelchair.</p> <p>On 10/30/24 at 09:04 AM, V11 Licensed Practical Nurse said urinary catheter bags need to hang on the bed frame or low on the wheelchair, so the urine drains into the bag and bacteria in urine doesn't back up into bladder. V11 said the urinary catheter tubing should not be on floor due to risk for bacteria.</p> <p>R49's Care Plan shows R49 has a diagnosis of neuromuscular dysfunction of the bladder and is at risk to develop urinary tract infections related to use of catheter, diagnosis of benign prostatic hypertrophy and history of urinary tract infection.</p> <p>The facility Guidelines for Indwelling Foley Catheter Care Policy dated 10/16/24 shows The main purpose of proper indwelling foley catheter care is to prevent catheter associated urinary tract infections. Always keep the urinary drainage bag below the level of the bladder in the body.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>40798</p> <p>Based on observation, interview, and record review, the facility failed to dispose of expired medications and failed to ensure the medication was refrigerated at the correct temperature for 9 of 35 residents (R175, R105, R152, R169, R46, R167, R156, R37 and R29) reviewed for medication storage in the sample of 35.</p> <p>The findings include:</p> <p>On 10/29/24 at 9:24 AM, while checking the medication cart on the second floor of the facility with V14, Licensed Practical Nurse, a glucagon injection labeled for R105 with an expiration date of 5/2024, eye drops labeled for R167 with 8/11/24 written on it, artificial tears labeled for R156 with 7/22/24 written on it, artificial tears labeled for R37 with 5/28/24 written on it, and eye drops labeled for R29 with 8/1/24 written on it were found. V14 said the nurse writes the date eye drops are opened on the box and they are good for 30 days after being opened.</p> <p>On 10/29/24 at 09:31 AM, the medication refrigerator in the second-floor medication room was checked with V14. The temperature was confirmed with V14 to be 50 degrees Fahrenheit (F). The refrigerator contained insulin (Lantus) for R175, (Lantus) R105, (Humalog) R152, and (Humalog) R169, eye drops (Latanoprost) for R46 and a multidose vial of Tuberculin.</p> <p>On 10/29/24 at 9:35 AM, V15, Registered Nurse, said the medication refrigerator temperature should be between 36- and 40-degrees F.</p> <p>The facility's Medication Storage in the Facility Policy (undated) shows medications and biologicals are stored safely, securely, and properly following the manufacturer or supplier recommendations. Medications requiring storage between 36- and 46-degrees F are kept in the refrigerator. Outdated medications will be immediately withdrawn and disposed of according to drug disposal procedures.</p> <p>The facility was unable to provide manufacturer's recommendations for the artificial tears/eye drops.</p> <p>The facility's United RX Long Term Care Pharmacy policy dated September 2022 shows Lantus, Humalog, and Latanoprost should be refrigerated until opened. Latanoprost should be stored between 2 to 8 degrees Celsius (C) (35.6- and 46.4-degrees F.) Tuberculin should be stored between 35- and 46-degrees F.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>47552</p> <p>Based on observation, interview, and record review the facility failed to ensure pureed broccoli and pureed ham were free of particles and at a smooth consistency. This applies to 4 of 4 residents (R172, R179, R155, R129) reviewed for pureed diets in the sample of 35.</p> <p>The findings include:</p> <p>Facility provided list of residents on a pureed diet shows that R172, R179, R155, and R129 received a pureed diet.</p> <p>On 10/28/24 at 10:01 AM, V7 (Cook) was pureeing the broccoli for the noon meal. At 10:08 AM, V7 finished the pureed broccoli and it appeared to have some small chunks when finished. V7 did not test the pureed broccoli before placing it into a steam table pan to use at service. V7 was already finished pureeing the ham before this surveyor watched.</p> <p>On 10/28/24 at 1:12 PM, the facility provided test tray of pureed ham, pureed broccoli, and pureed stuffing was reviewed. The pureed ham had small chunks in it, prompting and requiring chewing. The pureed broccoli also had small chunks in it, prompting and requiring chewing.</p> <p>On 10/28/24 at 1:21 PM, V9 (Cook) said the ham could be a little smoother and that the ham and broccoli should not have small chunks in the finished product.</p> <p>Facility Pureed Food Preparation dated 10/25/23 states, . 3. Pureed food will be the consistency of pudding or mashed potatoes.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER West Suburban Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 311 Edgewater Drive Bloomington, IL 60108	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47552</p> <p>Based on observation, interview, and record review the facility failed to ensure food service pans, trays, and utensils were handled in a way to prevent cross-contamination. This applies to all 183 residents receiving food from the kitchen.</p> <p>The findings include:</p> <p>The Centers for Medicare and Medicaid form 671 dated 10/28/24 shows there are 188 residents residing in the facility.</p> <p>Facility provided list of residents who receive nutrition strictly via tube feedings dated 10/29/24 shows there are 5 residents that do not receive food from the kitchen.</p> <p>On 10/28/24 at 9:33 AM, V5 (Dietary Aide) said V10 (Food Service Director) was on vacation this week and would not be on site.</p> <p>On 10/28/24 at 9:35 AM, V4 (Dietary Aide) was wearing teal rubber gloves that extended up to his elbows. V4 was draining the water from the three-compartment sink. V4 was clearing food debris from the first sink which was a yellowish color from being soiled. As V4 removed food debris from the sink, V4 would transfer the food debris to the garbage can located next to the three-compartment sink. V4 continued to drain the water from each sink in the three-compartment sink, cleaned the sink, then refilled the sinks with the corresponding detergent and chemical sanitizer solution. At 9:43 AM, V4 was still wearing the same gloves used to clean and drain food debris from the three-compartment sink and placed two full size four-inch steam table pans onto a black roll cart that was in the dish pit area. At 9:45 AM, V4 ran the two full size four-inch steam table pans through the dish machine on dish racks, while still wearing the same gloves. At 9:46 AM, when the dishes came out the sanitized side of the dish machine, V4 removed the pans from the dish racks while still wet, stacked one inside of the other, and placed them onto the drying rack atop clean, sanitized, and dry pans. At 9:47 AM, V4 was still wearing the same gloves and took the clean and sanitized trays that were on the drying rack, stacked them on a different black rolling cart, and wheeled the cart in front of the rack between the two steam tables. V4 removed the gloves and returned to the dish pit to break down meal trays from the morning meal.</p> <p>On 10/28/24 at 9:54 AM, V6 (Dietary Aide) started to place dirty dishes received from V4 into dish racks and running them through the dish machine. At this time, V6 was handling plate lids and running them through the dish machine. After running two racks through the machine, at 9:56 AM, V6 left the dish pit area and grabbed the drying rack for the plate lids and returned to the dish pit area. V6 did not wash her hands before leaving or after returning to the dish pit area. When V6 returned with the drying rack, V6 placed the clean, sanitized plate lids into the drying rack. At 9:58 AM, V6 returned to the dirty side of the dish machine and continued to go between clean and dirty dishes without washing her hands.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 10/28/24 at 11:24 AM, V8 (Dietitian) said the standard of practice to wash hands includes before serving, before touching food, if they throw something in the garbage, or if they drop something on the floor, staff should wash their hands immediately after. V8 also said hands should be washed between handling dirty dishes and clean dishes. If a staff member's glove becomes soiled, the glove should be removed before handling clean dishes. V8 also said that pots, pans, plates, or trays should not be stacked unless dry to prevent bacteria growth and contamination.</p> <p>Facility Handwashing policy dated 4/2017 states, The facility will practice safe food handling and avoid cross contamination through proper and adequate handwashing techniques.</p> <p>Facility Machine Dishwashing policy dated 4/2017 states, . Once clean, pots and pans will be dried on a rack and will not be stacked until they are completely dry.</p>