| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145547 | A. Building<br>B. Wing | 04/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Dekalb County Rehab & Nursing | 2600 North Annie Glidden Road<br>Dekalb, IL 60115 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488<br><br>Based on the interview and record review, the facility failed to ensure the Safety of a resident while pushing their wheelchair for one of 6 residents (R40) reviewed for Safety in the sample of 24.<br><br>The findings include:<br><br>R40's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include paroxysmal atrial fibrillation, lymphedema, bilateral primary osteoarthritis of bilateral knees, polyneuropathy, and age-related osteoporosis. R40's facility assessment dated [DATE] showed she has no cognitive impairment.<br><br>On 4/02/25 at 9:18 AM, R40 said she was recuperating from a fall. R40 said, I was negligent in some ways, and so were they. The girl got fired because of it. We have a rule about footrests. If you don't have foot pedals on, they are not allowed to push you . I was coming back to my room after an activity, I was maneuvering myself. The activity gal said, 'Let me give you a push' . It was a rush, rush, rush because they had to punch out before 4:30, so they didn't have overtime. She started to push me, and she was going a little fast; I said, 'Whoa, whoa?' As we turned to come out of the dining room, I must have put my feet down. I felt like I was shot out of a cannon. I fell and fell on my knees first, then my hands went out. They all came running .<br><br>R40's Health Status Note dated 3/18/25 showed, 4:05 PM, called to nursing station/north hallway and noted resident with hands and knees on the floor, wheelchair behind her. The incident was witnessed by staff. The resident was sitting in a wheelchair with her hands full of belongings and went forward.<br><br>On 4/03/25 at 10:46 AM, V20 LPN (Licensed Practical Nurse) said she didn't witness the incident. I was coming out of a room with a resident when they called for help. All I saw was where she was when I came out of the room. I was told that she was being pushed in her wheelchair, and when she came around the corner, she came out of her chair. She had mentioned to the person pushing her that her chair was acting funny. There were no foot pedals on her wheelchair. I think it was just unfortunately that someone thought they were being nice to help her . she had no injuries .<br><br>R40's care plan initiated on 10/21/21 showed, I am at risk for falls related to impaired mobility . Intervention 3/18/25: Staff education is needed to utilize leg rests at all times when transporting residents related to falls .<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/03/25 at 10:53 AM, V17 (Restorative Nurse) said she did the fall investigations. V17 said, Safety was the determining factor to [R40's] fall. The employee who was assisting the resident went back to her room. Apparently, she had items in her arms, and she asked the activity aide to transport her. She didn't follow our policy and didn't put the foot pedals on the chair prior to assisting her. [R40] put her feet down and fell forward out of the chair. No injuries .<br><br>On 4/03/25 at 11:34 AM, V2 DON (Director of Nursing) said the expectation is that if they are not able to propel themselves, we want foot pedals on the wheelchair vs. expecting them to hold their feet up. It is our expectation that they would have used the leg rests for Safety.<br><br>The facility's Safety Policy, revised in March 2025, stated, [The facility] and its staff recognize the importance of ensuring each resident's Safety while they reside at the Nursing Home. The following identified various types of security measures the Nursing Home has to ensure this Safety: 13. Leg Rests: Encourage residents who are able to propel themselves to allow staff to place leg rests on wheelchairs for transportation/safety needs. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891<br><br>Based on observation, interview, and record review, the facility failed to ensure that an indwelling catheter tube remained off the floor for one of two residents (R18) reviewed for catheters in the sample of 24.<br><br>The findings include:<br><br>R18's face sheet printed on 4/3/25 showed diagnoses including but not limited to left-side hemiparesis following a stroke, below-the-knee amputation, peripheral vascular disease, aphasia (difficulty talking), and neuromuscular dysfunction of the bladder. R18's facility assessment dated [DATE] showed no cognitive impairment and the use of a urinary catheter. The same evaluation showed no behaviors.<br><br>R18's April 2025 physician order report showed an order starting on 3/30/25 for 750 milligrams of Levofloxacin (an antibiotic) daily to treat pneumonia and a urinary tract infection for seven days.<br><br>On 4/1/25 at 12:24 PM, R18 was in her wheelchair while seated at the lunch table in the group dining room. R18's catheter tubing was fully resting on the floor during the entire meal. The tablemate's milk cup was inadvertently knocked over and spilled onto the floor and the tubing during the meal. Staff cleaned up the milk spill while the tubing remained in place on the floor.<br><br>On 4/3/25 at 10:34 AM, V3 (Assistant Director of Nurses) stated that catheter tubing needs to always stay off the floor. There is the potential for germs to cross contaminate the tubing and cause infections. Staff should be checking placement daily and frequently throughout the day. V3 said R18 has a behavior of pulling on the tubing by herself. However, it was noted that this behavior is not care planned and no interventions have been initiated, highlighting a significant gap in our care planning and execution.<br><br>R18's care plan showed a focus area related to the use of the indwelling urinary catheter revision dated 4/3/25 (during the survey). Interventions included do not allow tubing or any part of the drainage system to touch the floor. This revision underscores the need for continuous improvement and vigilance in our care planning and execution. The same care plan showed a focus area related to the history of past urinary tract infections.<br><br>The facility's undated Catheter Care policy states: Please remember that the bladder is ordinarily a sterile environment. Therefore, the introduction of any microorganisms will immediately start a chain of events resulting in a bladder infection. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45395<br><br>Based on observations, interview, and record review, the facility failed to ensure accurate monthly weights were obtained for 1 of 3 residents (R51); and failed to document accurate meal intakes and/or offer alternative meal options for 1 (R83) reviewed for nutrition in the sample of 24.<br><br>Findings include:<br><br>1. R51's face sheet indicated resident admitted to facility on 10/07/2022 and has a past medical history not limited to: dementia, cognitive communication deficit, dysphagia (oral phase), anxiety, and need for assistance with personal care.<br><br>R51's minimum data set section K dated 01/01/2025 documented weight loss of more than 5% or more in the last month or loss of 10% or more in the last 6 months.<br><br>R51's active orders as of 04/03/2025 showed the following: 120 cubic centimeters (cc) of [high calorie nutrition] two times a day for weight loss and monthly weight monitoring.<br><br>R51's care plan last revised on 04/03/2025 documented: lives on CVS unit; have maintained my weight last 3 months, current weight is 116 pounds; on comfort care with no hospitalization s; nutritional problem or potential for nutritional problems related to poor intakes and resistance for assistance at times with meals/intakes.<br><br>On 04/02/2025 at 03:32 PM, R51's weight summary that documented a weight of 127.5 lbs. (pounds) on 12/01/2024 at 09:39 AM with wheelchair; 111.0 lbs. on 01/01/2025 at 12:06 PM while sitting; 116.0 lbs. on 01/02/2025 at 13:13 (12:13 PM) with wheelchair; 128.0 lbs. on 02/02/2025 at 14:44 (02:44 PM) with mechanical lift; and 116.0 lbs. on 03/04/2025 at 15:04 (03:04 PM) with wheelchair. No April weight was documented at this time.<br><br>On 04/02/2025 at 02:35 PM, V2 (Director of Nursing) said when there is a discrepancy with a resident's monthly weight, they are reweighed. V2 then said she needed to follow-up with V5 (Dementia Unit Coordinator) regarding the weight discrepancies for R51 because she monitors weights on that unit.<br><br>On 04/03/2025 at 08:26 AM, review of R51's weight summary showed previous weight of 128.0 lbs. on 02/02/2025 was now struck out on 04/02/2025 at 4:31PM with a new weight of 118.0 lbs. documented on same date at 07:31. The Summary also documented a weight of 117.3 lbs. on 04/02/2025 at 08:25.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 04/03/2025 at 10:40 AM, V5 (Dementia Unit Coordinator) said R51's normal weight range is from 110 to 116 lbs. and her appetite is normally between 25-50% for most meals. V5 then said there was a weight discrepancy with R51's weight on 01/2025 with weight of 137.5 obtained. V5 added that after R51 was reweighed twice, and the last weight obtained was 128 lbs. V5 (Dementia Unit Coordinator) then said the weight of 128 lbs. obtained on 02/02/205 was likely an error because R51 had no signs of weight gain or edema, and her lungs were clear. V5 said she communicated these findings to R51's physician on 02/02/2025 with no new orders or concerns. V5 (Dementia Unit Coordinator) added that residents should be weighed with the same type as previous month, either wheelchair, standing, or with a mechanical lift and any residents with a discrepancy of 5 lbs., increase or decrease, should be reweighed. At 10:51 AM, V5 (Dementia Unit Coordinator) said after monthly weights are completed for the unit, she reviews the weights and if she finds any discrepancies, she requests a reweigh for that resident. V5 then said, we are<br><br>getting 2 new scales.<br><br>The facility Weight Protocol last revised 03/2021 documented it is the policy of the [NAME] County Rehab and Nursing Center to take and record the resident's weights at the following times: upon admission; monthly record on vital sign record; additional resident weights may be taken if resident's condition warrants; if unable to weight a resident per protocol, supportive documentation must be made in the resident's record; nutritional status including resident's weight is reviewed by Food Service Director. Upon admission, monthly, at resident's care plan session and more frequently if resident's weight status warrants; resident physician will be notified if resident has a 5% or greater weight gain or loss in a 30 day period, or 7.5% weight gain/loss during previous three months and 10% weight gain/loss during the previous six months. This notification will be recorded; upon admission, establish usual body weight from the social medical history form .If no information is available dietary will take the residents weight for the past year and average for the usual body weight; weekly weights for 1 month for any resident on food and fluid intake study.<br><br>The facility Weight Change policy revised 03/2021 documented: nursing to weigh residents monthly; reports weights to dietary manager; weights will be entered into prime program; list of resident weights will be produced given to nursing management; weights will then be monitored by the RD, Dietary Manager, Nursing Management for any significant weight losses, gains, trends; RD and/or Dietary Manger will chart on resident's condition and make recommendations as deemed necessary.<br><br>41639<br><br>2) R83's electronic face sheet printed on 4/3/25 showed R83 has diagnoses including but not limited to displaced fracture of right femur, displaced fracture of right humerus, osteoporosis, and dementia with behaviors.<br><br>R83's facility assessment dated [DATE] showed R83 has severe cognitive impairment.<br><br>R83's most recent dietary assessment dated [DATE] showed Thin BMI(body mass index) = 17. Intakes fair to good at meals. Follow intakes and weights .<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/1/25 at 12:18PM, R83 received her lunch tray. At 12:37PM, V11 (Activity aide) pushed R83's plate in front of her and stated, Here's your food you should eat. R83 stated she did not want the meal on her plate and V11 walked away. R83 was then given a health shake to drink and was not offered any additional meal options. R83 ate less than 25% of her lunch meal.<br><br>R83's meal intake documentation dated 4/1/25 showed R83 consumed 51-75% of her lunch meal.<br><br>On 4/2/25 at 8:51AM, R83 had a bowl of berries and hot cereal in front of her for her breakfast meal. R83 ate 2 bites of her oatmeal and none of her berries. R83 ate less than 25% of her breakfast meal. R83's meal tray was removed by dietary staff and no alternative meal options were offered.<br><br>R83's meal intake documentation dated 4/2/25 showed R83 consumed 76-100% of her breakfast.<br><br>On 4/2/25 at 12:06PM, R83's lunch tray was served and consisted of turkey, stuffing, green bean casserole, cranberries, and pumpkin pie. R83 fed herself bread, 4 bites of turkey, and the whipped cream off her pumpkin pie.<br><br>At 1:02PM, V15 (Certified Nursing Assistant-CNA) removed R83's lunch tray and stated, I'm going to take your tray since you're not eating it. V15 did not offer R83 any alternative meal options. R83 ate less than 25% of her lunch meal.<br><br>R83's meal intake documentation dated 4/2/25 showed R83 consumed 26-50% of her lunch meal.<br><br>On 4/2/25 at 2:14PM, V14 (CNA) stated, On this unit we offer a shake, ice cream, or cottage cheese if a resident is not eating their meal. I think there are other things but I'm not sure what they are. I did not feed (R83) this morning so I'm not sure how much she ate. I did document that she ate 76-100% but I'm not sure who told me that's how much she ate. The dietary staff and activity staff help clear the trays so if they don't tell me how much someone eats, we just talk amongst ourselves while we are charting to figure out who ate what. I guess I shouldn't be documenting the intakes if I didn't personally observe the resident's tray.<br><br>On 4/3/25 at 10:00AM, V2 (Director of Nursing) and V3 (Assistant Director of Nursing) stated, Dietary & CNA's document the meal intakes. If the CNA is feeding the resident or has the direct observation of the intake, then they can document it. It is important to document the correct amount to get an accurate picture of their intakes. Alternatives that we offer are ice cream, cottage cheese, health shakes, or the alternative menu options. There are plenty of things we can get for them, but I don't know if (R83) would accept any of them. We should ask residents though if they aren't eating if they want something else. I don't know how important it is to document meal intakes, the weights are a better indicator of their nutritional status.<br><br>The facility's policy titled, Documentation of Oral Intake dated 03/2021 showed, Purpose: To document oral intake of meals and supplements and to determine the adequacy of residents caloric and nutrient intake .3. The amount of food consumed for entire tray contents will be documented as: 25%=1/4 food taken 50%= 1/2 food taken 75%= 3/4 food taken 100%= all food taken .5. Intake record reviewed by registered dietician, dietary manager and/or nursing quarterly prior to care plan conference, and more frequently depending on resident's status . |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891<br><br>Based on observation, interview, and record review the facility failed to ensure oxygen was administered at the physician prescribed rate for 1 of 1 resident (R32) reviewed for oxygen in the sample of 24.<br><br>The findings include:<br><br>R32's face sheet printed on 4/3/25 showed diagnoses including but not limited to Parkinsonism, hypertension, dementia, and depression. R32's facility assessment dated [DATE] showed staff assistance needed for all ADLs (activities of daily living).<br><br>R32's April 2025 physician order summary report showed an order start dated 3/22/24 for oxygen to be administered at 1 liter per minute via nasal cannula to maintain oxygen saturation levels at greater than 90%. The order stated PLEASE WEAN AS TOLERATED every shift for hypoxia.<br><br>On 4/1/25 at 11:01 AM, R32 was in bed and asleep. R32 was wearing her oxygen and the meter showed it was being administered at a rate of 3 liters per minute. At 12:40 PM, R32 was in bed asleep and the oxygen was still running at a rate of 3 liters.<br><br>On 4/2/25 at 9:51 AM, R32 was in bed and the oxygen was being administered at a rate of 2 liters per minute. At 12:40 PM, the oxygen was still running at a rate of 2 liters. V12 (Certified Nurse Aide) confirmed the rate as 2 liters. V12 said the nurses are responsible for checking the levels and ensuring it is running at the correct rate.<br><br>On 4/3/25 at 9:00 AM, V13 (Registered Nurse) observed R32's oxygen setting and confirmed it was being administered at a rate of 2 liters per minute. V13 stated the order is for only one liter per minute. V13 said the rate should be set as ordered. If the setting is too high, it can cause carbon dioxide to build up. If the setting is too low, residents are not getting enough oxygen. V13 stated the setting should be checked at every medication pass and during resident care.<br><br>On 4/3/25 at 9:39 AM, V2 (Director of Nurses) stated oxygen should be administered as ordered by the physician. Nurses should be checking the levels frequently throughout their shifts when rounding. Being given too high or even too low has the potential to cause health problems. Incorrect rates are going against doctor orders and that is wrong. Errors in the administration rate should be found and corrected right away.<br><br>R32's care plan showed a focus area related to respiratory. Interventions included give oxygen via nasal cannula at 1-2 liters per minute continuously to maintain oxygen saturation levels greater than 92%. (Not the same as parameters as on order.)<br><br>The facility's Administration of Oxygen policy revision dated 5/15 states under the procedure section: Obtain specific order for the number of liters. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186<br><br>Based on observation, interview, and record review the facility failed to complete the cooling process for a turkey roast. This applies to all residents in the facility.<br><br>The findings include:<br><br>The Center for Medicare and Medicaid form 671 dated 4/1/25 shows there are 109 residents in the facility.<br><br>On 4/1/2025 at 10:20 AM, V6 Dietary Manager said a turkey roast was being cooked today to serve tomorrow. V6 said a cooling log would be completed for this. When asked for a copy of the cooling log, V6 could not find the cooling binder in the kitchen and went into her office and returned with a copy of a blank cool down label sticker sheet.<br><br>At 1:00PM on 4/1/25 the turkey roast was observed in the refrigerator covered with foil and dated 4/1/25. V6 pulled the roast from the refrigerator and checked its temperature and at 1:15 PM ( 2 1/2 hours after removed from the oven) the temperature was 100 degrees Fahrenheit (F). V6 was not sure what time the roast was placed in the refrigerator to cool and was not aware of who even cooked the roast. V6 had to go ask several staff members before she found out it was V8 [NAME] who had baked the roast. V6 said no cooling logs were started for the turkey roast.<br><br>On 4/1/25 at 1:30 PM, V8 said she cooked the roast that morning and when the temperature reached 165 degrees F, she pulled it from the oven at 10:45 AM. V8 said she cut the roast up into several pieces, labeled it with the date and placed in the refrigerator. V8 said she did not know when she was to check the temperature again and where to document the time and temperature of the roast, she would have to ask her supervisor.<br><br>On 4/1/25 at 1:35 PM, V7 Assistant Dietary Manager said, that is not our policy, a sticker should be put on the food being cooled when it is first stored in the refrigerator. The roast should have been at 70 degrees F by the 2-hour mark, I'll have to go get a new turkey roast now.<br><br>On 4/2/25 at 9:30 AM V6 said she had to throw away the turkey roast cooked yesterday due to proper cooling not taking place.<br><br>On 4/02/25 at 9:40 AM, V6 Dietary Manager and V7 said they have begun training the staff on cooling foods. A new binder has been made for the cooling logs. V6 said it's important to monitor the cooling of food to prevent food [NAME] illnesses.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The undated policy for cool down/leftovers provided by the facility shows all cooked items that will be utilized for service at a later time must have a cool down label and be recorded in the cool down log in the cool down binder. Temperature logging must include the date the food was made, the food item, temperature at the time when out of the oven, temperature at 2 hours, and temperature at 4 hours. The total cool down process should take no longer that 6 hours. Stage one cool foods from 135 degrees F to 70 degrees F within 2 hours, stage 2 cool foods from 70 degrees F to 41 degrees F within 4 hours. |

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| F 0825<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or get specialized rehabilitative services as required for a resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488<br><br>Based on observation, interview, and record review the facility failed to ensure occupational services were provided for 1 of 1 resident (R39) reviewed for therapy services in the sample of 24.<br><br>The findings include:<br><br>R39's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include Type 2 Diabetes, congestive heart failure, Chronic Obstructive Pulmonary Disease, chronic respiratory failure with hypoxia, emphysema, obstructive sleep apnea, hypertension, chronic kidney disease, hypothyroidism, hyperlipidemia, osteoarthritis left hand, and trigger finger. R39's facility assessment dated [DATE] showed she had moderate cognitive impairment and has upper extremity impairment in range of motion.<br><br>R1's Progress Notes from her 3/12/25 Orthopaedic Surgery visit showed, . Referral to Specialty: Occupational Therapy .<br><br>On 4/02/25 at 9:50 AM, R39 said, I'm supposed to start therapy for my hand. I had a lump that was removed and now for some reason these two fingers and my thumb feel like they are asleep. I don't know when I am going to start that, they haven't come to me about it yet.<br><br>R39's 3/27/25 Care Conference Note showed, . follow-up with [physician] where she received cortisone injection to left thumb r/t pain, MRI on 3/3/25 of hand and second cortisone injection on 3/12/25 in addition to new orders for OT and to follow-up again in 6 weeks .<br><br>R39's Care Plan initiated 6/19/23 and revised 3/9/25 showed, I I have arthritis of the left hand. I was admitted with a left-hand trigger thumb. I had surgical procedure performed on 3-8-24 per [physician] for Left Thumb Trigger Finger Release . Intervention: 3/12/25: OT referral, Follow Up with [physician] in 6 weeks, Received cortisone injection to thumb in office .<br><br>On 4/3/25 at 10:00 AM, V18 (Therapy Area Manager) said R39 has not been seen by the therapy department since 5/31/24 and there have been no recent evaluations. V18 said the order for scar management would be so the scar tissue does not adhere and to get better range of motion.<br><br>On 4/03/25 at 10:03 AM, V19 (Program Manager/Physical Therapy Assistant) said when an order is received for therapy services they are usually able to get the resident evaluated in 2-3 days depending on how long it takes to hear from insurance and authorize the therapy services. V19 said the therapy department did not receive the order dated 3/12/25 for therapy services for R39. V19 said he thinks the order he received for R39's therapy services was received Friday of last week (March 28). V19 said he finds out about new orders for therapy from V17 (Restorative Nurse) on a weekly basis.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145547 | A. Building<br>B. Wing | 04/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Dekalb County Rehab & Nursing | 2600 North Annie Glidden Road<br>Dekalb, IL 60115 |

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 0825<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/03/25 at 11:04 AM, V17 (Restorative Nurse) said R39 is not on any restorative programs such as range of motion, because she has refused programs in the past. V17 said she could not find documentation of R39's refusals for restorative programming. V17 said, . Our therapy company is informed of new orders as we get them. I would have to double check with them if they have done an evaluation yet or not. I'm not sure how he looks it up but usually he knows the orders before I put them out there for him. He would have been able to see them before 3/28/25. I type in a list for him for people to be reviewed or screened for therapy and [R39] was on the list. I update the list daily as I get the orders . I see the OT referral . I don't know how long it takes to get on therapy .<br><br>The facility's undated policy and procedure showed, Physician Orders . If therapy (Physical Therapy, Occupational Therapy, Speech Therapy, Respiratory Therapy) ordered: Call Rehab nurse at [extension] leave a voicemail if after hours . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>45395<br><br>Based on observation, interview, and record review, the facility failed to perform hand hygiene during lunch service and failed to follow its hand hygiene policy and procedure. This deficiency affected all 37 residents reviewed for infection control currently residing in the memory care unit and has the potential to affect all 109 residents currently residing in the facility.<br><br>Findings include:<br><br>On 04/01/2025, upon entering the facility, surveyors were provided with a resident daily census dated 04/01/2025 that documented 37 residents in the CVS (country view square) memory care unit. Centers for Medicare and Medicaid Services form 671 dated 04/01/2025 documented 109 residents currently residing at the facility.<br><br>On 04/01/2025 at 12:30 PM, during lunch service, V11 (Activities) was walking throughout the larger dining room/activity room on this unit, going table to table and removing dirty plates, cups, and silverware from resident dining tables. V11 also removed several soiled clothing protectors from the tables that she was holding close to her body and were touching her clothes. V11 (Activities) was observed interacting with residents in this unit's dining room and in the smaller dining room that is behind and to the left of this larger dining room. V11 was encouraging many residents to either eat more of their lunch or drink more fluids then moved the resident's dinnerware around with her hands then would place a different item within the resident's reach. V11 continued to remove dirty dishes and clothing protectors from table to table and was not observed performing hand hygiene at any time between tables.<br><br>On 04/01/2025 at 12:37 PM, V11 (Activities) coughed into her closed hand in the larger unit dining room then proceeded to move from table to table, clearing plates or moving food items within resident's reach. At 12:46 PM,V11 (Activities) checked her hands and appeared to be looking for something on her hands then proceeded to wipe her hands on a used clothing protector. V11 then continued to remove dirty dishes and clothing protectors from table to table and encouraged several residents to continue eating by moving resident's dinnerware within their reach. V11 (Activities) was not observed performing hand hygiene at any time during this observation period.<br><br>On 04/01/2025 at 1:07 PM, V11 (Activities) said this was her third day at facility and added that infection control policy and procedures were covered during her orientation training. V11 then said she should have performed hand hygiene after coughing into her hand and when clearing dirty dishes from table to table prior to handling any other resident's food of food or cup.<br><br>On 04/01/2025 at 09:17 AM, V4 (Infection Preventionist) said staff should perform hand hygiene after touching their hair, face, etc., and especially after coughing into their hand or blowing their nose. V4 added that staff should perform hand hygiene between residents, and if using hand sanitizer, staff should wash their hands with soap and water after using sanitizer three times and/or if their hands are visibly soiled.<br><br>Hand hygiene procedure for all staff reads in part: Purpose: to prevent the spread of disease organisms form one resident to another, and to safeguard the health of all employees.<br><br>(continued on next page) |

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|---|---|---|---|
| | 145547 | A. Building<br>B. Wing | 04/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Dekalb County Rehab & Nursing | 2600 North Annie Glidden Road<br>Dekalb, IL 60115 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Gloves provide additional protection from microorganisms but do not eliminate the need for hand hygiene before and after the use of gloves. In the absence of a true emergency, personnel should always wash their hands or use alcohol-based hand sanitizer when coming on duty .before and after contact with a source that is likely to be contaminated with secretions/excretions from residents, such as procedures involving the mouth and face-oral care, feeding .before and after eating, after handling soiled [tissue], after going to the bathroom, after blowing or wiping one's nose .In addition to hand washing, alcohol-based hand sanitizer may be used to disinfect hands .Regular handwashing should still be utilized when hands are visibly soiled and after every 3 uses of hand sanitizer .when serving meals, hand sanitizer is to be used between each resident served. |