STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145715	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheaton Village Nrsg & Rhb Ctr	1325 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff promptly reported an allegation of neglect to the facility's abuse coordinator/administrator for investigation. This applies to 1 of 9 residents (R8) reviewed for neglect. The findings include:A review of the Electronic Medical Record (EMR) showed that R8 is a [AGE] year-old male resident who was admitted to the facility from another facility on December 17, 2025. Diagnoses include bipolar disorder with psychotic features, chronic obstructive pulmonary disease, morbid obesity, Type 2 diabetes mellitus, Stage IV chronic kidney disease, anxiety disorder, chronic pain syndrome, difficulty walking, left leg pain, left hand fracture, lack of coordination, fracture of the shaft of the right tibia, and a history of open reduction internal fixation.Review of the Minimum Data Set (MDS) showed that R8 was cognitively intact and required partial to substantial assistance with Activities of Daily Living (ADLs).Review of the care plan dated March 5, 2026, showed that R8 exhibited behavioral distress related to ineffective coping mechanisms, poor communication skills, inability to appropriately express himself, chronic mental illness, and feelings of powerlessness and loss of control. The care plan documented verbally aggressive behaviors, use of profanity, demeaning statements, verbal threats, yelling, racial, ethnic, religious, and gender-based slurs, conflict with staff and residents, poor frustration tolerance, ineffective coping skills, repeated criticism of staff, unprovoked expressions of anger, and derogatory language.On June 6, 2026, at approximately 4:37 p.m., V24 (Social Worker) stated that R8 informed her of concerns regarding the care he received on May 21, 2026, prior to his transfer to the hospital. According to V24, R8 stated that although he was able to get out of bed independently, he required assistance with cleansing his buttocks and perineal area, which was not provided before his transfer to the hospital. R8 reported he was experiencing pain in his buttocks and did not receive pain medication. Additionally, R8 stated he and his wife felt threatened after reporting concerns and that he feared retaliation if he returned to the facility. V24 stated she contacted the facility and informed staff of R8's allegations regarding the care not provided and his fear of retaliation. V24 further stated she notified V10 (Nurse) and V18 (Facility Social Worker) of R8's allegations on May 21, 2026.On June 8, 2026, at approximately 10:00 a.m., V1 (Administrator) stated neither V10 nor V18 had informed her of R8's allegations. V1 stated she would initiate an abuse investigation upon learning of the allegations to determine whether neglect had occurred.On June 9, 2026, at approximately 10:30 a.m., V18 stated she did not report R8's allegations to V1 after being informed of the concerns by V24.On June 6, 2026, at approximately 11:00 a.m., R8 was observed lying in bed covered only by a top sheet. Redness and irritation were noted in the axillary areas, abdominal folds, and groin regions. A bed sheet was wrapped around his perineal area, and his buttocks were exposed. R8 stated that he was unable to reposition himself because of pain in his buttocks. R8 reported he had received pain medication at 8:00 a.m. and would not be eligible for another dose until noon. The bed linens contained bloody drainage and brown staining with a urine-like offensive odor. R8 stated, I guess I am okay now. I do not feel threatened or scared. R8 further stated he was not provided assistance with perineal care before he was transferred to the hospital on May 21, 2026.Review of the facility's Abuse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Prevention and Reporting Policy showed that all allegations of abuse, neglect, misappropriation of resident property, exploitation, or injuries of unknown source must be immediately reported to the Administrator or designated abuse coordinator to ensure prompt investigation and implementation of protective measures.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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, interview, and record review, the facility failed to ensure physician-ordered treatment for skin alterations was implemented to promote healing. This applies to 1 of 3 residents (R8) reviewed for skin alterations.The findings include:A review of the Electronic Medical Record (EMR) showed R8 is a [AGE] year-old male resident who was admitted to the facility from another facility on December 17, 2025. Diagnoses include bipolar disorder with psychotic features, chronic obstructive pulmonary disease, morbid obesity, Type 2 diabetes mellitus, Stage IV chronic kidney disease, anxiety disorder, chronic pain syndrome, difficulty walking, left leg pain, left hand fracture, lack of coordination, fracture of the shaft of the right tibia, and a history of open reduction internal fixation.Review of the Minimum Data Set (MDS) showed R8 was cognitively intact and required partial to substantial assistance with Activities of Daily Living (ADLs).Review of the care plan dated March 5, 2026, showed R8 exhibited behavioral distress related to ineffective coping mechanisms, poor communication skills, inability to appropriately express himself, chronic mental illness, and feelings of powerlessness and loss of control. The care plan documented verbal aggression, profanity, demeaning statements, verbal threats, yelling, racial, ethnic, religious, and gender-based slurs, conflict with staff and residents, poor frustration tolerance, ineffective coping skills, repeated criticism of staff, unprovoked anger toward staff, and derogatory language.On June 6, 2026, at approximately 11:00 a.m., R8 was observed lying in bed covered only by a top sheet. Redness and irritation were noted in the axillary areas, abdominal folds, and groin regions. A bed sheet was wrapped around his perineal area, and his buttocks were exposed. R8 stated he was unable to reposition himself because of pain in his buttocks. He reported he had received pain medication at 8:00 a.m. and would not be eligible for another dose until noon. The bed linens contained bloody drainage and brown staining with an offensive odor. Observation revealed no dressing covering the excoriated and open wound areas on R8's sacral region and buttocks.On June 7, 2026, at approximately 10:40 a.m., R8 was again observed lying in bed. R8 stated he had not been cleaned since the previous evening. V19 (CNA), who was present at the bedside, stated she would provide perineal care. R8 stated he was able to use the bathroom independently but required assistance cleansing his buttocks and sacral area because he was unable to reach those areas.R8 independently turned onto his right side for assessment. Observation revealed severe excoriation to both buttocks with multiple open areas ranging in size from approximately a nickel to a quarter in diameter. The sacral fold was reddened, excoriated, and contained open areas. R8 stated, I am having a lot of pain from my buttocks, and I need a pain pill. I do not even have a dressing there to provide cushioning to my wound. No dressing was present to protect the wound bed. V20 (Nurse) stated, It is not your time for your pain medication yet. I will give your Norco in 30 minutes. V20 confirmed no dressing was in place over the sacral wound area.At approximately 12:40 p.m. on June 7, 2026, R8 was reassessed. No dressing remained in place over the sacral wound area.Review of the Treatment Administration Record (TAR) dated June 7, 2026, showed no documentation the ordered wound treatment had been provided to R8.Review of the Physician Order Sheet (POS) for June 2026 showed the following physician order: May 15, 2026: Cleanse bilateral buttock wounds with normal saline and apply hydrocolloid dressing every Monday, Wednesday, Friday, and as needed.Review of the facility's wound care policy showed wound dressings were to be applied in accordance with physician orders and established wound care protocols to promote healing and prevent complications.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide adequate supervision during meals for a resident identified as being at high risk for choking. This failure resulted in a choking episode that required emergency intervention, hospitalization, and placement of a tracheostomy tube to establish and maintain the resident's airway. This applies to 1 of 1 resident (R6) reviewed for a choking incident.The Findings Include:Review of the Electronic Medical Record (EMR) showed that R6, a [AGE] year-old resident, was admitted to the facility on [DATE]. Diagnoses included drug-induced dyskinesia, schizophrenia, bipolar disorder, anxiety disorder, depression, hypertensive heart disease, type 2 diabetes mellitus, asthma, atherosclerotic heart disease, repeated falls, and right below-knee amputation.Review of the Physician Order Sheet (POS) for May 2026 showed R6 was prescribed a regular diet with regular consistency and was designated as a full code.Review of the Minimum Data Set (MDS) dated [DATE], showed that R6 was alert and oriented but had cognitive and behavioral impairments, including inattention, distractibility, difficulty maintaining focus, difficulty following conversations, and an altered level of consciousness characterized by continuous vigilance. The MDS further assessed R6 as requiring moderate assistance with eating, indicating staff provided more than half of the effort needed to complete the task.Review of the Speech-Language Pathology (SLP) Assessment and Treatment Report dated August 23-25, 2025, showed R6 received skilled speech therapy services for dysphagia. Documentation showed treatment included oral assessment, safe swallowing strategies, and cueing. The report noted R6 had upper extremity tremors that made self-feeding difficult. The SLP documented R6 demonstrated reduced bolus formation and control, suspected reduced base-of-tongue retraction, and would repeatedly hawk up and re-swallow food during meals. The report specifically stated R6 was at risk for choking with all consistencies. The SLP Discharge Assessment and Summary identified a medical alert requiring supervision with all meals due to risk for choking with all consistencies. Further documentation reviews showed nursing staff were educated to provide supervision during oral intake and cue R6 to slow the rate of eating and reduce bite size.Review of R6's current care plan, initiated February 19, 2025, identified limitations related to eating and drinking independently. The care plan specified R6 required cues, supervision, and staff assistance during all meals. The care plan further noted R6 was noncompliant, tended to rush while eating, and placed excessive amounts of food in his mouth despite reminders to slow down and chew thoroughly before swallowing. Interventions included following SLP recommendations, providing instruction on proper chewing and swallowing techniques, and implementing swallowing strategies.Review of the facility incident report dated May 14, 2026, at 8:05 a.m., showed R6 experienced a choking episode during breakfast in the main dining room. Staff performed the Heimlich maneuver, called 911, and initiated cardiopulmonary resuscitation (CPR). R6 was transported to a local hospital. Documentation showed R6 was found to be in asystole and subsequently required placement of a tracheostomy tube to establish and maintain an airway.During an interview on June 7, 2026, at 1:36 p.m., V12, (Certified Nursing Assistant (CNA/Restorative Aide), stated she delivered R6's breakfast tray, consisting of toast and scrambled eggs, and placed it in front of him. V12 stated after placing the tray, she turned away to distribute additional meal trays to other residents. V12 stated she did not stay and supervise R6 during the meal. V12 stated while several feet away, she saw R6 through her peripheral vision raising his right arm, signaling he was choking. V12 stated she immediately responded and called V14, another CNA who was serving coffee in the dining room. V12 stated she and V14 moved R6 away from the table to an open area, where V14 initiated the Heimlich maneuver. V12 stated R6 quickly turned blue in color and visible food was present in his mouth.During an interview on June 7, 2026, at 2:12 p.m., V14 stated she performed three abdominal thrusts on R6 after observing him choking on May 14, 2026, at approximately 8:05 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	a.m. V14 stated R6 immediately became cyanotic, 911 was called, and additional staff responded to the Code Blue.During an interview on June 7, 2026, at 2:30 p.m., V7, (Licensed Practical Nurse/LPN), stated R6 choked during breakfast on May 14, 2026. V7 reported responding after the Code Blue announcement and observed R6 had turned blue. V7 stated she initiated CPR while awaiting the arrival of emergency medical services.During an interview on June 7, 2026, at 1:52 p.m., V17, (Restorative Nurse and care plan staff member), stated R6 was with tremors on upper extremities, and this made it difficult feeding himself, with poor safety awareness, and limited ability to comprehend safety risks. V17 stated R6 should have received visual supervision and assistance during meals because he was at high risk for choking. V17 stated R6 frequently pocketed food, ate rapidly, and accumulated food in his mouth without ensuring previous bites had been swallowed. According to V17, continuous visual supervision was necessary to ensure R6's safety during meals.During an interview on June 8, 2026, at 11:30 a.m., V23, (R6's attending physician), stated R6 experienced a choking incident during breakfast on May 14, 2026.Review of the paramedic report dated May 14, 2026, showed facility staff were performing CPR when emergency medical personnel arrived. The report documented R6 was found in asystole. Paramedics assumed care and transported R6 to a local hospital.Review of hospital records dated May 14, 2026, showed R6 was admitted due to a choking incident. Diagnoses included acute hypoxemic respiratory failure and failed extubation on May 19, 2026. Documentation showed R6's family had elected to proceed with tracheostomy placement and gastrostomy tube feeding. Hospital records further showed R6 was critically ill, at risk for sudden deterioration, and required ongoing critical care management, monitoring, and complex medical treatment.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to adequately assess pain management effectiveness and failed to notify the physician for additional interventions when pain relief measures were ineffective. This applies to 1 of 3 residents (R8) reviewed for pain management.The findings include:A review of the Electronic Medical Record (EMR) showed R8 is a [AGE] year-old male resident who was admitted to the facility from another facility on December 17, 2025. Diagnoses include bipolar disorder with psychotic features, chronic obstructive pulmonary disease, morbid obesity, Type 2 diabetes mellitus, Stage IV chronic kidney disease, anxiety disorder, chronic pain syndrome, difficulty walking, left leg pain, left hand fracture, lack of coordination, fracture of the shaft of the right tibia, and a history of open reduction internal fixation.Review of the Minimum Data Set (MDS) showed R8 was cognitively intact and required partial to substantial assistance with Activities of Daily Living (ADLs).Review of the care plan dated March 5, 2026, showed R8 exhibited behavioral distress related to ineffective coping mechanisms, poor communication skills, inability to appropriately express himself, chronic mental illness, and feelings of powerlessness and loss of control. The care plan documented verbal aggression, profanity, demeaning statements, verbal threats, yelling, racial, ethnic, religious, and gender-based slurs, conflict with staff and residents, poor frustration tolerance, ineffective coping skills, repeated criticism of staff, unprovoked anger toward staff, and derogatory language.On June 6, 2026, at approximately 11:00 a.m., R8 was observed lying in bed covered only by a top sheet. Redness and irritation were noted in the axillary areas, abdominal folds, and groin regions. A bed sheet was wrapped around his perineal area, and his buttocks were exposed. R8 stated he was unable to reposition himself because of pain in his buttocks. He reported he had received pain medication at 8:00 a.m. and would not be eligible for another dose until noon. The bed linens contained bloody drainage and brown staining with an offensive odor.On June 7, 2026, at approximately 10:40 a.m., R8 was observed lying in bed and reported ongoing pain in his buttocks. During the observation, R8 independently turned onto his right side. Observation showed severe excoriation to both buttocks with multiple open areas ranging in size from approximately a nickel to a quarter in diameter. The sacral fold was reddened, excoriated, and contained open areas.R8 stated, I am having a lot of pain from my buttocks, and I need a pain pill. I do not even have a dressing there to provide cushioning to my wound. No dressing was present over the wound bed. V20 (Nurse) stated, It is not your time for your pain medication yet. I will give your Norco in 30 minutes.At approximately 12:40 p.m., R8 was reassessed and continued to complain of sacral pain. R8 stated the pain medication provided did not relieve his pain.Review of the Medication Administration Record (MAR) dated June 7, 2026, showed Hydrocodone/Acetaminophen was administered to R8; however, there was no documented post-medication pain assessment to evaluate the effectiveness of the medication or determine whether pain relief was achieved.Review of the Physician Order Sheet (POS) for June 2026 showed the following physician order:- May 15, 2026: Hydrocodone/Acetaminophen 10 mg/325 mg, one tablet every six hours as needed for chronic pain syndrome.Further review revealed no documented reassessment of R8's pain after medication administration and no evidence the physician was notified when R8 reported the medication was ineffective. Additionally, there were no physician orders for alternative or breakthrough pain management interventions despite R8's continued complaints of uncontrolled pain.Review of the facility's Pain Management Policy dated August 2008 showed staff were required to identify, assess, evaluate, and monitor pain, assess the effectiveness of pain interventions, and notify the physician when additional pain management measures were needed.