STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145743	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Suburban Medical Ctr	3 Erie Court Oak Park, IL 60302

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036 Based on observation, interview, and record review, the facility failed to ensure that it was safe for one resident (R3) to self-administer medications and did not follow doctors order and facility policy prior to leaving inhaler medication at bedside. This failure affected one resident in a total sample of 15 residents. Findings include: R3 is a [AGE] year-old resident admitted to the facility on [DATE], with diagnoses including but not limited to Chronic obstructive pulmonary disease. Order dated 09/24/2024 documents: please assess patient for appropriateness of medications at bedside, if appropriate allow designated medications at bedside. Per protocol. Order dated 09/24/2024 documents: fluticasone-vilanterol 100mcg-25mcg/inhaler inhalation powder. Inhale 1 powder inhalation daily. Care plan dated 09/24/2024 documents: Deficient knowledge: medication related to cognitive impairment or lack of information for oral medications. Resident/Caregiver/support system self-administration assessment tool subacute rehabilitation form dated 09/24/2024 shows 6 questions not answered. This document had a total of 6 questions. This document also stated: Inability to answer yes to all of the above requires removal of medications from bedside. Above form is signed by two nurses one of which was V5. In the area that stated medication name it documents none/Breo Inhaler. On 10/07/2024 at 10:38 AM, R3 had inhaler at bedside sitting on bedside table within reach. Inhaler was Breo ellipta 100mcg/25 mcg (fluticasone-vilanterol). R3 stated, I am not sure when to take it. They tell me when I should take it. I don't believe in all of them medicines. On 10/08/2024 at 2:40 PM, V5, Registered Nurse RN (Registered Nurse), stated, I signed the self-administration assessment tool sheet last week for (R3). I should not have signed the same assessment tool from admission. I should have done a whole new sheet and put the date and time. I could not find the Breo Ellipta so I ordered one and seen there were no medications on the assessment tool, so I added the Breo Ellipta. I did not get a chance to ask all questions. Usually this is done on admission. V5 stated, 09/24/2024 was the first day the Breo Ellipta was ordered. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145743	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/08/2024 at 2:43 PM, V2, Director of Nursing DON (Director of Nursing), stated, My expectation for all nurses regarding self administration assessment tool is that they fill out the paperwork properly and follow policy. If the assessment is not completed or indicates that resident cannot self-administer, medications should not be left at bedside. Policy dated 6/2016 with latest revision date of 03/2022 for Topical ointments, Inhalers and Nasal Spray at bedside documents: Process: 1. Physician writes an order for ointments, inhalers and or nasal spray to be kept at bedside. 2. Medications to be kept in resident's bedside drawer when not in use.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34071 Based on interview and record review, the facility failed to develop a person-centered care plan and interventions that meet the needs of a resident receiving dialysis treatment. This deficiency affects one (R65) of one resident in a sample of 15 reviewed for dialysis. Findings include: R65 is a [AGE] year old, female, admitted in the unit on 09/27/24, with diagnosis of End Stage Renal Disease. R65 goes to an outpatient dialysis center for hemodialysis three times a week. On 10/08/24 at 2:40 PM, R65 was observed in her room, sitting in bedside chair. R65 is alert, oriented, and verbal. R65 was asked regarding dialysis treatment. R65 replied, I go to dialysis Monday-Wednesday-Friday around 1-2 PM, for 3 and a half hours treatment. I go to outpatient dialysis center. R65's care plan read: Impaired fluid balance related to renal disease: Resident to go to Outpatient dialysis after scheduled therapy Hemodialysis - Monday, Wednesday, Friday schedule; fluid restriction. There were no other specific interventions written in R65's care plan regarding monitoring, amount of fluid to be restricted and access care. On 10/09/24 11:29 AM, V2 (Director of Nursing) was asked regarding dialysis care plan. V2 verbalized, Care plan is developed, depends on the order from doctors. If there is an order for fluid restriction or diet, it will be reflected in the care plan. Admitting nurses do the care plan. They don't usually do anything from the nursing standpoint in terms of interventions. There is not a written plan. It is not individualized. Facility was asked to present policy regarding care plan, but nothing was presented during the course of the survey period.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34071 Based on observation, interview, and record review, the facility failed to follow its policy related to ensuring flowsheets and dialysis communication forms are placed in chart on a resident on dialysis treatment. This deficiency affects one (R65) of one resident in a sample of 15 reviewed for dialysis. Findings include: R65 is a [AGE] year-old, female, admitted in the skilled unit on 09/27/2,4 with diagnosis of End Stage Renal Disease. R65 goes to an outpatient dialysis center for hemodialysis three times a week. On 10/08/24 at 2:40 PM, R65 was observed in her room, sitting in bedside chair. R65 is alert, oriented, and verbal. R65 was asked regarding dialysis treatment. R65 replied, I go to dialysis Monday-Wednesday-Friday around 1-2 PM, for 3 and a half hours treatment. I go to outpatient dialysis center. No, I don't bring anything to the dialysis center. I leave here without anything and back here without anything. No forms or papers that I need to bring to or bring back from. On 10/08/24 at 1:10 PM, V2 (Director of Nursing) was asked regarding R65's communication forms and flowsheets before and after dialysis treatment. V2 stated, She (R65) is on dialysis, goes to an outpatient dialysis unit. We don't get any communication forms from dialysis. We don't have that. We don't have the flowsheets in the chart, those were not uploaded in our system. On 10/08/24 at 3:40 PM, V3 (Director of Nursing Operations) also verbalized, We don't have her (R65) dialysis flowsheets in her chart. We don't have the communication form in her chart. Facility's policy titled, Dialysis, Residents Receiving, dated 8/2023, stated: Purpose: Resident can expect appropriate care, accurate documentation and communication between dialysis Staff and the skilled nursing (SNF) Staff. Process: 6. The dialysis communication form will be placed in the patients chart with pertinent information. 8. Copy of the dialysis flow sheet will be placed in the residents SNF chart post dialysis. 9. If dialysis sheet is not in the patients chart upon return to the unit, the SNF nurse will follow up with the dialysis unit and have them fax over a copy.