STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145761	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Nrsg & Rehab Center	14716 S Eastern Avenue Plainfield, IL 60544

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to identify a resident's change in condition with subsequent Physician notification, resulting in a delay of care and hospitalization.This applies to 1 resident (R69) reviewed for quality of care.Findings include:On 06/03/2026 at 11:03 AM, V35 (R69's family member) said R69 was admitted to the hospital ICU (Intensive Care Unit) on 05/24/2026 with septic shock. V35 said R69 was originally admitted to the facility from the hospital for therapy on 05/18/2026, and R69 has stage 4 cancer and takes water pills for maintenance therapy. V35 said she visited R69 on 05/22/2026 after 6 PM, and R69 was lethargic and warm. V35 said R69 was breathing heavily, and she asked for a pulse oximeter. V35 said R69's saturation was 77%, even with using oxygen at 2 liters via nasal cannula. V35 stated R69 was not sent to the hospital until 5/24/2026. V35 continued and said she asked the nurse to check R69's temperature, which showed normal, and then V35 asked the nurse to check it with a thermometer that was working. V35 said R69's temperature was 101.9 F, and she told the nurse that something was not right and that they should run some tests because she thought R69 was developing sepsis again. V35 said the nurse told her she would call the physician and order some lab tests. V35 said she does not think the facility called the doctor and did any labs or urine collection on R69. V35 said she and her sibling had to escalate the situation to have R69 sent to the hospital. V35 said her sister spoke to a nurse (unknown) on 5/23/26 who said EMS is closed and they can't send R69 to the hospital. V35 stated on 05/24/2026, her sibling called V1 (Administrator), and the facility arranged to send R1 to the hospital. V35 stated R69 was intubated and admitted to the ICU with septic shock.The hospital physicians' history and physical data dated 05/24/2026 and 05/25/2026 showed that R69's chief complaint was fever and shortness of breath. During the evaluation, R69 was in respiratory distress and speaking in short sentences due to conversational dyspnea, hypotensive, and was put on pressor support, requiring ICU admission. R69's pulse was 127, and respiration was 41. Further hospital physician's assessment and plan showed R69 presents with sepsis, acute chronic hypoxic respiratory failure, pneumonia of both lungs, and elevated troponin, and possible urinary tract infection upon admission. 05/25/2026 hospital attending physician's report showed that upon admission to the ICU, the patient had difficulty achieving adequate saturation, had abnormal lab results, and was intubated.On 06/04/2026 at 9:29 AM, V31 (Registered Nurse) stated that on 05/22/2026, V35 asked her to take the temperature, and when she did, it was normal. V31 said she realized her thermometer was broken and took the temperature with a different thermometer, which read 101.9 degrees Fahrenheit. V31 said V35 requested V31 to call the doctor and send R69 to the hospital. V31 said she told V35 that she would give R69 Tylenol and would check on her. V31 said she didn't call the doctor. V31 said she does not recall R69's saturation level and did not document anything in the electronic medical record.On 06/04/2026 at 11:08AM, V30 (Registered Nurse-Supervisor) said that if the family requests to call the doctor with concerns, the nurse should call the doctor. V30 said he was not made aware of the situation with R69.R69's face sheet showed that she was admitted to the facility from the hospital for physical therapy with diagnoses including pneumonia, chronic obstructive pulmonary disease, sepsis, lung cancer, pancreatitis, blood disorder, and supplemental oxygen use. On 06/04/2026 at 11: 10 AM, V1 (Administrator) said R69's family had called and said they would like to (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	send R69 to the hospital because she had a fever, and he spoke with V2 (Director of Nursing) and she said she would set it up. V2 said that when the family requests that the resident be transferred to the hospital, the facility needs to notify the doctor and facilitate the transfer. V2 further stated that family and residents have rights.The facility's Notification of Change in Condition Policy stated, in part, that changes in condition were reported immediately to the attending physician, and that the resident's family/representative was educated about treatment options and supported in making an informed decision.