

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145761	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Nrsg & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>46003</p> <p>Based on observation interview and record review the facility failed to update physician orders to reflect residents' resuscitation choice of DNR (Do Not Resuscitate) This applies to 1 of 2 residents (R56) reviewed for code status in a sample of 27 residents.</p> <p>Findings include:</p> <p>R56 diagnoses that includes dementia, anxiety, dysphagia, morbid obesity, hypertension, bradycardia, pain and weakness. R56 was admitted to hospice on 4/22/24. R56's has a signed POLST (Practitioner Order for Life Sustaining Treatment) dated 5/6/24 request comfort focused treatment, allow a natural death. R56's current physician ordered code status in the EMR (Electronic Medical Record) is full code. R56 current care plan goal for hospice is to experience death with dignity and physical comfort. Advanced directive wishes to be honored.</p> <p>On 05/23/24 at 9:32 AM, V16 LPN (Licensed Practical Nurse) stated R56 was on hospice and is comfort care only. V16 looked at R56 physician orders that listed her as a full code. V16 stated the physicians order should be DNR. V16 stated all staff should be looking at the residents advanced directives for their code status.</p> <p>On 05/23/24 at 9:20 AM, V12 C.N.A. (Certified Nursing Assistant) stated the resident code status can be found in the computer and on the crash cart. V12 stated she did not have access to the code status so she would ask the nurse.</p> <p>On 05/23/24 at 9:53 AM, V17 Restorative aid / C.N.A. stated she reviews the residents code status in the computer. V17 attempted to look up a resident's code status in the orders section of the EMR. V17 stated residents code status could also be found in a binder on the crash cart.</p> <p>On 05/23/24 at 1:40 PM, V2 DON (Director of Nursing) stated the residents code status can be found in the advanced directives uploaded into the computer, on the demographics page in the EMR, in the binder on the crash cart. The code status is also entered as a physician order.</p> <p>On 05/23/24 at 2:34 PM, V1 Administrator stated all residents should have a physician's order for their code status, full code or DNR. The physician's order should be consistent with the residents' choice on the POLST.</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
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy Advanced Directives dated November 2016 states if changes or revisions are required, the care plan team will initiate the necessary process to modify the status change in the resident's record, including contact of the resident's attending physician so that appropriate orders to reflect the status change is secured.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384</p> <p>Based on observation, interview, and record review, the facility failed to provide personal hygiene for 6 residents (R25, R97, R73, R3, R37 & R64), who are dependent on ADL care (Activities of daily living) in a sample of 27.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 05/21/24 at 10:36 AM, R25 was observed with long jagged curling fingernails. <p>R25's electronic health record showed that R25 is an [AGE] year old male admitted to the facility on [DATE] with diagnoses including Parkinson's disease, difficulty walking, lack of coordination, legally blind, dementia, and need for assistance with personal care. R25's 5/2/24 MDS (Minimum Data Set) section C showed that R25's cognition is severely impaired, and section GG for personal hygiene showed that R25 is dependent for care (helper does all the effort, & resident does none of the effort to complete the activity). R25's 4/28/2023 care plan for ADLs showed, self-care performance deficit related to decreased mobility, weakness, lack of coordination, dementia, and legally blind. R25 requires assistance for all ADL's. The approach showed, provide supervision, setup, and assistance as needed for hygienic cares.</p> <ol style="list-style-type: none"> On 5/21/24 at 10:47 AM, R97 was observed with long oily hair and severely dry flaking skin on his feet. R97 said that he receives a sponge bath once or twice a week and has not received any lotion to his body in a couple of months. R97 said that he has been asking for someone to come to his room to cut his hair because he cannot get out of bed. R97 said that he has asked staff, but he has not received an answer. <p>R97's health records showed that R97 is a [AGE] year old male admitted on [DATE] with diagnoses including morbid obesity, chronic obstructive pulmonary disease, dependence on supplemental oxygen, and need for assistance with personal care. R97's 3/11/24 MDS section C showed that R97's cognition is intact, and section GG showed under personal hygiene that R97 is dependent for care, (resident does none of the effort to complete the activity). R97's 1/9/24 ADL care plan showed, self-care performance deficit related to decreased mobility, weakness related to respiratory failure, morbid obesity, pain, weakness, and other disease process. The care plan approaches included, provide staff assistance as needed for maintaining personal hygiene.</p> <ol style="list-style-type: none"> On 5/21/24 at 11:34 AM, R73 was observed with oily hair. R73 said that the last time she received a shower was last Wednesday 5/15/24, 6 days past. R73 said that she is to get showers on Wednesdays and Saturdays, but she did not get a shower on last Saturday 5/17/24, because there was no help. <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R73's electronic health record showed that R73 is a [AGE] year old female admitted to the facility on [DATE] with diagnosis including chronic kidney disease, major depressive disorder, lack of coordination, mononeuropathy of left lower limb, weakness, and need for assistance with personal care. R73's 03/22/2024 MDS section C showed that R73's cognition is intact and section GG, Personal Hygiene showed that R72 needs supervision or touching assistance help, provides verbal cues and or touching steady and or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or it intermittently. R73's 12/22/2023 ADL care plan showed, activities of daily living self-care performance deficit related to decreased mobility, weakness, mononeuropathy of left lower limb, difficulty walking, and other disease processes. Require staff assistance for all ADL's. The approaches included provide staff assistance as needed for maintaining personal hygiene ADLs.</p> <p>4. On 5/21/24 at 12:10 PM, R3 was observed with long jagged nails.</p> <p>R3's electronic health record showed that R3 is a [AGE] year old female admitted to the facility on [DATE] with diagnoses including polyarthritis, osteoporosis with current pathological fractures, weakness, hemiplegia and hemiparesis affecting right dominant side, and muscle wasting and atrophy. R3's 2/29/2024 MDS section C showed that R3's cognition is intact, and section GG personal hygiene showed that R3 need substantial maximal assistance, (helper does more than half the effort). R3's 3/10/2023 ADL care plan showed, ADL self-care performance deficit related to decreased mobility, weakness, osteoarthritis, and hemiparesis hemiplegia affecting her right dominant side.</p> <p>5. On 5/21/24 at 12:13pm R37 was observed with long jagged nails. R37 said that she did not know the last time her nails were cut but she would like for someone to cut them.</p> <p>R37's electronic health record showed that R37 is a [AGE] year old female admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, hemiplegia and hemiparesis affecting right dominant side, muscle wasting and atrophy, and need for assistance with personal care. R37's 03/05/2024 MDS section C showed that R37's cognition is intact, section GG personal hygiene showed that R37 needs substantial maximal assistance for personal hygiene, (helper does more than half the effort.) R37's 03/09/2023 ADL care plan showed a self-care deficit related to history of CVA (cerebral vascular accident) with hemiparesis hemiplegia to right dominant side, dementia, weakness, and requires extensive assist. R37's 02/07/2024 care plan showed, resident has a splint/brace to right hand related to hemiplegia and hemiparesis affecting right dominant side and requires a restorative splint/brace program. The approaches include provide hygiene to appropriate extremity before applying splint.</p> <p>On 5/23/24 at 12:15pm, V2 DON (Director of Nursing) said that all ADLs should be done when it is needed. V2 said that nails should be trimmed and cleaned for infection control and so the resident doesn't injure himself or others. V2 said that lotion should be applied to skin and hair should be washed for infection control.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's Activity of Daily Living policy dated 2/2023 showed under Purpose: Based on comprehensive assessment of the resident and consistent with the residence needs and choices, our facility provides necessary care and services to ensure that our residents mobility and activities of daily living do not diminish . The policy showed under Guidelines: In accordance with the comprehensive assessment, together with respect for individual residents needs and choices, our facility provides care and services for the following activities: hygiene, bathing, dressing, grooming, oral care, and elimination - toileting.</p> <p>48526</p> <p>6. On 05/21/24 at 11:28 AM R64 was in her room, resting in the bed. R64's fingernails on her right hand were long with a dark colored substance underneath. R64's fingernails to her left hand were long with a dark colored substance underneath. R64 said she wanted her nails cleaned and clipped. On 05/23/24 at 09:12 AM R64 was resting in the bed. R64's fingernails to her right hand continued to be long with a dark colored substance underneath. R64's fingernails to her left hand continued to be long. R64 said I do not refuse to get my nails cut, any qualified person can cut and clean my nails.</p> <p>On 05/23/24 at 09:29 AM V7 (Registered Nurse) said the nursing department is responsible for cleaning and cutting residents fingernails. V7 said residents nails should be short and clean. V7 said fingernails should be filed so they are not sharp and cut the skin. If nails are long, residents can get skin tears and possible infections.</p> <p>On 05/23/24 at 09:50 AM V3 (Assistant Director of Nursing) said all residents nails should be trimmed and clean. The staff should check the residents nails every day while doing morning care. V3 said if the residents nails are long and dirty, they can scratch themselves, tear their skin or get an infection. The staff are expected to clean and trim nails if they are long, dirty, and or jagged.</p> <p>R64's Face Sheet showed R64 had diagnoses of peripheral vascular disease, mood disorder, neuromuscular dysfunction of bladder, weakness, unspecified fracture of T11-T12 vertebra, T12 compound fracture, polyarthritis, unilateral post traumatic osteoarthritis, right hip post-surgical, diabetes, and hypertension. R64's MDS dated [DATE] showed R64 was cognitively intact. The same MDS showed R64 required partial to moderate assistance with personal hygiene. R64's ADL care plan dated 02/06/24 showed provide staff assistance as needed for transfers, walk in room, walk in corridor, dressing, eating, toileting, and maintaining personal hygiene ADL's as an intervention.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384</p> <p>Based on observation, interview, and record review, the facility failed to verify G tube (gastric tube) placement for 1 resident (R71) in a sample of 27.</p> <p>Findings include:</p> <p>R71's electronic records showed that R71 is a [AGE] year old male admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, type 2 diabetes, tracheostomy, and gastrostomy. R71's 02/19/2024 physician order showed, Reglan 10mg (metoclopramide) via gastric tube every 8 hours 8am 2pm and 10pm. R71's 12/27/2023 physician order showed, acetaminophen extra strength 500 milligram 2 tablets every eight hours, 8am, 2pm & 10pm.</p> <p>On 5/21/24 at 2:07 PM V14 (Nurse) was giving medication to R71, via his G tube. V14 attached the syringe to R71's G tube and flushed the G tube with 60CC's of water. V14 did not check for residual or verify G tube placement before giving the flush. V14 then gave 2 acetaminophen 500 milligram crushed tablets with 20cc's of water, then flushed with 10cc of water, then gave Reglan 10mg (metoclopramide) with 10cc of water. R71 was coughing while V14 was giving the medications.</p> <p>On 5/21/24 at 2:07am, V14 said, I did not check for placement. When I do check for placement, I push a little bit of air. V14 said she did not verify placement before giving R71 his medication, but she should have. V14 said that if you don't check for placement, fluids and medications can go to the lungs. On 5/24/24 at 12:15pm V2 DON (Director of Nursing) said that the nurse should verify placement before starting a feeding, giving medications, or giving flush in a resident's G tube.</p> <p>The facility's Enteral Tube Medication Administration policy dated 10/25/2014 showed, the facility assures the safe and effective administration of enteral formulas and medications via enteral tubes.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39182</p> <p>Based on observation, interviews and record reviews the facility failed to provide oxygen therapy to resident dependent on continuous oxygen and contain reusable nebulizer treatment masks, and BIPAP masks (two levels of air pressure machine). This applies to 4 of 4 residents (R5, R97, R165 and R167) reviewed for respiratory care in a sample of 27.</p> <p>The Findings include:</p> <p>1. On 05/21/24 at 03:42 PM observed V22 (OTA-Occupational Therapy Assistant) wheeling R167 down the hallway from her room to the therapy room with oxygen cannula in her nostrils & the tubing in V22's hand, not connected to an oxygen cylinder or any source of O2. R167 was out of breath & gasping for breath. R167 stated, she cannot do the therapy without oxygen. V22 (OTA) stated, there was oxygen in the therapy room.</p> <p>On 5/21/24 at 11:40 AM, R167's nebulization mask with the medicine container (used) was on the bedside table, not covered.</p> <p>On 5/21/23 at 2:10 PM, R167's nebulization mask with med container (used) was on the bedside table, not covered.</p> <p>R167's face-sheet showed R167 is admitted on [DATE]. R165's diagnoses included chronic obstructive pulmonary disease with (acute) exacerbation. R167's POS (Physician Order Sheet) included albuterol sulfate solution for nebulization; 1.25 mg /3 mL, inhalation four times a day as needed and ipratropium-albuterol solution for nebulization; 0.5 mg-3 mg (2.5 mg base)/3 mL; inhalation, three times a day.</p> <p>2. On 5/21/24 at 10:30 AM, observed R165's nebulization mask with the nebulization medicine container with couple drops of the medicine left in it, on the bedside table uncovered. V23 (R165's son) stated, the facility staff never cleans it or changes it.</p> <p>On 5/22/24 at 9:34 AM, observed R165's nebulization mask with the nebulization medicine container on the bedside table uncovered.</p> <p>On 05/23/24 at 8:40 AM, observed R165's nebulization mask with the nebulization medicine container on the bedside table uncovered.</p> <p>On 5/23/24 at 10:15 AM, V3 (ADON- Assistant Director of Nursing) stated, they should wash and dry the nebulization container for the next use. Also that all respiratory masks should be bagged when not in use.</p> <p>On 05/23/24 at 10:15 AM, V2 (DON- Director of Nursing) stated, the nebulization mask should be stored in a plastic bag to avoid contamination by dust and potential infection. V2 stated, they don't have a policy that specifies how the nebulization mask should be stored.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R165's face-sheet showed R165 is admitted on [DATE]. R165's diagnoses included chronic obstructive pulmonary disease with (acute) exacerbation. R165's POS (Physician Order Sheet) included albuterol sulfate solution for nebulization 3 ml; inhalation every 6 hours as needed.</p> <p>41384</p> <p>3. On 5/21/24 at 10:47 AM, R97's BIPAP (bilevel positive airway pressure device) mask was observed on his bed side table uncovered.</p> <p>R97's electronic health records showed that R97 is a [AGE] year old male, admitted to the facility on [DATE] with diagnoses including morbid obesity, chronic obstructive pulmonary disease, obstructive sleep apnea, dependence on supplemental oxygen, and need for assistance with personal care. R97's 4/18/24 physician order showed, BIPAP O2 at bedtime. R97's 3/11/24 MDS (minimum data set) Section C showed that 97's cognition is intact.</p> <p>On 5/23/24 at 12:15pm V2 DON (Director of Nursing) said that all respiratory equipment including BIPAP masks should be stored in a bag to prevent contamination and that there is a high risk of spreading bacteria if it is not done.</p> <p>48526</p> <p>4. On 05/21/24 at 11:49 AM R5 was in her room, resting in bed. R5's mouthpiece for the nebulizer machine was not contained. On 05/23/24 at 09:08 AM R5's mouthpiece for the nebulizer continued to not be contained.</p> <p>R5's Face Sheet showed R5 had diagnoses of atherosclerotic heart of disease of native coronary artery, chronic obstructive pulmonary disease, acute sinusitis, weakness, polyarthritis, chronic pain, major depressive disorder, anxiety, diabetes, chronic respiratory failure with hypoxia, and peripheral autonomic neuropathy. R5's physician orders dated 05/01/24 showed an order for nebulizer treatments every four hours as needed. R5's MDS dated [DATE] showed R5 had moderate cognitive impairment.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>46003</p> <p>Based on observation, interview and record review the facility failed to provide thickened drinks as ordered by the physician for a resident with swallowing difficulties. This applies to one resident R56 reviewed for diet in a sample of 27.</p> <p>Findings include:</p> <p>R56 diagnoses that includes dementia, anxiety, dysphagia, morbid obesity, hypertension, bradycardia, pain and weakness. R56 physician orders includes puree diet with nectar thick liquids NCS (No Concentrated Sweets) NAS (No Added Salt). R56's MDS (Minimum Data Set) dated 4/19/24 shows R56 requires staff set up assistance for eating. R56's assessment for swallowing show loss of liquids / solids from mouth when eating or drinking. R56 also had coughing or choking during meals or swallowing medications. R56 was assessed to require a mechanically altered diet of pureed food and thickened liquids. The facility undated Dietary Services Policy states diets are prepared and served as prescribed by the attending physician.</p> <p>On 05/21/24 at 11:31 AM, R56 was receiving feeding assistance from V4 family member. V56 had a cup of unthicken coffee and cup of unthicken red juice drink. Both cups were half emptied. R56 and V4 Family Member did not know who the staff member was that provided the drinks.</p> <p>On 05/23/24 at 9:32 AM, V16 LPN (Licensed Practical Nurse) stated R56 is on a pureed diet with nectar thickened liquids and should not be given thin liquids.</p> <p>On 05/23/24 at 1:40 PM, V2 DON (Director of Nursing) stated she was aware R56 had been given thin liquids but did not discover who had given it to her. V2 stated R56 should not be given thin liquids.</p> <p>On 05/23/24 at 11:49 AM V24 Dietician stated residents who have been assessed to require thickened liquids should not be served thin liquids like coffee and juice because thin liquids pose a risk of aspiration.</p>