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	04/03/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855 Based on interview and record review the facility failed to ensure residents felt safe voicing grievances without fear of retaliation. This applies to 10 of 10 residents (R31, R36, R45, R48, R49, R50, R63, R79, R82, R167) reviewed for grievances in the sample 23. The findings include: On March 31, 2025 at 10:10 AM, R48 stated she has had other residents tell her not to say anything about the care for fear of retaliation. R48 is a [AGE] year old admitted to the facility on [DATE]. R48 Minimum Data Set (MDS) dated [DATE] showed her to be cognitively intact. On March 31, 2025, at 11: 00 AM, R167 stated it takes 2 hours for them to answer call lights. R167 stated, If you complain you get hurt. R167 stated she has reported to the staff regarding how long it takes to get help. R167 stated after she complained the help got worse. R167 stated the staff were rough-handling her and she had even longer times to wait for assistance. On March 31, 2025 at 11:16 AM, R63 stated she had a Certified Nursing Assistant (CNA) tell her they can't change R63 every time she urinates. R63 stated they are not nice when you tell them you need something. R63 stated, I'm not here because I want to be here. I'm tired of their attitudes. R79 is [AGE] years old and was admitted to the facility on [DATE]. R79 care plan dated August 12, 2024 showed she had a self-care performance deficit. On March 31, 2025 at 11:42 AM, R79 stated when she calls for help, if they don't want to come they don't come. R79, she doesn't complain because there is no use. 2. On April 1, 2025, at 12:54 PM, a resident council meeting was held during the facility's annual survey. In attendance were R31, R36, R45, R49, R50, R82, and R167. R31's EMR (Electronic Medical Record) showed R31 was admitted to the facility on [DATE], with diagnoses that included Guillain-Barre syndrome, weakness, disorder of muscle unspecified, and muscle atrophy. R31's MDS dated [DATE], showed R31 was cognitively intact. R31 required moderate staff assistance for toileting, showering, and dressing. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R36's EMR showed R36 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease, muscle wasting, and phantom limb syndrome with pain. R36's MDS dated [DATE], showed R36 was cognitively intact. R36 required set-up or clean up assistance for eating and showering. R45's EMR showed R45 was admitted to the facility on [DATE], with diagnoses that included rheumatoid arthritis, morbid obesity, muscle wasting and atrophy. R45's MDS dated [DATE], showed R45 had moderate cognitive impairment. R45 required moderate staff assistance with toileting, showering, and lower body dressing. R49's EMR showed was admitted to the facility on [DATE], with diagnoses that included chronic atrial fibrillation, chronic obstructive pulmonary disease, muscle wasting and atrophy of multiple sites. R49's MDS dated [DATE], showed R49 was cognitively intact and required staff moderate assistance for toileting, showering, and dressing. R50's EMR showed R50 was admitted to the facility on [DATE], with diagnoses that included disorder of the muscles, history of falls, dizziness and giddiness, weakness, and chronic obstructive pulmonary disease. R50's MDS dated [DATE], showed R50 was cognitively intact. R50 was dependent on staff for toileting, maximal assistance for showering, dressing, and personal hygiene. R82's EMR showed R82 was admitted to the facility on [DATE] with diagnoses that included rheumatoid arthritis without rheumatoid factor, unspecified acquired deformity of right and left hands, and muscle weakness. R82's MDS dated [DATE], showed R82 was cognitively intact. R82 was dependent on staff for toileting, and lower body dressing. R82 required maximal assistance for showering and personal hygiene. During the resident council meeting, all residents in attendance stated they were afraid to report a grievance to anyone in the facility because of fear of retaliation by the staff members. R82 said her roommate (R79) wanted to come to the resident council meeting but refused to come because she was afraid of retaliation. R167 said her roommate also refused to come to the meeting for fear of retaliation. R167 said there is retaliation by the staff members which included the staff not answering the call lights timely, not assisting them with care, and being rough with them when they do assist with care. R49 said retaliation from staff is always in the back of her mind when she has concerns and R31, R36, R45, R50, and R82 all agreed with R49. The facility's Resident Rights given at admission, show the following: The facility must ensure that you are free from retaliation and discrimination in exercising your rights. The facility's resident rights guideline revised October/2023 showed that residents have, the right to voice grievances to the staff of the facility, or any other person, without fear of discrimination or reprisal. 43389 Based on interview and record review the facility failed to ensure residents felt safe voicing grievances without fear of retaliation. This applies to 10 of 10 residents (R31, R36, R45, R48, R49, R50, R63, R79, R82, R167) reviewed for grievances in the sample 23. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The findings include: On March 31, 2025 at 10:10 AM, R48 was able to be interviewed and stated she has had other residents tell her not to say anything about the care for fear of retaliation. R48 is a [AGE] year old admitted to the facility on [DATE]. R48 Minimum Data set (MDS) dated [DATE] showed her to be cognitively intact. On March 31, 2025, at 11: 00 AM, R167 stated it takes 2 hours for them to answer call lights. R167 stated, If you complain you get hurt. R167 stated she has reported to the staff regarding how long it takes to get help. R167 stated after she complained the help got worse. R167 stated the staff were rough-handling her and she had even longer times to wait for assistance. R167 stated, It puts some fear in you. On March 31, 2025 at 11:16 AM, R63 was able to be interviewed and stated she had a Certified Nursing Assistant (CNA) tell her they can't change R63 every time she urinates. R63 stated they are not nice when you tell them you need something. R63 stated, I'm not here because I want to be here. I'm tired of their attitudes. R79 is [AGE] years old and was admitted to the facility on [DATE]. R79 care plan dated August 12, 2024 showed she had a self-care performance deficit. On March 31, 2025 at 11:42 AM, R79 was able to be interviewed and stated when she calls for help, if they don't want to come they don't come. R79, said she doesn't complain because there is no use. It is not good for us. They will take actions on us. They will gang up on you. I don't want to say anything because I will get problems. They will gang up on you and we suffer. The facility's Resident rights given at admission show the following: The facility must ensure that you are free from retaliation and discrimination in exercising your rights. The facility's resident rights guideline revised 10/2023 showed that residents have, the right to voice grievances to the staff of the facility, or any other person, without fear of discrimination or reprisal.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 36567 Based on observation, interview and record review, the facility failed to do a smoking assessment and revise the plan of care when a resident resumed smoking. This applies to 1 of 1 residents (R71) reviewed for smoking in the sample of 23. The findings include: R71's EMR (electronic medical records) showed diagnoses of type 2 diabetes mellitus with hyperglycemia, cerebral infarction, difficulty in walking, not elsewhere classified, need for assistance with personal care, history of falling. R71's POS (Physician Order Sheet) admitted to Hospice on February 6, 2025 with diagnoses of liver cancer. R71's Significant Change MDS (minimum data set) dated February 7, 2025 showed that R71 was cognitively intact. On March 31, 2025 at 10:10 AM, R71 stated I am a smoker. I smoke outside depending on the weather. My CNA (Certified Nursing Assistant) or somebody takes me. Review of R71's EMR on March 31, 2025 did not show any current Smoking Assessment or current plan of care for smoking. The same EMR showed that R71 had signed a smoking contract on April 19, 2024. Facility also provided an initial Smoking Assessment and care plan done for R71 on April 16, 2024. On April 1, 2025 at 9:57 AM, V11 (Social Service Assistant) stated that the facility fills out a smoking contract and also does an assessment and plan of care for resident's who smoke. V11 stated that he is not aware that R71 currently smokes. V11 stated that he will look into the matter and provide information. On April 1, 2025 at 10:12 AM, V11 returned with V10 (Social Service Director) who stated that V11 had done an evaluation in February 2025 and at that time R71 stated that she is not smoking. V10 stated that R71 has had a previous smoking contact in place on April 19, 2024 and an assessment and plan of care was done then. V10 stated We are hearing from nursing that she is wanting to smoke again and we are going to update her contract and review the smoking policy with R71 and do an assessment and plan of care. V10 stated that the contract is renewed and assessment and care plan done during an Annual, quarterly, significant change and as needed if the resident decides to smoke. On April 1, 2025 at 11:12 AM, R71 was seen smoking outside the facility in enclosed courtyard seated beside V16 (Hospice Volunteer). R71 had a lighter and cigarette and was able to light the cigarette by herself. R71 stated that her son provides the cigarettes and lighter. V16 stated that she visits every Friday and for the past 4 Fridays has taken R71 out to smoke. V16 stated that counting April 1, 2025, she has accompanied R71 five times. V16 stated that she gets a pouch containing cigarettes and a lighter from nursing staff as they keep the pouch in a cart. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 2, 2025 at 11:53 AM, V24 (Registered Nurse) stated that he recalls that R71 has been smoking after she was moved to the current unit and has been more than one month. V24 stated that R71's pouch with cigarettes and lighter is kept in the cart near the nurses station. Facility policy titled Resident Smoking (effective date November 1, 2023) included as follows: Standards: It is the policy that smoking is allowed in designated smoking areas. Responsible Party: All facility personnel, residents and visitors. 2. All residents who desire to smoke will have a smoking assessment performed by a member of the Social Services Department an/or nursing department to determine if they are safe to smoke independently. The assessments will be reviewed by the interdisciplinary team for determination of appropriate interventions, if needed as well as care plan development. 3. Smoking risk assessment's are performed upon admission and quarterly or with any changes which could affect the safety of the resident. These assessments are reviewed by the interdisciplinary team for agreement and planning of interventions including adaptive devices, safety precautions and or further evaluation by therapy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52539 Based on observation, interview and record review, the facility failed to assist residents, who were identified as needing assistance, with hygiene and grooming. This applies to 5 of 5 residents (R54, R81, R86, R366, R368) reviewed for ADL (activities of daily living) in the sample of 23. The findings include: 1.R81 has multiple diagnoses including disorder of the muscle and need for assistance with personal care based on the face sheet. R81's admission MDS (minimum data set) dated February 25, 2025, showed the resident is cognitively intact. The same MDS showed the resident has functional limitation in range of motion on both sides of his upper extremities and he needs assistance with personal hygiene. On March 31, 2025, at 9:52 AM, R81 was observed sitting in his wheelchair. He is alert, oriented, and verbally responsive. He was observed to have long and unkempt facial hair. When asked, R81 stated he wanted the staff to shave him. On April 1, 2025, at 9:30 AM, R81 was sitting in his wheelchair and still had long and unkempt facial hair. R81 stated he wants the staff to trim his facial hair. V2 (Director of Nursing) was present during this observation. He said to V2 food gets stuck in the hair. V2 acknowledged the resident needs facial hair grooming. R81's current care plan initiated on February 21, 2025, showed he has ADL self-care performance deficit due to decreased mobility, weakness, and other disease processes. The same care plan states R81 requires staff assistance for all ADLs. The facility's policy for ADL effective February 2023 showed under guidance, In accordance with the comprehensive assessment, together with respect for individual resident needs and choices, our facility provides care and services for the following activities: Hygiene: bathing, dressing, grooming and oral care. 16746 2. R54 had multiple diagnoses including displaced intertrochanteric fracture of the left femur and muscle wasting and atrophy, based on the face sheet. R54's admission MDS dated [DATE] showed that the resident was moderately impaired with cognition. The same MDS showed that R54 had functional limitation in range of motion to both upper extremities and required total assistance from the staff with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 31, 2025 at 10:22 AM, R54 was sitting in her wheelchair inside her room. R54 was alert and oriented. R54's fingernails were long and jagged. According to R54 she had asked the staff several times for her fingernails to be trimmed and no one had assisted her with the trimming. On April 1, 2025 at 9:38 AM, R54 was sitting in her wheelchair inside her room. R54 was alert and oriented. R54's fingernails were long and jagged. R54 stated that she wanted the staff to trim her fingernails. V2 (Director of Nursing) was present during the observation and acknowledged that R54's fingernails were long and needed to be trimmed. R54's active care plan initiated on March 12, 2025 showed that the resident has ADL self-care performance deficit related to decreased mobility, weakness, and other disease processes. The same care plan showed that R54 required staff assistance for all ADLs. 3. R366 had multiple diagnoses including acute respiratory failure with hypoxia, and muscle wasting and atrophy, based on the face sheet. R366's admission MDS dated [DATE] showed that the resident was cognitively intact. The same MDS showed that R366 had functional limitation in range of motion to both upper extremities and required assistance from the staff with personal hygiene. On March 31, 2025 at 11:34 AM, R366 was sitting in her wheelchair inside her room. R366 was alert and oriented. R366's fingernails were long, jagged with black substances under some of her fingernails. R366 wanted the staff to trim and clean her fingernails. On April 1, 2025 at 9:16 AM, R366 was in bed, alert and oriented. R366's fingernails were long, jagged with black substances under some of her fingernails. In the presence of V2, R366 stated that she wants the staff to trim and clean her fingernails. V2 acknowledged that R366's fingernails needed trimming and cleaning. R366's active care plan initiated on March 26, 2025 showed that the resident has ADL self-care performance deficit related to decreased mobility, weakness, and other disease processes. The same care plan showed that R366 required staff assistance for all ADLs. 4. R368 had multiple diagnoses including multiple sclerosis, muscle wasting and atrophy, stiffness of the left and right hand, and functional quadriplegia, based on the face sheet. R368's admission MDS dated [DATE] showed that the resident was cognitively intact. The same MDS showed that R368 had functional limitation in range of motion to both upper extremities and required assistance from the staff with personal hygiene. On March 31, 2025 at 10:53 AM, R368 was sitting in his motorized wheelchair inside his room. R368 was alert and oriented. R368's fingernails were long and jagged. The resident wanted the staff to trim his fingernails. On April 1, 2025 at 9:46 AM, R368 was in bed, alert and oriented. R368's fingernails were long and jagged. R368 stated that he wants the staff to trim his fingernails. V2 was present during the observation and acknowledged that the resident needs assistance with fingernails trimming. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R368's active care plan initiated on February 10, 2025 showed that the resident has ADL self-care performance deficit related to multiple sclerosis, decreased mobility, weakness, and other disease processes. The same care plan showed that R368 requires staff assistance for all ADLs. On April 2, 2025 at 9:35 AM, V2 stated that it is part of the nursing care and service, and the staff are expected to assist residents needing assistance with ADL including trimming of facial hair and nail care to ensure and maintain resident's good hygiene and grooming. 41855 5. R86's EMR (Electronic Medical Record) showed R86 was admitted to the facility on [DATE], with diagnoses that included acute and chronic respiratory failure, chronic obstructive pulmonary disease, type 2 diabetes, morbid obesity, weakness, dependence on supplemental oxygen, and dependence on other enabling machines and devices. R86's MDS (Minimum Data Set) dated March 12, 2025, showed R86 was cognitively intact and was dependent on staff for toileting, showering/bathing, and personal hygiene. R86 was incontinent of bowel. R86's care plan showed R86 had an ADL (Activity of Daily Living) self-care performance deficit related to decreased mobility and weakness, related to respiratory failure, morbid obesity, pain, weakness and disease process. The interventions included staff are to provide assistance as needed for transfers, walk in room, walk in corridor, bathing dressing, eating, toileting hygiene, and oral hygiene ADLs. On March 31, 2025, at 9:52 AM, R86 was in bed and there was a foul odor noted when standing next to the bed. R86 had long facial whiskers and said he needs help to shave because he cannot see to do it himself. R86 said he prefers bed baths and his scheduled days are Monday and Thursday. R86 said his last bed bath was last Monday (March 24, 2025). R86 said if it is not his shower day, they do not offer to provide any care at all. R86's urinal with 800 ml (Milliliters) was sitting on his over the bed tray table. R86 said was sitting there when the staff brought his breakfast tray. He said the staff just set his breakfast next to the urinal. At 12:07 PM, urinal with 400 ml sitting on his over the bed tray table. At 12:55 PM, Resident was eating lunch in his room, tray was on the over the tray table next to his urinal which had 400 ml of urine. Resident said this bottle has been sitting for a while, since before they brought my lunch tray. R86 said he is not able to get out of bed to use the bathroom and that is why he has the urinal and not able to empty it himself. On April 2, 2025, at 10:03 AM, V2 (DON/Director of Nursing) stated that on non-shower days the expectation is that the CNAs (Certified Nurse Assistants) still provide hygienic care to the resident and that includes washing face, hands, perineal care, underarms, oral hygiene, combing hair, and dressing. V2 added that normally residents get shaved on shower days, but it can be done whenever needed. V2 stated that nail care should be done when needed and that staff from activities will also go around and help with nail care for the residents. V2 stated that emptying the urinal is part of R86's toileting care.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29562 Based on observation, interview, and record review, the facility failed to ensure that foot care is provided for a resident who needs total assistance for personal care. This applies to 1 of 1 resident (R56) reviewed for foot care in the sample of 23. The findings include: Face sheet shows R56 is [AGE] years-old who has multiple medical diagnoses including needs for assistance with personal care, Alzheimer's disease with late onset. Minimum Data Set (MDS) dated [DATE], shows that R56 has severe cognitive impairment and requires total care for all her activities of daily living. On April 1, 2025, at 1:45 PM, R56 was lying in her bed, she was non-verbal and displayed flat affect. V13 (Nurse/LPN), removed R56's socks and revealed skin flakes and very dry skin on the feet. R56's toenails were noted to be overgrown on both feet. V13 measured. R56's toes were all in its proper upright position, however, all her left and right toenails grew sideways each measuring 0.5 centimeter (cm) in length on the small toes. The left big toenail which was also overgrown was slightly misaligned from the toe. The bottom left side of the left big toenail separated from the nail matrix and cuticle creating a gap with unknown black substance in between. While the right big toenail was sticking sideway as well measuring 1.8 cm in length. On April 1, 2025, at 2:04 PM, V13 (Nurse/LPN) stated that the facility certified nursing assistants (CNA) or the hospice CNA staff should notify the nurses for R56's needs of podiatry consult for toenail clipping. It should have been clipped because it can snag into the socks which can cause discomfort or misalignment of the nails, or it can cause the nail to get pulled off the nail bed. V13 was unable to tell when R56 was last seen by the podiatrist. On April 1, 2025, at 3:04 PM, V2 (Director of Nursing (DON) stated that toenails should be assessed by the staff. If the toenails needed clipping, the staff should refer it and obtain consent from either the resident or family member for podiatry consult as needed. Care of Fingernails/Toenails Policy and Procedure dated April 2007: Purpose: The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines: 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 52539 Based on observation, interview and record review, the facility failed to follow physician's order for oxygen administration. The facility also failed to change the oxygen tubing and maintain water level in humidifier bottle per facility's policy and procedure. This applies to 1 of 1 resident (R81) reviewed for oxygen therapy in the sample of 23. The findings include: R81 has multiple diagnoses including acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, and dependence on supplemental oxygen based on the face sheet. On March 31, 2025, at 9:52 AM, R81 was observed sitting in his wheelchair. R81 had oxygen via nasal canula at one liter per minute using an oxygen concentrator. The oxygen tubing was dated March 23, 2025. The water in the humidifier bottle was almost empty and there were no bubbles noted. There was no date on the humidifier bottle. On April 1, 2025, at 9:30 AM, R81 was sitting in his wheelchair. V2 (Director of Nursing) was present during this observation. V2 was asked to look at the oxygen concentrator. She acknowledged that the tubing was dated March 23, 2025, and the patient was receiving one liter per minute of oxygen. V2 stated the oxygen tubing is changed weekly every Wednesday and as needed. R81's current physician's order dated February 26, 2025, showed an order for continuous oxygen at two liters per minute via nasal canula. R81's current care plan initiated on February 19, 2025, showed R81 has chronic obstructive pulmonary disease, obstructive sleep apnea, and hypoxia. Under interventions, it showed oxygen to be administered as directed. On April 2, 2025, at 9:41 AM V2 (Director of Nursing) acknowledged physician orders need to be followed for oxygen administration since oxygen is a medication. The oxygen tubing is to be changed weekly and as needed for infection control purposes. V2 also acknowledged humidifier bottles on oxygen concentrators need to have appropriate water level and it should be bubbling when in use to provide moisture to the residents. The facility's policy for oxygen administration last revised in March 2004 showed under preparation, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. Under steps in the procedure showed in-part, 11. Periodically re-check water level in humidifying jar.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 29562 Based on observation, interview, and record review the facility failed to ensure accurate and timely accounting of controlled medications, and failed to ensure that narcotic medication is stored in a sealed packaging. This applies to 4 of 5 residents (R5, R32, R91, R315) reviewed for controlled medications in the sample of 23. The findings include: 1. On April 1, 2025, at 4:12 PM, controlled medication was counted with V9 (Nurse) of the 700 hallway's medication cart. R315's blister pack of Tramadol HCl 50 mg (milligrams) with 16 tablets remaining that were intact and sealed. R315's controlled drug receipt/record/disposition form for the Tramadol showed that there should be 17 remaining in the blister pack. V9 stated that he gave a tablet of Tramadol to R315 earlier and he forgot to sign it out. 2. On April 1, 2025, at 4:41 PM, controlled medication was counted with V25 (Nurse) of the 600 hallway's medication cart. R5's blister pack of Tramadol HCl 50 mg has 1 tablet remaining (tablet number 1). The seal of the packaging of tablet number 1 was broken and taped over. On April 1, 2025, at 5:10 PM, controlled medication was counted with V8 (Nurse) of the 100 hallway's medication cart and the following were observed: 3. R91's blister pack of Lorazepam 0.5 mg number 15 tablet was torn. 4. R32's blister pack of Methylphenidate 10 mg with 10 tablets remaining that were intact and sealed. R32's controlled drug receipt/record/disposition form for the Methylphenidate showed that there should be 11 remaining in the blister pack. V8 stated that she gave a tablet of Methylphenidate earlier to R32. On April 2, 2025, at 1:46 PM, V2 (Director of Nursing/DON) stated that as soon as the nurse pulls out a narcotic medication from the container, the nurse must sign it out at the controlled drug receipt/record/disposition form for accurate tracking or inventory of the medication. If a narcotic packaging is torn, the nurse should not tape it over, but instead they should discard it with another nurse as witness to prevent potential diversion of drugs. The facility's Policy and Procedure for Controlled Substances dated October 25, 2014, shows: Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. Procedures: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Accurate accountability of the inventory of all controlled drugs is maintained at all times. When controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the administration record (MAR): 1. Date and time of administration. 2. Amount administered. 3. Remaining quantity. 4. Initial of the nurse administering the dose, completed after the medication is actually administered. E. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It must be destroyed according to facility policy and the disposal documented on the accountability record on the line representing that dose.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 29562 Based on observation, interview, and record review, the facility failed to follow physician's order during medication administration. There were 26 medication opportunities with 2 errors resulting to 7.69% medication error rate. This applies to 1 of 4 residents (R15) reviewed for medication administration in the sample of 23. The findings include: On March 31, 2025, at 5:05 PM, V8 (Nurse/RN) prepared and administered multiple medications to R15 including, 10 milliliters (ml) of Lactulose Solution (10 mg/15/ml) orally and 6 units of Novolog (Aspart) to R15 subcutaneously. Prior to medication administration R15's blood sugar level was checked, and the result showed 213 mg/dl (milligrams per deciliter). R15's Medication Administration Record (MAR) dated March 2025, showed that R15 is supposed to receive Lactulose 30 ml (20 grams) and the Novolog sliding scale shows that R15 is supposed to receive 4 units based on his blood sugar reading of 213. On April 1, 2025, at 12:21 PM, V2 (Director of Nursing/DON) stated the nurse must administer medication per physician order. They should follow the 5 rights of administering medications which include right dose. Facility's medication administration policy and procedure with effective date of October 25, 2014, shows: Medications are administered in accordance with written orders of the prescriber.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29562 Based on observation, interview, and record review, the facility failed to label medication for the date it was opened to determine expiration date. The facility also failed to remove medication upon its used by date. This applies to 4 of 6 residents (R4, R32, R33, R315) reviewed for labeling and storage of medication in the sample of 23. The findings include: On April 1, 2025, from 3:56 PM to 5:10 PM, medication carts and medication room inspection was conducted with V8, V9, and V25 (All Nurses) and the following were observed: 1. R315's Trelegy Ellipta (Fluticasone furoate, umeclidinium, and vilanterol inhalation powder) 100 mcg/62.5 mcg/ 25mcg was opened and not dated. The Pharmacy Audit Assistance Service ([NAME]) form shows to discard 6 weeks after this medication was opened. 2. R32's Trelegy 200 mcg/62.5 mcg/25 mcg was opened and not dated. [NAME] form shows to discard 6 weeks after this medication was opened. 3. R4's Fluticasone propionate/Salmeterol Inhaler 250 mcg-50 mcg showed that it was opened on 1/20/25 and used by 2/20/25. [NAME] shows to discard 1 month after it was opened. In addition, R4's Incruse Ellipta 62.5 mcg opened and not dated. [NAME] shows to discard this medication 6 weeks after it was opened. 4. R33's Arnuity Ellipta 100 mcg (Fluticasone Furoate) was opened and not dated. [NAME] shows to discard 6 weeks after this medication was opened. On April 2, 2025, at 1:36 PM, V2 (Director of Nursing/DON) stated the staff must date all insulin, inhalers, eye drops, upon opening to determine expiration date based on manufacturer's guidelines.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 36567 Based on observation, interview and record review, the facility failed to follow the menu extension sheet to provide portions as shown for mechanical soft and pureed consistency diets. This applies to 6 of 6 residents (R2, R14, R17, R19, R33, and R34) reviewed for dining. The findings include: Week at a glance menu for week 2 (Monday) lunch meal included Lemon Baked Tilapia and Sliced Zucchini, Dinner roll. Facility menu extension sheet for mechanical soft diets showed to serve 1 each [piece] of Lemon Baked Tilapia. The extension sheet for pureed diets showed to provide 1/2 cup pureed Lemon Baked Tilapia and 1/3 cup pureed zucchini. Facility Portion Control Chart for scoops showed as follows in cups or oz (ounce) capacity. #16=1/4 cup or 2 oz, #12 =1/3 cup , #10 =3 oz, #8 =1/2 cup or 4 oz On March 31, 2025 at 12:07 PM, V6 (Cook) was platting the food for the lunch meal service in the facility kitchen. V6 used a #16 scoop to serve ground Lemon Baked Tilapia and R2, R14, R17, R33, and R34 who were on mechanical soft diets received the same. V6 used two #16 scoops to serve pureed Lemon Baked Tilapia and one #16 scoop pureed zucchini to R19 who was on a pureed diet with double protein. R19 did not receive pureed soup nor pureed bread. On March 31, 2025 at 12:50 PM, V5 (Dietary Manager) was asked how many ounces one piece of Lemon Baked Tilapia was and why the scoop size for mechanical soft Lemon Baked Tilapia was not listed on the menu. V5 responded I have no idea. I am not a big fan of this menu program. The lady who helps with the program is on vacation. V5 was shown the scoop sizes used on the tray line for above diets observed, V5 stated that V6 should have provided the portion sizes as shown on the menu for pureed diets. V5 stated that she will consult with the menu services to report back on serving portions for mechanical soft diets. V5, on checking with V6, stated that the pureed soup and pureed bread was not prepared. V5 added that soup is an always available item served on the menu for all consistency diets. On April 2. 2025 at 9:50 AM and 2:10 PM, V18 (Dietitian) stated that Lemon Baked Tilapia is 3 oz portion and that the facility should have used a #10 scoop instead of the #16 scoop for the mechanical soft diets in order to receive 3 oz portions. V18 stated that the facility should have used #8 scoop to provide 1/2 cup portion of pureed Lemon Baked Tilapia instead of using #16 scoop and that for double portions protein the resident should receive two #8 scoops. V18 stated that the facility should have used a #12 scoop to serve 1/3 cup of pureed zucchini instead of using the #16 scoop. V18 added that the Pureed diets should receive whatever is offered to other residents. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility Diet Type Report listing diet orders of residents printed on March 31, 2025, showed that R2, R14, R17, R33, and R34 were on mechanical soft consistency diets, and R19 was on pureed diet with double protein.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 36567 Based on observation, interview and record review, the facility failed to provide lunch meal options of similar nutritive value to the main entree. This applies to 2 of 2 residents (R32, R266) reviewed for dining in the sample of 23. The findings include: Week at a glance menu for week 2 (Monday) lunch meal included Lemon Baked Tilapia, Wild [NAME] Blend and Sliced Zucchini. Facility Alternate Menu listing included grilled cheese sandwich. On March 31, 2025 on 12:12 PM and 12:24 PM during lunch meal service, R32 and R266 received a grilled cheese sandwich with a side of zucchini. R32 and R266 meal tickets showed that they had ordered the grilled cheese sandwich in substitute for the main meal. V6 (Cook) who prepared the sandwiches stated that he used 2 slices of American cheese with 2 slices of bread to make the grilled cheese sandwich. Nutrition facts for American cheese slices included that 1 slice has 3 grams protein. On April 2, 2025 at 2:10 PM, V18 (Dietitian) stated that Lemon Baked Tilapia is a 3 oz/ounce portion. V18 stated that 1 oz =7 grams of protein and that 3 oz portion=21 grams of protein. V18 agreed that since only 2 slices of cheese was used to make the grilled cheese sandwich, the item only had 6 grams of protein. V18 also agreed that the facility should have offered an additional item to provide 21 gram of protein for the substitute meal to meet the nutrition needs for the meal. Facility policy titled Selective Menus (effective June 2023) included as follows: Policy: It is the Policy of [facility] if selective meals are offered, selections will be provided within allowed dietary modifications Purpose: The purpose of this policy is to create nutritious menus and portion control in which will be freshly prepared and served by culinary chefs at the communities and to identify the basic factors involved in menu planning.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 16746 Based on observation, interview and record review the facility failed to assess and provide appropriate adaptive eating equipment to maintain ability to eat independently for a resident identified with limited range of motion on the upper extremities. This applies to 1 of 1 resident (R51) reviewed for adaptive eating equipment in the sample of 23. The findings include: R51 had multiple diagnoses including dementia without behavioral disturbance, cerebral infarction, cerebral ischemia and cognitive communication deficit, based on the face sheet. R51's quarterly MDS (minimum data set) dated January 8, 2025 showed that the resident was severely impaired with cognition. The same MDS showed that R51 had functional limitation to both upper extremities and required setup or clean-up assistance from the staff with eating. On March 31, 2025 at 12:58 PM, R51 was sitting in her recliner wheelchair inside the first floor main dining room. R51 was eating her lunch meal independently. R51 was not able to move her left arm and hand and uses only her right hand to eat using a fork. While attempting to get/scoop her food consisting of baked fish and rice, most of the food fell out of her plate to the table and while eating, some of her food fell on the resident's protective clothing because, R51 was having a hard time bringing the fork with food to her mouth. No staff assisted R51 during this meal observation. During the same meal observation V21 (Restorative Nurse) removed a chunk of fish from R51's protective clothing, but no assistance was provided to the resident to ensure that the resident consumes the rest of her meal. On April 1, 2025 at 12:48 PM, R51 was sitting in her recliner wheelchair inside the first floor main dining room. R51 was eating her lunch meal independently. R51 was not able to move her left arm and hand and uses only her right hand to eat using a fork. While attempting to get/scoop her food consisting of stuffed cabbage roll, two chunks of meat fell on the floor and while eating the cabbage, some of it fell on the resident's protective clothing. R51 was observed getting the cabbage that fell on her protective clothing using her right hand fingers and eating it. During this meal observation, no staff assistance was provided. At 1:02 PM, V22 (Restorative Certified Nursing Assistant) removed the cabbage from R51's protective clothing and started to assist R51 with eating. During this time, V2 (Director of Nursing) was called to the main dining room. It was pointed to V2 that two chunks of meat from the stuffed cabbage roll fell on the floor while R51 was attempting to get/scoop her food. V2 was also informed of R51's lunch meal observation on March 31, 2025. V2 was asked if R51 was assessed for the need to use any adaptive equipment for eating. V2 stated that she will ask the restorative department or the therapy department to assess R51. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R51's restorative nursing program documentation dated April 1, 2025 at 3:26 PM created by V21 (Restorative Nurse) showed, that eating restorative program was assessed. The restorative nursing program documentation showed that R51 had limited ability to feed self independently. The goal was for R51 to feed self, using a scoop plate as adaptive equipment and the staff to assist R51 as needed daily. The same program documentation showed, She participates with occasional cueing and staff assist as needed. Resident continues to spill food occasionally during self-feed but does benefit from a scoop plate. On April 2, 2025 at 9:28 AM, V21 stated that she assessed R51 on April 1, 2025 after lunch, for the need for adaptive eating equipment to aide in resident self-feeding. V21 stated that based on her assessment, R51 needed a scoop plate as an adaptive eating equipment to prevent her food from spilling out of her plate and to improve her ability to eat independently. V21 added that R51 can grip the regular utensils like fork or spoon and the resident does not need a special utensil. During the same interview, V21 stated that the staff should provide cueing and/or assistance to R51 as needed to ensure nutritional intake. On April 2, 2025 at 9:43 AM, V2 (Director of Nursing) stated that as part of the nursing care and services, the nursing staff are expected to report to the nurse or to the therapy or restorative department any resident needing adaptive eating equipment or utensils, to ensure that the resident is assessed appropriately and promptly, so that needed adaptive eating equipment or utensils could be provided to ensure nutritional intake.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855 Based on observation, interview, and record review, the facility failed to follow infection control practices during provisions of ADL (Activities of Daily Living) care, medication pass, or while providing therapy services. This applies to 6 of 6 residents (R15, R86, R111, R265, R365, R366) reviewed for infection control in the sample of 23. The findings include: 1. R86's EMR (Electronic Medical Record) showed R86 was admitted to the facility on [DATE], with diagnoses that included acute and chronic respiratory failure, chronic obstructive pulmonary disease, type 2 diabetes, morbid obesity, weakness, dependence on supplemental oxygen, and dependence on other enabling machines and devices. R86's MDS (Minimum Data Set) dated March 12, 2025, showed R86 was cognitively intact and was dependent on staff for toileting, showering/bathing, and personal hygiene. R86 was incontinent of bowel. R86's care plan showed R86 had an ADL (Activity of Daily Living) self-care performance deficit related to decreased mobility and weakness, related to respiratory failure, morbid obesity, pain, weakness and disease process. The interventions included staff are to provide assistance as needed for transfers, walk in room, walk in corridor, bathing dressing, eating, toileting hygiene, and oral hygiene ADLs. On March 31, 2025, at 9:52 AM, R86 was in bed with his over the bed tray table in front of him. He had a urinal with 800 ml (milliliters) of urine sitting on his over the bed tray table. R86 said it was sitting there since before breakfast. R86 said the staff delivered his tray and just left the urinal with urine sitting next to his breakfast tray. At 12:07 PM, R86 had a urinal with 400 ml of urine in it sitting on his over the bed tray table. At 12:55 PM, R86 was eating his lunch in bed and his urinal with 400 ml urine in it was sitting next to his lunch tray. R86 said this was the same urine from earlier. On April 2, 2025, at 8:04 AM, R86 had 450 ml of urine in his urinal sitting on his over the bed tray table next to his breakfast tray. On April 2, 2025, at 8:15 AM, V2 (DON/Director of Nursing) went into R86's room with surveyor and saw the urinal on the over the bed tray table next to his breakfast tray. V2 said the staff should be emptying the urinal and not leaving a urinal with urine on the over the bed tray table especially when eating meals. 36567 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R265's face sheet included diagnoses including extended spectrum beta lactamase (ESBL) resistance, neuromuscular dysfunction of bladder, unspecified, urinary tract infection, site not specified, encounter for fitting and adjustment of urinary device, other abnormalities of gait and mobility. R265's POS (Physician Order Summary) showed EBP (Enhanced Barrier Precautions) due to indwelling urinary catheter. On April 1, 2025 at 10:41 AM, R265's doorway had a signage of Enhanced Barrier Precautions. Signage included directives that providers and staff should wear gloves and gown for following high contact resident care activities including transferring. Outside the room door there was a bin that contained PPE (personal protective equipment) that included gloves and gown. Two staff members (V19 Occupational Therapist and V20 Physical Therapist) were noted going into R265's room and after applying gloves was seen holding R265 by the gait belt and arm while walking R265 back and forth in the room, guiding R265 as he used his walker. R265 had an indwelling catheter and was wearing a hospital gown. R265's nurse V17 (Registered Nurse), who was in the hallway, stated that V19 and V20 are from therapy. V17 stated that R265 is on EBP related to his indwelling catheter and his roommate R2 is also on EBP for having a colostomy bag. V2 (DON) who also was in the vicinity stated that V19 and V20 should be wearing gloves and gown when providing physical therapy as R2 is on EBP. Facility policy titled Enhanced Barrier Precautions (revised March 21, 2024) included as follows: It is the practice of this facility to implement enhanced barrier precautions for prevention of transmission of multi drug-resistant organisms. Definitions: Enhanced barrier precautions refer to use of gown and gloves for use during high-contact resident care activities for residents to be colonized or infected with MDRO [multi drug-resistant organisms] as well as those at increased risk of MDRO acquisition (Example: residents with wounds or indwelling medical devices). Enhanced barrier precautions should be followed outside the residents room . when working with residents in the therapy gym, specially when anticipating close physical contact while assisting with transfers and mobility, or high contact activity. 29562 3. On March 31, 20225, at 5:11 PM, V8 (Nurse/RN) administered insulin to R15. V8 removed the cap of R15's insulin needle and dropped the syringe causing the needle to make direct contact to R15's blanket. V8 picked up the syringe and proceeded to administer the medication to R15 without discarding the old syringe and drawing a new insulin syringe. 4. On April 1, 2025, at 9:00 AM, V9 (Nurse/LPN) prepared 9 different medications and vitamins in a tablet form. V9 placed the medications in a medicine cup and handed it to R111. R111's hands were unsteady, and she dropped the medicine cup. The medicines spilled all over her lap and wheelchair. V9 picked the medications with bare hands and handed it back to R111. Again, R111 took the medicine cup from V9 and accidentally dropped it and V9 picked it up again bare handed and gave it to R111 to take. R111 was able to eventually take all the same medications all over her lap and wheelchair and touched by V9's bare hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 1, 2025, at 12:28 PM, V2 (DON) stated that when a nurse accidentally dropped an open insulin syringe and the needle contacted an object or surface, the nurse must discard the contaminated syringe and must prepare a clean a new one. If the oral medications were dropped on the resident's lap, wheelchair or floor, the nurse must clean it up and prepare new set of medications. This must be done because the medications were potentially contaminated. 16746 5. R365 had multiple diagnoses including sacral region pressure injury, and acute local infection of the skin and subcutaneous tissue, based on the face sheet. On March 31, 2025 at 11:02 AM, R365 was in bed, alert, oriented and verbally responsive. While donning a gown and a pair of gloves, V15 (Licensed Practical Nurse) handled the urinary catheter bag of R365 to check for sediments and then reposition the said catheter bag. While using the same pair of gloves, V15 was about to touch R365's right upper arm PICC (Peripherally Inserted Central Catheter) line. V15 had to be prompted to remove his used gloves, perform hand hygiene and put on a new pair of gloves before touching/handling R365's PICC line. On April 1, 2025 at 2:33 PM, V2 (DON) stated that V15 should remove his gloves after handling R365's urinary catheter bag, perform hand hygiene then put on a new pair of gloves, before touching/handling the resident's PICC line. V2 added that this is performed to prevent cross contamination and prevent infection. 6. On April 1, 2025 at 8:59 AM, V7 (Registered Nurse) prepared R366's medications, including Aspirin. V7 poured three Aspirin tablets inside the said medication container cap/lid, then she (V7) used her ungloved finger to get one of the Aspirin tablet out of the container cap, transferred it inside the medication cup and then administered the Aspirin tablet and the rest of the medications to R366. After administering the medications (consisting of tablets and capsule) to R366, V7 put on a pair of gloves and touched R366's left arm to check for edema. V7 then removed R366's socks and palpated both of the resident's lower extremities to check for edema. After the procedure, using the same gloved hands, V7 picked up the medication cup containing R366's Nystatin suspension medication and handed the said medication cup to the resident to take. On April 2, 2025 at 9:38 AM, V2 stated that nurses should not touch a resident's medications using bare hands or fingers. V7 should use a spoon or put on gloves to take the medication out from the container cap/lid to ensure not touching the medication with bare finger. V2 also stated that V7 should remove her gloves after touching R366 to check for edema on the arm and lower extremities. After removing the gloves, V7 should perform hand hygiene, either use of alcohol rub or washing hands, then re-gloved, before handling R366's Nystatin suspension medication cup. According to V2, this is to prevent cross contamination and to maintain infection control. The facility's glove use guideline last revised on August 2024 showed in-part, Sterile gloves and examination gloves are removed and placed into appropriate waste containers: .d. Before moving from a contaminated surface/area to an uncontaminated surface/area.

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	04/03/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16746 Based on observation, interview and record review, the facility failed to ensure that the electronic monitoring alarm control panel was functioning. This applies to 4 of 4 resident (R48, R58, R70, R95) reviewed for use of electronic monitoring devise in the sample of 23. The findings include: 1. R58 had multiple diagnoses including dementia without behavioral disturbance and Alzheimer's disease, based on the face sheet. R58's admission MDS (minimum data set) dated February 26, 2025 showed that the resident was cognitively impaired. On March 31, 2025 at 11:17 AM, R58 was in bed and had an electronic monitoring device on his left ankle. According to V15 (Licensed Practical Nurse), the resident had the monitoring device because R58 would attempt to leave the facility, especially at night. R58's progress notes dated March 13, 2025 at 5:18 PM, created by Social Service showed in-part, Social Service informed by [Director of Nursing] that [R58] was exit-seeking. Social Service completed elopement risk assessment. Upon completion of assessment, it is noted that the resident is high risk for elopement. An [electronic monitoring device] was placed for monitoring on [R58's] left ankle. Advised representative [family] of resident exit seeking behaviors and monitoring device being placed on the resident. Family verbalized understanding and reason for elopement monitoring. R58's elopement risk assessment dated [DATE] showed that the resident is high risk for elopement. R58 had an active physician order dated March 13, 2025 for an electronic monitoring device. On April 1, 2025 at 9:53 AM, R58 was observed with an electronic monitoring device on his left ankle. At 3:23 PM, the facility was requested to test the electronic monitoring device to ensure that it was functioning. V2 (Director of Nursing) stated that the facility checks the electronic monitoring device for functioning by bringing the resident to the exit doors. R58 was walking independently with V1 (Administrator) to the front lobby/main door to test the electronic monitoring device. When R58 reached the main door, the electronic monitoring alarm control panel did not activate, and no alarm sounded. The electronic monitoring alarm control panel that was mounted on the wall close to the main door was not lit to indicate that there was power on it. V23 (Maintenance Director) checked the alarm control panel and confirmed that there was no power on it, which was why it was not alarming when R58 was close to the front lobby/main exit door. At 3:45 PM, V23 stated that he spoke to the electronic monitoring device company and was informed that the transformer of the alarm control panel was not working, and it needs to be replaced. On April 2, 2025 at 9:45 AM, V2 (Director of Nursing) stated that the facility has four residents (R48, R58, R70 and R95) identified as high risk for elopement. V2 stated that the facility expects for the electronic monitoring device and alarm control panels on all exit doors to be always functioning, to ensure the safety of the residents who are elopement risk. (continued on next page)

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	04/03/2025

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

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R48 had multiple diagnoses including dementia with other behavioral disturbance, restlessness and agitation and cognitive communication deficit, based on the face sheet. R48's quarterly MDS dated [DATE] showed that the resident was moderately impaired with cognition. The same MDS showed that R48 uses wheelchair for mobility and can also ambulate with moderate assistance from the staff. On April 2, 2025 at 12:09 PM, R48 was observed sitting in her wheelchair inside the main dining room. R48 had an electronic monitoring device on her left ankle. V2 stated that R48 uses her wheelchair for locomotion. According to V2, R48 is high risk for elopement. R48's elopement risk assessment dated [DATE] showed that the resident is high risk for elopement. R48 had an active physician order dated June 27, 2024 for an electronic monitoring device. 3. R70 had multiple diagnoses including vascular dementia without behavioral disturbance, based on the face sheet. R70's quarterly MDS dated [DATE] showed that the resident was severely impaired with cognition. The same MDS showed that R70 uses wheelchair for mobility. On April 2, 2025 at 12:08 PM, R70 was observed sitting in her wheelchair inside the main dining room. R70 had an electronic monitoring device on her right ankle. V2 stated that R70 uses her wheelchair for locomotion. According to V2, R70 is high risk for elopement. R70's elopement risk assessment dated [DATE] showed that the resident is high risk for elopement. R70 had an active physician order dated February 28, 2025 for an electronic monitoring device. 4. R95 had multiple diagnoses including dementia without behavioral disturbance, based on the face sheet. R95's quarterly MDS dated [DATE] showed that the resident was moderately impaired with cognition. The same MDS showed that R95 uses wheelchair for mobility and can also ambulate with supervision or touching assistance from the staff. On April 2, 2025 at 12:10 PM, R95 was observed sitting in a regular chair inside the main dining room. R95's rolling walker was beside her. R95 had an electronic monitoring device on her right ankle. V2 stated that R95 ambulates using a rolling walker. According to V2, R95 is high risk for elopement. R95's elopement risk assessment dated [DATE] showed that the resident is high risk for elopement. R95 had an active physician order dated February 28, 2025 for an electronic monitoring device. The facility's elopement and search guideline revised on September 4, 2024 showed in-part, 5. Residents who have been identified as cognitively impaired and who have been assessed as an elopement risk will be provided with an elopement prevention device (arm or ankle bracelet). 6. Bracelets will be observed for placement and checked for function daily. Facility exit door alarms are checked daily for function. All personnel are responsible for promptly reporting/replacing malfunctioning elopement prevention devices. Maintenance is responsible for fixing/replacing any exit doors that do not alarm.