

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145840	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Tabor Hills Health Care Fac		STREET ADDRESS, CITY, STATE, ZIP CODE 1347 Crystal Court Naperville, IL 60563	
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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>35267</p> <p>Based on observation, interview and record review, the facility failed to provide restorative therapies to a resident scheduled for therapies per her plan of care. This applies to 1 of 1 resident (R41) reviewed for rehabilitation in a sample of 19.</p> <p>The findings include:</p> <p>R41's Medical Record, dated May 2024, shows R41's diagnoses included artificial hip, osteoarthritis right and left shoulders, cerebral infarction and transient ischemic attack, osteoarthritis left shoulder, scoliosis, and osteoporosis.</p> <p>Restorative Joint Mobility Evaluation 3/12/24, shows R41 had limited ROM of the front left shoulder related to stiffness, arthritic digits of the left and right hand. The evaluation shows R41 required AROM (Active Range of Motion) of BUE (Bilateral Upper Extremity) and bilateral ankles. R41 had a diagnosis of osteoarthritis of bilateral shoulders and transferred with a standing lift assisted by two staff.</p> <p>Care plan, initiated 3/12/24, shows R41 had a wedge compression fracture of her thoracic 11-12 vertebrae, thoraco-lumbar anterolisthesis of L4 on L5, osteoarthritis of bilateral knees and bilateral shoulders, bilateral hip replacements, lumbar degenerative joint disease, osteoarthritis, pain in the thoracic spine, and left shoulder effusion. The approaches include, Place me in a Range of Motion program.</p> <p>On May 6, 2024, R41 stated she was not sure if she was receiving rehabilitation services.</p> <p>Facility Task Description and Frequency list, undated, shows R41 was to receive restorative sit to stand exercises on days and evenings.</p> <p>POC (Plan of Care) Response History for staff task Restorative - NuStep: Participate NuStep for 15 minutes 3x/wk (three times per week) dated 4/16/24 to 5/7/24, shows R41 received restorative therapy exercises twice and refused twice in 22 days reviewed. The document shows staff responded NA (Not applicable) 30 times regarding R41 being offered NuStep restorative exercise during the time period.</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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>POC Response History for staff task Restorative Sit-To Stand: pull self to a standing position at a hall/bathroom railing and balance for 30 seconds x 3 reps (repetitions) with x2 (2 staff) assistance. The report shows R41 received restorative sit to stand exercises on only 7 of 28 days and several days had responses of NA (Not Applicable) or 0.</p> <p>On May 7, 2024, at 1:37 PM with V2 (Director of Nursing, V7 (Restorative Nurse) stated she needed to speak with staff regarding how they were documenting residents' restorative therapies. V7 stated it was her expectation that staff inform her if a resident is not performing restorative exercises so she can reassess the resident. V7 stated she was not aware that R41 was not performing her restorative exercises as staff did not notify her.</p> <p>Facility Policy and Procedure Restorative Services, undated, shows, The objectives of our restorative services are to: . 3. To coordinate rehabilitative services with objectives of the facility and patient's plan of care. 4. To provide and maintain a continuous restorative care program.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>35267</p> <p>Based on observation, interview and record review, the facility failed to apply palm protectors to a resident's contracted hands per her plan of care. This applies to 1 of 3 residents (R14) reviewed for ROM (Range of Motion) in a sample of 19.</p> <p>The findings include:</p> <p>R14's Care Plan, initiated March 20, 2020, shows R14 was at risk for contractures due to decreased strength, impaired coordination, poor endurance and balance, and poor memory. The care plan shows R14 was to wear a palm protector which should be applied in the morning and removed at bedtime. The care plan shows staff should check for redness on the surrounding area.</p> <p>Physician order, dated March 18, 2024, shows R14 was to have Palm Protector applied to her hands every morning and removed before bedtime. The staff were to check for redness in the surrounding areas.</p> <p>On May 6, 2024, at 10:56 AM, R14 was in reclining wheelchair in the dining room. The fingers of both of R14's hands were very contracted and were closing toward palm of each hand. R14 was holding white gauze between her contracted fingers and palm in her left hand. R14 had no gauze or palm protector between her contracted fingers and palm of her right hand.</p> <p>On May 6, 2024, at 11:20 AM with V14 (Registered Nurse), R14 continued to have white gauze only between her contracted fingers and palm of her left hand and no gauze in her right hand between her contracted fingers and palm. V14 (Registered Nurse) stated the staff usually only put a cloth in her left hand between her contracted fingers and palm but no cloth in her right hand.</p> <p>On May 6, 2024, at 11:15 AM, V15 (CNA - Certified Nursing Assistant) stated R14 sometimes refuses to put anything between her contracted fingers and hands. V15 stated in the morning the staff look at both hands and place gauze in the one hand that has redness. V15 stated the staff usually use gauze as the hand protector and no palm protectors.</p> <p>On May 7, 2024, at 1:37 PM, V7 (Restorative Nurse) described a palm protector as sheep skin with and adhesive strap. V7 stated gauze was not considered a palm protector. V7 stated CNA or Restorative staff must do ROM (Range of Motion) exercises with R14's hands before they are able to apply her palm protectors to reduce the risk of injury to her contracted hands. V7 stated it was her expectation that R14 wear palm protectors bilaterally in both hands to protect her palms from her contracted fingers. V7 stated the facility should have a physician order if staff use gauze instead of the palm protectors for R14 if she did not tolerate the palm protectors.</p> <p>Facility Response History for Task: Palm Protector on in AM off at HS (bedtime) and check for redness on the surrounding area. Review of responses show R14 received her protector on in AM and off at HS on days including May 6, 2024, AM during which no palm protectors were observed to be applied. Observations on 5/6/24 AM as of 11:15 AM showed R14 did not have her palm protectors in place on either hand.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was properly positioned in a shower chair during a shower. This applies to 1 of 2 residents (R265) reviewed for falls in the sample of 19.</p> <p>The findings include:</p> <p>R265's EMR (Electronic Medical Record) showed R265 was admitted to the facility on [DATE], with multiple diagnoses including encephalopathy, fall, weakness, and dementia.</p> <p>R265's Brief Interview for Mental Status dated May 7, 2024, showed R265 was cognitively intact.</p> <p>R265's Functional Abilities and Goals dated May 1, 2024, showed R265 required maximal assistance from facility staff for transferring to and from the tub/shower.</p> <p>On May 8, 2024, at 11:28 AM, R265 said she got a shower a few days ago and the shower chair tipped over when the CNA (Certified Nursing Assistant) was done washing her.</p> <p>On May 8, 2024, at 11:38 AM, V9 (CNA) said she was giving R265 a shower in her room and R265 attempted to stand up to wash herself. V9 said she instructed R265 to sit back down and R265 was not evenly seated in the chair. V9 said while R265 was unevenly seated in the shower chair, V9 maneuvered the shower chair from the shower stall to the bathroom. V9 continued to say there is an uneven ledge from shower into the bathroom. V9 said since R265 was not properly positioned in the shower chair, R265 fell out of the shower chair when V9 pushed the shower chair over the shower ledge.</p> <p>On May 8, 2024, at 11:53 AM, the shower in R265's bathroom had an approximately one inch raised ledge for the transition from the shower into the bathroom.</p> <p>The facility's fall report dated May 4, 2024, showed V2 (DON/Director of Nursing) documented Upon follow up with the resident and CNA present at the time of fall incident. It was likely the resident was not positioned all the way to the back of the shower chair due to resident scooting forward in the shower chair, attempting to assist the CNA with care, resulting with resident sliding off the chair. Interventions to include providing a larger shower chair, grip strips to shower room floor. OT (Occupational Therapy) to provide positioning education to resident. Staff reeducated on the proper assessment of resident positioning in shower chair.</p> <p>On May 8, 2024, at 1:19 PM, V2 said her expectation is facility staff are to ensure a resident is properly positioned in the shower chair before moving the shower chair.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308</p> <p>Based on observation, interview, and record review the facility failed to ensure the hot water dish machine reached 160 degrees Fahrenheit rinse temperature, failed to ensure staff changed gloves between handling soiled and clean dishes and failed to ensure the dry storage area did not contain expired canned food products. This applies to all 63 residents who receive oral diets from the kitchen.</p> <p>The findings include:</p> <p>On [DATE], at 10:11 AM, V6 (Dietary Aide) was washing dishes using the hot water dish machine. V3 (Maintenance Director) and V4 (Dining Room Supervisor) were present and were asked to validate the dish machine temperature, V3 placed the disc thermometer in the dish rack. V3 then placed the rack on the conveyor and ran it through the dish machine. Upon exiting the machine, the thermometer showed a temperature of 153 F (Fahrenheit) degrees. V3 and V4 were both present and aware of the temperature reading. At 10:19 AM, V3 placed the thermometer in the dish rack again, placed the dish rack on the conveyor, and upon exiting the machine the thermometer showed 157.6 F. V6 was placing soiled cups on the dish rack, sending the rack through the dish machine and removed the rack from the machine and touched the clean glasses, without changing gloves. V6 put soiled bowls on the dish rack, put the rack on the conveyor, then retrieved the rack from the clean side and began touching the clean bowls without changing gloves or perform hand hygiene.</p> <p>On [DATE], at 9:40 AM, in the dry storage room canned items were found on the shelf past the expiration dates. There were 5 cans of pineapple tidbits, 107 ounces, with an expiration date of [DATE], and 2 cans of pineapple chunks, 107 ounces, with an expiration date of [DATE]. V3 and V4 were both present in the dry storage room and made aware of the expired products.</p> <p>On [DATE], at 9:45 AM, V4 (Food Service Supervisor) was unable to explain the system he uses for rotating stock. V4 stated he was made aware yesterday of the expired stock, and also stated he does not track food delivery dates and therefore is not able to ensure that food products that are delivered first are used first.</p> <p>The Facility's policy titled Dishwashing Machine Operation, undated, showed Paper thermometers are used to determine correct rinse temperature of the dishwashing machine.</p> <p>The Facility's policy titled Hand Washing, undated, showed Food and nutrition employees will thoroughly wash their hands .after handling soiled equipment and utensils .</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303</p> <p>Based on interview, and record review, the facility failed to administer the pneumococcal vaccine to residents according to the CDC (Centers for Disease Control and Prevention). This applies to 4 of 5 residents (R8, R13, R17, and R56) in the sample of 19.</p> <p>The findings include:</p> <p>On May 7, 2024, at 1:22 PM, V7 (Infection Preventionist Nurse) said the facility follows CDC recommendations for pneumococcal vaccine timing.</p> <p>1. R8's EMR (Electronic Medical Record) showed R8 was a [AGE] year-old resident, admitted to the facility on [DATE], with multiple diagnoses including hypertension, pneumonia, and anemia.</p> <p>R8's Immunization Record showed R8 received the PCV13 (13-valent pneumococcal conjugate vaccine) on March 15, 2022.</p> <p>R8's undated Consent to Administer Pneumococcal Polysaccharide (PPSV) Vaccine showed R8's Resident Representative consented for R8 to receive the pneumococcal vaccine.</p> <p>On May 8, 2024, at 1:01 PM, V8 (Infection Control Nurse) said R8 should have received the PPSV23 vaccine one year after receiving the PCV13 vaccine. V8 continued to say R8's POA (Power of Attorney) consented to the PPSV23 vaccine, but R8 has not received the vaccine.</p> <p>Facility documentation showed R8's POA consented for R8 to receive the PPSV23 (23-valent pneumococcal polysaccharide vaccine) on April 4, 2024.</p> <p>The facility does not have documentation to show R8 received the PPSV23 vaccine.</p> <p>2. R13's EMR showed R13 was an [AGE] year-old resident, admitted to the facility on [DATE], with multiple diagnoses including atrial fibrillation, hypertension, and hyperlipidemia.</p> <p>R13's Immunization Record showed as of May 6, 2024, R13 had not received a pneumococcal vaccine.</p> <p>R13's Consent to Administer Pneumococcal Conjugate Prevnar (PCV13) Vaccine showed Check residents medical records first then ask resident if she wants shot.</p> <p>On May 8, 2024, at 12:43 PM, V8 said R13 should have been offered the pneumococcal vaccine before April 2024.</p> <p>The facility does not have documentation to show R13 was offered a pneumococcal vaccine prior to April 4, 2024.</p> <p>3. R17's EMR showed R17 was an [AGE] year-old resident, admitted to the facility on [DATE], with multiple diagnoses including type 2 diabetes, asthma, and dementia.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R17's Immunization Record showed R17 received the PCV13 vaccine on August 30, 2017.</p> <p>R17's Consent to Administer Pneumococcal Polysaccharide (PPSV) Vaccine showed Unknown when last received vaccination, but I wish to receive the Pneumococcal Vaccine. R17's consent was signed by R17's Resident Representative on January 31, 2021.</p> <p>As of May 6, 2024, the facility does not have documentation to show R17 received the PPSV23 vaccine.</p> <p>On May 8, 2024, at 12:43 PM, V8 said R17 was eligible for the PPSV23 vaccine one year after receiving the PCV13 vaccine. V8 said R17 should have received the PPSV23 vaccine when she was admitted to the facility.</p> <p>4. R56's EMR showed R56 was an [AGE] year-old resident, admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease, hyperlipidemia, and tachycardia.</p> <p>R56's Immunization Record showed R56 received the PCV13 vaccine on September 1, 2015.</p> <p>R56's Consent to Administer Pneumococcal Polysaccharide (PPSV) Vaccine showed Unknown when last received vaccination, but I wish to receive the Pneumococcal Vaccine. R56's consent was signed by R56's Resident Representative on June 9, 2022.</p> <p>As of May 6, 2024, the facility does not have documentation to show R56 received the PPSV23 vaccine.</p> <p>On May 8, 2024, at 12:43 PM, V8 said R56 was eligible for the PPSV23 vaccine one year after receiving the PCV13 vaccine. V8 continued to say R56 should have received the PPSV23 vaccine when she was admitted to the facility.</p> <p>The facility's Pneumococcal Vaccination policy dated April 2024, showed, Purpose: All residents are provided the opportunity and encouraged to receive pneumococcal vaccinations. The resident may refuse the offer of the vaccine or may not have the vaccine administered if medically contraindicated. There are currently four types of pneumococcal vaccines: pneumococcal conjugate vaccines (PCV13, PCV15, and PCV20) and pneumococcal polysaccharide vaccine (PPSV23). The numerical value after the letters represents the number of pneumococcal bacteria strains present in a particular vaccine that render protection if a person is exposed to that component strain. CDC recommends routine administration of pneumococcal conjugate vaccine (PCV15 or PCV20) for all adults [AGE] years or older who have never received any pneumococcal conjugate vaccine or whose previous vaccination history is unknown. AS such, we adapt the 2022 CDC recommendation for Pneumococcal Vaccination Timing for our residents. Policy: 1. The admitting nurse is responsible to review the medical record and history to determine if any pneumococcal vaccination has been given to the resident. 2. The estimate of the date vaccine as indicated by the resident/responsible party is recorded in the resident's HER (Electronic Health Record). Procedure: .5. For adults less than [AGE] years and older who previously received PCV13 but who have not received all recommended doses of PPSV23, may give one dose of PPSV23 or may use PCV20 if PPSV23 is not available .</p> <p>(continued on next page)</p>		

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