

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145874	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Meadowbrook Manor - Naperville		STREET ADDRESS, CITY, STATE, ZIP CODE 720 Raymond Drive 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 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** 16746</p> <p>Based on observation, interview and record review, the facility failed to assist residents identified as needing assistance with personal hygiene and grooming.</p> <p>This applies to 7 of 7 residents (R29, R58, R129, R149, R152, R153 and R180) reviewed for ADL (activities of daily living) in the sample of 35.</p> <p>The findings include:</p> <p>1. R29 had multiple diagnoses including dementia without behavioral disturbance and weakness, based on the face sheet.</p> <p>R29's admission MDS (minimum data set) dated September 27, 2024 showed that the resident was moderately impaired with cognitive skills for daily decision making and required substantial/maximum assistance with personal hygiene.</p> <p>On October 7, 2024 at 12:11 PM, R29 was eating inside the unit dining room. R29 was non-verbal. R29 had accumulation of facial hair above her upper lip.</p> <p>On October 8, 2024 at 10:20 AM, R29 was sitting in her wheelchair inside the unit dining room. R29 had accumulation of facial hair above her upper lip. V3 (Assistant Director of Nursing) was present and stated that R29's facial hair needs to be removed and that R29 needs the assistance of the staff with shaving.</p> <p>R29's active care plan initiated on October 4, 2024 showed that the resident requires assistance with grooming related to impaired mobility. R29's active care plan initiated on September 27, 2024 showed that the resident has an ADL self-care performance deficit. The same care plan showed multiple interventions including, Requires substantial staff participation with personal hygiene.</p> <p>2. R180 Had multiple diagnoses including metabolic encephalopathy, cerebral infarction and dementia with psychotic disturbance, based on the face sheet.</p> <p>R180's quarterly MDS dated [DATE] showed that the resident was moderately impaired with cognition and required substantial/maximum assistance with personal hygiene.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On October 7, 2024 at 11:11 AM, R180 was in bed, alert, oriented and verbally responsive. R180's fingernails were very long, jagged with accumulation of black substances under his fingernails. R180 stated that he wants the staff to trim and clean his fingernails because he cannot do it on his own.</p> <p>On October 8, 2024 at 10:24 AM, R180 was in bed, alert, oriented and verbally responsive. R180's fingernails were very long, jagged with accumulation of black substances under his fingernails. In the presence of V3, R180 requested for the staff to trim and clean his fingernails. V3 acknowledged that R180's fingernails needs trimming and cleaning. According to V3, R180 needs staff assistance to trim and clean his fingernails.</p> <p>R180's active care plan initiated on April 12, 2024 showed that the resident has an ADL self-care performance deficit. The same care plan showed multiple interventions including, Requires substantial assist of 1 staff participation with personal hygiene.</p> <p>On October 9, 2024 at 3:33 PM, V3 stated that it is part of the facility's nursing care and services to assist all residents needing assistance with ADLs including shaving/removal of unwanted facial hair, especially for female residents and nail care. V3 added that all residents needing assistance with ADLs should be assisted by the staff to ensure and maintain the residents good hygiene and grooming.</p> <p>29562</p> <p>3. Face sheet shows that R129 is [AGE] years-old who has multiple medical diagnoses which include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.</p> <p>On October 7, 2024, at 9:55 AM, R129 was observed lying in bed, alert and oriented. R129 able to verbalize needs. R129 was displaying unkempt or disheveled, overgrown beard and mustache and long uneven fingernails having brown/black substances underneath nails. R129 said that he wanted his facial hair shaven and his nails to be clipped.</p> <p>On October 8, 2024, at 4:50 PM, R129 was awake and resting in bed, he remained with unkempt facial hair and long dirty fingernails.</p> <p>R129's MDS (Minimum Data Set) dated August 19, 2024, shows that R129 requires moderate assistance with hygiene and grooming.</p> <p>4. Face sheet shows that R153 is [AGE] years-old who has multiple medical diagnoses which include hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.</p> <p>On October 7, 2024, at 10:50 AM, R153 was resting on her bed. She was alert and oriented alert and oriented when she was being interviewed. R153 displayed long dirty fingernails with brown/black substance underneath, stated she wanted it clip, she also had unkept/uncombed hair. R153 said she feels dirty and uncomfortable.</p> <p>On October 8, 2024, at 11:00 AM, R153 said that she was given a bed bath last night around 10 PM, however, her hair remained unkept and her fingernails remained long with black/brown substances underneath the fingernails.</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>R153's MDS dated [DATE], shows R153 requires extensive assistance for grooming and hygiene.</p> <p>5. Face sheet shows that R152 is [AGE] years-old who has multiple medical diagnoses which include unspecified dementia, unspecified severity, with other behavioral disturbance.</p> <p>On October 7, 2024, at 1:07 PM, R152 was eating in the dining room, picking her food from the plate to eat it. R152 was confused and was unable to answer surveyor's questions. R152's hair was uncombed, she has whiskers on her chin, and has long fingernails with black/brown substances underneath.</p> <p>On October 9, 2024, at 10:20 AM, R152 was in the dayroom/dining room with other residents. R152 remained with whiskers on her chin and long fingernails with black/brown substances underneath.</p> <p>R152's MDS dated [DATE], shows R152 requires extensive assistance for grooming and hygiene.</p> <p>On October 09, 2024, at 2:03 PM, V2 (Director of Nursing/DON) stated the provision of ADL (activities of daily living) care includes shaving, trimming the nails, oral care, combing hair, and shower/bathing, during shower/bathing days and as needed.</p> <p>48308</p> <p>6. R149's EMR (Electronic Medical Record) showed R149 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia and hemiparesis following a cerebral infarction, other specified disorders of the brain, epilepsy, unspecified, unsteadiness on feet, adult failure to thrive, presence of left artificial hip joint and Alzheimer's disease.</p> <p>R149's MDS (Minimum Data Set) dated August 23, 2024, showed R149 was severely cognitively impaired, and required assistance with ADL's including substantial assistance with personal hygiene, bathing, toileting, dressing, bed mobility, dependent on staff for transfer and set up assistance for eating.</p> <p>On October 8, 2024, at 11:20 AM, R149, an alert, female, was seated in her wheelchair in the dining room. R149 had many long gray strands of facial hair above her lip, on her chin and the sides of her mouth. R149 stated she would like the hair removed but did not know how to remove it. V14 (Registered Nurse/Third Floor Unit Manager) was present and made aware of the need for facial hair removal.</p> <p>On October 9, 2024, at 10:55 AM, R149 was again observed seated in the dining room with the continued presence of long gray strands of facial hair on her chin, upper lip, and sides of her mouth.</p> <p>7. R58's EMR showed R58 was readmitted to the facility on [DATE], with multiple diagnoses including Parkinson's disease, Diabetes type 2 with hypoglycemia, diabetic neuropathy, adult failure to thrive and Alzheimer's disease.</p> <p>R58's MDS dated [DATE], showed R58 had severe cognitive impairment, and required assistance with all ADL's including substantial assistance with eating, oral hygiene, dressing toileting, bathing and personal hygiene and was dependent on staff assistance for transfer.</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>On October 8, 2024, at 11:27 AM, R58 was observed in the dining room, seated in a reclining wheelchair, with his hands in his lap. R58's fingernails on both hands, had black/brown substance beneath the tips of the nails. V14 was present and made aware of the need for nail care.</p> <p>On October 10, 2024, at 11:30 AM, V2 (DON/Director of Nursing) stated nursing staff should provide grooming and nail care for residents to maintain a presentable appearance. V2 stated hair should be combed, nails should be kept clean and trimmed and shaving should be provided in accordance with a male resident's preference and females should not have unwanted facial hair.</p> <p>The facility policy titled Fingernails/Toenails, Care of, dated February 2018, showed The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection .General Guidelines .1. Nail care includes daily cleaning and regular trimming.</p> <p>The facility policy titled Activities of Daily Living (ADLs), Supporting dated March 2018, showed Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</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 provide wound treatment as ordered.</p> <p>This applies to 1 of 7 residents (R112) reviewed for pressure ulcer prevention and treatment in the sample of 35.</p> <p>This failure resulted in the worsening of an acquired pressure ulcer wound from a stage 2 to an unstageable wound.</p> <p>The findings include:</p> <p>R112's EMR (Electronic Medical Record) showed R112, was admitted to the facility on [DATE], with multiple diagnoses including unspecified dementia, age related osteoporosis, unspecified macular degeneration, cognitive communication deficit, adult failure to thrive and mild protein-calorie malnutrition.</p> <p>R112's MDS (Minimum Data Set) dated September 10, 2024, showed R112 had severe cognitive impairment and required assistance with ADLs (Activities of Daily Living) including substantial assistance with eating, oral hygiene, toileting, bathing, dressing, personal hygiene, and bed mobility and was dependent on staff for transfer.</p> <p>R112's wound assessment dated [DATE], showed R112 had developed newly acquired pressure wounds on the sacrum and right buttock identified on October 6, 2024. The pressure wound on the sacrum measured 3.00 cm (centimeter) x 1.50 cm (centimeter) with a surface area of 4.5 cm and was identified as unstageable. The pressure wound on the right buttock measured 1.0 cm x 1.0cm x 0.10 cm depth with a surface area of 1.00 cm and was identified as a stage 2 wound with 100% (percent) pink tissue in the wound bed.</p> <p>On October 9, 2024, at 9:52 AM, V32 (Licensed Practical Nurse-Wound Care Nurse) and V14 (Registered Nurse- Unit Manager Third floor) performed wound care to the pressure wounds on the sacrum and right buttock. Upon removing the disposable brief, there was no dressing covering the right buttock wound present. V32 was asked if there should be a dressing covering the right buttock wound and V32 responded yes. V32 stated the right buttock wound was now worse and now an unstageable wound with 100% slough covering the wound bed. V32 stated the last time she saw the wound was October 7, 2024, when she assessed the wound and did the treatment.</p> <p>On October 9, 2024, at 2:24 PM, V18 (Nurse Practitioner) stated R112, right buttock wound, if left uncovered without a dressing, would leave the wound exposed to urine and fecal contamination and that exposure could cause the wound to get worse. V18 also stated unrelieved pressure would contribute to pressure wound development but was not sure if R112 had unrelieved pressure from sitting in the wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R112's October 2024, TAR (Treatment Administration Record) showed an order for the right buttock wound initiated October 7, 2024, Right buttock cleanse with normal saline pat dry. Apply hydrocolloid dressing as needed for wound care. There is no documentation that this treatment had been administered on October 7, 8, or 9th. There also was an order initiated and discontinued on October 9, 2024, that showed right buttock cleanse with normal saline pat dry. Apply hydrocolloid dressing every day shift Mon, Wed, Fri for wound care. There is no documentation this treatment was administered.</p> <p>On October 9, 2024, at 11:10 AM, V33 (CNA/Certified Nursing Assistant) stated she was the primary CNA assigned to R112 on the day shift and often worked the evening shift as well. V33 stated she was present on October 6, 2024, when the wounds to the sacrum and right buttock were discovered and informed V14. V33 stated that R112's normal routine was to get up on the night shift, maybe around 5:00 AM and was up already when V33 arrived to work at 6:00 AM. V33 stated R112 required a full mechanical lift for transfer and R112 would remain sitting in the wheelchair until after lunch when V33 would put R112 back to bed and change her incontinent brief. When asked if R112 had been repositioned while seated in the wheelchair from early morning until after lunch, V33 replied that R112 did not wet the brief very much because R112 would not drink much and did not need changing very often.</p> <p>During intermittent observations on October 7, and October 8, 2024, R112 remained seated in the high back wheelchair in the dining room.</p> <p>R112's care plan for risk for developing unavoidable skin breakdown-initiated February 12, 2024, showed an intervention to turn and reposition resident at regular intervals and as needed. There is no intervention to identify for staff how to reposition R112 while seated in the wheelchair.</p> <p>On October 10, 2024, at 11:30 AM, V2 (DON) stated it is the expectation if a new wound is discovered that the CNA would report to the Nurse and the Nurse would assess the wound, contact the Physician, obtain a treatment order, and notify the wound team for follow up. V2 stated upon observation of a wound dressing missing, the CNA should report the missing dressing to the nurse and the nurse would replace the wound dressing in accordance with the Physician orders. V2 stated residents should be repositioned in accordance with clinical standards of practice, every 2 hours.</p> <p>The facility's policy title Wound Care dated October 2010, showed . Purpose .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing .and .Preparation .1. Verify that there is a Physician's order for this procedure. The Facility's policy titled Prevention of Pressure Injuries dated April 2020, showed Mobility/Repositioning .1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team.</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>36567</p> <p>Based on observation, interview and record review, the facility failed to apply a resting hand splint for a resident to prevent contractures.</p> <p>This applies to 1 of 4 residents (R155) reviewed for range of motion in the sample of 35.</p> <p>The findings include:</p> <p>R155's face sheet included diagnoses of Parkinson's disease without dyskinesia, without mention of fluctuations, cognitive communication deficit, spinal stenosis, site unspecified.</p> <p>R155's significant change MDS (minimum data set) dated August 30, 2024 included that R155 is cognitively intact and has upper extremity impairment on both sides.</p> <p>R155's care plan-initiated May 15, 2024 included that R155 requires splint to left hand related to further deterioration. Interventions for the same included to apply splint/brace to left hand. On AM/Off at lunch by the restorative nurse.</p> <p>R155's Physician Order Sheet showed Patient to wear left hand resting splint, on with morning ADL (activities of daily living) and off after lunch, off for hygiene, exercise and skin check every shift by nursing staff.</p> <p>On October 7, 2024 at 12:12 PM, R155 was seen in her room seated on a wheelchair beside her spouse R37 who also resided in the same room. V15 (R155's daughter) was also in the room visiting. R155 was noted to be wearing a protective sleeve on her right arm. V15 stated She wears that sleeve on her right hand to bring down the swelling. No hand splint was seen on R155's left hand or anywhere within sight in the room.</p> <p>On October 7, 2024 at 03:10 PM, R155 was revisited and enquired about how often she wears the hand splint on her left hand. As R155 was having difficulty expressing herself clearly, R37 who was very alert and oriented, remarked She does not have it at all except when V13 (Restorative Aide) puts it on twice a week when she see's her [R155] for exercise. V16 (Certified Nursing Assistant) who was in the vicinity, was called to the room to enquire about the hand splint. V16 stated that he was not aware of the same and stated that it is the restorative staff that put on the splint for the residents. V16 called the restorative department who relayed to him that the splint is in the room. On searching the room, the resting hand splint was not able to be located. R37 remarked Its in one of the (dresser) drawers. After searching in all the dresser drawers of dressers in the room, the resting hand splint was located in the second drawer of the dresser behind R155's wheelchair.</p> <p>On October 8, 2024 at 11:16 AM, V13 stated that she sees R155 for AROM (active range of motion) and PROM (passive range of motion) 5-6 times a week. V13 stated that she is the one who puts on the splints for the residents. V13 stated that she had put on R155's resting hand splint in the morning and it must have been removed when she received a shower that morning.</p> <p>(continued on next page)</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>On October 8, 2024 at 12:01 PM, V17 (Certified Nursing Assistant) stated that R155 was not wearing a resting hand splint when she took her for a shower that morning.</p> <p>On October 9, 2024 at 2:05 PM, V28 OT (Occupational Therapist) stated that she saw R155 between March 25-May 15, 2024 for occupational therapy and evaluated her and recommended a resting hand splint to prevent further contractures on discharge from therapies.</p> <p>V28's OT Discharge Summary for R155 dated May 15, 2025 included Patient will be issued left hand splint due to emerging flexion contracture, establish appropriate wearing schedule and placed on appropriate nursing restorative programs.</p> <p>Facility policy for Contracture/Splint Management included as follows:</p> <p>Devices should provide support for the body skeleton, offer a reduction in amount of shearing force exerted on the body surface, and relieve/reduce pressure</p> <p>Purpose: To prevent contractures of joints</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** 29562</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe transfer for a resident who requires 2 staff assistance for transfer from one area to another.</p> <p>This applies to 1 of 3 residents (R99) reviewed for transfers in the sample of 35.</p> <p>The findings include:</p> <p>Face sheet shows R99 is [AGE] years-old who has multiple medical diagnoses which include Alzheimer's disease, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, encounter for palliative care. R99 is under hospice care. Minimum Data Set (MDS) dated [DATE], shows R99 is cognitively impaired and requires maximum assistance for activities of daily living (ADL) care.</p> <p>On October 7, 2024, at 11:18 AM, V7 (Hospice Certified Nursing Assistant/CNA) transferred R99 from bed to the reclining wheelchair via mechanical lift. V7 transferred R99 by himself (V7) without another staff to help him.</p> <p>On October 9, 2024, at 10:53 AM, V35 (Restorative Director) stated, there should always be two staff transferring a resident on a mechanical lift, for safety measure.</p> <p>R99's active care profile report has a special instruction which shows that his transfer code is a full lift with total assist of 2 staff.</p> <p>Care Plan shows, R99 has an ADL self-care performance deficit, he has limited mobility, and is on hospice. The same care plan shows multiple interventions to include TRANSFER: Requires dependent assist of 2+ with full lift with transfers.</p> <p>R99's fall assessment dated [DATE], shows that R99 is at risk for fall.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>36567</p> <p>Based on observation, interview and record review, the facility failed to provide the alternate meal with similar nutritive value as the main entree for residents that had history of weight loss.</p> <p>This applies to 2 of 6 residents (R60, R152) reviewed for nutrition in the sample of 35.</p> <p>The findings include:</p> <p>Facility spread sheet for Week 2 Tuesday showed that the main meal for lunch consisted of Turkey Burger Patty Melt (1 portion=3 oz protein).</p> <p>On October 8, 2024 at 12:05 PM, V12 (Assistant Cook) stated that she prepared egg salad sandwich for the substitute menu and put 2 oz/ounce of egg salad per sandwich using a #16 scoop. The egg salad sandwiches that were already prepared appeared to have a thin layer of egg salad within each sandwich.</p> <p>Facility scoop guidance titled Disher Capacity showed that blue color #16 scoop =2.07 fluid oz.</p> <p>Recipe for Egg Salad Sandwich for 3 oz portion serving included to portion 2 #10 scoops of egg salad unto half of bread slices. Serve 1 sandwich (2 halves) with 2,#10 scoops of egg salad for 3 oz protein serving.</p> <p>1. R152's face sheet included diagnoses of cerebrovascular disease, type 2 diabetes mellitus without complications, unspecified dementia, with other behavioral disturbance.</p> <p>On October 8, 2024 at 12:35 during lunch meal service on the second floor R152 received egg salad sandwich with tater tots.</p> <p>Dietician Progress notes dated September 8, 2024 included that R60 has had significant weight loss for one month and six months.</p> <p>R152's current weight history showed as follows: 135.0 Lbs (10/1/2024), 137.0 Lbs (9/5/2024), 152.5 (8/6/2024), 155.1 lbs (7/2/2024), 152.9 (6/4/2024).</p> <p>2. R60's face sheet included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia, oral phase, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>On October 8, 2024 at 12:42 PM, during lunch meal service on the second floor, R60 received a room tray with egg salad sandwich with tater tots.</p> <p>Dietitian Progress note dated August 22, 2024 included that R152 had exhibited significant weight loss in 6 months and has requested for extra portions.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Meadowbrook Manor - Naperville		STREET ADDRESS, CITY, STATE, ZIP CODE 720 Raymond Drive Naperville, IL 60563	

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On October 8, 2024 at 3:02 PM, V9 (Director of Dining Services) stated that she agrees that a substitute item for the meal should equal to the same amount served at the meal.</p> <p>Facility policy titled Substitute or Alternate Menu included as follows:</p> <p>At least one substitute will be of similar nutritive value. This means that a substitute food will be offered from the same group in an equivalent amount as the food eaten. For example, a three-ounce portion of hamburger could be substituted for a three ounce portion of fish</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>29562</p> <p>Based on observation, interview, and record review, the facility failed to follow physician's order during medication administration. There were 32 medication opportunities with 5 errors resulting to 15.63% medication error rate.</p> <p>This applies to 2 of 4 residents (R25 and R164) reviewed for medication administration in the sample of 35.</p> <p>The findings include:</p> <p>1. On October 8, 2024, at 9:35 AM, V4 (Nurse) administered multiple medications to R25. Prior to the administration, V4 prepared the medications by putting it in the medication cup and identifying each medication and its dosage one of the medications and/or vitamins included was Vitamin D3 (Cholecalciferol). V4 said that she was giving one tablet of Vitamin D3 1000 units (IU) or 25 micrograms (mcg). V4 took one tablet of the Vitamin D3 from the container bottle in the cart and the bottle was labeled Vitamin D3 10mcg (400IU). R25's Medication Administration Record (MAR) for the month of October 2024, shows multiple medications scheduled for the morning which included Cholecalciferol 1000 units, Cyanocobalamin 1000 mcg, and Polyethylene Glycol 3350 17 gm (gram). The Cyanocobalamin and Polyethylene Glycol medications/supplements were not observed given to R25.</p> <p>2. On October 8, 2024, at 10:30 AM, V6 (Nurse) administered multiple medications to R164. One of the medications she administered was Albuterol Sulfate HFA inhaler. V6 administered 3 consecutive puffs to R164 without a minute interval in between dose. V6 said the order was to give 2 puffs, however, R164's routine was to get 3 puffs, otherwise she would get very upset.</p> <p>R164's MAR dated October 2024, shows Albuterol Sulfate inhaler to give 2 puffs for shortness of breath, and Fluticasone Propionate nasal spray, to give 2 sprays in each nostril. However, the Fluticasone Propionate nasal spray was not observed administered to R164.</p> <p>On October 9, 2024, at 3:48 PM, V6 stated that R164 usually refuses the Fluticasone Propionate nasal spray so she did not bring the medication to R164.</p> <p>On October 9, 2024, at 2:16 PM, V2 (Director of Nursing/DON) stated that when administering medications, the nurses must follow the physician's order. The nurses should also remember the 5 rights of administering medications, such as the right person, right route, right time, right medications, and right dose. On October 9, 2024, at 3:56 PM, V2 also stated that if a resident is continuously refusing the medication, the nurse should call and notify the physician to discontinue the medication.</p> <p>Facility's Policy and Procedure for Administering Medications through Metered Dose Inhaler dated October 2010 shows:</p> <p>Purpose: The purpose of this procedure is to provide guidelines for the safe administration of inhaled medications.</p> <p>Steps in the Procedure:</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>15. Repeat inhalation, if ordered. Allow at least one (1) minute between inhalations of the same medication and at least two (2) minutes between inhalations of different medications.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>29562</p> <p>Based on observation, interview and record review, the facility failed to label and date medications after it was opened to determine expiration dates and failed to remove expired medications from the medication carts. In addition, the facility failed to ensure that a narcotic with a broken package/container is discarded.</p> <p>This applies to 10 of 10 residents (R16, R27, R88, R106, R115, R129, R132, R146, R148, and R180) reviewed for medication storage in the sample of 35.</p> <p>The findings include:</p> <p>On October 09, 2024, from 10:59 AM through 12:16 PM, multiple medication carts were inspected with the corresponding nurses (V23, V29, V30, V31) assigned to each cart, and the following were observed.</p> <ol style="list-style-type: none"> 1. R180's Insulin Glargine and Insulin Lispro were opened and not dated. 2. R27's Lantus Pen was opened and not dated. 3. R129's vial of Lispro has a label which shows that it was opened on 9/1/24 and expired on 10/1/24. 4. R16's Alprazolam 0.25 mg tab #25 container was torn open and taped over. 5. R148's Insulin Lispro has a label which shows that it was opened on 8/24/24 and expired on 9/23/24. In addition, R148's Insulin Glargine also has a label which shows that it was opened on 8/25/24, and it expired on 9/24/24. 6. R146's Insulin Lispro with a label that showed that it was opened on 8/25/24 and expired on 9/24/24, and there was a vial of Lantus vial that was opened on 8/5/24 and expired on 9/4/24. 7. R88's Insulin Lispro has a label which shows that it was opened on 8/1/24 and expired on 9/1/24. 8. R132's Insulin Lispro has a label which shows that it was opened 8/3/24 and expired 9/2/24. 9. R115's Insulin Lantus was opened on 6/28/24 and expired 7/28/24. R115 has another vial of Insulin Lantus which was opened and not dated. 10. R106's Insulin Glargine -YFGN was opened and not dated. <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On October 9, 2024, at 2:31 PM, V2 (Director of Nursing/ DON) stated that Insulins should be labeled and dated when it is opened the first time because it's only good for 28 days this is to determine expiration. V2 also said if the packaging of the narcotic medication gets torn, the medication should be wasted with a second nurse as witness to ensure that it's not being diverted somewhere.</p> <p>Facility's policy and procedure for controlled medication with revision date of April 2019 shows:</p> <p>b. Medications that are opened and subsequently not given (refused or only partly administered) are destroyed. Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet.</p> <p>The Pharmacy's Storage Recommendations for Injectable Diabetes Medications dated 2023 shows that Lantus and Lispro insulins' expiration date is 28 days after it was opened.</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>36567</p> <p>Based on observation, interview the facility failed to ensure that sanitary practices are maintained to prevent cross contamination during dishwashing procedure and storage of dish rags.</p> <p>This applies to 199 residents that receive foods prepared and served from the facility kitchen.</p> <p>The findings include:</p> <p>The facility provided information that on October 7, 2024 the facility census was 203 residents with 4 residents on NPO (nothing by mouth) status.</p> <p>On October 7, 2024 at 9:20 AM, during initial tour of the kitchen, multiple rags that were both dry and wet/dirty were seen strewn on free standing carts.</p> <p>On October 7, 2024 at 9:24 AM, during the dishwashing procedure at the high temperature dish machine, V10 (Dietary Aide), who was wearing gloves, was observed washing and rinsing dirty dishes prior to loading them on racks to send through the dish machine for sanitation. V10 was then seen going to the clean side without changing her gloves or washing her hands and unloading cleaned water pitchers and a plate guard and put them away on a shelf. V11 (Dietary Aide) was seen walking in from outside the kitchen and without washing hands or putting on gloves, put away some of the cleaned cups that were air drying after being washed. V11 left the dish room for a few minutes and then came back again and put away more cleaned dishes. When asked where he came from, V11 stated that he had gone upstairs to bring down the carts with the used tableware after breakfast. V11 was asked why he did not wash his hands before touching the cleaned dishes and V11 then proceeded to go to the hand sink. V9 (Director of Dining Services) was notified of the observations and relayed that the dishes that were touched by both V10 and V11 will have to be rewashed. V9 agreed and stated that V10 should have stayed in the dirty side of the dish washing area and V11 should have washed his hands prior to putting away the cleaned dishes.</p> <p>On October 9, 2024 at 12:10 PM, V9 added that the clean dish rags should have been placed in a bucket assigned for wash and/or with sanitizing solution and the dirty rags in a separate container for dirty linen. V9 stated that the facility does not have a policy for the same.</p> <p>Facility also did not have a policy for dishwashing procedures that included directives about cross contamination.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>29562</p> <p>Based on observation, interview, and record review, the facility failed to follow infection control practices related to hand hygiene, removal of gown after leaving resident's bedroom, and disposal of soiled linen and gown.</p> <p>This applies to 3 of 35 residents (R25, R129, and R146) reviewed for infection control in the sample of 35.</p> <p>The findings include:</p> <p>1. R25 is on EBP (Enhanced Barrier Precaution). On October 8, 2024, at 9:35 AM V4 (Nurse) administered intravenous (IV) medication to R25. Prior to administration, V4 donned isolation gown and gloves. After V4 administered the IV medication, V4 removed her gloves and left the bedroom still wearing the isolation gown. V4 went to the medication cart which was parked across the hallway from R25's bedroom, where V4 continued to prepare R125's oral medications. V4 re-entered R25's bedroom to administer the oral medications, while wearing the same gown. V4 came out again without removing the gown to write a label for the IV medication. When asked why she had not removed the gown, V4 said that that she was not yet done with R25.</p> <p>2. On October 8, 2024, at 10:08 AM, V34 (CNA/Certified Nursing Assistant) was observed coming out of R146's bedroom, carrying the soiled linens and gown of R146 without a plastic bag. V34 carried it down the hallway and placed in the soiled linen bin, while wearing gloves. V34 was also carrying a plastic bagful of soiled items which she threw in the garbage in the garbage bin.</p> <p>3. On October 8, 2024, at 12:46 PM, V36 (Certified Nursing Assistant/CNA) delivered the lunch tray to R129. V36 assisted R129 to reposition and straightened his beddings and set up his meals. After she assisted R129, V36 removed her gloves and left the bedroom without hand hygiene.</p> <p>On October 9, 2024, at 2:08 PM, V2 (Director of Nursing/DON) stated that staff must place the soiled linens and gowns in a plastic bag before bringing it out of the bedroom to prevent potential spread of infection. The staff must perform hand hygiene prior to leaving the bedroom. The staff should also remove the isolation gown prior to leaving the bedroom of EBP (Enhance Barrier Precaution) and isolation rooms, this is to prevent spread of potential infection.</p> <p>Facility's Policy and Procedure for Handwashing/Hand Hygiene dated 2019 shows:</p> <p>This facility considers hand hygiene the primary means to prevent the spread of infections.</p> <p>7. Use alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (anti-microbial or non-anti-microbial) and water for the following situations:</p> <p>b. Before and after direct contact with the resident.</p> <p>m. After removing gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8. Hand hygiene is the final step after removing and disposing of personal protective equipment.</p> <p>9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.</p> <p>The Facility's Policy and Procedure for Soiled Laundry and Bedding with revision date of October 2018 shows:</p> <p>Policy Statement: Soiled laundry and bedding shall be handled, transported, and processed according to best practices for infection prevention and control.</p> <p>Policy Interpretation and Implementation:</p> <p>Handling:</p> <p>1. All used laundry is handled as potentially contaminated until it is properly bagged and labeled for appropriate processing.</p> <p>b. Laundry that is contaminated with blood and body substances is placed in a leak-proof bags or containers.</p>