| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145901 | A. Building<br>B. Wing | 01/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lemont Nursing & Rehab Center | 12450 Walker Road<br>Lemont, IL 60439 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>36567<br><br>Based on observations, interview and record review, the facility failed to provide personal hygiene to a resident that was dependant on care.<br><br>This applies to 1 of 3 residents (R1) reviewed for improper nursing in the sample of 6.<br><br>The findings include:<br><br>R1's face sheet included diagnoses of osteomyelitis, pressure ulcer of sacral region, stage 4, pressure ulcer of right buttock, stage 4, unspecified severe protein-calorie malnutrition, adult failure to thrive, other cerebral palsy, dysphagia, oropharyngeal phase, anorexia nervosa.<br><br>R1's Annual MDS (minimum data set) dated November 06, 2024 showed that R1 was moderately impaired in cognition and was dependent on staff for all ADL's (activities of daily living) including personal hygiene.<br><br>On 1/16/25 at 10:52 AM, when viewed through the door, R1 was seen lying in bed in hospital gown. Signage on R1's door showed Contact Isolation. V4 (Registered Nurse) who was in the hallway stated that R1 is on contact isolation for MRSA [Methicillin- resistant Staphylococcus Aureus) of wounds and gown and gloves are needed prior to room entry. On entry, R1 made eye contact and some sounds but did not respond to queries. There was a stale odor coming from R1. R1's hair appeared greasy and uncombed. R1's hands appeared contracted and R1 had long jagged fingernails that had blackish substance underneath some of the nails. R1's chin and pillow had remnants of food particles and stains. R1's neck under her chin and upper chest had powdery blackish substance on it.<br><br>On January 16, 2025 at 11:02 AM, V4 (Certified Nursing Assistant) was called to the room and shown above observations. V4 stated that she is from agency and not regular staff and has not taken care of R1 before. V4 stated that the student nurses were in R1's room earlier and fed her. V4 stated that she is not sure when the facility staff last cut R1's nails. V4 stated I will get a towel and clean her up and comb her hair.<br><br>On January 16, 2025 at 12:44 PM, V9 (Student Instructor) stated that she watched the student feed R1 and had wiped her mouth. V9 added that a towel was placed on R1's chest prior to feeding R1 and therefore did not notice anything on her neck.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Nurse Practitioner's progress notes dated January 13, 2025 included that R1 has contractures and she is dependent on staff for all ADLs.<br><br>R1's restorative care plan initiated May 03, 2023 included that R1 is at risk for deterioration in ADL related to medical diagnosis of Cerebral palsy, osteomyelitis, lack of coordination, adult failure to thrive, and weakness. Interventions included : do not rush resident, allow extra time to complete ADLs, have consistent approach among caregivers.<br><br>On January 16, 2025 at 3:02 PM and on January 17, 2025 at 9:27 AM, V2 (Director of Nursing) stated that the CNA's provide ADL care and should provide personal hygiene daily for the residents. V2 stated that R1 is contracted and therefore it is difficult to cut her nails. V2 stated that staff should wipe R1's face off after providing feeding assistance.<br><br>Facility policy for ADL effective February, 2023 (2/2023) included as follows:<br><br>Guideline: 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:<br><br>Hygiene: bathing, dressing, grooming and oral care<br><br>Our collaborative professional team, together with the resident and/or resident representative:<br><br>2. Develop and implement interventions in accordance with the resident's evaluated need, goal for care and preferences and will address the identified limitation in an ability to perform ADLs. |

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| NAME OF PROVIDER OR SUPPLIER: Lemont Nursing & Rehab Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 12450 Walker Road Lemont, IL 60439 | |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>36567<br><br>Based on observations, interview and record review, the facility failed to serve pureed diet as ordered by a Physician to a resident (R1) that has had a recent history of swallowing problems. This failure contributed to the resident having a significant weight loss.<br><br>This applies to 1 of 3 residents (R1) reviewed for improper nursing in the sample of 6.<br><br>The findings include:<br><br>R1's EMR (electronic medical records) included diagnoses of osteomyelitis, pressure ulcer of sacral region, stage 4, pressure ulcer of right buttock, stage 4, unspecified severe protein-calorie malnutrition, adult failure to thrive, other cerebral palsy, dysphagia, oropharyngeal phase, anorexia nervosa.<br><br>R1's Annual MDS (minimum data set) dated November 06, 2024 showed that R1 was moderately impaired in cognition and was dependent on staff for all ADL's (activities of daily living) including eating.<br><br>R1's diet order on POS (Physician Order Summary) showed Pureed diet (start date January 09, 2025).<br><br>R1's weight (in lbs/pounds) history in EMR included as follows:<br><br>81.8 lbs (January 16, 2025), 89.8 lbs (December 17, 2024), 88.8 lbs (November 25, 2024), 89.6 lbs (October 18, 2024), 88.6 (September 18, 2024), 89.9 (July 14, 2024).<br><br>Dietitian progress notes dated January 16, 2025 included the following information in summary: R1's diet order was pureed texture diet with thin liquids and super cereal at breakfast. Weight: 81.8 lbs (January 16, 2025). BMI [Body Mass Index]: 16 which is underweight. Weight loss of 8.9% since December 17, 2025 and 8.7% since October 18, 2025 and is not desired or planned.<br><br>On January 16 at 2025 at 10:52 AM, R1 was seen lying in bed in hospital gown. R1 made eye contact and some sounds but did not respond to queries.<br><br>On January 16, 2025 at 11:02 AM, V4 CNA (Certified Nursing Assistant) was called to the room to ask about R1's oral intake. V4 stated I am from Agency. I don't know anything about her. The (CNA) students were in here this morning to feed her.<br><br>On January 16, 2025 at 12:44 PM, V9 (Student Instructor) stated that she watched the students feed R1, and R1 ate some of the eggs and most of the oatmeal and drank the orange juice. V9 stated She (R1) did not eat the potatoes (hash brown) and sausage.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On January 16, 2025 at 12:36 AM, R1 received a room tray (served by V4) of mechanical soft consistency chicken, regular consistency coleslaw and cornbread and pudding for dessert, and 4 oz/ounces of juice in a glass and 8 oz carton of 2% milk. R1's diet card showed Mechanical Soft consistency. V4 spoon fed R1 and R1 ate 100% of the pudding and drank 100% of juice and most of milk via a straw. On return to the room a few minutes later, V4 remarked that R1 ate all of the pudding and if she (R1) would have received a pureed diet, she would have eaten better.<br><br>On January 16, 2025 at 1:00 PM, R1's diet order on POS was checked in the EMR and it showed Pureed diet.<br><br>On January 16, 2025 at 1:02 PM, V3 ADON (Assistant Director of Nursing) was shown R1's tray consisting of mechanical soft diet received and relayed that diet order on EMR showed pureed diet and V1 DON (Director of Nursing) was subsequently notified of the same.<br><br>On January 16, 2025 at 1:58 PM, V6 (Dietary Manager) stated I got the form today to change the diet from mechanical soft to pureed. Prior to today resident [R1] was getting mechanical soft diet. The nurse brings the diet order change form and put's it in my mailbox and I will update it in the system [computer] before printing the diet cards. V6 stated that he does not recall receiving the diet change slip [from mechanical soft to pureed diet] prior to today.<br><br>On January 16, 2025 at 3:00 PM, V2 (DON) stated that if nursing is downgrading the diet, the Physician is notified and then referred to the Speech Therapist. V2 stated that once the diet is downgraded in the POS, the diet order is printed and brought down to the kitchen. V2 stated that she does not know what happens after that. V2 stated that V3 ADON (Assisted Director of Nursing) had put the diet change in the EMR/POS and brought the diet order down to the kitchen.<br><br>On January 16, 2025 at 3:04 PM, V3 (ADON) stated that [sometime beginning in the month of January/unknown date] the nurse on duty had come to her office with the V10 NP (Nurse Practitioner) and stated that R1 was not swallowing her medications and feels that the diet should be downgraded. V3 stated that she used her judgement and downgraded the diet to pureed and printed the diet order and placed it on V6's desk. V3 added that she also sent V6 a What's App message (about the diet change) as that is the mode of communication for managers.<br><br>On January 16, 2025 at 2:34 PM, V7 (Speech Therapist) stated that she was aware that the nursing downgraded R1's diet to pureed in the beginning of the month. V7 stated that she works three days a week at the facility and sees patients that V8 (Rehab Director) refers her to. V7 stated that V8 put R1 on her schedule to be seen today (January 16, 2025) and she did a swallow evaluation for R1 at the bedside this afternoon. V7 stated that she recommended to keep R1 on the current diet order of pureed consistency with thin liquids. V7 stated that R1 is at risk for aspirating on a mechanical soft diet because of suboptimal positioning. V7 added that while evaluating R1, R1 told her that she had a lot of pain while swallowing.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On January 17, 2025 at 12:24 PM, V12 (Medical Director) stated that he is R1's Primary Care Physician and the staff have been updating him about R1's recent concerns about eating. V12 stated that recently R1 has been eating less as her dysphagia was progressing and the diet was downgraded from mechanical soft to pureed diet. V12 stated that the facility should carry out the order for diet change within the day in 24 hours. V12 stated that R1's oral intake can be affected by dysphagia and pain medications (Morphine). V12 stated that he was notified of R1's weight loss which can be affected by declined oral intake.<br><br>Nursing progress notes dated January 15, 2025 included that R1 was not able to tolerate medication and holding her medication in her mouth and the family and MD (Medical Doctor) notified.<br><br>NP progress notes dated January 13, 2025 included the following information It was reported by the nurse that the patient was unable to swallow his medications and the patient was ordered speech evaluation and treatment. Her pain medication (Norco by mouth) was discontinued due to swallowing difficulties and Morphine liquid 0.25 ml[Milliliters] q [every] 4 hours was ordered for pain and her diet was downgraded to puree<br><br>Nursing progress notes dated January 09, 2025 included R1 holding medication and food in her mouth not swallowing NP, DON and relieving nurse made aware. New order given by NP for speech consultation.<br><br>Resident Listing Reports dated January 16, 2025, with current diet orders served in the facility kitchen showed R1's diet order as Mechanical Soft.<br><br>Speech Language Pathologist Plan of Treatment bed side swallow evaluation for R1 dated January 16, 2025 for trials of diet consistencies included as follows in summary :<br><br>Patient reporting severe pain and unable to reposition to upright position, thus trials completed at about 20-30 degrees. Suspect reduced laryngeal elevation<br><br>Thin liquids via straw: mildly delayed oral transit time and no overt signs and symptoms of aspiration, however patient reports pain swallowing and motions to her neck.<br><br>Mechanical soft trials noted with prolonged mastication and transit time, as well as observed inadequate mastication of trials and minimal trials attempted due to patient's increased risk of aspiration.<br><br>Puree trials via teaspooon: moderately delayed oral transit time .with no overt signs and symptoms of aspiration, however patient continues to report pain swallowing and motions to her neck.<br><br>Recommendations for Pureed diet with thin liquids for patient to swallow safely.<br><br>R1's Nutrition care plan revised October 06, 2024 included that R1 benefits from a mechanically altered diet due to dysphagia with interventions for the same included to provide and serve diet as ordered and goal to adhere to diet as ordered by physician through next review 3/11/25.<br><br>On January 17, 2025 at 1:59 PM, V2 (DON) stated that the facility does not have a policy for the process of diet order implementation. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>36567<br><br>Based on observations, interview and record review, the facility failed to serve pureed diet as ordered by a Physician to a resident (R1) that has had a recent history of swallowing problems.<br><br>This applies to 1 of 3 residents (R1) reviewed for improper nursing in the sample of 6.<br><br>The findings include:<br><br>R1's EMR (electronic medical records) included diagnoses of osteomyelitis, pressure ulcer of sacral region, stage 4, pressure ulcer of right buttock, stage 4, unspecified severe protein-calorie malnutrition, adult failure to thrive, other cerebral palsy, dysphagia, oropharyngeal phase, anorexia nervosa. R1's Annual MDS (minimum data set) dated November 06, 2024 showed that R1 was moderately impaired in cognition and was dependent on staff for all ADL's (activities of daily living) including eating.<br><br>R1's diet order on POS (Physician Order Summary) showed Pureed diet (start date January 09, 2025).<br><br>R1's weight (in lbs/pounds) history in EMR included as follows:<br><br>81.8 lbs (January 16, 2025), 89.8 lbs (December 17, 2024), 88.8 lbs (November 25, 2024), 89.6 lbs (October 18, 2024), 88.6 (September 18, 2024), 89.9 (July 14, 2024).<br><br>Dietitian progress notes dated January 16, 2025 included the following information in summary: R1's diet order was pureed texture diet with thin liquids and super cereal at breakfast. Weight: 81.8 lbs (January 16, 2025). BMI [Body Mass Index]: 16 which is underweight. Weight loss of 8.9% since December 17, 2025 and 8.7% since October 18, 2025 and is not desired or planned.<br><br>On January 16, 2025 at 11:02 AM, V4 CNA (Certified Nursing Assistant) was called to the room to ask about R1's oral intake. V4 stated I am from Agency. I don't know anything about her. The (CNA) students were in here this morning to feed her.<br><br>On January 16, 2025 at 12:44 PM, V9 (Student Instructor) stated that she watched the students feed R1, and R1 ate some of the eggs and most of the oatmeal and drank the orange juice. V9 stated She (R1) did not eat the potatoes (hash brown) and sausage.<br><br>On January 16, 2025 at 12:36 AM, R1 received a room tray (served by V4) of mechanical soft consistency chicken, regular consistency coleslaw and cornbread and pudding for dessert, and 4 oz/ounces of juice in a glass and 8 oz carton of 2% milk. R1's diet card showed Mechanical Soft consistency.<br><br>On January 16, 2025 at 1:00 PM, R1's diet order on POS was checked in the EMR and it showed Pureed diet.<br><br>Resident Listing Reports dated January 16, 2025, with current diet orders served in the facility kitchen showed R1's diet order as Mechanical Soft.<br><br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On January 16, 2025 at 1:58 PM, V6 (Dietary Manager) stated I got the form today to change the diet from mechanical soft to pureed. Prior to today resident [R1] was getting mechanical soft diet. The nurse brings the diet order change form and put's it in my mailbox and I will update it in the system [computer] before printing the diet cards. V6 stated that he does not recall receiving the diet change slip [from mechanical soft to pureed diet] prior to January 16, 2025.<br><br>On January 16, 2025 at 3:00 PM, V2 (DON) stated that if nursing is downgrading the diet, the Physician is notified and then referred to the Speech Therapist. V2 stated that once the diet is downgraded in the POS, the diet order is printed and brought down to the kitchen. V2 stated that she does not know what happens after that. V2 stated that V3 ADON (Assisted Director of Nursing) had put the diet change in the EMR/POS and brought the diet order down to the kitchen.<br><br>On January 16, 2025 at 3:04 PM, V3 (ADON) stated that [sometime beginning in the month of January/unknown date] the nurse on duty had come to her office with the V10 NP (Nurse Practitioner) and stated that R1 was not swallowing her medications and feels that the diet should be downgraded. V3 stated that she used her judgement and downgraded the diet to pureed and printed the diet order and placed it on V6's desk. V3 added that she also sent V6 a What's App message (about the diet change) as that is the mode of communication for managers.<br><br>On January 16, 2025 at 2:34 PM, V7 (Speech Therapist) stated that she was aware that the nursing downgraded R1's diet to pureed in the beginning of the month. V7 stated that she works three days a week at the facility and sees patients that V8 (Rehab Director) refers her to. V7 stated that V8 put R1 on her schedule to be seen today (January 16, 2025) and she did a swallow evaluation for R1 at the bedside this afternoon. V7 stated that she recommended to keep R1 on the current diet order of pureed consistency with thin liquids. V7 stated that R1 is at risk for aspirating on a mechanical soft diet.<br><br>Nursing progress notes dated January 15, 2025 included that R1 was not able to tolerate medication and holding her medication in her mouth and the family and MD (Medical Doctor) notified. |