STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145901	A. Building B. Wing	06/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lemont Nursing & Rehab Center	12450 Walker Road 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update a Care Plan indicating the need for transfer assistance after a significant change in condition for R1. This deficiency affects one (R1) of three residents reviewed for Care Plan revision.Findings include:On 6/6/26 at 12:00PM, physician note dated 4/18/26 was reviewed and indicates the following for R1: Right Lower Extremity- non weight bearing due to fracture (RLE-NWB d/t fracture).R1 has an Activity of Daily Living (ADL) self-care performance/mobility deficit Care Plan-date Initiated: 10/01/2025 with intervention TRANSFER: The resident is able to: move between surfaces with max assist x 1person date Initiated: 10/27/2025.On 6/6/26 at 2:15PM, V1 (Director of Nursing) said that for R1 the Transfer status as of 4/18/26 should be updated to reflect the residents non weight bearing status. V1 said she is unsure why the care plan shows transfer status x 1 person assist and should be a Mechanical lift transfer due to non-weight bearing to the right lower extremity. R1 is a [AGE] year-old admitted to the facility on [DATE] with the following diagnosis in part but not limited to: encounter for other orthopedic aftercare, infection and inflammatory reaction due to internal right hip prosthesis, subsequent encounter, methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, history of falling, periprosthetic fracture around internal prosthetic right hip joint, subsequent encounter.Minimum Data Set (MDS) dated [DATE] section GG - Functional Abilities- Mobility indicated R1 is 01-Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. For Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).Facility Policy on Care Plans (Comprehensive) revised 10/2022Policy: An individualized Comprehensive Care Plan that indicates measurable objectives and timetables to meet the resident's medical, nursing, mental and/or psychological needs is developed for each resident.Policy specifications:The Facilities Care Planning/Interdisciplinary team, in coordination with the resident, his/her family or his/her representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain.5. Care plans are revised as changes in the residents condition dictates.

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