

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER West Suburban Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 311 Edgewater Drive Bloomington, IL 60108	

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 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845</p> <p>Based on observation, interview and record review, the facility failed to provide incontinence care in a timely manner and thoroughly cleanse the perineum area during provision of care. This failure resulted in multiple patches and cluster groups of MASD (Moisture Associated Skin Damage) to R1's bilateral thighs and buttocks and caused R1 to suffer pain and aggravation.</p> <p>This applies to 3 of 3 residents (R1, R2, R3) reviewed for skin alteration and incontinence care.</p> <p>The findings include:</p> <p>1) The Face Sheet showed that R1 was a [AGE] year-old female with diagnoses that included pulmonary embolism, acute respiratory failure with hypoxia, lymphedema, difficulty walking, morbid obesity due to excess calories, anemia, lack of coordination, major depressive disorder, history of COVID-19 infection, pneumonia due to corona virus disease, muscle wasting and atrophy to multiple sites, muscle weakness and GERD (Gastro-Esophageal Reflux Disease). R1 was admitted to the facility from the hospital on 5/19/2021.</p> <p>Review of the weight record history showed R1's weights:</p> <p>-06/18/2021= 629 pounds</p> <p>-06/25/2021=632 pounds</p> <p>-07/02/2021=633 pounds</p> <p>-08/09/2021=633.4 pounds</p> <p>-09/07/2021=608 pounds</p> <p>-10/01/2021=600 pounds</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 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/04/2021 at 12:30 P.M., R1 was lying in her bariatric bed. The width's dimension of R1's bed showed that R1's had approximately 4-6 inches space between the side of her body and edge of the bed. The lack of space meant that R1 could possibly end up on the floor if R1 attempted to turn due to lack of space. R1 was alert and oriented times three. R1 said Don't worry, I cannot turn myself on my own and have to depend on 5 to 6 staff to turn me. If there is a male staff, then 5 staff will do, otherwise 6 staff if all females. The facility does not have enough people to handle me, so my diaper change was only 3 times a day at 10:00 A.M., 4:30 P.M. and 9:30 P.M. I am usually soaked with urine and stool. I have developed more skin sores and the sores do not heal because I am soaked with urine most of the time. My position in bed is the same and I am never turned to sides. Last time I was changed today was around 9:30 to 10:00 A.M. I never got out of bed or sat on a chair. It really does sting my skin when my diaper is soaked with urine. They don't apply my wound dressing most of the time to protect my skin from the burning sensation. It is a very aggravating situation.</p> <p>During this interview, R1 was calm, cooperative and was compliant when asked to check her skin and incontinence care. V5 (LPN/ Licensed Practical Nurse), V6 (LPN); V7 (CNA/Certified Nurse Assistant) were present when R1 talked about her schedule for incontinence care. They validated that R1 was scheduled to be changed 3 times a day. (10:00 A.M, 4:30 P.M. and 9:30 P.M.).</p> <p>After the interview with R1 on 10/4/21, the following staff were present to turn R1, V3 (Licensed Practical Nurse /LPN/Wound Treatment Nurse); V4 (LPN/Wound Treatment Nurse); V5 (LPN); V6 (LPN); V7 (CNA/Certified Nurse Assistant) and V9 (Male Restorative Aide). A total of 6 staff with 1 male and 5 females. R1 had to be moved towards the edge of the bed, to give room for turning to the opposite side. R1 was observed with 2 diapers under her buttocks and 1 diaper on the frontal aspect of her pubis area. R1 was saturated with urine. V7 said she just changed R1's diaper around 10:00 A.M. There was no wound dressing on R1's perineum or thighs. V7 failed to open R1's multiple skin folds, around the groin area and labial folds for thorough cleansing. V7 also failed to wipe and clean R1's buttocks and failed to apply skin ointment barrier. R1 was noted with multiple skin folds that were not easily accessible for visual skin inspection.</p> <p>On 10/4/21, R1 was compliant when was asked if we could do a thorough skin check. Same staff, except that this time 2 males were helping V9 and V8 (Restorative Aide). R1 was observed with multiple patches of open skin sores surrounding her posterior thighs (left and right) and left and right buttocks. V4 measured the wounds that V4 categorized it as MASD (Moisture Associated Skin Damage). The following measurements were provided by V4: V4 started measuring the biggest open skin area on the same group of clustered wounds. V4 failed to measure the surrounding open area with same cluster group of wounds. When V4 was asked if that was how she measured wounds (without measuring smaller size wounds and measuring the widest and longest part of wound), V4 said she was new to the job as a treatment nurse and was not trained. V4 then measured the cluster wounds from the longest and widest part of the wounds in a cluster group.</p> <ol style="list-style-type: none"> 1) Right distal posterior thigh= 4 cm x 4 cm and 1.0 cm. 2) Right proximal posterior thigh= 1 cm x 1 cm. x 1 cm. 3) Left buttock= 1.5 cm. x 1.0 cm. x 0.5 cm. 4) Right buttock= 2 cm. x 1 cm. x 1 cm. <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>5) Left proximal posterior thigh= 1 cm. x 1 cm. x 0.5 cm.</p> <p>6) Left distal/inner thigh= 0.5 cm. x 0.5 cm. x 0.2 cm.</p> <p>V3 (Licensed Practical Nurse /LPN/Wound Treatment Nurse) stated during the skin check observation that only the MASD (Moisture Associated Skin Damage) on the right proximal posterior thigh was observed on 10/3/2021 and that V3 applied foam dressing on it at that time. V3 also added that the rest of the MASD were new. V3 and V4 said R1 had history of MASD before but had healed and they were not as much as observed on 10/4/2021.</p> <p>The care plan dated 5/19/2021 and 8/19/2021 showed that R1 has alteration in skin integrity and is at risk of deterioration and or additional skin issues related to limited mobility, incontinence with bladder and bowel, morbid obesity, lymphedema, refusing air mattress, refusing peri-care at times. The interventions to prevent deterioration and acquired additional skin alteration included but not limited to: good peri care; apply protective barrier; reposition frequently when in bed, chair, and or wheelchair; pressure redistributing mattress/air loss mattress; off load bilateral heel from pressure with pillow.</p> <p>Review of the care plan showed that R1's incontinence care to prevent skin sores was not addressed. The limited size of the bariatric bed which had no air mattress and prevented R1 from turning to sides was also not addressed. R1's refusal of treatment on the care plan showed no revised intervention.</p> <p>On 10/6/2021 at 3:00 P.M., V1 (Administrator) stated that the facility does not accept residents that weigh more than 350 pounds because it lacks staff to provide care.</p> <p>On 10/6/2021 at 5:00 P.M., V2 (Director of Nursing) added that V4 was new to her position as a wound treatment nurse and was not trained yet. V2 also said that facility does not accept residents that weigh more than 350 pounds. V2 also added that they try their best to provide care to R1 but R1's situation needed additional support.</p> <p>On 10/6/2021 at 6:30 P.M., V14 (Wound Care Physician Specialist) said he saw and examined R1 on 10/5/2021. V14 said R1 had multiple patches/clusters of MASD (Moisture Associated Skin Damage) on the posterior bilateral thighs and buttocks area. V14 said R1 was on a bariatric bed but the bariatric bed was only rated for a 350-pound person. R1 weighs ~600 pounds and her bariatric bed cannot accommodate R1 for turning and repositioning. V14 also validated R1 needed to be kept clean and dry from urine and stool and should be checked for incontinence care at least every 2 hours, should be turned every 2 hours to offload pressure and an air loss mattress be implemented to prevent pressure sores, MASD or other skin alterations. V14 also said these preventions should be implemented even if a resident has multiple comorbidities. V14 added that if these interventions were implemented and pressure sores and MASD still existed, then the sores were unavoidable. V14 stated all possible interventions should be provided to determine if sores were avoidable or not. V14 said if R1 had complained of burning sensation due to urine, then a foam dressing should be applied to protect the damaged skin. V14 said Peri-care that is not done timely, which is at least every 2 hours, causes urine and stool to saturate the skin and not cleansing the perineum thoroughly will cause MASD and pressure sores and even a non-medical person knows that.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The undated facility's policy for incontinence care states, It is the policy of the facility to ensure that resident's receive as much assistance as needed for cleansing the perineum and buttocks after an incontinence episode . Frequency depends on bladder diary and /or routine of minimal every 2 hours. The policy also showed to .cleanse the peri-area and buttocks wiping from front of perineum toward the rectum. For a female resident, separate the labia and wash area using downward strokes from pubic area to rectal area and to cleanse in skin folds.</p> <p>The POS (Physician Order Sheet) for the month of October 2021, the facility's policy for incontinence care and the interview with V14 showed conflicting plan of care to prevent skin alteration. The POS showed to change and clean (R1) daily on this time range 10:00 A.M., 4:30 P.M., and 9:30 P.M. There was no assessment to justify this time range for changing and cleaning R1's incontinence care.</p> <p>2) On 10/4/2021 at 3:35 P.M., R2 was observed regarding her skin alteration. R2 has a stage 4 pressure ulcer on the sacrum. V4 (LPN/Wound Treatment Nurse) provided wound dressing to R2. R2 was saturated with urine and soft stool. V4 failed to cleanse R2 thoroughly by not cleaning the frontal/pubic area and separating labial folds to clean. V4 provided wound dressing change on R2's sacrum and the foam dressing were loosely adhering to the surrounding skin because it was still wet when V4 cleansed the rectal area. R2 was visibly dripping urine and V4 continued to fasten the incontinence brief with the wound dressing edges not sealed properly to the skin.</p> <p>The care plan dated 3/9/2021; 6/9/2021 and 9/7/2021 showed that R2 has alteration in skin integrity and is at risk for deterioration and /or additional skin issues related to limited mobility, incontinence of bladder and bladder. The interventions included but not limited to good peri care and drying of skin, apply protective barrier.</p> <p>3) On 10/4/2021 at 3:45 P.M., R3 was observed regarding skin alteration. R3 has a stage 4 pressure ulcer on the sacrum. R3 was saturated with urine and liquid stool. V4 failed to provide R3 incontinence care. V4 proceeded to change R3's sacrum wound dressing without ensuring that R3 was clean and dry. V4 said I will let (V15, CNA) provide incontinence care to (R3). At this time, V15 was providing hygiene to R10.</p> <p>The care plan dated 9/7/2021 showed that R3 has alteration in skin integrity and is at risk for deterioration and /or additional skin issues related to limited mobility, incontinence of bladder and bladder . The interventions included but not limited to good peri care and drying of skin, apply protective barrier.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845</p> <p>Based on observation, interview, and record review, the facility failed to provide sufficient staffing to assist residents who required positioning, incontinence care and grooming/hygiene assistance.</p> <p>This applies to 4 of 4 residents (R1, R2, R3, and R10) reviewed for staffing needs.</p> <p>The findings include:</p> <p>1) The Face Sheet showed that R1 was a [AGE] year-old female with diagnoses that included pulmonary embolism, acute respiratory failure with hypoxia, lymphedema, difficulty walking, morbid obesity due to excess calories, anemia, lack of coordination, major depressive disorder, history of COVID-19 infection, pneumonia due to corona virus disease, muscle wasting and atrophy to multiple sites, muscle weakness and GERD (Gastro-Esophageal Reflux Disease). R1 was admitted to the facility from the hospital on 5/19/2021.</p> <p>Review of the weight record history showed R1's weights:</p> <ul style="list-style-type: none"> -06/18/2021= 629 pounds -06/25/2021=632 pounds -07/02/2021=633 pounds -08/09/2021=633.4 pounds -09/07/2021=608 pounds -10/01/2021=600 pounds <p>On 10/04/2021 at 12:30 P.M., R1 was lying in her bariatric bed. The width's dimension of R1's bed showed that R1's had approximately 4-6 inches space between the side of her body and edge of the bed. The lack of space meant that R1 could possibly end up on the floor if R1 attempted to turn due to lack of space. R1 was alert and oriented times three. R1 said Don't worry, I cannot turn myself on my own and have to depend on 5 to 6 staff to turn me. If there is a male staff, then 5 staff will do, otherwise 6 staff if all females. The facility does not have enough people to handle me, so my diaper change was only 3 times a day at 10:00 A.M., 4:30 P.M. and 9:30 P.M. I am usually soaked with urine and stool. I have developed more skin sores and the sores do not heal because I am soaked with urine most of the time. My position in bed is the same and I am never turned to sides. Last time I was changed today was around 9:30 to 10:00 A.M. I never got out of bed or sat on a chair. It really does sting my skin when my diaper is soaked with urine. They don't apply my wound dressing most of the time to protect my skin from the burning sensation. It is a very aggravating situation.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The schedule of the night nursing staffing during the past two weeks showed an average of 10-12 both nurses and CNAs throughout the facility. The residents' census as of 10/4/2021 was 190 per V1 (Administrator).</p> <p>During this interview, R1 was calm, cooperative and was compliant when asked to check her skin and incontinence care. V5 (LPN/ Licensed Practical Nurse), V6 (LPN); V7 (CNA/Certified Nurse Assistant) were present when R1 talked about her schedule for incontinence care. They validated that R1 was scheduled to be changed 3 times a day. (10:00 A.M, 4:30 P.M. and 9:30 P.M.).</p> <p>After the interview with R1 on 10/4/21, the following staff were present to turn R1, V3 (Licensed Practical Nurse /LPN/Wound Treatment Nurse); V4 (LPN/Wound Treatment Nurse); V5 (LPN); V6 (LPN); V7 (CNA/Certified Nurse Assistant) and V9 (Male Restorative Aide). A total of 6 staff with 1 male and 5 females. R1 had to be moved towards the edge of the bed, to give room for turning to the opposite side. R1 was observed with 2 diapers under her buttocks and 1 diaper on the frontal aspect of her pubis area. R1 was saturated with urine. V7 said she just changed R1's diaper around 10:00 A.M. There was no wound dressing on R1's perineum or thighs. V7 failed to open R1's multiple skin folds, around the groin area and labial folds for thorough cleansing. V7 also failed to wipe and clean R1's buttocks and failed to apply skin ointment barrier. R1 was noted with multiple skin folds that were not easily accessible for visual skin inspection.</p> <p>On 10/4/21, R1 was compliant when was asked if we could do a thorough skin check. Same staff, except that this time 2 males were helping V9 and V8 (Restorative Aide). R1 was observed with multiple patches of open skin sores surrounding her posterior thighs (left and right) and left and right buttocks. V4 measured the wounds that V4 categorized it as MASD (Moisture Associated Skin Damage). The following measurements were provided by V4: V4 started measuring the biggest open skin area on the same group of clustered wounds. V4 failed to measure the surrounding open area with same cluster group of wounds. When V4 was asked if that was how she measured wounds (without measuring smaller size wounds and measuring the widest and longest part of wound), V4 said she was new to the job as a treatment nurse and was not trained. V4 then measured the cluster wounds from the longest and widest part of the wounds in a cluster group.</p> <ol style="list-style-type: none"> 1) Right distal posterior thigh= 4 cm x 4 cm and 1.0 cm. 2) Right proximal posterior thigh= 1 cm x 1 cm. x 1 cm. 3) Left buttock= 1.5 cm. x 1.0 cm. x 0.5 cm. 4) Right buttock= 2 cm. x 1 cm. x 1 cm. 5) Left proximal posterior thigh= 1 cm. x 1 cm. x 0.5 cm. 6) Left distal/inner thigh= 0.5 cm. x 0.5 cm. x 0.2 cm. <p>V3 (Licensed Practical Nurse /LPN/Wound Treatment Nurse) stated during the skin check observation that only the MASD (Moisture Associated Skin Damage) on the right proximal posterior thigh was observed on 10/3/2021 and that V3 applied foam dressing on it at that time. V3 also added that the rest of the MASD were new. V3 and V4 said R1 had history of MASD before but had healed and they were not as much as observed on 10/4/2021.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/6/2021 at 3:00 P.M., V1 (Administrator) stated that the facility does not accept residents that weigh more than 350 pounds because it lacks staff to provide care.</p> <p>On 10/6/2021 at 5:00 P.M., V2 (Director of Nursing) added that V4 was new to her position as a wound treatment nurse and was not trained yet. V2 also said that facility does not accept residents that weigh more than 350 pounds. V2 also added that they try their best to provide care to R1 but R1's situation needed additional support.</p> <p>On 10/6/2021 at 6:30 P.M., V14 (Wound Care Physician Specialist) said he saw and examined R1 on 10/5/2021. V14 said R1 had multiple patches/clusters of MASD (Moisture Associated Skin Damage) on the posterior bilateral thighs and buttocks area. V14 said R1 was on a bariatric bed but the bariatric bed was only rated for a 350-pound person. R1 weighs ~600 pounds and her bariatric bed cannot accommodate R1 for turning and repositioning. V14 also validated R1 needed to be kept clean and dry from urine and stool and should be checked for incontinence care at least every 2 hours, should be turned every 2 hours to offload pressure and an air loss mattress be implemented to prevent pressure sores, MASD or other skin alterations. V14 also said these preventions should be implemented even if a resident has multiple comorbidities. V14 added that if these interventions were implemented and pressure sores and MASD still existed, then the sores were unavoidable. V14 stated all possible interventions should be provided to determine if sores were avoidable or not. V14 said if R1 had complained of burning sensation due to urine, then a foam dressing should be applied to protect the damaged skin. V14 said Peri-care that is not done timely, which is at least every 2 hours, causes urine and stool to saturate the skin and not cleansing the perineum thoroughly will cause MASD and pressure sores and even a non-medical person knows that.</p> <p>The undated facility's policy for incontinence care states, It is the policy of the facility to ensure that resident's receive as much assistance as needed for cleansing the perineum and buttocks after an incontinence episode . Frequency depends on bladder diary and /or routine of minimal every 2 hours.</p> <p>2) On 10/4/2021 at 3:15 P.M., together with V4, R2 was to be observed regarding her skin alteration. R2 has a stage 4 pressure ulcer on the sacrum. R2 was lying in bed in a semi-fetal position. V4 stated there was no CNA around here on the 600 unit, they have lack of staff, and I have to go around to look for a CNA for assistance. V4 together with V17 (CNA from staffing Agency) came to assist at 3:35 P.M. V17 stated she was assigned to the first floor and 600 wing was on the second floor. V4 unfastened R2's incontinence brief. R2 was saturated with urine and soft bowel movement.</p> <p>The care plan dated 8/31/2021 showed that R2 has self-care deficit and requires assist with ADL's to maintain highest possible level of functioning as evidence by the following limitations and potential contributing diagnoses; impaired functional mobility, with poor strength coordination, cognitive deficit, Alzheimer's disease, edema, weakness and psychosis.</p> <p>After the V4 provided wound care and incontinence care to R2, V18 (Registered Nurse) was seen in the dining room with group of residents approximately 10-12 residents. V18 said that she had no CNA on the floor (600 wing) because the two morning CNAs had left at 3:00 P.M. V18 said that she was waiting for her reliever and CNAs assigned for the second shift.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845</p> <p>Based on interview and record review, the facility failed to follow up in a timely manner for transportation services from an outside entity for a resident needing medical evaluation for an appropriate skilled therapy placement.</p> <p>This applies to 1 of 3 residents (R1) requiring transportation services from an outside entity.</p> <p>The findings include:</p> <p>The Face Sheet showed that R1 was a [AGE] year-old female with diagnoses that included pulmonary embolism, acute respiratory failure with hypoxia, lymphedema, difficulty walking, morbid obesity due to excess calories, anemia, lack of coordination, major depressive disorder, history of COVID-19 infection, pneumonia due to corona virus disease, muscle wasting and atrophy, to multiple sites, muscle weakness and GERD (Gastro-Esophageal Reflux Disease). R1 was admitted to the facility from the hospital on 5/19/2021.</p> <p>The weight record history showed R1's weights:</p> <p>-06/18/2021= 629 pounds</p> <p>-06/25/2021=632 pounds</p> <p>-07/02/2021=633 pounds</p> <p>-08/09/2021=633.4 pounds</p> <p>-09/07/2021=608 pounds</p> <p>-10/01/2021=600 pounds</p> <p>On 10/04/2021 at 12:30 P.M., R1 was lying in her bariatric bed. The width's dimension of R1's bed showed that R1's had approximately 4-6 inches space between the side of her body and edge of the bed. The lack of space meant that R1 could possibly end up on the floor if R1 attempted to turn due to lack of space. R1 was alert and oriented times three. R1 said Don't worry, I cannot turn myself on my own and have to depend on 5 to 6 staff to turn me. If there is a male staff, then 5 staff will do, otherwise 6 staff if all females. R1 said, I have therapy in bed, they stretch my legs and my arms. This place is not for me. I want to have skilled therapy in an acute rehabilitation center. However, my appointments with the rehabilitation hospital have been canceled twice because the ambulance refused to take me there because of my weight. The facility did not help me with transportation. I missed my August and September (2021) appointments. Now I have an appointment on October 14, 2021 but I don't know what will happen or if they will help me with my transportation. No one told me yet what was going on with that.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER West Suburban Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 311 Edgewater Drive Bloomington, IL 60108	
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 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/4/2021 at 11:40 A.M., V11 (Medical records/Scheduler for medical transportation) said R1 had the first appointment to the acute rehabilitation hospital on August 26, 2021. V11 said a week or two prior to the appointment, V11 had called the private ambulance contracted by facility for residents' transport for outside medical appointments. V11 said that she informed the private ambulance that R1 was morbidly obese and needed a bariatric transport service. V11 said that the ambulance denied the request for transport. V11 said she informed V1 (Administrator), V2 (Director of Nursing) and V12 (Social Service staff) that the private ambulance had denied the transport. V11 said R1 had a second appointment on 9/9/2021 since the first appointment was canceled. V11 said that she called again the private and said she needed bariatric service for a resident to go to the acute rehabilitation hospital. V11 said the private ambulance again denied transporting R1. V11 stated R1 has the third appointment to the rehabilitation hospital on October 14, 2021. V11 added that hopefully this time around, the private ambulance will transport R1.</p> <p>On 10/4/2021 at 2:00 P.M., V1 stated the ambulance that facility uses does not have enough manpower to transport R1. V1 also added that the private ambulance' CEO (Chief Operating Officer) and the facility's CEO had communicated and that it was approved as of today (10/4/2021) that R1 will be transported on 10/14/2021.</p> <p>On 10/5/2021 at 11:00 A.M., V12 (Social Service) stated the private ambulance had not transported R1. V12 said he was just waiting to see what the facility's plan was. V12 said that the transportation approved as of 10/4/2021.</p>		