STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046169	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD NRSG & REHAB CENTER	**14716 S EASTERN AVENUE , PLAINFIELD, Illinois, 60544**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigation 257466/IL193010	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

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

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S9999	Continued from page 1 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to assess the urinary status of a resident with an indwelling urinary catheter. This failure resulted in the resident experiencing urinary retention and being hospitalized with a diagnosis of UTI (Urinary Tract Infection). This applies to 1 of 3 residents (R1) reviewed for catheters in a sample of 3. The findings include: R1's face sheet shows an admission date to the facility on 2/24/25. R1's face sheet showed his diagnoses chronic kidney disease, benign prostatic hyperplasia without lower urinary tract symptoms, and neuromuscular dysfunction of bladder. R1's 4/30/2025 MDS (Minimum Data Set) showed he was severely cognitively impaired and had an indwelling urinary catheter. R1's progress note from 5/17/25 at 12:21 PM showed "[R1] being discharged to another nursing home ...Ambulance here to transfer [R1] during transport with paramedic staff informed writer that due to vital signs and resident's mentality status, they were diverting [R1] to [local hospital] ..." R1's 5/17/2025 "History of Present Illness" ER note from 2:07 PM showed "he had his [indwelling urinary catheter] changed out with doing this there was frank pus in the [catheter] and he had about 1.9 liters of	S9999		

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S9999	Continued from page 2 brisk urine output with replacement of the [catheter]." On 5/28/25 at 9:52 AM, V3 LPN (Licensed Practical Nurse) stated she was R1's nurse on 5/17/2025 and she couldn't remember anything about his catheter. V3 stated the CNA (Certified Nursing Assistant) most probably emptied it out and the CNAs performed catheter care on R1. V3 stated "if something was wrong with his catheter, I would attempt to irrigate it. If that doesn't work, I will change it." R1's 5/17/2025 Emergency Room (ER) notes showed "Diagnosis: Urinary Tract Infection associated with indwelling urethral catheter. On 5/17/25 at 12:26 PM, Bladder exceptionally full unable to fully measure on bedside ultrasound. He does have chronic indwelling Foley catheter ... however it is dry, there is no urine in the bag. Suspect, [it] has been displaced. At this point, high suspicion for urosepsis due to urinary retention, likely [acute kidney injury] and electrolyte disturbance present ...will reassess ...once his bladder is decompressed ... Imaging studies: CT (Computerized Tomography) abdomen pelvis with IV Contrast-Final Result ... Bilateral urothelial thickening suspicious for ascending urinary tract infection ..." R1's Electronic Medical Record (EMAR) showed the order "Catheter: Record output from urinary catheter every shift." R1's last recorded output was 300 cc at 10:30 PM on 5/16/2025, with nothing documented at the end of night shift (approximately 6:30 AM on 5/17), or prior to R1 discharging the facility around noon on 5/17/2025 (approximately 13 hours after the last documented output). On 5/28/25 at 9:29 AM, V2 (DON-Director of Nursing) stated the following: Catheter care is done daily and as needed by the CNA's (Certified Nursing Assistants) or nurses. On 5/30/25 at 12:16 PM, V2 stated nurses are to assess the resident's catheter to see if it's patent and draining. V2 stated they should look at the bag and at the urine color and see if it's normal. V2 stated nurses should check the abdomen for distention and should feel the abdomen and assess for discomfort. V2 stated nurses should change the tubing when the urine is cloudy or when it's not draining, adding "nurses have to do a basic nursing assessment." V2 stated as long as the CNAs see the catheter draining and they empty it, they don't consider there is a blockage	S9999		

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S9999	Continued from page 3 anywhere. V2 stated there are not specific times when the staff empty the catheters, but it should be per shift. V2 stated normally, CNAs empty catheters at the end of the shift. V2 verified there was no documentation of R1's urinary output on 5/17/2025. On 5/30/25 at 12:30 PM, V6 (Nurse Practitioner) stated she did not see R1's catheter on the day he was discharged. V6 stated that as long as there is urine output and the catheter is draining, then the catheter is functioning. V6 stated there should be urine that's not bloody or cloudy in the tubing. V6 stated nurses should look to see if the catheter is draining appropriately. R1's POS (Physician Order Sheet) shows orders for Indwelling Catheter: Catheter Care daily and as needed. Catheter: Record output from urinary catheter every shift. The facility's Catheter Care, Urinary (revised September 2005) policy showed "The purpose of this procedure is to prevent infection of the resident's urinary tract .... 7. Maintain an accurate record of the resident's daily output, per facility policy and procedure... 12. Empty the collection bag at least every eight (8) hours ... 14. Observe the resident for signs and symptoms of urinary tract infection and urinary retention ... Report findings to the supervisor immediately ..." (B)	S9999		