

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145611	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER St James Wellness Rehab Villas		STREET ADDRESS, CITY, STATE, ZIP CODE 1251 East Richton Road Crete, IL 60417	

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 - Few</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** Based on observation, interview, and record review, the facility failed to provide timely incontinence care for residents who require assistance with toileting and hygiene.</p> <p>This applies to 3 of 4 residents (R1, R2, R3) reviewed for activities of daily living (ADL) care in the sample of 19.</p> <p>The findings include:</p> <p>1. R1's Face sheet shows that R1 is [AGE] year-old who has multiple medical diagnoses including morbid obesity, personal history of urinary tract infection, chronic pain, depression, unspecified (mood) affective disorder, unsteadiness on feet, and weakness.</p> <p>On March 18, 2025, at 10:28 AM, a very strong urine odor was coming from R1's room. R1 was lying in bed, alert and oriented. R1's bed sheets, incontinence brief, and incontinence pad, were heavily saturated with urine, and were all stained with brownish discoloration from the urine. R1 also said she has not been changed yet this shift. R1 used the call light to ask for help, but the staff turned off the light stating she will come back for her. R1 said she placed the bedpan underneath herself to move her bowel. R1 said she (R1) has been lying on her bedpan for an hour now waiting for the CAN/Certified Nursing Assistant staff (V13) to come and assist her.</p> <p>On March 18, at 10:58 AM, V13 (CNA) stated that R1 can walk and go to the rest room but she's refusing. Every morning the staff find her wet and won't get up to the washroom. R1 has behavior she goes to the shower and ambulate to hallway when she wants to. R1 doesn't want to move, she wants staff to do everything for her when she feels like it.</p> <p>R1's Minimum Data Set (MDS) dated [DATE], shows R1 is alert and oriented, she's always incontinent, and requires substantial to maximal assistance for toileting hygiene.</p> <p>R1's care plan dated January 31, 2025, shows R1 has mixed bladder incontinence related to impaired mobility and obesity. This same care plan shows multiple interventions including check and change every 2 hours and as needed, and clean peri-area with each incontinence episode.</p> <p>2.R2's Face sheet shows R2 is [AGE] year-old who has multiple medical diagnoses including weakness, unspecified dementia, non-pressure chronic ulcer of unspecified left lower leg limited to breakdown of skin.</p> <p>On March 18, 2025, at 1:15 PM, R2 was lying in bed, stated that she was last changed early this</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145611	If continuation sheet Page 1 of 6

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>morning. She (R2) could not remember who changed her this morning because she was still half asleep. R2 turned on the call light and V19 (CNA) responded and checked R2. V19 said the last time she changed R2 was right after breakfast, because she was very busy getting up other residents. R2 was observed heavily saturated with urine, with pervasive urine odor, which overflowed from the incontinence brief to her incontinence pad. R2 also had a large bowel movement.</p> <p>R2's Minimum Data Set, dated [DATE], shows that R2 is completely dependent on staff for her toileting and personal hygiene. R2 was alert and oriented but forgetful.</p> <p>3. R3's Face sheet shows R3 is [AGE] year-old who has multiple medical diagnoses including cerebral infarction dur to unspecified occlusion or stenosis of left middle cerebral artery, morbid obesity, unspecified mental disorder.</p> <p>On March 18, 2025, at 1:34 PM, R3 was resting in bed. R3 was alert, oriented but has difficulty understanding inquiries and instructions. R3 was heavily saturated with urine and had a bowel movement which was dry and pasty. V19 said that she has not changed R3. V19 stated she usually waits for R3 to tell her when she needed to be change. R3's MDS dated [DATE], shows R3 has short-term memory problem, and is completely dependent on staff for toileting hygiene.</p> <p>R3's care plan dated February 10, 20,25, shows R3 has functional bladder incontinence related to impaired mobility, and physical limitations. This same care plan shows multiple intervention including check and change every 2 hours and as needed, and to clean peri-area with each incontinence episode.</p> <p>On March 19, 2025, at 9:16 AM, V4 (Regional Consultant Nurse) stated staff must check and change residents for incontinence every 2 hours and as needed, to prevent skin breakdown, and promote comfort and dignity.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review, the facility failed to follow physician orders for wound treatment and wound dressing changes as needed.</p> <p>This applies to 1 of 3 resident reviewed for wounds in the sample of 19.</p> <p>The findings include:</p> <p>R4's Face sheet shows R4 is [AGE] year-old who has multiple diagnoses including type 2 diabetes mellitus, unspecified dementia, infection of intervertebral disc, sacral and sacrococcygeal region, and unstageable pressure ulcer of the sacral region.</p> <p>On March 19, 2025, around 6AM, R4 was lying in bed. She has a wound dressing to sacral region which was heavily saturated with wound discharges and exudates. This wound dressing was dated 3/18/25 and was detached from R4 exposing her unstageable sacral ulcer. Surrounding area of the wound was wet with exudates. R4 was noted with a rectal tube that was leaking on the side with fecal matter near the exposed wound. V10 (Certified Nursing Assistant/CNA) changed the brief and said he did not notify the nurse about R4's need for dressing change because he was busy trying to complete his assignment.</p> <p>On March 20, 2025, at 10:43 AM, V8 (Wound Care physician) stated that V4's wound dressing should be change daily and as needed. When wound dressing becomes very soiled, the staff must immediately change the dressing as the exudate can cause potential skin breakdown.</p> <p>The weekly skin assessment dated [DATE], shows this unstageable wound is measured as Length (L) 10-centimeter (cm) x Width (W) 10 cm.</p> <p>Physician Order Summary (POS) with revision date of March 7, 2025, shows Cleanse sacrum with normal saline, apply medihoney, and cover with dry dressing every day shift and Cleanse sacrum with normal saline, apply medihoney, and cover with dry dressing as needed if dressing comes loose or becomes soiled.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that there is a physician order for self-administration of an inhaler medication, and failed to ensure that medication was administered to residents accurately as prescribed by physician.</p> <p>This applies to 2 of 7 residents (R1 and R5) reviewed for medication administration in the sample of 19.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. R1's Face sheet shows that R1 is [AGE] year-old who has multiple medical diagnoses including morbid obesity, recurrent major depressive disorder, unspecified (mood) affective disorder, chronic obstructive pulmonary disease, and asthma. <p>On March 18, 2025, at 10:28 AM, R1 was resting in bed, there was a Symbicort inhaler at her bedside. R1 said she needed it. However, her Physician Order Summary (POS), does not have evidence of documentation that she may keep the medication at bedside. There was no updated care plan with regards to R1's self-administration of medication.</p> <ol style="list-style-type: none"> 2. R5's Face sheet shows that R5 is [AGE] year-old who has multiple medical diagnoses including type 2 diabetes mellitus, unspecified dementia, dysphagia, oral phase, Vitamin D deficiency, hypertension, weakness, and cognitive communication deficit. <p>On March 19, 2025, at 9:00 AM, V14 (Restorative Aid) was observed feeding R5. There were unidentified white very small circular granules, and some small pieces of irregular shape substances mixed and sprinkled to R1's pureed bread. When surveyor asked what it was, V14 said that she doesn't know. V14 said that she didn't know who set up the tray for R5.</p> <p>On March 19, 2025, at 9:04 AM, V3 (Assistant Director of Nursing/ADON) said that the white substance was substitute sugar. However, upon comparison of the sugar substitute to the unidentified substance, there was a difference in appearance/consistency.</p> <p>At around 9:10 AM, V6 (Nurse) who was the primary nurse of R5, was passing medication at the end of the 2-north hallway, far from the dining room. As V3 and surveyor approached V6, he (V6) informed surveyor and V3 that the unidentified white substances were R5's medications which V6 mixed in the food when R5 refused the medications with apple sauce.</p> <p>On March 18, 2025, at 12:55 PM, V19 said she had seen medications mixed in the residents' food when she collects meal trays from the bedroom and dining room, but unable to tell specific residents. Sometimes the resident does not eat, so the food is left untouched along with the meds. V19 said she had seen V6 (Nurse) do it.</p> <p>On March 19, 2025, at 9:16 AM, V4 (Regional Consultant Nurse) said inhaler medication can be left at bedside if there's an order and assessment of self-administration. The staff can mix the medication with the resident's meal if they are the one who will feed the resident to ensure that the medications are taken by the resident.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility's Medication Administration Policy dated October 25, 2014, shows:</p> <p>Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to do so only after they have been properly oriented to the medication management system in the facility. The facility has sufficient staff and a medication distribution system to ensure sage administration of medications without unnecessary interruptions.</p> <p>Procedures:</p> <p>7. The person who prepares the dose for administration is the person who administers the dose.</p> <p>14. The residents are allowed to self-administer medication when specifically authorized by the attending physician and in accordance with procedures for self-administration of medication.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation, interview, and record review, the facility failed to repair their leaking ice machine in the nourishment room.</p> <p>This applies to 7 of 7 residents (R13, R14, R15, R16, R17, R18, R19) who are ambulatory and with impaired cognition.</p> <p>The findings include:</p> <p>The facility has nourishment room in each floor. On March 18, 2025, at 12:00 PM, the door of the second-floor nourishment room was wide open, the doorknob was not equipped with a lock. The ice maker machine that was inside the nourishment room was leaking water on the floor. A puddle of water was observed.</p> <p>On March 18, 2025, at 12:12 PM, V17 and V18 (Both Certified Nursing Assistant/CNA) said the ice machine has currently been leaking for a week, and they reported it.</p> <p>On March 19, 2025, at 7:06 AM, the nourishment room was unlocked. There were folded bedsheets on the floor absorbing the water leaking from the base of the ice machine. As surveyor stepped on the sheets, water squeezed out of the wet bedsheets. V6 (Nurse) said the sheets are for the leaking ice machine.</p> <p>On March 19, 2025, at 10:13 AM, V5 (Maintenance/Housekeeping Director) stated that they repaired the ice maker machine on the second floor because it was not making enough ice. He was aware that the ice machine was leaking, and he was only notified the day before.</p> <p>The second floor has residents who are identified as ambulatory and has impaired cognition based on their most recent Minimum Data Set. These residents include R13, R14, R15, R16, R17, R18, R19. From March 18 to March 19, 2025, during observation on the second floor, there were residents observed ambulating in the hallway and day area.</p> <p>On May 19, 2025, at around 8:15 AM, R14 was observed wandering in the 2 North hallway where the ice machine was located, entering one bedroom to another of other residents, and attempted to open closed doors.</p>		