FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C IL6001259 08/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5801 SOUTH CASS AVENUE** BURGESS SQUARE HEALTHCARE CTR WESTMONT, IL 60559 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 000 **Initial Comments** S 000 Facility Reported Incident of August 14, 2021 IL137298 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610 a) 300, 1210 b) 300.1210 d)2) Section 300.610 Resident Care Policies 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

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Pursuant to subsection (a), general

care needs of the resident.

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

TITLE

Attachment A

ament of Licensure Violations

(X6) DATE

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pressure and pain. Under the "Assessment and Plan" portion of R1's hospital history and physical,

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can become ill."

On 8/25/21 at 12:03 PM, V4, RN (Registered Nurse), said, "When giving a resident a bolus feeding first check the physician's order. If you give the wrong amount of feeding the resident

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Illinois Department of Public Health **FORM APPROVED** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED IL6001259 B. WING 08/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BURGESS SQUARE HEALTHCARE CTR 5801 SOUTH CASS AVENUE** WESTMONT, IL 60559 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE TAG **PREFIX** TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 3 S9999 On 8/28/21 at 11:50 AM, R1 was in her wheelchair at her bedside. R1 stated she "remembered going to the hospital because she didn't feel well." The facility's May 2021 Enteral Tube Bolus Feeding policy showed "Preparation 1. Verify the physician's order General Guidelines 3 Check the following information: g. Rate of administration" (A) s Department of Public Health

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