STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	C 01/23/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEALTH AND REHAB CENTER	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

(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
F 354	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based upon facility records and staff interviews the facility failed to have a DON (Director of Nursing) from 1/13/07 through 1/18/07. Findings Include: A review of the facility staffing records on 1/17/07 identify that E2's (Director of Nursing/DON) last day was Friday 1/12/07. E1 (Administrator) was interviewed on 1/17/07 and stated,"We are trying to hire...we have ads in the paper I am a RN (Registered Nurse). I am filling in until we hire someone." E1 was informed on 1/17/07 by surveyor that the administrator position and the director of nursing were separate positions each requiring full time status. E1 responded, "Okay I will hire my wife she will start tomorrow." On 1/18/07 E1 provided surveyor a staffing schedule reflecting E18 as the new DON. The schedule depicted E18 as providing less than 8 hours per day. E1 ws informed and stated, "My wife will start." E1 returned to surveyor at approximately 2pm on 1/18/07 with an amended schedule denoting E19 and E18 sharing the DON position. E1 stated,"... this schedule is until we hire a DON..."	F 354		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.1210a)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	C 01/23/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEALTH AND REHAB CENTER	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

(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
F9999	Continued From page 17 300.1210b)1) 300.1210b)2) 300.3220f) 300.3240a) 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis. 1) Medications including oral, rectal hypodermic, intravenous, and intramuscular shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure faciltiy compliance with such orders. (Section 2-104(b) of the Act)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	C 01/23/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEALTH AND REHAB CENTER	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

(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
F9999	Continued From page 18 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: I. Based upon record reviews, staff interviews and review of facility policies the facility failed to: 1. provide hemodialysis to 1 of 6 residents (R7) and failed to administer medication to a physically, cognitively and medically compromised resident. 2. Ensure that 2 of 8 sampled (R2, R7) residents on ventilators received their medicications as prescribed by their physician. II. Based upon record reviews, staff, physicians, and medical examiner interviews the facility failed to provide supervision and staff monitoring for 1 resident (R2) in the sample with an identified neuro impairment. Subsequently, R2 manually removed his trach tube and expired. R2's death was documented by the medical examiner to be an accidental death by self affliction (self extubation due to displacement of trach tube). R2 and R7 expired shortly after the omission of medications and the lack of treatment and care. Findings Include: 1. R7 was admitted to the facility on Thursday 12/7/06 at 11:20pm with a diagnosis listed on the admission record including Vent/Trach Dependent, Diabetes, Hypertension, and	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	C 01/23/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEALTH AND REHAB CENTER	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

(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
F9999	Continued From page 19	F9999		

Dialysis. The patient information and transfer form that accompanied R7 on admission notes HD (Hemodialyses) MWF (Monday-Wednesday-Friday).

Nurses note by E9 Saturday 12/9/06- 8:00am in part reflects: "resident complaint SOB (shortness of breath) and pain all over. I need a breathing treatment. respiratory notified. Post neb given; resident requested pain medication, Vicodin given."

R7 continues with documentation noted at 8:35am reflecting the following: "8:10am respiratory staff went to do vent checks and found resident unresponsive and pulseless, code blue called, and 911 called ASAP. 9 am transferred to hospital attempt to notify family three times (with) no response."

E9 (admitting nurse) was interviewed on 1/22/07 via telephone regarding the orders for hemodialysis on the transfer sheet, and stated, "I only wrote the admitting note, I was going home, I did not take the medication orders, (E20) did. I did not know he was on dialysis until I sent (R7) out after he coded. I was going through the paperwork in the chart and that is when I found out about dialysis. I then asked (E16) she is in charge of dialysis. (E16) told me that (E12) and (E17) would have to submit papers to allow (R7) to get dialysis."

E20 (nurse) was interviewed on 1/22/07 stating, "I did not admit (R7); (E9) did. I only called the doctor (Z1) for pain meds; not the dialysis. I did not know (R7) was supposed to have dialysis."

E16 (dialysis supervisor) was interviewed in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	C 01/23/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEALTH AND REHAB CENTER	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

(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
F9999	Continued From page 20 facility on 1/18/07 and stated, "I have not heard of the resident (referencing R7). If we had, (E17) would have let me know. We have a process. I did not have that resident for dialysis." E16 was further interviewed on 1/18/07 regarding the complaint from R7 regarding shortness of breath and pain all over and stated, "If (R7) had an order for dialysis for three times a week day and he missed one day, it is quite possible that he may have had fluid overload." E17 (admission coordinator) was interviewed on 1/18/07 and stated, "(E1, Administrator) took over for this case, he told me he would take care of the dialysis. Normally I would receive the admission papers and pass them to (E2, Director of Nursing) and once approved I would contact (E16), but (E1) told me he would do it. I did not do anything but give the admission information to (E1)." E1 was interviewed on 1/18/07 and stated, "We have an admission process. Normally (E17) takes care of notifying (E16). I did not tell (E16) about (R7's) need for dialysis." Z1 (pulmonary consultant physician) was interviewed by phone on 1/18/07 regarding the hemodialysis order noted on the transfer sheet and stated, "I get several calls a day, I cannot remember if they called me but if they told me the resident was on dialysis I would have continued the order." R7 was admitted to the facility on Thursday and was found on Saturday unresponsive. R7 did not have dialysis on Friday according to the transfer orders.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	C 01/23/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEALTH AND REHAB CENTER	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

(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
F9999	Continued From page 21 Z3 (physician) for R7 was interviewed on 12/28/06 at 1:00pm and stated, "I never saw him (R7), (R7) came on Thursday night and they told me he died, I gave them to continue orders from hospital." In addition, neither the MAR (medication administration record) or nurses notes from 12/7/06 to 12/9/06 for R7 have a nurse signature to indicate whether the following medications were given: 1. Insulin Glargine 14 units Subq daily 8am (due for 12/8 and 12/9/06) 2. Losarlan 50mg. q 12 hours- 6am& 6pm (due 12/8 and 12/9 6am, 2006). 3. Clonidine HCL 0.1mg q 12 hours (6am&6pm) (due 12/8 and 12/9/06- 6am) 4.Warfarin 5mg po daily-9am (Due 12/8/06) 5. Morphine Sulfate 50mg q 24 hour. (Due 12/8/06 at 9am) 6. Enalapril 20mg. q 12 hour (6am & 6pm) (due 12 12/8 and 12/9/06-6am) 7. Carvedilol 25mg po q 12 hours (6am/6pm) (due 12/8 and 12/9 6am) 8. Ferrous Sulfate 325mg Q 12hours (6am/6pm) (due 12/8 and 12/9 6am) 9. Folic Acid 1mg po daily 9 am (due 12/8/06) E1 was informed on 1/18/07 of the above medications not documented as given by the nurse and stated, "I will look into it." E1 did not provide any further documentation. 2. R2 is a 71 year old male admitted to the facility on 01/05/07 from a local hospital at approximately 1:30pm according to E4 (nurse). The record contained a progress note that	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	C 01/23/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEALTH AND REHAB CENTER	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

(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
F9999	Continued From page 22 accompanied the resident denoting: "Neuro: somewhat confused (may pull lines if not restrained)." In addition, the facility physician orders dated 1/5/07 denotes resident is Ventilator Dependent. On 1/05/07 per record review the nurse notes documented by E4 (nurse), in part read: "3pm-11pm, received (R2) via stretcher non-responsive accompanied with paramedics with trach/vent; distended abdomen; bilateral wheezing sounds noted need complete assistance in ADL (activities of daily living); agitated Ativan 1mg. administered as ordered." On 1/5/07 per record review the nurses note documented by E12 (nurse) 11pm -7 am shift, in part reads: "repeated attempts to pull out trach, requires increased staff supervision for safety." The documentation did not show that the Ativan medication was given according to Z1's 1/5/07 order for agitation. E12 was interviewed on 1/16/07 by phone and stated,"I told (E1) that we needed more staff to monitor and that I did not feel safe but E1 just cut my hours down." Nurses note dated 1/6/07 at 2:50pm by E13 denotes in part "received resident in bed with vent tubing in hand. Resident has been observed taking himself off the vent. Z1 notified ordered soft mitt restraints if family approves. Family contacted approved restraints will continue to monitor." Again, medication Ativan for agitated behaviors is not documented as dispensed, and there is no documentation to denote whether or not Haldol that was ordered was given, along with the soft mitt order.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	C 01/23/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEALTH AND REHAB CENTER	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

(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
F9999	Continued From page 23 The record of R2 does not contain a documented plan of monitoring for the known behaviors of agitation and repeated removal of the vent tubing, as noted on the admission progress notes, and assessments by E4, 12, and E13. In addition. Z1's physician orders of 1/5/07 are for Ativan 1mg every 8 hours PRN and on 1/6/07 Z1 added Haldol 1mg. IM every 12 hours and PRN, along with soft hand mitts. This was not developed into a documented individualized plan that was carried out. R2's nurses notes depict Ativan was given only on the 3 to 11 shift 1/5/07 as documented on the MAR (medication administration record) at 9:00pm. The record also documents on the nurse notes that Ativan was given at 4:00pm 1/6/07. The resident's behavior of pulling out tubes was noted by E12 on the 11-7 shift- 1/5/07, and the record is void of documentation that the medication Ativan as prescribed by Z1 was administered. Further review of R2's MAR and nurses notes did not reflect Haldol was ever administered. Ativan is a benzodiazepine tranquilizer, and may be prescribed for agitation to relax and/or make an individual tranquil or sleepy. Haldol is classified as an antipsychotic and may be used for acute psychiatric situations. It affects part of the hypothalamus that control alertness. Nurses note dated 1/6/07 by E5 (nurse) denotes in part: "3pm received resident...no restraints restraints applied 5:30pm called by CNA (certified nurse aide) inner cannula out...patient appears	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	C 01/23/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEALTH AND REHAB CENTER	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

(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
F9999	Continued From page 24 unresponsive, pulse faint, no BP (blood pressure) Respiratory therapist at bedside CPR started Z1 called to hospital 911 called 5:40pm resident left with paramedics." E5 (nurse) was interviewed on 1/16/07 by phone at approximately 9:45am and stated, "(E15, CNA) told me (R2) pulled out cannula...." E6 (Respiratory Therapist) was interviewed on 1/12/07 and stated, "CNA (cannot remember who) ran all the way down to our office and said R2 did not look like he was breathing...no code was called, our office is on the opposite end of the hallway from where (R2) was. I was coming off duty, and we (my relief and I) ran to (R2's) room. No one was there. I started bagging (R2) and (E14) started compression." Z3 (medical examiner) was interviewed on 1/16/07 at approximately 2:00pm and stated, "manner of death will be accident self extubation due to displacement of trach tube and Chronic COPD." E2 (Director of Nursing) was interviewed on 1/12/07 at approximately 11:00am and stated, "nurses are supposed to document if meds are given." The facility failed to administer medications according to the timeline of Z1's orders. These medications could have aided in decreasing agitated behaviors. The facility failed to implement consistent measures of monitoring that would assist R2 in the prevention of pulling out the trach tube, and the facility failed to administer medications	F9999		