	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDIN	G		C
		14G378	B. WING _			9/2010
	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE S 410 WYATT DRIVE GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 331	adequate ROM and the touch. E9 stated pain - including faci hand. E9 stated sh (nurse). E9 stated previously seen R1 opinion to determin E9 stated after E19 R1's calf was more E9 stated she contareceived orders to sroom for an evaluar observed R1's left I and it needed to be that after giving R1 seem to help. FINAL OBSERVAT LICENSURE VIOLA 350.1210 350.1220j) 350.3240a) Section 350.1210 H The facility shall promaintain each residence of a resider the presence of incomparison.	E9 stated R1 did not have did her left knee was warm to did that R1 showed signs of all grimacing and biting of her nee contacted E1 and then E19 she was aware that E19 had is bruise so she wanted E19's e if R1's bruise had worsened. To observed R1 she stated that swollen at this time. Cated the on call physician and send R1 to the emergency tion. E9 stated that when she eg bruise, "It didn't look good assessed." E9 also stated pain medication, it did not stone and send R1 to the emergency to death as services have been been been been didn't look good assessed." E9 also stated pain medication, it did not stone and send R1 to the emergency to death Services here all services necessary to dent in good physical health.	W 331			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		14G378	B. WI	NG _			ට 9/2010	
	PROVIDER OR SUPPLIER JND RICHARD HOME			1	REET ADDRESS, CITY, STATE, ZIP CODE S 410 WYATT DRIVE GENEVA, IL 60134			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W9999	or agent of a facility resident. These Regulations by: Based on interview failed to provide nu notify the physician was noted to have with an impacted fr. (6 days later). Findings include: R1, per review of he Program Plan), is a diagnoses include I Cerebral Palsy, Sei Impairment, Acquire Osteoporosis. E2 (Lead CNA - Ceinterviewed 1/22/10 is non-verbal and need to E2 stated R1 is dep (Activities of Daily Lexpresses pain with her hands. E2 stated by smilling, and R1 happy. On 1/22/10 surveyor	d of 30 days	W9:	999				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUI	LDIN	G	Ι,	C
		14G378	B. WIN	IG _			9/2010
	PROVIDER OR SUPPLIER JND RICHARD HOME			1	EEET ADDRESS, CITY, STATE, ZIP CODE S 410 WYATT DRIVE EENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	report (R1) that invoorigin. The 1/2/10 incident description: "Client was being of (post) bruising was emergency transfer after water main but stable (with) frequestaff. Today CNA from and client seemed attempted ROM (RADL care. Call to (received to transfer TIBIAL FX (fracture Hospital X-ray reportion following diagnosis fracture of the proxitibia. This may be severe osteopenia. The facility's investif fracture noted the from 12/27/09 at app was an emergency Richard Home due and sounding the fif (Emergency Medicathe assigned aide to bathing another client the pipe had broken indicated that at 9:3 discoloration noted time the clients were she did not observe the wing on the oth.	provided surveyor 1 incident olved an injury of unknown report notes the following bserved during past week noted on 12/29 after due to evacuation on 12/29 rst. Client had appeared nt observation by nursing elt leg appeared more swollen in more discomfort with ange of Motion) during AM on call physician) (with) orders for Eval. DX (diagnosis) o)." rt, dated 1/2/10, notes the "There is an impacted imal metaphysia of the left an acute fracture. However, is seen in the bones."	W99	999			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUI	LDIN	G	Ι,	C
		14G378	B. WIN	IG			9/2010
	PROVIDER OR SUPPLIER JND RICHARD HOME			1	EET ADDRESS, CITY, STATE, ZIP CODE S 410 WYATT DRIVE EENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	the small area that present in is though sustained this fractitibia would indicate when more than like was how she was sevacuation This osteoporosis and is During the evacuation inadvertent bumpin caused the initial we further fractured with being positioned are Review of R1's MA Record) noted R1 we 650mg for pain/disc following dates: - 12/27/09 9:00pm - 12/28/09 8:20am - 12/28/09 8:20am - 12/29/09 6:00am - 11/10 9:15am - 1/2/10 8:00am R1's nursing notes following was noted of the second in th	all the staff and clients were at to be how this client ure. An impact fracture to the that the leg was bumped ely in the sitting position which sitting at the time of the client has a diagnosis of at high risk for fractures. It is not find the left leg may have eakening of the area and later that he normal use of the leg and diapering of this client." R (Medication Administration was given Acetaminophen comfort (of left knee) on the leg at 4:30pm and 8:30pm	W99	999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION IG	(X3) DATE SU COMPLE	TED
		14G378	B. WI	NG _) 9/2010
	ROVIDER OR SUPPLIER		- I	1	REET ADDRESS, CITY, STATE, ZIP CODE S 410 WYATT DRIVE SENEVA, IL 60134		,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPRICED TO THE APPRICED T	JLD BE	(X5) COMPLETION DATE
W9999	remains. Client did emergency evacua Physician of client of closed. Will continue 12/29/09 3:00 am monitored, skin war "Temp 98.1, acetar pain due to facial gleg. Will continue to 12/29/09 1:00 pm continues. Left knee to 12/29/09 1:00 pm continues. Left knee a 12/29/09 7:00 pm monitored, skin war 12/31/09 " (Left fading" 1/1/10 10:20 pm, discolored, client where Acetaminophen at continue to monitor 1/2/10 10:45 am, pain during AM carres (Left) leg (with) swebruising (Left lower knee and upper leg 650 mg given at 8 Al grimacing and biting (at) time of this writtleg elevated. Staff (with) (increased) sprevious visual from call physician) (with new order to transfer 1/2/10 3 pm, "(ho	have emergency transfer for tion 12/27/09 10:30am. DOT (out of town). Office ue to monitor" a, " left leg bruising rm to touch" 6:00am, minophen 625mg given for rimace upon touching the (left) o monitor" a, " Discoloration to left calf ee continues warm to touch, a yesterday - slight warmth facial grimace noted upon and calf " a, " Left knee discoloration rm to touch " t) calf and knee discoloration "(Left) calf remains as given 650mg 9:15pm for discomfort Will	W9:	999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUBBLIED/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		14G378	B. WIN	IG			C 9 /2010
	ROVIDER OR SUPPLIER		1	1	EET ADDRESS, CITY, STATE, ZIP CODE S 410 WYATT DRIVE ENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	E7 verified that she to 11pm shift. E7 stold her there was a house) due to a wa E7 stated that arou told her that R1 had observed a bruise and around R1's kn documented R1's kn documented R1's knotified the Adminismeasured R1's X5cm (as per bruistime (12/27/09 8:50 observed to be "a li E7 stated she also - 12/29/09 2nd sh touch - 12/31/09 2nd sh touch - 12/31/09 2nd sh touch - 11/1/10 2nd shift, "good size bruise" not re-measure R1 E7 was asked why physician of R1's b stated she did not to notified. On 1/22/10 at 11:23 received verbal courseling symptoms of a sus in this particular ca assessment on 12/29/10 at 12/20 assessment on 12/20/20 as was assessment on 12/20/20/20/20/20/20/20/20/20/20/20/20/20	erviewed 1/22/10 at 2:53pm. worked 12/27/09 on the 3pm stated that E1 (nurse manager) an emergency evacuation (in ster pipe break on this date. Ind 8:50pm an aide (E4 - CNA) da bruise. E7 stated she on the lateral side of R1's kneed ene. E7 stated she or the lateral side of R1's kneed ene. E7 stated she or the "Bruise Log" and strator. E7 stated she ise at this time. E7 verified a bruise at 4cm X3cm and 4cm e log). E7 stated that at this opm) R1's bruise was sittle warm". worked the following shifts: iff, noted bruise to be warm to iff, bruise fading - "nothing Acetaminophen given due to E7 stated at this time she did is bruise. she did not notify R1's ruise of unknown origin. E7 hink the physician should be Bam E1 stated that E7 unseling and was re-inserviced dication and not taking it ed, to surveyor, the following: ing of E7 (undated); "The pected fracture were present se since your nurse 27/09 and these symptoms	W99	999			
		esent up to 1/1/10. You failed to ensure her timely treatment					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G378	B. WI	1G _			ට 9/2010
	PROVIDER OR SUPPLIER JND RICHARD HOME		•	1	REET ADDRESS, CITY, STATE, ZIP CODE I S 410 WYATT DRIVE GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	did not follow the acthe policy. Your fairesponsibility result treatment and could the client. In order for you to pacceptable standar with the policy regardislocations, suspering dislocations, suspering for the facility's policy, Dislocations Susperevised 11/11/04 no "POLICY / PROCE of a suspected frace ACTION TO BE TA 1. Immediately place. Notify the physicorders to monitor of 3. Nurse to write "Canal Suspected (if any) will can acceded to the fraction of	icy and Procedure. You also ctions to be taken required by lure to perform this ed in the delay of timely d have caused further injury to berform at Marklund's ds, you will be re-in serviced rding fractures and cted and diagnosed " titled "Fractures (FX) and cted and Diagnosed" last otes the following: DURE: Identify the symptoms ture or dislocation: KEN: ce all activity on hold cian and proceed with any rx-ray on hold" in client's Goal Book record) indicating that affected wh, application of affected rease immediately policy & procedure for Internal Investigation Report will be clearly identified to staff	W99	999			

-	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	ILDING (X3) DATE SURV		TED	
		14G378	B. WI	NG _) 9/2010
	PROVIDER OR SUPPLIER		l	1	REET ADDRESS, CITY, STATE, ZIP CODE S 410 WYATT DRIVE GENEVA, IL 60134	01/2	3/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	were counseled an fracture policy. E8 nurses charted, in I physician should habruise. E8 also verof severe osteoport fractures. The facility failed to R1's physician of h first observed on 12 8:50pm. R1 has a osteoporosis and is Nursing staff failed unknown origin and shape, color and si E18 (physician) wa 2:35pm via a phonon-weight bearing E18 was asked if h should have been runknown origin, du osteoporosis and h verified it is the nur physician and then further evaluation is E4 (CNA - Certified 1/22/10 at 1:48pm. 12/27/09 she bathe approximately 9:30 R1 did not have an Sunday night (approbserved a bruise I stated that this area then stated it was "	d re-inserviced on the facility's stated based on what the R1's nursing notes, R1's ave been notified of R1's rified that R1 has a diagnosis osis and is at a high risk for ensure nursing staff notified er bruise of unknown origin 2/27/09 at approximately diagnosis of severe at a high risk for fractures. To monitor R1's bruise of document changes in the ze of the bruise. Is interviewed 1/22/10 at e call. E18 stated that R1 is and has "paper thin bones." e, or the physician on call, notified of R1's bruise of e to her diagnosis of severe high risk for fractures. E18 ses responsibility to notify the the physician will decide if a necessary. If Nurses Aid) was interviewed E4 stated that on Sunday and R1 and had her dressed by the R4 stated that at this time y bruises. E4 stated that on roximately 8:50pm) she below R1's left knee. E4 a was warm to the touch, E4 hot". E4 stated at this time rse). E4 stated she also told	W9:	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTI LDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G378	B. WI	NG _			C 9/2010
	PROVIDER OR SUPPLIER JND RICHARD HOME			1	REET ADDRESS, CITY, STATE, ZIP CODE S 410 WYATT DRIVE GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W9999	on 1/1/10. E4 states on she told E17 (nure R1's temperature and E17 told E4 it was on E4 stated that at the stated that expresses the stated that E10 (CNA) was interested to the stated that E10 (CNA) was interested to the stated that E10 (nurse manager) we E10 stated that E10 (nurse) sent R1 to the stated that E10 (nurse) sent R1 to the stated that O11 (nurse) sent R1 to	ed with R1 again on first shift ed that R1 was biting her hand arse). E4 stated she checked and it was normal at this time. E4 to get R1 up and dressed. The end of her shift (7am to ported R1's condition to E1 E4 stated she told E1 that R1's arm. E4 stated that she hursing staff several times that I about R1's left leg. The erviewed 1/26/10 at 11:03am are 10 stated she first saw R1's are (on campus) day training site 2/31/09. E10 stated that R1's as swollen. E10 stated that R1 and in her mouth and had are notified of R1's status. The told her that R1's bruise was stated that on 1/2/10 E9 the hospital where she was	W99	999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	COMPLE	TED
		14G378	B. WIN	IG _		01/29) 9/2010
	PROVIDER OR SUPPLIER			1	SEET ADDRESS, CITY, STATE, ZIP CODE S 410 WYATT DRIVE SENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	stated she immedia stated she observe below R1's left knew below her knee - (Fix knew I had to be catime she had anoth R1 a bath. E13 state to the back of R1's CNA to get the sup into the tub room at to E1. E13 stated I were aware of R1's E13 stated she wor was given the same for R1. E13 stated be approximately 4 stated she told E7, regarding R1. E13 (nursing staff) were E15 (CNA) was inte E15 stated she wor from 2:00pm until 1 beginning of her sh from nursing staff tileg. E15 stated she when she bathed R bruise was approximand the color was limited to be staff. E15 stated she was approximand the color was limited to be staff. E15 stated she was approximand the color was limited to be staff. E15 stated she was approximand the color was limited to be staff. E15 stated she was approximant to be stated she was approximant to be stated she was approximant to be stated she was approximant. E15 stated she was approximant to be stated she was approximant.	1 had a bruise to her leg. E13 ately went to see R1. E13 d a light green/bluish bruise e. E13 stated, "I touched R1) had facial expression so I areful." E13 stated that at bath er CNA assist her with giving sted she saw the discoloration left leg so she told the other ervisor. E13 stated E1 came and she expressed her concerned told her they (nursing staff) bruise. Taked on Tuesday 12/29/09 and the instructions in how to care she observed R1's bruise to inches by 3 inches. E13 "Something is not right" stated E7 told her they	W99	999			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		14G378	B. WI			C 01/29/2010	
	PROVIDER OR SUPPLIER		.	1	REET ADDRESS, CITY, STATE, ZIP CODE S 410 WYATT DRIVE BENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	she worked the 7:0 stated that she obs during a bed check that R1's bruise loo widespread. E15 st her hand and was i the physician and FE9 was interviewed phone call. E9 state morning, a CNA as E9 stated the CNA look good". E9 stated swelling to R1's left not have adequate warm to the touch. signs of pain - inclubiting of her hand. and then E19 (nurs that E19 had previous wanted E19's opinical had worsened. E9 she stated that R1's time. E9 stated she physician and receivemergency room for that when she obsedidn't look good and	Oam until 11:00pm shift. E15 erved R1 in the morning, with E9 (nurse). E15 stated ked darker in color and more ated at this time R1 was biting n pain. E15 stated E9 called R1 was sent to the hospital. I 1/26/10 at 9:48am via a ed that on 1/2/10, in the ked her to look at R1's bruise. told her R1's left leg, "didn't ted she observed bruising and r lower leg. E9 stated R1 did ROM and her left knee was E9 stated that R1 showed ding facial grimacing and E9 stated she contacted E1 e). E9 stated she was aware ously seen R1's bruise so she on to determine if R1's bruise stated after E19 observed R1 is calf was more swollen at this e contacted the on-call lived orders to send R1 to the or an evaluation. E9 stated erved R1's left leg bruise,"It d it needed to be assessed." after giving R1 pain	W99	999			