STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089

(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 498	Continued From page 21 on the facility's abuse and transfer policy and procedures. When asked how the facility ensure that staff continued to followed or implement the training they received, E2 told surveyor by receiving monthly training. But, E2 did not identify any other method being in place to ensure that staff was effectively trained, or monitored to ensure nursing staff performed duties daily as trained. During a meeting with E2 on 1/11/202012, E2 stated she had changed the Transfer Lift Policy to clearly define Total Assist-...mechanical lift as requiring 2 persons. E2 also said she added 2 persons assist to the direct care nursing staff card being carried with staff's identification cards. During the Daily Status Meetings on 1/05/2012 and 1/06/2012, surveyor asked E1 (administrator) about any method being put in place to ensure/monitor that the nursing staff performed duties as trained. E1 identified the Quality Assurance he would be implementing as part of his abatement plan. However, E1 did not identify any other method/plan having been implemented until start of abatement plan on 1/05/2011 other than monthly inservice. But the facility's monthly inservice had been ineffective in giving the nursing staff an understanding of the need to perform duties as trained, as demonstrated by their failure to follow facility's policy and procedures.	F 498		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.690a)b)c) 300.1210b)5)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089

(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	F9999		

300.1210c)
300.1210d)6)
300.3240a)b)c)d)

Section 300.690 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.
b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.
c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	**150 NORTH WEILAND ROAD** **BUFFALO GROVE, IL 60089**

(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 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089

(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 the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) Based on observations, interviews and record review, the facility failed to ensure : 1. The facility's direct care staff implement and follow safety measures, while transferring one residents (R3) using a mechanical lift. 2. Assistive devices / equipment (e.g., mechanical lifts and transfer aids) are used properly or according to manufacturer's specifications and implement interventions as planned to meet the resident's needs across various shifts. 3. Ensure a system is in place to monitor staff's performance to prevent avoidable incidents and accidents. This failure resulted in two different nursing staff members (E15/Certified Nurses Aide on 12/10/2011 and E16/Certified Nurses Aide on 12/14/2011) causing an avoidable accidents/incidents during the care/transfer of a resident (R3). This failure resulted in R3 sustaining multiple serious injuries (such as: Contusion/Close Head Injury, Fractures of the Right Shoulder/Scapula and 3 chest ribs.)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	**150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089**

(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 25 Findings include: Review of the facility's Accidents and Incidents Reports documented the following: "Date of Incident: 12/10/2011 Time of Incident: 10 AM Location: Resident's (R3's) room... Type of Injury: Right Cheek hit by ...(mechanical lift)... Describe the Incident... CNA (E16, certified nurses aide) reported to writer when he was transferring resident with ...(mechanical lift), the mechanical lift accidently hit the resident's right cheek. Resident (R3) complained of slight pain... Actions taken to prevent further injury: Always use two people for ...(mechanical lift) with transfers to and from wheel chair and bed..." The Accident and Incident Reports documented a second incident of staff not following safety measures while transferring R3, as follows: "Date of Incident: 12/14/2012 Time of Incident: 5:30 PM Describe the Incident... What did the resident state what happened?: Nurse giving med to the resident (R3), resident talking to her husband (Z2) in Spanish. Husband (Z2) asked the nurse if the resident fell? Nothing was reported to this nurse. Will ask the CNA (E15). CNA (E15) denies that the resident fell. Resident (R3) said she fell, hit her right shoulder and back of head on the floor."... Hospitalization Required: Yes... Where: ...(local hospital) Emergency Room" The following was documented in the community hospital's emergency room, on 12/14/2011 regarding R3's medical condition: "Date: 12/14/2011... Time: 9:30 PM... Chief Complaint: Status Post (S/P) Fall, Head/ Right Injury... History of Present Illness: transferring	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	**150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089**

(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 26	F9999		

with CNA- fell backwards hitting head right side/upper body on ground... Headache/Positive for Right shoulder/elbow/wrist pain... Symptoms: pain, swelling... Headache..."

After performing several assessments and diagnostic evaluations on 12/15/2011, the hospital physician documented the following assessment of R3's medical condition:
"Concussion/closed head injury-S/P fall...Right Scapula Fracture...
Right Multiple Rib Fractures (3-6th)..."

Review of the facility's Investigation of the 12/14/2011 incidents involving R3 documented the following:
"Investigation Form (dated 12/21/2011)...
Description of Occurrence: ...By all accounts the patient (R3) was functioning at baseline and did not complain of pain until the time of the alleged incident. The patient's roommate did not witness the incident due to the fact that the privacy curtain was pulled closed.... Resident (R3) was sent to... (local community hospital) reports that the patient (R3) was admitted with a diagnosis of fracture of Right (rib) 3rd through 6 ribs, fracture of Right Scapula...
Occurrence Resolution... The employee named above was terminated for failure to follow the facility's resident transfer policies."

Review of R3's Face Sheet documented R3 is 72 year old female with diagnosis including: History of Falls with Fractures (Fracture Femur on 11/02/2011), Right Knee Surgery, Generalized Muscle Weakness and Abnormal Gait.

The manufacturer's instruction for the mechanical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089

(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 27	F9999		

Continued From page 27

lift used in the care of R3 on 12/14/2011 was reviewed. The manufacturer of this mechanical lift recommends that "two (2) assistants be used for all lifting preparation..."

R3's Physical Therapy Assessment, dated 12/08/2011, documented physical limitations, which required R3 to bear no weight on her lower extremities, and required use of a mechanical lift to transfer her.

The facility's Policy and Procedure for Transferring resident documented that mechanical lift required total assistance. However, this policy did not document clearly if it was two persons assist or one person.

On 12/30/2011, R3 was observed in recliner. R3 was alert and her husband (Z2) was at her side. R3 was going to dialysis. So, Z1 was interviewed. Z2 told surveyor he visited his wife on 12/14/2011. Z2 said he came to his wife room and a CNA was in the room during something with his wife, and asked him to wait outside of the room. When he went into the room, Z2 said he found his wife crying and complaining of being in severe pain. Z2 stated: "She (R3) said she fell when she came from dialysis. One lady (CNA) changed her to the bed with the lift. She (R3) fell down. She (R3) got broken ribs and shoulder... My wife was in too much pain!"

Z1, R3's primary physician was interviewed by phone on 1/5/2012 at 1:34 PM. When asked, Z1 told surveyor R3 went to the hospital after experiencing a fall in the facility. When asked what caused R3's injuries, Z1 stated that her fractures were caused by trauma.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	**150 NORTH WEILAND ROAD** **BUFFALO GROVE, IL 60089**

(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 28	F9999		

Z4 (an emergency room nurse, who worked at the community hospital, R3 was sent to for evaluation and treatment.) was interviewed by phone on 1/10/2012 at 2:59 PM. Z4 stated she received a report from a facility nurse R3 fell from a sling during a transfer with a mechanical lift. Z4 told surveyor R3's family also talked to the CNA, who transferred R3 on 12/14/2011. Z4 said the family wanted to know what happened to R3. Z4 stated the CNA told the family that she (CNA) was not sure how to put the strap on, the sling slipped off the hook of the mechanical lift, and she (the CNA) did not know what to do.

The CNA, E15, was involved in R3's incident of 12/14/2011. E15 was interviewed by phone on 1/10/2012. E15 said she could not recall her last inservice on transferring a resident.
E15 complained inservice and training was usually offered to her after something happening or an incident. E15 stated it would be better if the training was given before something bad occurred.
E15 also said she was rushing to get R3 back into bed on 12/14/2011. She reported looking for other staff to help her and found no body to assist her. So, E15 said she transferred the resident by herself. E15 stated, "I'm not the only one doing this." E15 said, it's not unusual for other nursing staff to transfer resident by themselves, while using a mechanical lift. E15 said a supervisor is on duty, but she stays in her office doing paper work. E15 described the sling not being positioned appropriately, which caused her weight to be unevenly disturbed, during the transfer.
E15 claimed that R3 got "jerked" hard, and complained of shoulder pain. E15 said she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	**150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089**

(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 29	F9999		

going to inform the nurse of R3's complaints of shoulder pain, but got distracted caring for other residents.
E15 said she never returned to the facility after she left work on 12/14/2011 at 11:30 PM, and received a call from the facility's ADON (Assistant Director of Nursing) that she was terminated.

E4,who was R3's nurse on 12/14/2011, was interviewed on 12/30/2011. E4 said, "It was around 5:30 PM, the resident had dialysis, and I was passing medications. The resident (R3) was talking in Spanish. The husband (Z2) at her side. Then he asked me if she fell. I told him No. ...She (R3) had pain in her shoulder... Then the husband complained of her shoulder swelling... Then, the husband complained of her head hurting... I called the medical doctor because she was on heparin. He order her to the emergency room." E4 told surveyor that R3 should have two persons transferring her while using the mechanical lift. When asked why, E4 stated: "She (R3) can't stand because of her broken leg."

E13, was the nurse caring for R3 on 12/13/2011, was interviewed on 1/05/2012. E13 described R3 as alert and oriented times 3. E13 stated: "If something happens to her (R3), she knows. If she (R3) has pain she can speak that too."
When asked what safety measures should be implemented while transferring R3, E13 stated: "At the time (in December 2011), she (R3) had a brace on the right leg. So, no weight bearing on the lower extremities, especially right... The physical therapist evaluated her and according to their assessment she needed two person with the mechanical lift... It's also our policy it should be 2 persons."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089

(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 30	F9999		

E5 (physical therapist) was interviewed on 12/302011 at 3:23 PM. E5 stated: R3 was evaluated on 12/08/2011. R3 was very weak... None weight bearing on the right leg because her leg was broken. She was also very nervous and worried. She can't help in anyway." E5 stated the safest way to transfer R3 with the use of mechanical lift with two persons. E5 said, "It suppose to be 2 people (using the mechanical lift). It's the rule here and safe."

E18 was the nurse caring for R3 on 12/10/2011, when E16 transferred R3 by himself and hit R3 in the face on 12/10/2011. E18 was interviewed by phone at 1/05/2012 at 11:46 AM. E18 stated, "I remember sometime in the afternoon, he (E16) stated, he had to tell me something, because the residents's (R3's) husband was upset with him. He (E16) said the ...(mechanical lift) accidently hit one side of her (R3's) cheek. He (E16) was operating the lift by himself... He said it occurred around 10 AM. He came and told me at 12 PM. Yes, they should report any accident right away... Yeah, whenever using the ...(mechanical lift), they tell us to ensure that we should have two people." E18 also reported R3 was on Heparin and was at risk for bruising, and bleeding at the site she was hit with the mechanical lift. So, the physician order her next dose of Heparin medication be held to prevent bruising and bleeding in R3's face.

E14 is a CNA and restorative aide, who was identified by the director of nursing (DON) as the person providing staff training for the use of the mechanical lift and monthly inservices to CNA's. E14 stated she provided the monthly training for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	**150 NORTH WEILAND ROAD** **BUFFALO GROVE, IL 60089**

(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 31 CNA's. E14 said direct care staff are trained to have two people present to transfer resident using the mechanical lift. E14 stated one person is required to operate the lift and the other person is required to support the resident in the sling. When asked how she (E14) monitor to ensure CNA's continued to performed transfer as trained, E14 stated: "After they (CNA's) get training they should know. I don't follow up unless there is an incident, then I retrain. Once we train them (CNA's), we assume they (CNA's) know." The director of nursing was interviewed on 12/30/2011 and 1/05/2012. E2 reported that the nursing staff was provided with inservice /training on the facility's abuse and transfer policy and procedures. When asked how the facility ensure that staff continued to followed or implement the training they received, E2 told surveyor by receiving monthly training, and re-inservice. But, E2 did not identify any other method being in place to ensure that staff was effectively trained, or monitored to ensure nursing staff performed as trained. During the Daily Status Meetings on 1/05/2012 and 1/06/2012, surveyor asked E1 (administrator) about any method being put in place to ensure/monitor the nursing staff performed duties as trained. E1 identified the Quality Assurance Tool he would be implementing as part of his abatement plan. However, E1 did not identify any other method/plan having been implemented until start of abatement plan on 1/05/2011 other than monthly inservice. But the facility's monthly inservice had been ineffective in giving the nursing staff an understanding of the need to perform duties as trained, as demonstrated by	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. BUILDING ______ B. WING ______	C 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAREMONT REHAB & LIVING CTR	**150 NORTH WEILAND ROAD** **BUFFALO GROVE, IL 60089**

(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 32 their failure to follow facility's policy and procedures. (A)	F9999		