		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTI	PLE CONSTRUCTION	(X3) DATE SL	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI			COMPLE	TED
		145304	B. WIN	1G			C 5/2012
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BRENTW	OOD NORTH HC &R	EHAB CTR			705 DEERFIELD ROAD RIVERWOODS, IL 60015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	rib fractures. The 1-2-2012 Hosp	ital Discharge Summary	F 3	323			
	the hospital on 12-2	ation that R2 was admitted to 25-2011 with diagnoses of s, 8th, 9th, and 10th. rib al fracture.					
	1-25-2012 at 12:55 identified above we had been implement Additionally, E8 and degeneration, only	) and E8, (ADON) on pm. affirmed interventions re the only interventions that nted by the facility for R2. d E9 affirmed R2 has macular seeing shadows, has hearing falls with injury of rib fractures e.					
	Director) stated, "I of falls since 2008. I of	2:05pm. Z2, (Physician/Medical did not know (R2) was having do know I asked the facility n for her. I don't follow (R2)					
F9999	"I know (R2's) medi other interventions	1-25-2012 at 12:17pm. stated, ical history. I don't know what the facility has implemented weakened bones, disease IONS	F99	999			
	Licensure Violation	IS:	l				
	300.610a) 300.1210a) 300.1210b)4)5) 300.1210c) 300.1210d)6) 300.3240a)						

Facility ID: IL6001119

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		AND HUMAN SERVICES				FORM	APPROVED
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N		TIPLE CONSTRUCTION	(X3) DATE SU	0938-0391 JRVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDI	NNG	COMPLE	
		145304	B. WI	NG _			C 5/ <b>2012</b>
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRENTW	VOOD NORTH HC &R	EHAB CTR			3705 DEERFIELD ROAD RIVERWOODS, IL 60015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa	.ge 17	F9	999	9		
	<ul> <li>a) The facility shall procedures, govern the facility which sh Resident Care Polic least the administrative medical advisor representatives of r the facility. These p with the Act and all These written polici operating the facility least annually by this written, signed and meeting.</li> <li>Section 300.1210 G Nursing and Person a) Comprehensive and Person a) Comprehensive carrincludes measurable meet the resident's guardian applicable, must de comprehensive carrincludes measurable meet the resident to provide for discharg restrictive setting baneeds. The assess the active participation resident's guardian applicable level of provide for discharg restrictive setting baneeds. The assess the active participation resident's guardian applicable level of provide for discharg restrictive setting baneeds. The assess the active participation resident's guardian applicable level of provide for discharg restrictive setting baneeds. The assess the active participation resident's guardian applicable for discharg resident's guardian applicable level of provide for discharg restrictive setting baneeds. The assess the active participation resident's guardian applicable for discharg resident's guardian applicable for discharg resident's guardian applicable for discharg restrictive setting baneeds. The assess the active participation resident's guardian applicable for discharge restrictive setting baneeds. The assess the active participation resident's guardian applicable for discharge res</li></ul>	hursing and other services in policies shall be in compliance rules promulgated thereunder. ies shall be followed in y and shall be reviewed at is committee, as evidenced by dated minutes of such a					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	/UL	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY
			A. BUI			С	
		145304	B. WI	NG		01/2	5/2012
NAME OF P	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE 3705 DEERFIELD ROAD		
BRENTW	OOD NORTH HC &R	EHAB CTR			RIVERWOODS, IL 60015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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
F9999	Continued From pa	ge 18	F99	99	9		
	and services to atta practicable physical well-being of the res each resident's com plan. Adequate and care and personal of resident to meet the care needs of the res shall include, at a m procedures:	provide the necessary care in or maintain the highest l, mental, and psychological sident, in accordance with prehensive resident care properly supervised nursing care shall be provided to each total nursing and personal esident. Restorative measures ninimum, the following					
	encourage resident in activities of daily circumstances of th demonstrate that di This includes the re dress, and groom; t eat; and use speech functional communi who is unable to ca shall receive the se	nnel shall assist and s so that a resident's abilities living do not diminish unless e individual's clinical condition minution was unavoidable. sident's abilities to bathe, ransfer and ambulate; toilet; h, language, or other cation systems. A resident rry out activities of daily living rvices necessary to maintain ming, and personal hygiene.					
	encourage resident transfer activities as	nnel shall assist and s with ambulation and safe s often as necessary in an retain or maintain their highest functioning.					
		giving staff shall review and about his or her residents' care plan.					
		ection (a), general nursing at a minimum, the following					

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SU COMPLE	
		145304	B. WI	NG _			C 5/2012
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BRENTW	OOD NORTH HC &R	EHAB CTR			3705 DEERFIELD ROAD RIVERWOODS, IL 60015		
(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 SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa and shall be practic	-	F99	999	3		
	seven-day-a-week l						
	assure that the resi as free of accident nursing personnel s	ecautions shall be taken to idents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents.					
		Abuse and Neglect ee, administrator, employee or nall not abuse or neglect a					
	These requirements by:	s were not met as evidence					
	facility failed to ensu- transferred one of c mechanical lift trans- residents. This failu a left femur fracture	iew and record review the ure two staff members one residents sampled, with a sfer, (R1), in a sample of three ure resulted in (R1) sustaining e, undergoing surgical ged pain, hospitalization, res and therapy.					
	facility failed to instr transfer procedures slide board for one slide board, (R3) in of this failure (R3) s fracture, suffered es	iew and record review the ruct and train staff on proper s and did not utilize a transfer of one residents utilizing a a sample of three. As a result sustained a right humerus xtreme pain, prolonged by and emotional distress.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		145304	B. WI	NG	·····		C 5/2012
	rovider or supplier	EHAB CTR		3	REET ADDRESS, CITY, STATE, ZIP CODE 1705 DEERFIELD ROAD RIVERWOODS, IL 60015		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	facility failed to devi individualized interv falls for one of three known history of ree As a result of this fa multiple rib and ster Findings include: A. The 1-1-2012 th Order Sheet contain diagnoses that inclu- below knee amputa Annual MD'S, (Mini and Quarterly MDS Functional Status, F documentation that two staff members. The 12-4-2011 Phy contains document the hospital on 11-2 off of a (mechanica sustained a left fem reduction interventi R2 has a prior med right below knee an E2, (DON/Director of approximately 2:30 complete and curree 7-29-2011 Care Pla contains the followi (R1) has an (ADL), Care Performance	iew and record review the elop and implement rentions to prevent recurrent e residents sampled with a current falls and injuries, (R2). ailure R2 has sustained rnal fractures. rough 1-31-2012 Physician ns documentation that R1 has ude paraplegia and has a tion. mum Data Set), of 7-29-2011 of 10-28-2011 Section G: 3. Transfer, contain R1 is "totally dependent on " sician Discharge Form ation that R1 was admitted to to 29-2011, after sustaining a fall I lift), during transfer. R1 pur fracture and had closed on with percutaneous pinning. ical history of paraplegia and	F9	999			

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		AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		145304	B. WI	NG			C 5/2012
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 705 DEERFIELD ROAD		
BRENTV	VOOD NORTH HC &R	EHAB CTR		-	RIVERWOODS, IL 60015		
(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
F9999	Interventions: Tran person total assista (Portable Total Bod for falls characterize related to use of ps paraplegia. Interve requires two person transfers using (Por 7-29-2011 Intervent standing mechanica replace portable tot E4, (CNA)/Certified Statement complete 11-29-2011 at 10:10 "Proceeded to get ( from hallway, whee (R1) was assisted t (Standing Mechanic front of (R1), applie to lift (R1) to standin then placed behind off platform. (R1) w hands. The harnes went to the doorway nurse assistance w wearing non-skid so The 11-29-2011 at 10:1 Assistant/E4), calle was observed holdi Lift), supported with observed resting or wheelchair. (R1) of	<ul> <li>Insfer: (R1) requires two since with transfers using y Lift). Focus: (R1) is at risk ed by multiple risk factors ychotropic medications, antions: Transfer: (R1) is total assistance with rtable Total Body Lift)." The tions is crossed out, and al lift is handwritten in to rail body lift.</li> <li>Invursing Assistant)'s Witness ed 11-20-2011, for the Dam. incident involving R1 is, 'Standing Mechanical Lift) and the position in bed, cal Lift) was then placed in red harness to (R1). Proceeded in gosition, wheelchair was (R1). (R1's) left foot slipped vas holding onto lift with both as was also supporting (R1). I y and asked for assistance, ith transfer. (R1) was not</li> </ul>	F9	999			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		(X3) DATE SU	JRVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLE	C
		145304	B. WING				5/2012
NAME OF F	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP	CODE		
BRENTV	OOD NORTH HC &R	EHAB CTR		3705 DEERFIELD ROAD RIVERWOODS, IL 60015			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOU THE APPR	ULD BE	(X5) COMPLETION DATE
F9999	given at 9:45am." According to Lexi-C Handbooks, 12th E Handbook page 750 narcotic analgesic u severe pain. Obser and may cause drov Notification on 11-3 Department of Publ during transfer. Co upper leg. Physicia (R1) sent to emerge admitted with right f The 11-30-2011 unt 11-29-2011 (R1's) k (R1) complained of was sent to hospita fracture. Medical re staff interviews reve 1. (R1) was assiste (Standing Mechanic approximately 10:10 2. (R1's) left foot sl standing on the lift. supported by harne 3. (R1) observed n 6. (R1) at approxim pain again to right h 7. (R1) sent to (Na with right femur frac A review of the facil investigation it is re (R1) had inappropri slipped off platform	A pelvis. As needed Dilaudid comp's Drug Reference dition Geriatric Dosage 0-753, Dilaudid is a controlled used to manage moderate to rve patient for oversedation wsiness. 0-2011 at 4:54pm. to Illinois lic Health is, "(R1's) foot slid, mplained of pain on right in notified and ordered x-ray. ency room for evaluation and femur fracture." itled narrative report is, "On eft foot slid during transfer. pain to right hip. The resident I and admitted with right femur ecord review, resident and ealed the following facts: ed to transfer using a cal Lift) on 11-29-2011 at Dam. ipped off platform while Resident held onto lift ss. No fall incident occurred. ot wearing non-skid socks. nately 1:00pm. complained of nip. Order for x-ray received. me) Hospital and admitted	F999				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/04/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		145304	B. WING _			C 5/2012
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
BRENTW	OOD NORTH HC &R	EHAB CTR		3705 DEERFIELD ROAD RIVERWOODS, IL 60015		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 23	F9999			
		arness at a lower position. ht away by lowering (R1) onto				
	(E4/CNA) did not for (R1) by himself and 1-29-2011. (E4) wa Mechanical Lift) to staff members for r	10pm. E2, (DON) stated, "Yes, Illow Policy, by transferring I not two staff members on as using the (Sitting transfer (R1). We require two nechanical transfers. (E4) the improper transfer."				
	Report of 11-30-20 documentation: "Employee Action/E 12-2-2011 for impro (E4) was inserviced 11-30-2011. Will do 12-5-2011." Addition contains mechanica	nel file contains Employee 11 containing the following Discipline: Suspension until oper transfer of resident. I on transfer techniques on o another competency on onally, E4's personnel file al lift and transfer competency etion on 1-10-2008 and				
	(CNA) of 11-30-201	etency Mechanical Lift for E4, 1 includes documentation that are required for transfers with				
	transferred and fell was doing the trans doing the lifting, by started to fall off the falling and (E4) ran Practical Nurse). I They both tried to s	2:05pm. stated, "When I was off the standing lift one person sfer. (E4) was the person herself. The lift began to fail, I e lift and (E4) noticed. I was out and got (E5/LPN/Licensed was hanging onto the bar. hove me into the wheelchair. t the wheelchair. I was in a lot				

		AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		145304	B. WI	NG			C 5/2012
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BRENTV	VOOD NORTH HC &R	EHAB CTR			705 DEERFIELD ROAD RIVERWOODS, IL 60015		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	of pain. I had surge in my hip. I develop had lifted me alone 10 or 15 times prior staff members." B. The Physician C contains document that include depres bone cancer, and c hip and leg fracture Facility notification, 11-3-2011 at 8:02pr of Public Health reg incident contains th "Complete Descript transfer (R3's) right (R3) complained of meds provided. Se evaluation. (R3) ale Z4, (Family Member provided the followi R3 had just returne 10-29-2011, after si leg fracture. R3 is members and a slip the surgery. R3 had weakened bones. known history due to facility. R3 had a fe declining medical c coherent. E6, (CN/ transferring R3 from E6 placed a walker	ery. I still have significant pain bed a hernia after this. (E4) , with the mechanical lift, alone r to this. Other people use two Order Sheet of 1-1-2012 ation that R3 has diagnoses sion, morbid obesity, stage 4 hronic pain with a history of s. with fax date/time stamp of m., to the Illinois Department garding the 10-29-2011 e following documentation. tion of Occurrence: During a rm slipped on the bed rail. right shoulder pain. Pain ent out to hospital for ert and orientated."	F9	999			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	LTIPLE	CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
AND FLAN C	S CONNECTION	IDENTIFICATION NOMBER.	A. BUILD	DING			C
		145304	B. WING	i			5/2012
NAME OF P	ROVIDER OR SUPPLIER		s		TADDRESS, CITY, STATE, ZIP CODE		
BRENTW	OOD NORTH HC &R	EHAB CTR			DEERFIELD ROAD ERWOODS, IL 60015		
(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
F9999	surgery. During the unsteady and went bed and it was not I on her arm on the r cried out in pain. E in and moved her fi x-ray was ordered a get a good picture of That x-ray showed through 11-1-2011 I continued. Z4 cont Physician, (Z1). Z1 to say R3 was going due to her extreme on 11-1-2011 and w and shoulder fractur rehabilitation and th delayed due to the take care of person could not apply mal worse. R3 required appointments and s On 1-25-2012 at 12 "(Z1/Orthopedic Ph send out (R3) for ev E2, (DON) on 1-25- R3's Timeline conta documentation: "2-15-2011 (R3) addi ischial fracture due metastasis, uncontri 4-6-2011 Discharge therapy. 8-24-2011 Admitted	e slide board prior to the e transfer R3 became to grab the side rail on the ocked and R3 went down hard ail and fell on the bed. R3 11, (Nursing Supervisor) came ngers around. A portable and the technician could not due to the pain R3 was in. no fracture. From 10-29-2011 R3's pain was severe and acted R3's Orthopedic 's nurse contacted the facility g to the hospital for evaluation pain. R3 went to the hospital vas diagnosed with a right arm re. R3 is right handed. R3's ierapy was prolonged and fracture. R3 could no longer al hygiene after toileting and ke-up. R3's depression grew I out of facility specialty suffered extreme pain. 2:35pm. E2, (DON) stated, ysician) called for the facility to valuation on 11-1-2011."	F999	99			

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			(X3) DATE SU COMPLE	
		145004	B. WI			(	
	ROVIDER OR SUPPLIER	145304				01/25	5/2012
				s	STREET ADDRESS, CITY, STATE, ZIP CODE 3705 DEERFIELD ROAD		
BRENTV	OOD NORTH HC &R	EHAB CTR			RIVERWOODS, IL 60015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F9999	from hospitalization fracture of the left ti 10-6-2011 Returned appointment: femur impending fracture 10-27-2011 Dischar open reduction inte impending patholog 10-29-2011 Readm reduction internal fix shoulder pain. Pair positioning; able to without pain. 10-30-2011 Compl physician notified w x-ray; x-ray comple 10-31-2011 Result no acute fracture w moth eaten pattern. 11-1-2011 Continue shoulder pain. Phy send (R3) to emerg right shoulder pain. room with sling. 11-3-2011 Confirm humerus pathologic Nursing Note of 10- complained of elboy range of motion. N x-ray ordered for sh The Nursing Note of "(R3) complains of taken and showing	B-19-2011: imaging results show possible compression bia. d from orthopedic stable; questionable left tibia. rge to hospital for planned rnal fixation left tibia for gical fracture. hitted after left tibia open xation. Complaints of right resolved with ice pack and complete range of motion aints of right shoulder pain; ith order for right shoulder ted. of right shoulder x-ray shows ith metastatic disease and . Physician notified. es to complain of right sician notified with order to pency room for evaluation of Returned from emergency ation of diagnosis of right	F9	99	39		

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		145304	B. WI	۱G			C 5/2012
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BRENTW	OOD NORTH HC &R	EHAB CTR			3705 DEERFIELD ROAD RIVERWOODS, IL 60015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	complains of right a The 10-31-2011 at "(R3) in bed with rig compress applied, j Nursing Note of 11- complained of right no effect, given at 1 referred to psych/ps 11-2-1011 Palliative symptom managem (R3) was doing well right humerus fractu Psychology Progres expressed frustratic surgery. Which (R3 fracture. Processed surgery that she rep Talked about reaso be ok as well. Supp 11-9-2011 Palliative pain to arms and co decisionsDisgust Psychology note of is increasingly depr helplessness and h The 11-1-2011 at 3: "(Z1/Orthopedic Ph	-31-2011 "Time 7-3 (R3) arm pain." 10:00pm. Nursing Note is, ght arm still sore. Hot pain med given for relief." -1-2011 "Time 7-3 (R3) shoulder pain, 2 tabs given, pm., still complaining of pain sychotropic, to see patient." • Care Note, "Seeing (R3) for nent involving breast cancer. I until the recent setback of ure. Discouraged." ss Note of 11-3-2011 is, "(R3) on over events following leg 3) reports resulted in shoulder d feelings. Redirected to leg ported is very successful. nable hope that shoulder will portive treatment." • Care Note, "Seeing (R3) for omplex medical ted with current situation." 11-14-2011 at 10:00am. "(R3) essedfeelings of	F99	999			
	uncontrollable and	unmanageable pain to right d that x-ray shows no fracture,					

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		AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			JRVEY TED
145304		B. WI	NG			C 5/2012	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BRENTWOOD NORTH HC &REHAB CTR				-	705 DEERFIELD ROAD RIVERWOODS, IL 60015		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	emergency room." Accident/Incident R 10-29-2011 injury ir E6, (CNA), E7, (CN Supervisor). E6 an document R3 refus not mention the slice Nursing Assistant A 10-29-2011 does no how R3 should be t review of the same Sheet on 12-25-20° cannot see any doc transfer. I'll see if w regarding an asses training for (R3) afte hospital and surgica No further informati E6, (CNA) on 1-25- worked at the facilit CNA. I received tra and Procedures for many times. When hospital on 10-29-2 Her husband was th (E7/CNA). Before (was always very an transferred her, so with two people. (F before she went to the Wound Nurse w (R3). (E10) said us sliding board. (R3)	age 28 pain managed at the Report of 10-31-2011 for R3's includes three interviews with IA) and E11, (Nursing id E7's signed statements ed to wear a gait belt and do de board for transfer. Assignment Sheet of ot contain documentation of transferred. E2, (DON) after Nursing Assistant Assignment 12 at 11:05am. stated, "I cumentation about (R3's) we have any documentation isment, staff instructions or er she returned from the al procedure on 10-29-2011." ion could be provided. 2012 at 2:45pm. stated, "I've ty for six or seven months as a aining in each unit on Policies <sup>1</sup> CNA's. I've worked with (R3) n (R3) came back from the 2011 she asked to get into bed. here also. I asked for (R3) went to the hospital she pxious and afraid when we we always transferred (R3) R3) was using the sliding board the hospital. That day (E10) vas asked how to transfer se the gait belt, didn't specify just came back from the anxious, so be careful. I	F9	999	DEFICIENCY)		

Facility ID: IL6001119

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		AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			JRVEY TED
145304		145304	B. WI	NG _			C 5/2012
NAME OF PROVIDER OR SUPPLIER BRENTWOOD NORTH HC &REHAB CTR				3	REET ADDRESS, CITY, STATE, ZIP CODE 3705 DEERFIELD ROAD RIVERWOODS, IL 60015		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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
F9999	transfers. She's ver to do a two person walker as support. were going to do . (R3) tried to grab w bed. She didn't fall belt. We put the ga grab the bed rail. T said oh my god my time with wounds, h came back after sh how to transfer (R3 desk. I don't remen night." After asked stated, "(E7) offeren refused." The 020806 Mobilit Competency is, "1. transfer. 2. Identify and additional assiss On 10-25-2012 at 3 stated, "On 10-29-2 the hospital and he to bed because she (E6/CNA) I would li slide board. (E6) s hospital? Did they said yes. (E6) said get you up with a ga perfectly clear, she told (E6) that she n and preferred that. a terrific fear of falli fracture and bone of	eavy and very afraid of eavy and very afraid of with gait belt transfer, use (E7) and I told (R3) what we Put (R3) in bed with gait belt. ralker. She wasn't near the . She then accepted the gait ait belt on her. She tried to The bed rail was down. (R3) shoulder. (E10) works full ne's a registered nurse. (R3) ift report, so I asked (E10) ) because (E10) was at the mber who the nurse was that about a sliding board, E6 d the sliding board and (R3) y Transfer and Ambulation Assess resident's ability to y need for transfer equipment	F9	999			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	05/04/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
145304			B. WI	NG _			5/2012
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE	-	
BRENTWOOD NORTH HC &REHAB CTR					3705 DEERFIELD ROAD RIVERWOODS, IL 60015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Facility for rehabilita August she had a fr and returned to the October 27-2011 sh leg due to healing a to the Facility on 10 around 4 or 5pm. I R3 on 1-24-2012 at (E6) and one other from the wheelchain board, and dropped I broke my arm. My bed. I had a lot of p of pain. I asked for they would transfer walker. I went back x-ray. I couldn't get the x-ray at the faci was horrible. My re my leg." On 1-24-2012 at 2:: Physician) stated, " is riddled with stage throughout her entin pathologic. (R3) wa recent surgical frac multiple people for pathologic area of a responsibility of fractur of (R3's) arm was p was incorrect, yes. transfer. However, need assessment of	ge 30 of her pelvis. She went to the ation and went home. Then in ractured left leg, after a fall Facility for rehabilitation. On he required surgery to her left and alignment. (R3) returned -29-2011 in the evening was there the whole time." c 2:45pm. stated, "Two CNAs, CNA were transferring me r to the bed, without a slid d me onto the side of my bed. y arm hit the side rail on the bain. First, no pain, then a lot the slide board and they said me with the gait belt and to the hospital and had an tin good enough position for lity due to the pain. The pain shabilitation was delayed for 27pm. Z1, (Orthopedic (R3) is morbidly obese. She e 4 metastatic bone cancer re body. The fracture was as pivoting on weight after a ture repair. (R3) requires transfer. A metastatic any bone is of much greater ff during a transfer due to the e. I don't know if the fracture preventable, but if the transfer I wasn't there during the common sense is (R3) would of her condition at the time of d need assistance with morbid	F9	999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER: 145304       (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING       (X3) DATE SURVEY COMPLETED C 01/25/2012         NAME OF PROVIDER OR SUPPLIER BRENTWOOD NORTH HC &REHAB CTR       STREET ADDRESS, CITY, STATE, ZIP CODE 3705 DEERFIELD ROAD RIVERWOODS, IL 60015       (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDER'S PLAN OF CORRECTION (EACH OF RECET TO THE APPROPRIATE DEFICIENCY)       C O(M) ETC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY         F9999       Continued From page 31 obesity, weakened bones, and just getting back from the hospital and recent surgical repair on her leg. (R3) is at greater risk for fracture and was known to the facility to have these medical problems and co-morbidities."       F E8, (ADON/Assistant Director of Nursing) on 1-24-2012 at 12:55pm. stated, "I helped with the investigation of (R3's) 10-29-2012 incident and injury. I don't know why a sliding board wasn't used. I think we asked the CNAs' about the sliding board and I don't recall the CNAs' response."			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
Image:	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
Image:								
BRENTWOOD NORTH HC &REHAB CTR     ID     PROVIDER'S PLAN OF CORRECTION IVERWOODS, IL 60015       IX4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID     PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COMPLETIC DATE       F9999     Continued From page 31 obesity, weakened bones, and just getting back from the hospital and recent surgical repair on her leg. (R3) is at greater risk for fracture and was known to the facility to have these medical problems and co-morbidities."     F9999       E8, (ADON/Assistant Director of Nursing) on 1-24-2012 at 12:55pm. stated, "I helped with the investigation of (R3's) 10-29-2012 incident and injury. I don't know why a sliding board wasn't used. I think we asked the CNAs' about the sliding board and I don't recall the CNAs' response."     F8999			145304	B. WI	NG _			
BRENTWOOD NORTH HC &REHAB CTR       RIVERWOODS, IL 60015         (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)       COMPLETIC DATE         F9999       Continued From page 31 obesity, weakened bones, and just getting back from the hospital and recent surgical repair on her leg. (R3) is at greater risk for fracture and was known to the facility to have these medical problems and co-morbidities."       F9999         E8, (ADON/Assistant Director of Nursing) on 1-24-2012 at 12:55pm. stated, "I helped with the investigation of (R3's) 10-29-2012 incident and injury. I don't know why a sliding board wasn't used. I think we asked the CNAs' about the sliding board and I don't recall the CNAs' response."       F9999	NAME OF F	ROVIDER OR SUPPLIER						
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       computing Date         F9999       Continued From page 31 obesity, weakened bones, and just getting back from the hospital and recent surgical repair on her leg. (R3) is at greater risk for fracture and was known to the facility to have these medical problems and co-morbidities."       F9999         E8, (ADON/Assistant Director of Nursing) on 1-24-2012 at 12:55pm. stated, "I helped with the investigation of (R3's) 10-29-2012 incident and injury. I don't know why a sliding board wasn't used. I think we asked the CNAs' about the sliding board and I don't recall the CNAs' response."       F9999	BRENTW	OOD NORTH HC &R	EHAB CTR					
<ul> <li>obesity, weakened bones, and just getting back from the hospital and recent surgical repair on her leg. (R3) is at greater risk for fracture and was known to the facility to have these medical problems and co-morbidities."</li> <li>E8, (ADON/Assistant Director of Nursing) on 1-24-2012 at 12:55pm. stated, "I helped with the investigation of (R3's) 10-29-2012 incident and injury. I don't know why a sliding board wasn't used. I think we asked the CNAs' about the sliding board and I don't recall the CNAs' response."</li> </ul>	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
E9, (Charge Nurse) and E8, (ADON) on 1-24-2012 at approximately 1:10pm. affirmed R3 was transferred using a sliding board during her residence at the facility. Z2, (Physician/Medical Director) on 1-25-2012 at 12:05pm. stated, "I am (R3's) physician. She has metastatic cancer and brittle bone disease. I don't know about the assessment and transfer information after (R3) returned from the hospital on 10-29-2011. I know the staff transferred (R3), basically the same way during her stay at the facility." The 8-31-2011 Admission MDS and 11-24-2011 Quarterly MDS, Section C. Cognitive Patterns document R3 does not have short or long term memory deficits. Section G. Functional Status: B. Transfer document R3 requires extensive two plus staff member assistance. G0300 Balance During Transitions and Walking, A. Moving from seated to standing position, E. Surface to surface transfer "Not steady, only able to stabilize with human assistance."	F9999	obesity, weakened from the hospital ar her leg. (R3) is at o was known to the fa problems and co-m E8, (ADON/Assista 1-24-2012 at 12:55 investigation of (R3 injury. I don't know used. I think we as sliding board and I o response." E9, (Charge Nurse) 1-24-2012 at appro was transferred usi residence at the fac Z2, (Physician/Med 12:05pm. stated, "I metastatic cancer a don't know about th information after (R on 10-29-2011. I kr basically the same facility." The 8-31-2011 Adm Quarterly MDS, See document R3 does memory deficits. S B. Transfer docum plus staff member a During Transitions a seated to standing surface transfer "No	bones, and just getting back of recent surgical repair on greater risk for fracture and acility to have these medical orbidities." Int Director of Nursing) on pm. stated, "I helped with the 's) 10-29-2012 incident and why a sliding board wasn't ked the CNAs' about the don't recall the CNAs' and E8, (ADON) on ximately 1:10pm. affirmed R3 ng a sliding board during her cility. ical Director) on 1-25-2012 at am (R3's) physician. She has and brittle bone disease. I he assessment and transfer 3) returned from the hospital how the staff transferred (R3), way during her stay at the hission MDS and 11-24-2011 ction C. Cognitive Patterns not have short or long term ection G. Functional Status: ent R3 requires extensive two assistance. G0300 Balance and Walking, A. Moving from position, E. Surface to ot steady, only able to stabilize	F9	999			

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		AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTI	IPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	LDIN	IG	COMPLETED		
	145304		B. WIN	IG			5/2012	
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE			
BRENTWOOD NORTH HC &REHAB CTR					705 DEERFIELD ROAD RIVERWOODS, IL 60015			
(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 SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F9999	Continued From pa	ige 32	F9:	999				
	after R3 returned fro contains documentation	Il Risk Evaluation completed rom the hospital, prior to injury, ation that R3 is, "A. Alert. B. Balance, Not able to perform a for falls."						
	through 1-21-2012 R2 has diagnoses t macular degenerati recurrent rib fractur	Order Sheet of 1-2-2012 contains documentation that that include osteoarthritis, ion and a history of falls with res and sternal fracture. s admitted to the facility on						
	Log contains docun 10-4-2011 at 2:00ar hospital with resultin 12-6-2011 at 7:45ar a bruise. 12-21-2011 at 1:05p injury.	m., fell in bedroom, sustained pm. fell in dining room, no am. fell in bedroom, sent to						
	requested to provid 2011 to January 20	15pm. E2, (DON), was le a timeline from February 12 and interventions e facility for R2's recurrent falls es.						
	Timeline and Interv facility, for R2's recipility follows:	5-2012 at 9:15am. provided a entions, implemented by the urrent falls with injuries, which an updated; Educated (R2)						

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SU	(X3) DATE SURVEY COMPLETED	
		A. BUILD	ING		C	
145304		B. WING			5/2012	
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COL	Æ	
BRENTWOOD NORTH HC &REHAB CTR				3705 DEERFIELD ROAD RIVERWOODS, IL 60015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F9999	regarding recomme grooming. 3-31-2011 Care Pla therapy for ambulat 5-30-2011 Seen by medications review completed, negative 7-31-2011 Care Pla recommended by n walker. 8-21-2011 Care Pla on use of call light a kept in medication of assist in applying he 10-4-2011 Care Pla giver as determined 10-14-2011 Care Pla giver as determined 10-14-2011 Care Pla giver as determined 10-14-2011 Care Pla call for assistance w labs done. Investig 12-25-2011 Care Pla call for assistance w labs done. Investig	an updated, started physical ion, gait training, and transfer. Nurse Practitioner; ed and urinalysis and culture e. an updated; non-skid shoes ursing for safety and use of an updated; Re-educated (R2) and that hearing aide will be cart when not in use. Staff to earing aide. In updated; One to one care d by resident need. Plan update; re-educated with assist and Medical Investigation concludes no an update; Re-educated to when going into her closet; ation concludes no fall. Plan update; re-educated on e to one sitter as determined rsical therapy evaluation." 2012 at 9:15am. stated, rventions that have been 2), and therapy evaluated her. of falls prior to her admission, ad numerous falls with rib	F999			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM	APPROVED
		& MEDICAID SERVICES	0.000				0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		145304	B. WIN	G			C 5/2012
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	• • • •	<i>5/2012</i>
BRENTWOOD NORTH HC & REHAB CTR				-	705 DEERFIELD ROAD IVERWOODS, IL 60015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
TAG F99999	Continued From parestorative therapy assist with transfers On 1-25-2012 at 10 3:45pm., any support one to one sitter us implementation of s (DON) on 1-25-201 have two CNAs that work here. We do the documentation regand and R2." R2's Fall Risk Asse 1-2-2012-1-18-2012 Risk" for falls. Hospital History and contains documentation that skin tear to right for arm. "Sent to hosp admitted with diagn Accident/Incident R complains of right reference Hospital Discharge	Ige 34 programs, one to one sitter, s." 0:10am., 12:55am., and orting documentation regarding age, time frames, or sitters was requested. E2, 2 at 12:25pm. stated, "We t do 1 to 1 sitting. Both CNAs not have supporting arding the one to one sitter ssment of 12-26-2011, 2 document R2 is at "High d Physical of 3-8-2011 ation that R2 sustained 3rd, ctures with a sternal fracture	F99				
		leport of 12-6-2011 at 7:45am. ation that R2 had a bruise of he right forearm.					

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		AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			JRVEY TED
145304			B. WI	1G			C 5/2012
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BRENTWOOD NORTH HC &REHAB CTR					705 DEERFIELD ROAD RIVERWOODS, IL 60015		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	.ge 35	F9!	999			
	documentation that	Report of 12-25-2011 contains R2 was found on floor. Sent agnosis of 8th, 9th, and 10th.					
	contains documenta the hospital on 12-2	oital Discharge Summary ation that R2 was admitted to 25-2011 with diagnoses of s, 8th, 9th, and 10th. rib al fracture.					
	1-25-2012 at 12:55 identified above we had been implement Additionally, E8 and degeneration, only	) and E8, (ADON) on pm. affirmed interventions are the only interventions that need by the facility for R2. d E9 affirmed R2 has macular seeing shadows, has hearing falls with injury of rib fractures e.					
	Director) stated, "I of falls since 2008. I of	2:05pm. Z2, (Physician/Medical did not know (R2) was having do know I asked the facility n for her. I don't follow (R2)					
	"I know (R2's) medi other interventions	1-25-2012 at 12:17pm. stated, ical history. I don't know what the facility has implemented weakened bones, disease					

Facility ID: IL6001119

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