TATEMENT	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IULTIPLE CONSTRUCTION	(X3)	DATE SU	
				ILDING	<u> </u>		
		145358	B. WIN	NG		02/06/2012	
-	PROVIDER OR SUPPLIER	HAB CTR		STREET ADDRESS, CITY, STAT 1136 NORTH MILL STREE NAPERVILLE, IL 60563	г		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLA IX (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD E		(X5) COMPLETION DATE
F 353	Continued From pa	age 23	FS	353			
F9999	kinky hair that app FINAL OBSERVAT	eared unkempt and uncombed. TONS	F99	999			
	Licensure Violatio	ns:					
	300.610a) 300.610c)2 300.1210a) 300.1210b)3) 300.1210b)4) 300.1210b)5) 300.1210c) 300.1210d)3 300.1210d)3 300.12104)C) 300.1220b)3) 300.3240a)						
	Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.						
	c) These written po minimum the follow	blicies shall include, at a ving provisions:					

If continuation sheet Page 24 of 34

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/04/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145358	B. WI	NG	i	02/00	6/2012
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
сомми	NITY NURSING & REI	IAB CTR			1136 NORTH MILL STREET NAPERVILLE, IL 60563		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	 2) Resident care sets services, emergence nursing services, reservices, pharmace services, social services, social services, social services, and diagnal aboratory and x-ray. Section 300.1210 Constrained and participation resident's guardian applicable, must de comprehensive car includes measurable meet the resident's and psychosocial needs. The assess the active participation resident's guardian applicable level of provide for discharge restrictive setting bar needs. The assess the active participation applicable b) The facility shall and services to attapracticable physica well-being of the research resident's complan. Adequate and care and personal construction and services to attapresident to meet the resident to meet the resident's complan. 	ervices including physician cy services, personal care and estorative services, activity eutical services, dietary vices, clinical records, dental ostic service (including /).	F9	99	9		

Facility ID: IL6006175

If continuation sheet Page 25 of 34

		AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			(X3) DATE SU COMPLE	
		145358	B. WI	NG	à	02/0	6/2012
NAME OF F	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY NURSING & REH	HAB CTR			1136 NORTH MILL STREET NAPERVILLE, IL 60563		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From parshall include, at a magnetic procedures: 3) All nursing personencourage resident incontinent of bower appropriate treatment urinary tract infection normal bladder funds personnel shall asses who enters the facilicat condition de catheter is not catheter is and catheter is of daily circumstances of the demonstrate that did This includes the reading dress, and groom; it eat; and use speec functional communion who is unable to catheter is assessible to the personal communion of the personal communion is unable to catheter is assessible to the personal communication of the personal communic	ge 25 ninimum, the following annel shall assist and s so that a resident who is and/or bladder receives the ent and services to prevent ons and to restore as much ction as possible. All nursing ist residents so that a resident lity without an indwelling eterized unless the resident's emonstrates that necessary. Innel shall assist and is so that a resident's abilities living do not diminish unless the individual's clinical condition iminution was unavoidable. esident's abilities to bathe, transfer and ambulate; toilet; h, language, or other ication systems. A resident rry out activities of daily living rvices necessary to maintain oming, and personal hygiene. Innel shall assist and s with ambulation and safe s often as necessary in an retain or maintain their highest functioning.	F9		DEFICIENCY)		

Facility ID: IL6006175

If continuation sheet Page 26 of 34

	-	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		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145358	B. WI	NG _		02/00	6/2012
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
СОММИ	NITY NURSING & REI	IAB CTR			1136 NORTH MILL STREET NAPERVILLE, IL 60563		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	 d) Pursuant to subs care shall include, a and shall be practic seven-day-a-week 3) Objective observer resident's condition emotional changes, determining care refurther medical eval made by nursing staresident's medical refurction further medical eval made by nursing staresident's medical refurction (a) Personal care shares and by nursing staresident's medical refurction and by nursing staresident's medical refurction (a) Personal care sharesident's medical refurction (b) Each resident shares indicated should be street closed) Section 300.1220 S Services b) The DON shall s nursing services of (a) Developing an up each resident bases comprehensive ass and goals to be accord and personal care a representing other starts activities, dietary, a are ordered by the p the preparation of the starts of the starts of the starts of the starts of the starts of the starts of the starts of the starts of the starts of the starts	ection (a), general nursing at a minimum, the following ed on a 24-hour, basis: ations of changes in a , including mental and , as a means for analyzing and quired and the need for luation and treatment shall be aff and recorded in the ecord. all be provided on a 24-hour, basis. This shall include, but e following: hall have clean, suitable be comfortable, sanitary, free nt in appearance. Unless by his/her physician, this thes and shoes. Supervision of Nursing upervise and oversee the the facility, including: b-to-date resident care plan for	F9	999	9		

Facility ID: IL6006175

If continuation sheet Page 27 of 34

		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	(X3) DATE SU COMPLE	JRVEY
		145358	B. WI	NG		02/0	6/2012
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
СОММИ	NITY NURSING & REH	IAB CTR			136 NORTH MILL STREET NAPERVILLE, IL 60563		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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	indicated by the res shall be reviewed a	with the care needed as ident's condition. The plan t least every three months.	F9	999			
		Abuse and Neglect ee, administrator, employee or nall not abuse or neglect a					
	This Requirement is	s not met as evidenced by:					
	review the facility fa thoroughly assess 4 43) outside the sam the sample (R19) o incontinence. The f and implement a bo procedure. This failure resulted psychosocial and e being told she cann in her diaper sating embarrassed about diaper.	on, interview and record ailed to accurately and 4 residents (R23, 41, 47 and pple and for 1 resident inside f 21 residents having urinary acility also failed to develop owel and bladder policy and d in R23 expressing feelings of motional distress as result of not use the toilet and must void she feels humiliated ans t being told to void in her					
	These failures also incontinent resident	has the potential to affect all ts in the facility.					
	Findings include:						
	shows that the facil occasionally or freq and 49 residents will frequently incontine	ident Census and Condition ity has 56 residents who are juently incontinent of bladder ho are occasionally or ent of bowel. The 672 states re on individual bladder					

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/04/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145358	B. WI	NG _		02/06	6/2012
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
СОММИ	NITY NURSING & REI	HAB CTR			1136 NORTH MILL STREET NAPERVILLE, IL 60563		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	training programs, i individual bowel tra for the list of reside program, E2 (direct dated 1/4/12 with 1 inconsistent with th 672 as being in a p asked on 1/12/12 a needed to be revise that E19 (restorativ program and its nu All B & B (bladder a the 31 residents list requested on 1/12/ presented 5 of the 3 ' t have time to obta assessments. Whe ' s toileting program being on individual E19 described a pr which involves toile waking, before and as needed. This is training program. R residents on toiletin has not developed implemented speci to prevent or minim Per E19 and review assessments, the f whether the causes reversible or irrever R23 was observed the second floor dir 9:40am. R2 stated lower back and but bathroom. R23 stat	and of the 21, 10 are on ining programs. When asked ents on a bowel and bladder tor of nursing) provided a list 3 resident names. This is is e 31 residents listed on the rogram. E1 and E2 were at 10:55 am if the numbers ed and both declined, stating re nurse) would explain the mber of participants. and bowel) assessments for ted in the program were 12 and E19 (restorative nurse) 31 on 1/13/12 stating she didn ain the remaining 26 en asked to describe the facility n for the residents identified as toileting programs on the 672, compted toileting program in eting/prompting residents upon 1 after meals, before bed and not an individualized bladder Review of care plans of ng programs show the facility individualized goals or fic plans/interventions in order nize decline. Examples follow. v of incontinence acility has not identified s of resident's incontinence are	F9	999			

Facility ID: IL6006175

If continuation sheet Page 29 of 34

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/04/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145358	B. WING _		02/06	6/2012
NAME OF F	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
СОММИ	NITY NURSING & REI	IAB CTR		1136 NORTH MILL STREET NAPERVILLE, IL 60563		
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	aide) stated on 1/10 when she has to go transferred onto the E25 (nurse) assiste placing R23 onto the was observed to ha diaper, onto her par wheelchair. Following concerns reassessment after " lowered to the floo sit-to-stand lift in Oo nursing) stated on " had been reassess using a total body n interviews with direc 1/13/12 stated that she has to go to the to know." "She alw go." Now that R23 the hoyer lift into the staff stated "I told h now. She never poo upset. We don't kno she says she has to dignity." R23 stated on 1/13 telling her she has diaper and it makes embarrassed." R2 the toilet when I hav Review of medical years old with diagr sided weakness, hi failure, hypertensio most recent Activitie	ore 7:00am. E15 (nurse's 0/12 at 9:55am R23 knows of to the bathroom and R23 is a toilet via a sit-to-stand lift. Ind E15 in utilizing the lift and e toilet in her bathroom. R23 we urine soaked through her nts when lifted out of the to facility regarding a lack of an incident in which R23 was or " while utilizing the ctober 2011, E2 (director of 1/12/11 at 1:25pm that R23 ed and will now be transferred nechanical lift. Confidential ct care staff on 1/12/12 and R23 "absolutely knows when e bathroom-she is alert enough ways tells us when she has to is a hoyer lift, "we can't get e bathroom." One direct care ner she has to go in her diaper ops in her diaper, she was so ow how to address her when o go. That is taking away her (12 at 2:34pm that staff is to go to the bathroom in her sher feel "humiliated and i3 said "I'm used to going to	F9999			

Facility ID: IL6006175

If continuation sheet Page 30 of 34

		AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145358	B. WI	√G		02/00	6/2012
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY NURSING & REI				136 NORTH MILL STREET IAPERVILLE, IL 60563		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	dated 11/29/11 and facility states that R one to two assist fo bladder and contine bedpan for toileting bowel assessment contradictory inform incontinent of urine toilet and is aware w identified to have fu assessment and co motivated to particin and therefore will nu unclear what is mea there is no docume supporting this state was observed by R during the survey. I staff interviews stat to be toileted. The f assessment is chee "dependent care: R toileted. Care is foc clean and dry." R2 11/29/11 is also con stating R23 is incor due to poor motivat in the program cons specific or individua clean, dry and odor bladder diary for R2 to assist in determin This was confirmed The following samp reviewed and found inaccurate informat direct care staff:	A provided upon request by R23 is oriented x2, requires or transfers, is incontinent of ent of bowel and uses a g. Most recent bladder and dated 6/6/11 contains nation stating R23 is e, has the ability to go to the when she is wet. R23 is unctional incontinence in this oncludes that R23 is poorly ipate in the toileting program tot be in such a program. It is ant by " poor motivation " as entation in the medical record tement and is contrary to what R23 requesting to be toileted It is not supported by multiple ting R23 knows when and asks	F99	999			

Facility ID: IL6006175

If continuation sheet Page 31 of 34

		AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145358	B. WI	NG		02/06	6/2012
NAME OF PRO	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
COMMUNI	ITY NURSING & REF	1AB CTR			136 NORTH MILL STREET IAPERVILLE, IL 60563		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
1 v con 1 ti v sb r fr v iii iii F n u 1 e F 2 b a fr b u a a ii ti 0 h ti o tr ti fr	when she has to go one and go by herse most of the time. Re 10/25/11 states R41 the ability to ask to go wanders looking for section states that F because of Dement reason not to be in for R41 to be promp voiding diary does r in determining a voi incontinence care p R41 " will toilet voic meals, at HS and pu urinary elimination. 11:10am that there established for R41 R47 E21 (nurse ' s 2:15pm that R47 km bathroom and takes alarms in place in h falls E21 stated but bathroom most of th urinal. E21 said R47 alarms so he can go assessment dated incontinent of urine, the bathroom, uses Comment section s his need to toilet bu there in time (urgen dated 10/15/11 state toileting. " The voic the data to assist in for R47. The inconti	confused at times but knows to the bathroom and will find eelf. E23 said R41 stays dry 41's B & B assessment dated 1 is incontinent of urine, has go to the bathroom but r the bathroom. The Summary R41 cannot be in the program tia. This is not sufficient a B&B program. The plan is pted to use the toilet. The not analyze the data to assist iding pattern for R41. The blan dated 10/25/11 states d in toilet upon rising, after rm to establish a routine for " E19 stated on 1/13/12 at has not been a pattern	F9	999			

Facility ID: IL6006175

If continuation sheet Page 32 of 34

		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		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145358	B. WI	NG _		02/06	6/2012
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
СОММИ	NITY NURSING & REI	HAB CTR			1136 NORTH MILL STREET NAPERVILLE, IL 60563		
(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	prompted toileting p 1/13/12 at 11:10am pattern established R43 E20 (nurse's a 2:10pm that R43 is sit-to-stand lift to go R43 says certain the right" or tugs at he has to go to the bat in her care plan or voiding diary does n in determining a vo assessment dated incontinent of urine the bathroom but ca because of her den Comment section s feels like she has to time she asks. The prompted to use the Review of facility's policy and procedur assessment will be irreversible causes the above care plan P only describes a resident to the toile breakfast and every Acello, Barbara RN Nursing Desk Refe Chapter 13 pg 215 toileting residents e means of keeping t dated and ineffectiv incontinence is man individualized to the management is a "	brogram. " E19 stated on that there has not been a for R47. aide) stated on 1/13/11 at confused and uses a to to the bathroom. E20 said ings like "It doesn ' t feel r pants to let staff know she hroom. This information is not B & B assessment. The bot analyze the data to assist iding pattern for R43. B & B 10/21/11 states R43 is , has the ability to ask to go to annot be in a B & B program nentia and mood disorder. The states that R43 can state she o go but it is "too late" by the e plan is for R43 to be e toilet. Bowel and Bladder Training re states the B & B used to assess reversible and of incontinence. Review of all hs found none listed. The P & policy for staff to take the t or provide a bedpan before	F9	999			

Facility ID: IL6006175

If continuation sheet Page 33 of 34

		AND HUMAN SERVICES				FORM	: 05/04/2012 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY ETED
		145358	B. WI	NG _		02/0	6/2012
	Rovider or Supplier	HAB CTR			REET ADDRESS, CITY, STATE, ZIP CODE 1136 NORTH MILL STREET NAPERVILLE, IL 60563		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	toileting the resider most likely to elimir able to participate i retraining programs	inge 33 ing or relearning. It involves that times in which he or she is thate. Many residents will not be in an active bowel and bladder s, but most will benefit from a the based toileting schedule." (B)	F9	995			

Facility ID: IL6006175

If continuation sheet Page 34 of 34