STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145630	A. BUILDING _____ B. WING _____	C 02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VILLA NSG & REHAB, LLC	**6840 WEST TOUHY AVENUE NILES, IL 60714**

(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 309	Continued From page 8 emergency exists, then send the resident to the hospital via 911. 6. Documentation will be present in the resident record."	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210b) 300.1220b)1)2) 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. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145630	A. BUILDING _____ B. WING _____	C 02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VILLA NSG & REHAB, LLC	**6840 WEST TOUHY AVENUE NILES, IL 60714**

(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 9 percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145630	A. BUILDING _____ B. WING _____	C 02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VILLA NSG & REHAB, LLC	**6840 WEST TOUHY AVENUE NILES, IL 60714**

(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 10 These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to obtain timely physician's orders for treatment and provide appropriate services and timely care for 1 resident (R1) by failing to promptly report critical laboratory findings to the physician and by failing to notify physician of significant change in condition in a timely manner. This failure to provide appropriate and timely medical interventions resulted in a rapid deterioration of R1's condition. R1 expired the next morning 10/18/2011. Findings include: According to Physician Order Sheet dated 8/2011, R1 was an 88 year old resident with multiple diagnoses significant for Acute Left Lower Extremity Deep Vein Thrombosis, Renal Failure, Senile Psychosis, and Parkinson's disease. Clinical record documented that R1 had a fall on 8/11/2011 with no apparent injury. 72 hour post incident documentation stated that there were no injuries noted. During this time, R1 was on Lovenox and coumadin therapy as shown on Physician Order Sheets. On 8/15/2011 a bruise on the right lower arm was noted. R1 was transferred to a local area hospital on 8/22/2011 for swelling and hematoma of the right lower arm and returned to the facility on 8/28/2011. On 9/8/2011, R1 was again transferred to the hospital for right arm necrosis and returned to the facility on 9/17/2011 with diagnosis of Methicillin	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145630	A. BUILDING _____ B. WING _____	C 02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VILLA NSG & REHAB, LLC	**6840 WEST TOUHY AVENUE NILES, IL 60714**

(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 11	F9999		

Resistant Staphylococcus Aureus of right arm wound with wound vacuum treatment, contact isolation and intravenous antibiotics. Nurses Notes documented the following:
-on 10/12/2011 documented first reported diarrhea;
-on 10/14/2011 started on Oxygen at 2 liters per nasal cannula as needed for shortness of breath, stool specimen collected for Clostridium difficil.
-on 10/15/2011 noted poor appetite and scheduled for Comprehensive Metabolic Profile, Complete Blood Count, Urine Analysis and Culture/Sensitivity for 10/17/2011.
-on 10/16/2011 R1 was maintained on isolation for Clostridium difficil of the stool.

Laboratory report for Comprehensive Metabolic Profile documented the following:
-Date reported : 10/17/2011.
-Time reported: 05:00 PM.
-BUN (Blood Urea Nitrogen) 143.0 High Panic (Normal 7-30 milligrams/deciliter)
-Sodium 172 High Panic (Normal 137-147 milliequivalents/liter)
-Chloride 137.8 High Panic (Normal 96-108 milliequivalents/liter)

Nurses Notes failed to show that the physician was notified at any time of the high panic laboratory results dated 10/17/2011.

Nurses Notes dated 10/18/2011 starting at 12 midnight noted R1 with increasing restlessness, agitation, deteriorating condition, and that family was notified but not the physician. At 7:20 AM, R1 was noted unresponsive, vital signs unappreciated At 7:35 AM Nurses Notes documented that Z1 (Attending Physician/Medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145630	A. BUILDING _____ B. WING _____	C 02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VILLA NSG & REHAB, LLC	**6840 WEST TOUHY AVENUE NILES, IL 60714**

(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 12	F9999		

Director) was notified of R1's condition. This was the only time that physician notification was documented from the time the laboratory high panic report was received and up to the time the change in R1's condition was noted.

On 2/20/2012 at 9:10 AM, E1 (Administrator) stated that she was on maternity leave for the period from October 2011 until January 2012.

In a phone interview on 2/21/2012 at 5:20 PM, Z1 (Attending Physician/Medical Director) stated that he should have been notified immediately of the critical laboratory results and that they never called him. Z1 said that it was faxed to his office at 10:00 PM that night (10/17/2011) and that (R1) expired the following morning (10/18/2011). Z1 stated that those critical values can cause a patient to go into renal failure and that as medical information was available, the family could have been provided with options if they wanted to send (R1) out to the hospital or not. Z1 added that it was a question of the degree of clinical judgement on the part of the staff.

On 2/22/2012 at 8:25 AM, E3 (Director of Nursing) stated over the phone that the nurse on duty pages the attending physician for change in condition notification. E3 added that if resident condition deteriorates, it is the nurse's judgement to call 911. Regarding the high panic laboratory results on 10/17/2011, E3 stated that the nurse on the floor missed the report in the fax machine, and then faxed it to the doctor's office at 10:00 PM, and never placed a call to the doctor.

Policy and Procedure on Notification of the Physician states, "Nursing will notify the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145630	A. BUILDING _____ B. WING _____	C 02/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VILLA NSG & REHAB, LLC	**6840 WEST TOUHY AVENUE NILES, IL 60714**

(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 13 physician or nurse practitioner when: b. There is a significant change in the resident's physical, mental or emotional status, e. It is deemed necessary or appropriate in the best interest of the resident." Policy and Procedure on Change in the Resident's Condition states, "Responsibility: RN (Registered Nurse), LPN (Licensed Practical Nurse). 1. Should there be a change in the resident's physical, mental or emotional status, the attending physician should be notified. 2. If the attending physician does not respond within 30 minutes, contact the medical director. 4. If at anytime during this process the resident condition deteriorates or it is determined a medical emergency exists, then send the resident to the hospital via 911. 6. Documentation will be present in the resident record." (A)	F9999		