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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	COMPLE	TED	
		146011	B. WIN	IG				
	ROVIDER OR SUPPLIER	HEALTH CARE		50	REET ADDRESS, CITY, STATE, ZIP CODE D2 NORTH MAIN PRIGHTON, IL 62012	RECTION (X5)		
(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 CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999	FINAL OBSERVAT		F99	999				
	300.610a) 300.610c)2) 300.696a) 300.1010h) 300.1210b) 300.3240a)	LATIONS:						
	a) The facility shall procedures, govern the facility which shall resident Care Police least the administrative medical advisor representatives of the facility. These point with the Act and all These written police operating the facilitiest annually by the	have written policies and ning all services provided by nall be formulated by a cy Committee consisting of at ator, the advisory physician or ry committee and nursing and other services in policies shall be in compliance rules promulgated thereunder. ies shall be followed in ry and shall be reviewed at its committee, as evidenced by dated minutes of such a						
	minimum the follow 2) Resident care so services, emergen nursing services, ro services, pharmac services, social services	ervices including physician cy services, personal care and estorative services, activity eutical services, dietary rvices, clinical records, dental nostic service (including						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	
		146011	B. WIN	NG _			3/ 2012
	ROVIDER OR SUPPLIER S MANOR REHAB & I	HEALTH CARE	.		REET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH MAIN BRIGHTON, IL 62012	00,2	
(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)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 9	F99	999	9		
	Section 300.696 Inf	ection Control					
		cedures for investigating, venting infections in the facility d and followed.					
	Section 300.1010 N	Medical Care Policies					
	of any accident, injuresident's condition safety or welfare of limited to, the prese decubitus ulcers or percent or more wit facility shall obtain a of care for the care	notify the resident's physician ury, or significant change in a that threatens the health, a resident, including, but not ence of incipient or manifest a weight loss or gain of five hin a period of 30 days. The and record the physician's plan or treatment of such accident, condition at the time of					
	Nursing and Person b) The facility shall and services to atta practicable physica well-being of the re- each resident's com plan. Adequate and care and personal of	provide the necessary care lin or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE S COMPLI	
		146011	B. WING			C 3/2012
	ROVIDER OR SUPPLIER S MANOR REHAB &	HEALTH CARE		REET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH MAIN BRIGHTON, IL 62012	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F9999	Section 300.3240 A a) An owner, licens agent of a facility stresident. (Section	Abuse and Neglect see, administrator, employee or hall not abuse or neglect a 2-107 of the Act)	F9999			
	Based on record refailed to monitor, as infection for 1 of 3 urinary tract infection failure resulted in Furinary tract infection					
	part, of Parkinson's depressive disorde documented R3 ha physician, Z1, orde and sensitivity. The 2/17/12 documente "negative"; "WBC" normal as "negative greater than 100 w bacteria as 2+ with The "Culture Urine collection of 2/17/1 documented under	the facility with diagnoses, in a disease, dementia, and major r. On 2/17/12 the nurses notes d "tea colored urine" and the red a urinalysis and culture e "Urinalysis" results dated ed "blood 3+" with normal as (white blood count) 11-20" e"; "RBC" (red blood count) as ith normal as 0-5; and, normal as "none". with Colony Count" dated with 2 and "resulted" of 2/20/12 "Culture Comment(s)" a later than 100,000/ML				

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

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	TED
		146011	B. WIN	۱G _		05/23	C 3/ 2012
	PROVIDER OR SUPPLIER S MANOR REHAB & F	HEALTH CARE		5	REET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH MAIN BRIGHTON, IL 62012	00,20	3/2012
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	than 100,000/ML gridentified "organism (promir)" and "organism (promir)" and "organism (promir)" and "organism (promir)" and "organism (promir)" with each antibious (1)" with each antibious "Intermediate" or "F" "promir" was identified "Trimethoprim/Sulfator There was no antibious (2)" organism. At the "Comment" it documusually sensitive to Rifampin, Vancomy Gentamicin". Organism of the culture and sensitive documented. The nurses notes of was notified of the culture and sensitivity and orded day) x 5 days re: Under the culture and sensitivity and orded day) x 5 days re: Under the nurses notes of the culture and sensitivity and order day) and ordered a urina sensitivity. The nurse notes of the culture specimen was also and ordered a urina sensitivity. The nurse notes of the nurses nurses nurses nurses of the nurses n	egative bacillus and greater ram positive cocci. The report in #1" as "Proteus mirabilis nism #2" as "Streptococcus teurianus (strpas)". The tics for Organism #1 "promir iotic listed as "Susceptible", Resistant". Organism #1 ied as sensitive to Septra or amethox". Indicate the "strpas in the top of the report under mented "Strept Galloyticus is Penicillin, Ampicillin, roin, and high levels of anism #2 "strpas" was not to the top of the report under mented "Strept Galloyticus is Penicillin, Ampicillin, roin, and high levels of anism #2 "strpas" was not to to Septra. Z1 initialed the ity lab report with no date Occumented on 2/20/12 that Z1 urinalysis culture and red Septra DS "BID (twice a II (urinary tract infection)". Occumented R3 was "not de temp (temperature) noted	F99	999			

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PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		146011	B. WIN				C 3/2012
NAME OF PROVIDER OR SUPPLIER ROBINGS MANOR REHAB & HEALTH CARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			•	50	EET ADDRESS, CITY, STATE, ZIP CODE 02 NORTH MAIN RIGHTON, IL 62012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	"called (and) faxed Practical Nurse (LF interview. E8, LPN the "results of cultu with results of "(grepositive cocci". Z1 3/8/12. E8 stated in 9:40 AM that she whate. The report did There was no cultured the chart to identify to antibiotics. E8 where sensitivity was recelled the lab on 5/requested the culture confirmed that there sensitivity report in E1, Administrator, s5/22/12 at 12:00 Pt policy and procedu the physician. E1 sin the 24 hour report in the stated on 5/21/1 faxes the lab report in the facility "Guideli of Resident Change Tests/Diagnostic Procession of the Indonesia of	(Z1)" by E7, Licensed (Z1)" by E7 was unavailable for documented on 3/8/12 that re" were sent to Z1's office ater than) 100,000/ML gram initialed the report dated an an interview on 5/22/12 at as not sure why the lab was donot identify the organism. The organism or the sensitivity was not aware if the culture and sived by the facility. E3, LPN, 21/12 at 11:00 AM and re and sensitivity report. E3 e was no culture and the medical record of R3. Stated in an interview on M that there was no specific re for reporting lab reports to stated the nurses note the labs at and keep track of it that way. 2 at 2:35 PM that the lab also its to the physician. E2, was not available for	F99	99			

Facility ID: IL6008072

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SU COMPLE	
		146011	B. WIN	G			3/ 2012
	ROVIDER OR SUPPLIER S MANOR REHAB &	HEALTH CARE	•	50	EET ADDRESS, CITY, STATE, ZIP CODE 12 NORTH MAIN RIGHTON, IL 62012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	identified a colony of gram positive cocci identified as "Strept pasteurianus". The comments section Penicillin, Ampicillir high levels of Genta antibiotic therapy of was at the facility a 4/3/12 documented. There are no further are no further are no further at the Septra should be sensitivity for the 3/felt the Septra should be sensitivity for the 3/felt the Septra should be sensitivity and sensitivity urinalysis had any hospitalization as it period. Z1 stated us a week and the lab hospitalization. The nurses notes of documented R3 was and she stated "downs notified and one mergency room. Of any problems with According to the nurse admitted to the hypotension, dehyourinary tract infections."	count greater than 100,000 of i. The organism was again tococcus gallolyticus sspere report noted under the "Strept Gal Past is sensitive to n, Rifampin, Vancomycin and amycin". There was no redered by the physician. Z1 and the nurses notes dated I "N.N.O" (no new orders). For nurses notes until 4/15/12. The interview on 5/22/12 at 3:35 of get a copy of the culture and 17/12 urinalysis. Z1 stated he ald have worked when ordered that have ordered a different same organism was present lysis if he had received the lity. Z1 did not feel the 3/7/12 effect on the 4/15/12 had been too long of a time burosepsis occurs within days to was done a month prior to the lated 4/15/12 at 9:00 AM as pale with warm, moist skin not feel good". The physician dered R3 sent to the E3 stated she was not aware the R3 prior to 4/15/12. The physician dered R3 sent to the lated 4/15/12, R3 et hospital with diagnoses of diration and thrombocytopenic	F99	99			

Facility ID: IL6008072

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	TED
		146011	B. WIN	NG_			C 3/2012
	PROVIDER OR SUPPLIER S MANOR REHAB & F	HEALTH CARE		5	REET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH MAIN BRIGHTON, IL 62012	00,20	3/2012
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	R3 did not act like he to the nurse. E4, C5/21/12 at 1:00 PM work on 4/15/12 and of it". E4 stated she she was sent to the The "Emergency Pf 4/15/12 documented feeling well" for the results documented HP (high panic) with was 2.9 H (high) with the History and Ph documented the change, weakness "Assessment and Pencephalopathy, and thrombocytopenia, and advanced dem An infectious diseased dated 4/18/12 ident infection with sepsis present on admission confirmed blood and for group D Strepto The urinalysis was cells per high powered blood cells per R3 was responding Ceftriaxone. The hospital "Progradocumented R3 had	2 at 12:50 PM that on 4/15/12 herself and she had reported it NA, stated in an interview on that she had come back to d R3 was "confused" and "out e reported it to the nurse and hospital. hysician Record" dated d R3 was sent due to "not "past 2 days". The initial lab d Blood Urea Nitrogen as 84 n normal of 10-33. Creatinine th normal of 0.6-1.3. hysical dated 4/16/12 ief complaint as mental status and lethargy. The Plan" indicated metabolic	F99	999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146011	B. WI				C
NAME OF P	ROVIDER OR SUPPLIER	140011		STR	REET ADDRESS, CITY, STATE, ZIP CODE	05/2	3/2012
ROBING	S MANOR REHAB & I	HEALTH CARE		50	D2 NORTH MAIN PRIGHTON, IL 62012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	streptococcus bacteridentified the organ gallolyticus". The programment of the programment of the hospital "Dischidentified the admit shock" The report to the hospital due attributed to septic bacteremia". The to Proteus and Streorganisms. R3 was care unit and had to due to respiratory facute renal failure of after intravenous fluplaced to support R3 was readmitted orders for a gastrosoral diet, and skilled "Nursing Transfer Sdocumented R3's "Septic Shock due"	eremia". The progress note ism as "Streptococcus progress note also documented cute renal injury, urinary tract athrombocytopenia, bumonia, and lactic acidosis. Parge Summary" dated 5/1/12 ting diagnosis as "Septic adocumented R3 was brought to "change in mental status shock as well as UTI and urinary tract infection was due eptococcus Group D and admission and this resolved and admission and this resolved aids. A tube feeding was a statement of the facility on 5/1/12 with stomy tube feeding as well as a therapy. The hospital summary" dated 5/1/12 Summary of Patient's Stay" as to Proteus and Group D Strept support-improved since-peg	F9:	999			