STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W 376	Continued From page 55 Review of the nursing progress notes and April 2012 MAR, note that R3's medication Bactroban (ordered on 3/31/12) was not initiated until 7pm on 4/3/12. R3 did not receive 5 scheduled doses of this medication. E4 was interviewed on 5/16/12 at 1:50pm. E4 verified that R3's medication order for Bactroban was not initiated until 4/3/12 at 7pm. E4 verified that this medication was ordered on 3/3/1/12. E4 stated she found the prescription on 4/2/12. E2 was interviewed on 5/18/12 at 12:40pm. E2 verified that R3's physician was not notified that R3 did not receive his medications as ordered. E1 (QMRP) was interviewed on 5/16/12 at 9:55am. E1 was asked if the facility had reported any medication errors to the physician during the months of April 2012 and May 2012. E1 stated there were no reports, from nursing, of any medication errors during these 2 months. E1 stated their were no medication errors reported to the physician.	W 376		
W9999	FINAL OBSERVATIONS FINAL OBERSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1230d)1)2) 350.3240a) 350.3240b) 350.3240e) Section 350.620 Resident Care Policies	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 56	W9999		

a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.1210 Health Services

The facility shall provide all services necessary to maintain each resident in good physical health.

Section 350.1230 Nursing Services

d) Direct care personnel shall be trained in, but are not limited to, the following:
1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.
2) Basic skills required to meet the health needs and problems of the residents.

Section 350.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999		W9999		

Continued From page 57
that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to implement their policy to prevent abuse and neglect for 16 of 16 clients residing at the facility (R#'s 1 thru 16) when they failed to:

1. Ensure 1 client (R3) was free from staff abuse when it was determined that staff pinched his nose to get him to open his mouth to eat.
2. Ensure 2 clients are free from neglect (R1 and R5) when nursing failed to complete a physical assessment in a timely manner.
3. Ensure 1 allegation of physical abuse (R3) and 1 allegation of peer to peer abuse (R6 and R7) were immediately reported to the Administrator.
4. Ensure 1 allegation of physical abuse (R3), and 4 allegations of neglect (R1, R4 and R5) were thoroughly investigated.
5. Ensure 16 of 16 clients (R#'s 1 thru 16) were free from further potential abuse when an employee continued to work after an allegation of physical abuse.

Findings include:

The facility's Abuse / Neglect Policy, last revised 2/1/1997, was reviewed. The policy includes the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD** **LOCKPORT, IL 60441**

(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
W9999	Continued From page 58 "Purpose: To protect each person served and keep them free from physical, verbal, sexual, and psychological abuse, exploitation, or punishment. To establish reporting and investigative procedures to ensure all allegations of abuse / neglect are thoroughly investigated. Procedure Implementation: 1. All persons served have the right to be free from physical, verbal, sexual and psychological abuse or punishment. It is the responsibility of all staff members to assure that persons served are free from abuse / neglect and that any occurrence is reported immediately to the proper authorities. 2. When any incidents or possible incidents of abuse or neglect are observed, it is the responsibility of each staff member, no matter what his / her position or responsibility, or if officially or or off duty, to immediately report the incident to his / her supervisor, who in turn will inform the Unit / Program Director / Administrator. 3. The Unit / Program Director / Administrator will notify the Associate Executive Director and the appropriate licensing agent, and the parent / legal representative within 24 hours of the reported alleged incident. 4. All persons involved in the alleged incident will prepare a detailed written report of the incident. 5. The person served will be examined and observed immediately in order to note any observable findings. If any visible sign of injury on the person served is present, pictures of the injury will be taken. 6. The staff member identified as involved in the alleged abuse will be immediately suspended from work with pay until the investigation is completed. ...	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD LOCKPORT, IL 60441**

(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
W9999	Continued From page 59	W9999		

1) R3, per review of his May 2012 POS (Physician's Order Sheet), is a 49 year old male diagnosed with Profound Mental Retardation and Cerebral Palsy. R3, observed on 5/15/12 at 4:10pm is non-ambulatory and essentially non-verbal.

On 5/15/12 at 10:30am E1 (QMRP) told surveyor that the facility was currently investigating an allegation of abuse that was first reported on 5/14/12. On 5/16/12 at 9:55am E1 stated that on Monday 5/14/12 during a training class, E16 (direct care) reported to E8 (Supervisor) that she observed E17 (direct care) pinch R3's nose.

E2 (QMRP) was interviewed on 5/17/12 at 1:30pm. E2 explained that on Monday 5/14/12 she was teaching a DSP (direct support person) class from approximately 9:30am until 1:00pm. The topic was ADL's (Activities of Daily Living) and included the do's and don't when assisting a client with feeding. One of the don't was - do not pinch a client's nose to get them to open their mouth during feeding. At this time E16 got up and left the training. A short time later E16 returned to the training. After the training was complete, E8 (Supervisor) told E2 that E16 reported that she saw E15 (direct care) pinch the nose of R3 during the dinner meal on Sunday 5/13/12. E2 stated the facility investigated the allegation and there is a finding of abuse. E2 stated the facility believes that abuse did occur and it resulted in termination of E15.

The facility's investigation (undated) was reviewed and noted the following:
- E12 (direct care) was interviewed and stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 60	W9999		

that she has seen several staff members pinch R3's nose to get him to eat on several occasions. E12 stated she does not remember specifically who and does not want to wrongly accuse a staff person. The investigation notes that E12 was interviewed a second time and did not identify the staff persons who have previously pinched R3's nose to get him to eat.
- E18 (Food Service Manager) was interviewed and stated that on one occasion he saw an agency staff pinch the nose of a client to get them to eat. E18 reported this occurred several months ago and only occurred one time.
The facility's investigation concluded that E15 was abusive towards R3 and E15's employment was terminated. E12 and E18 stated, per facility investigation, that they observed different staff members pinch the nose of a client(s) and the facility did not determine who these staff were and or what clients were alleged to be abused.

E1 (QMRP) was interviewed on 5/18/12 at 2pm. E1 verified the facility's investigation includes documentation that E12 and E18 identified that the have previously observed abuse (pinching a clients nose to get them to eat). E1 verified the facility's investigation does not identify the staff person(s) alleged to abuse clients and / or the client(s) alleged to have been abused.

The facility was notified on Monday 5/14/12 (between 9:30am and 1:00pm) of an allegation that E15 abused R3 on Sunday 5/13/12. However, E15 was observed providing services to R3 and R7 on Tuesday 5/15/12 at 3:00pm and 3:18pm without any supervision.

E15 was interviewed, with E13 (Supervisor)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 61	W9999		

present, on 5/16/12 at 2:27pm. E15 was asked if she worked on Monday 5/14/12. E15 stated that she worked on 5/14/12 from 2:15pm until 11pm. E15 was asked if she was supervised during this time period. E15 stated that she was not supervised and was not aware of any monitoring of her during this time.
E13 stated that on Monday 5/14/12 she monitored E15 during the evening meal.

E14 (Supervisor) was interviewed on 5/15/12 at 3:15pm. E14 stated that she would be monitoring E15 due to the allegation of abuse. E14 stated that she was told today (5/15/12) to closely supervise E15 when she interacts with clients. At 3:20pm E14 stated that originally she was told by E17 (Administrator) to monitor E15 during dinner only. E14 stated then she spoke to E1 (QMRP) today and was told to closely supervise E15.

E13 stated that on Monday 5/14/12 she monitored E15 during the evening meal. E13 stated that she was told by the Administrator to monitor E15 during the evening meal. E13 stated that today she was told by E1 to closely supervise E15.

The facility was notified on Monday 5/14/12 (between 9:30am and 1pm) of an allegation that E15 abused R3 on Sunday 5/13/12. E1 verified, on 5/16/12 at 9:55am, that the allegation that E15 abused R3, was not immediately reported to the Administrator.

E15 worked on Monday 5/14/12 from 2:15pm until 11pm (with monitoring during the dinner meal). E15 also worked on Tuesday 5/15/12 and was observed to have direct contact with R3 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 62	W9999		

R7 at 3:00pm and 3:18pm without any supervision.

2) R1, per review of his May 2012 POS (Physician's Order Sheet), is a 30 year old male diagnosed with Profound Mental Retardation and Cerebral Palsey.

On 4/24/12 the facility notified IDPH (Illinois Department of Public Health) of a change in R1's condition. The facility noted that on the evening of 4/23/12 R1 "appeared to be in distress." "This was apparent through vocalizations and body posture. Direct care staff called 911 and notified supervisor on duty."
"(R1) has been admitted with fecal impaction."

R1's nursing progress notes were reviewed. E3 (LPN - Licensed Practical Nurse) documented the following: "4/24/12 8A Notified from staff, res (resident) sent out to Hosp. (hospital) @ 11pm 4/23/12, admitted (with) fecal impaction."
E3 documented that R1 was readmitted to the facility on 4/28/12 at 10:00am.

E1 (QMRP) provided a copy of R1's hospital report as well as a copy of the paramedics report. The narrative summary of the paramedics report includes the following: " ... Upon arrival, EMS (Emergency Medical Services) found 30 Y/O (year old) male Pt. (patient) A O (Active and Oriented) to his norm. Laying in bed screaming out. Health care staff states he has been screaming for the last six hours. ... "
A hospital consult report, dated 4/24/12 included the following: R1 was referred because of a fever of 101 and pain. There is a report of fecal impaction. X-Ray of the femur shows left femoral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD LOCKPORT, IL 60441**

(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
W9999	Continued From page 63	W9999		

Continued From page 63

head subluxation.
Orthopedic consultation is recommended, if attending physician agrees, due to left femoral head subluxation.

E1 was interviewed on 5/17/12 a 12:30pm. E1 was asked if there was an investigation regarding;
- R1 being admitted to the hospital and diagnosed with fecal impaction and
- R1 having a left femoral head subluxation and
- R1 screaming for 6 hours prior to the EMS transporting R1 to the hospital.

E1 stated there was no investigation other than a statement that R1 had a normal consistency bowel movement 4 out of the last 5 days.

E2 (QMRP) was interviewed on 5/18/12 at 12:40pm. E2 verified the facility did not complete an investigation regarding R1's hospitalization from 4/24/12 thru 4/28/12.

3) R1, per review of his May 2012 POS (Physician's Order Sheet), is a 30 year old male whose diagnoses include Profound Mental Retardation and Cerebral Palsy.

The facility's Incident Reports and subsequent investigations were reviewed. On 5/3/12 at 1:05pm R1 was noted to be "screaming" and "crying" during a transfer with a mechanical lift at his Day Training program. At 1:15pm R1 was assessed by Z1 (Occupational Therapist) who noted R1's left knee to be swollen and warm to the touch. At 2:30pm R1 was assessed by E3 (LPN - Licensed Practical Nurse). E3 arranged for a transfer to the hospital and R1 was diagnosed with a fractured left tibia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ____ B. WING ____	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD** **LOCKPORT, IL 60441**

(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
W9999	Continued From page 64 E7 (Day Training Supervisor) was interviewed on 5/22/12 at 10:30am. E7 stated that on 5/3/12 at approximately 1:05pm she called E8 (Supervisor) and told her that R1 was screaming and appeared to be in pain. E7 stated that E8 told her that the nurse was at lunch, however, she would tell her. E7 stated that at approximately 1:15pm Z1 (Occupational Therapist) assessed R1. At this time Z1 paged the nurse to come and assess R1. E3 (LPN) then called Z1 and stated she would assess R1 when he returns to his residence (around 2:15pm /2:30pm). Z1 was interviewed on 5/23/12 at 9:50am. Z1 stated that on 5/3/12 he was asked to look at R1's leg/knee because R1 was screaming. Z1 stated that he assessed R1 and observed his left knee to be "significantly swollen." Z1 stated that R1's knee was red and warm to the touch. Z1 stated that R1 had pain upon movement and when touched. Z1 stated that R1 would scream anytime his knee was touched and / or moved. Z1 confirmed that he texted the nurse (E3) on 5/3/12 at approximately 1:15pm. Z1 stated that E3 called him back and told him that R1 would be assessed when he returns home. R1's nursing progress notes were reviewed. On 5/3/12 E3 documented the following "Late entry 2:30pm, Notified from ws (workshop) (left) knee swollen, warm to touch, 2:30pm upon inspection noted (left) knee swollen, light red warm to touch, (left) (lower) left and anterior foot also swollen PPP (positive pedal pulse) (lower) left cool to touch. Supervisor and staff notified to transfer to (hospital) ER (Emergency Room) for evaluation, mom notified, staff getting resident ready for	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD LOCKPORT, IL 60441**

(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
W9999	Continued From page 65	W9999		

transfer."
"3:30pm (G-tube) feeding off res. (resident) to (hospital) per staff for eval (left) knee and (lower) leg."

E8 (Supervisor) was interviewed on 5/22/12 at 11:35am and 11:42am. E8 stated that on 5/3/12 she received a phone call from E7 (Day Training Supervisor) regarding R1 screaming in pain. E8 stated that she told E7 that E3 (nurse) was "on lunch" but she would give her the message. E8 stated she then went into the dining room and told E7 that R1 was screaming in pain and his knee was red and swollen. E8 stated that E3 said, "Ok" but did not go to assess R1.

E3 (nurse) was interviewed on 5/22/12 at 11:40am. E3 verified that on 5/3/12 she was told by E8 (Supervisor) that R1's day training staff called regarding R1. E3 stated that E8 told the day training staff she was at lunch. E3 stated she was told by Z1 that R1's leg was swollen and warm to the touch. E3 verified she did not immediately assess R1 as she was on her lunch break. E3 verified she assessed R1 at approximately 2:30pm (approximately 1 1/2 hours after R1 was reported to be screaming in pain).

E4 (LPN) documented the following on 5/4/12. "5/4/12 8:15am Staff reported resident returned 5/3/12 approx (approximately) 11:00pm (with) (diagnosis) (fracture) (left) tibia present - has (compression) wrap from foot to (upper) (left) thigh with soft cast to (left) (lower) leg, foot swollen as prior, PPP toes warm and pink, resident in bed alert to surroundings. Resident to have follow up with Ortho MD for permanent cast appt. made per QMRP for 5/7/12. No discomfort

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 66 noted to (left) leg at this time. G-tube intact with (feeding) at 60ml (milliliter) per hour. (Head of Bed) (elevated) resident quiet and resting, remaining home from day program to complete G-tube feeding. While he was at (hospital) last (night) and to prevent further injury to (left) leg (temperature) 97.4 completed antibiotics. 11:00AM Resident remained in bed G-tube feeding completed. (Feeding) 1.5 intake 843ml feeding off remains in bed, ice applied to (left) tibia ..." The facility documented an addendum to R1's Incident Report of 5/3/12. The addendum notes that R1 was seen by an orthopaedic doctor on 5/7/12. The physician did not see a fracture for R1, however, R1 was diagnosed with Hemarthrosis. E1 (QMRP) was interviewed on 5/22/12 at 11:45am. E1 stated that she was aware that E8 (Supervisor) told E3 (nurse) that R1 was screaming in pain. E1 stated that E8 told E3 that she should go and assess R1 as he was screaming in pain. E1 stated that E3 told E8 that she was eating her lunch. E1 stated it is not acceptable for the nurse to not assess a client who is screaming in pain. E14 completed an investigation regarding R1's original diagnosis of a fractured left tibia. This investigation is dated 5/5/12. The investigation concludes, "There is no indication of abuse / neglect or mistreatment based on information available." However, the facility's investigation does not address that when R1 screamed in pain on 5/3/12 at 1:05pm, nursing did not assess R1 until	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 67	W9999		

2:30pm.
E8 stated, 5/22/12 at 11:42am, that E3 (nurse) was told that R1 was screaming in pain and his knee was red and swollen. E8 also stated that E3 did not go and assess R1 when she was informed of his condition.
The facility's investigation does not address that the nurse failed to assess R1 when she was notified that he was screaming and had a swollen and inflamed knee.

4) R5, per review of her May 2012 POS (Physician's Order Sheet), is a 56 year old female whose diagnoses include Profound Mental Retardation, Seizure Disorder and Autism.

On 5/15/12 at 10:30am E1 (QMRP) told surveyor that an investigation was in progress as R5 was diagnosed with a fractured arm on 5/14/12.

E1 completed an investigation (undated) and noted that the cause of R5's injury remains unknown. The following information is based on E1's investigation:
R5 was sent to the local hospital on 5/14/12 and was diagnosed with a right ulnar shaft fracture.
Z1 (Occupational Therapist) was interviewed by E1 and stated that around 4:00pm on 5/14/12 he noticed swelling from R5's elbow to her wrist with bruising on her right forearm. Z1 notified E13 (Supervisor) at this time.
E4 (LPN) was interviewed by E1 and stated that she was not notified of R5's injury until 6:00pm on 5/14/12. After E4 was notified of R5's injury of unknown origin, R5 was sent out to the local hospital.
E1 concluded, per the investigation, that R5's injury of unknown origin remains unknown. E1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 68	W9999		

also concluded there is no indication of abuse/neglect or mistreatment based on information available.

E4 (LPN) documented, in nursing progress notes, the following:
"5/14/12 ... 6pm Supervisor reports incident from 5/12/12 Bil (bilateral) knees (with) bruises (right) knee 3 cm (centimeter) green purple bruise (and) (left) knee 3 cm faded green bruise also (right) forearm (with) lateral side (with) 10 cm X 9 cm purple / red bruise. Swelling to site (and) wrist, resident keeps fingers clenched (and) yells out "huh" when checking site - area also warm to touch staff to take to (local) hosp. (hospital) ER (Emergency Room) for eval."
"5/15/12 8:30am Notified from QMRP of (Rt.) ulna fx (fracture), splint and (compression) wrap intact to (right) arm, fingers pink / warm, slightly swollen. Sitting up in (wheelchair) (no) discomfort noted."

E1 (QMRP) was interviewed on 5/22/12 at 10:12am. E1 was asked about the 2 hour delay from when R5's arm was first noted to be bruised and swollen until it was reported to the nurse on duty. E1 did not know why R5's injury of unknown origin was not reported in a timely manner to the nurse on duty.

Z1 (Occupational Therapist) was interviewed on 5/23/12 at 9:50am. Z1 stated that he observed R5 on 5/14/12 at 4:00pm. Z1 stated that he observed that R5's entire right forearm was swollen and bruised (9 to 10cm bruise). Z1 stated that R5 appeared to be in a fair amount of pain. Z1 stated that R5 was protective of her arm. Z1 stated that he told E13 (Supervisor)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD LOCKPORT, IL 60441**

(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
W9999	Continued From page 69	W9999		

about R5's bruised and swollen right forearm.

E13 was interviewed on 5/22/12 at 3:32pm. E13 verified that Z1 told her about R5's injured arm. E13 stated that she then told the nurse (E4). E13 was asked why there was a 2-hour delay from the time R5's injury was first noted until the time that E4 (LPN) was made aware of R5's injury. E13 stated she was not certain as to why there was a 2-hour delay in reporting R5's injury of unknown origin to the nurse.

E1 was interviewed on 5/22/12 at 10:12am. E1 was asked if E13 was interviewed regarding R5's injury of unknown origin. E1 stated that E13 was not interviewed. E1 verified that E13 was the Supervisor on duty and was the Supervisor to whom Z1 reported R5's injury of unknown origin.

5) R4, per review of the facility roster dated 5/15/12, is a 51 year old male whose diagnosis includes Profound Mental Retardation.

On 4/29/12 the facility notified IDPH (Illinois Department of Public Health) of a change in R4's condition. The facility noted: "In the evening and night of 4/28/12 and early morning of 4/29/12 (R4) , a resident of (facility), has been vomiting. ... The transfer took place at 8:15am (4/29/12) ... At approximately 1:00pm, on 4/29/12 (R4) was admitted for observation.... "

R4's nursing progress notes identify that R4 was admitted to the hospital on 4/29/12 and returned to the facility on 5/2/12 at 3:35pm.
E3 (LPN) documented, on 5/2/12 at 3:35pm, that R4 was diagnosed with Duodenitis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD LOCKPORT, IL 60441**

(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
W9999	Continued From page 70	W9999		

R4's nursing progress notes were reviewed. E3 (LPN) documented the following: "4/29/12 7am Sent resident to (hospital). Notified from staff, resident vomited 4/28/12 and during Noc. (night) (and) early this AM - Dr (dark) Brown emesis. Family notified. Supervisor notified."

E1 (QMRP) provided a copy of R4's hospital records, including the ER (Emergency Room) report. The ER report notes R4 arrived at the hospital on 4/29/12 at 09:32am. The ER report includes the following: "Presenting complaint: EMS (Emergency Medical Services) states: called to (facility) nursing home for c/o (complaint of) pt (patient) having vomiting with coffee ground emesis since last noc. (night) unable to ask pt regarding history due to hx (history) of Profound Mental Retardation, pt non-verbal. ... "

E2 (QMRP) was interviewed on 5/18/12 at 12:40pm. E2 was asked if the facility investigated R4's 4/29/12 hospitalization, including the ER report that notes R4 had coffee ground emesis the evening prior to going to the Emergency Room. E2 was also asked if there was a delay in sending R4 to the ER. E2 stated that the facility did not investigate R4's hospitalization of 4/29/12.

6) On 5/18/12 at 9:35am E1 (QMRP) told surveyor that she read a progress note entry today (5/18/12) that notes R6 hit R7 on 5/14/12. E1 stated that she was never informed of this allegation of peer to peer abuse until 5/18/12. E1 stated that E16 (direct care) wrote a progress note entry but did not notify the Administrator of this allegation.

(B)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 71 350.1210 350.1230d)1)2) 350.1420a) 350.1430d) 350.1430e) 350.3220f) 350.3750 Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. Section 350.1420 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 350.1610. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 72 ordered by the licensed prescriber and at the designated time. d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report. Section 350.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) Section 350.3240 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) Section 350.3750 Consultation Services and Nursing Services	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 73	W9999		

Continued From page 73

Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month.

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to ensure nursing needs were met for 5 of 5 clients in the sample (R2, R1, R4, R3 and R5) when the facility failed to:

1. Ensure nursing assessed the health care needs adequately and in a timely manner.

2. Ensure nursing is available to assess pain management and administer pain medication as needed.

3. Ensure medications are given as per physician order.

4. Ensure only licensed personnel monitor G-tube feedings.

5. Ensure that all medication errors are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 74	W9999		

immediately reported to the physician.

Findings include:

1) R2, per review of his May 2012 POS (Physician's Order Sheet), is a 54 year old male diagnosed with Profound Mental Retardation, Cerebral Palsy and Seizure Disorder. R2 was observed on 5/15/12 at 2:30pm in his residence. R2 can verbalize some words and partial sentences. R2 was observed with a cast on his right leg and was seated in his wheelchair.

1a) On 4/2/12 E2 (QMRP) notified IDPH (Illinois Department of Public Health) that R2 was sent to an urgent care center. R2 was noted by E3 (LPN - Licensed Practical Nurse) to have swelling to his feet and R2 complained of pain in his right foot. R2 returned to the facility with a diagnosis of right foot contusion.

When R2 was discharged from the urgent care on 4/1/12 he was given a prescription for the following medication:
"Norco 5 - 325mg (milligram) Oral Tablet, Dispense # 6 (six) tablet, Sig: take 1 tablet by ORAL route every 6 hours As needed Pain Control."

On 4/8/12 E3 (LPN) documented the following in the nurses progress notes: "4/8/12 7am found script from 4/1/12 noc (night) for Norco. Orders noted and faxed to pharmacy."

E3 was interviewed on 5/15/12 at 4:02pm. E3 was asked why she documented that she found R2's order for Norco (pain medication) on 4/8/12 for an order that was written on 4/1/12. E3 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD LOCKPORT, IL 60441**

(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
W9999	Continued From page 75	W9999		

that she found R2's order for Norco on 4/8/12. E3 stated that staff put the prescription in a mail box and nursing was not aware of the order. E3 verified that R2's medication Norco was not available to be given, as ordered, for 7 days. E3 was asked if there is a nurse available to assess R2's pain during the night time and administer PRN (as needed) medication. E3 stated there is no nurse available during the night time. E3 stated that the nurse is scheduled to work from 7am to 7pm. E3 stated that R2's physician was not notified that R2's medication was not given as ordered.

1b) R2's April 2012 POS was reviewed. On 4/8/12 R2's medication Dilantin was changed from 60mg three times a day to 70mg three times a day. E3 (LPN) documented in nursing progress notes, on 4/8/12 at 12:00pm, that R2's physician ordered an increase in R2's Dilantin.

R2's April 2012 MAR was reviewed. On 4/9/12 E4 (LPN) documented that only 60mg was available for R2's Dilantin. On 4/10/12 E3 (LPN) documented that only 60mg of Dilantin was available. Nursing did not document when R2's Dilantin (70mg as ordered) became available.

E2 (QMRP) was interviewed on 5/18/12 at 12:40pm. E2 verified that R2 did not receive his Dilantin as ordered by the physician. E2 also verified that nursing did not notify the physician and/or supervisor that R2 was not receiving his Dilantin as ordered.

1c) On 4/4/12 R2 was seen by his physician for complaint of right foot pain. R2's physician ordered two new medications (Indocin 25mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ____ B. WING ____	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 76 three times a day and Medrol Dose Pack). R2's April 2012 MAR (Medication Administration Record) was reviewed. R2's Indocin was initiated on 4/5/12 at 3:00pm. R2's Medrol Dose Pack was not initiated until 4/6/12 at 7:00am. Both medications were ordered on 4/4/12. E2 was interviewed on 5/18/12 at 12:40pm. E2 verified that R2 did not receive his Indocin and Medrol Dose Pack as ordered by the physician. E2 verified that R2's physician was not notified that R2 did not receive his medications as ordered. 1d) R2's nursing progress notes dated 5/5/12 4:00pm note that R2 was readmitted to the facility after a 6 day hospitalization. R2 was hospitalized with a diagnoses of Pneumonia and Urinary Tract Infection. Upon R2's readmission he was prescribed the following medication Cefuroxime 500mg at 7:00am and 5:00pm. This medication was ordered with a start date of 5/5/12 and a stop date of 5/12/12. Review of R2's May 2012 MAR noted that the Cefuroxime did not start until 5/7/12 at 5:00pm. R2 did not receive any doses of this medication on 5/5/12 and 5/6/12, and only received 1 dose on 5/7/12. E2 was interviewed on 5/18/12 at 12:40pm. E2 verified that R2 did not receive his Cefuroxime as ordered by the physician. E2 also verified that nursing did not notify supervisory personnel that R2 did not receive his Cefuroxime as ordered. E2 also verified that R2's physician was not notified that R2 did not receive his medications as ordered 1e) The facility reported to IDPH (Illinois	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD LOCKPORT, IL 60441**

(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
W9999	Continued From page 77	W9999		

Continued From page 77

Department of Public Health) that on 4/12/12 R2 was sent to an urgent care center due to R2's complaints of pain in his right leg. R2 was diagnosed with a right Distal Tibia Fracture. The investigation notes that on 4/10/12 R2 was en route to his DT (Day Training) program, via his electric wheelchair, when his wheelchair got stuck in a rut. The investigation notes that E3 (LPN) assessed R2 and R2 was experiencing no pain.

R2's nursing progress notes, dated 4/10/12, were reviewed. There is no documentation by E3 that R2 was physically assessed at the time of the incident to ensure R2 did not have an injury.

E3 was interviewed on 5/15/12 at 11:25am. E3 was asked if she assessed R2 after his wheelchair got stuck in a rut on 4/10/12. E3 stated she thought that she assessed R2. E3 verified that she did not document any assessment of R2 on 4/10/12.

E10 (direct care) was interviewed on 5/15/12 at 11:05am. E10 stated that when she left R2's residence she saw that R2's wheelchair was stuck in a ditch/rut. E10 stated she asked two other staff to help her pull R2 and his wheelchair out of the ditch/rut. E10 stated the rear wheels of R2's wheelchair were in the air and the footrests were in the mud.

On 4/12/12 E3 documented the following in the nursing progress notes: "4/12/12 3pm Spoke (with) physical therapist. Concerned about (right) foot and (lower) leg. On call supervisor notified. Resident going out for X-Ray.
5pm (Right) foot 2 (plus) faded yellow bruising to (right) anterior foot. Re-wrapped (with)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD** **LOCKPORT, IL 60441**

(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
W9999	Continued From page 78	W9999		

(compression) wrap. (Complaint of) pain when (right) foot lifted or touched. To (urgent care) per staff for X-Ray.
8pm Returned from (urgent care). Fx. (fracture) Rt. (right) distal tibia, on call supervisor and guardian notified. Splint on Rt. (right) (lower) leg (with) (compression) wrap. Order for Norco faxed to pharmacy. QMRP notified need to F/U (follow up) (with) Ortho Dr. in 1 - 2 days. 9pm Norco given per residents request (up) in w/c (wheelchair) foot (up)."

R2 received an order for the following medication: Norco 5-325mg (milligrams) Oral Tablet, 1 tablet by Oral route every 4 - 6 hours As needed Pain Control.

E3 was interviewed on 5/15/12 at 11:25am. E3 was asked if she gave R2 any pain medication after he was diagnosed with a fractured tibia on 4/12/12. E3 stated that she gave him Norco on 4/12/12 at 9:00pm. E3 was asked if R2 was in pain after 9:00pm. E3 stated there is no nurse available to administer PRN (as needed) pain medication during the night time hours.

On 4/13/12 at 9:15am E4 (LPN) documented that R2 was given Norco for right leg discomfort. E4 documented that R2 was given Norco at 3:30pm for "(right) left discomfort as not to be in pain later evening." E4 documented that Norco was again administered at 7:30pm, "for (right) leg to prevent pain while sleeping."
On 4/14/12 at 9:30am E4 documented that R2 was given Norco to prevent pain.
There is no documentation that R2 was assessed by nursing throughout the evening from 4/13/12 after 7:30pm until 4/14/12 at 9:30am to determine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ____ B. WING ____	C **06/20/2012**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD** **LOCKPORT, IL 60441**

(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
W9999		W9999		

Continued From page 79
R2's need for further pain medication.

2) R1, per review of his May 2012 POS (Physician's Order Sheet), is a 30 year old male diagnosed with Profound Mental Retardation.

2a) On 4/24/12 the facility notified IDPH (Illinois Department of Public Health) of a change in R1's condition. The facility noted that on the evening of 4/23/12 R1 "appeared to be in distress." "This was apparent through vocalizations and body posture. Direct care staff called 911 and notified supervisor on duty."
"(R1) has been admitted with fecal impaction."

R1's nursing progress notes were reviewed. E3 (LPN - Licensed Practical Nurse) documented the following: "4/24/12 8A Notified from staff, res (resident) sent out to Hosp. (hospital) @ 11pm 4/23/12, admitted (with) fecal impaction."
E3 documented that R1 was readmitted to the facility on 4/28/12 at 10:00am.
E3 did not document, on 4/28/12, R1's physician orders regarding medication orders post hospitalization.
On 4/29/12 at 10:30am E3 documented, in nursing progress notes, that she spoke with the attending physician and verified medication orders. E3 also documented the new medication orders were faxed to the pharmacy on 4/29/12 (1 day after R1 returned from the hospital).

R1's hospital discharge instructions and "Discharge Medication List," dated 4/28/12 and timed 0717, were reviewed. The following new medications were ordered:
- Docusate Sodium 100 MG (milligrams) - once a day - next dose due "Today" (4/28/12)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 80	W9999		

- Augmentin 875 MG - twice daily, every 12 hours - next dose due" 9AM Today" (4/28/12)
- Vibramycin 100 MG - every 12 hours - next dose due "9AM Today" (4/28/12)

R1's POS, dated April 2012, was reviewed. E3 documented on 4/29/12 R1's above noted new medication orders. According to the hospital orders these medications were to be given on 4/28/12. E3 did not clarify these medications until 4/29/12.

R1's April 2012 MAR (Medication Administration Record) was reviewed. R1 did not receive his first dose of Docusate until 4/30/12 at 3:00pm. Therefore R1 did not receive his first 2 doses of Docusate.
R1's Augmentin was initiated on 4/29/12 at 7:00am. R1 did not receive 2 doses of his prescribed Augmentin.
R1's Vibramycin was initiated on 4/29/12 at 7:00am. R1 did not receive 2 doses of his prescribed Vibramycin.

E2 was interviewed on 5/18/12 at 12:40pm. E2 verified that R1 did not receive his medications as ordered. E2 also verified that R1's physician was not notified that R1 did not receive his medications as ordered

R1's hospital records, dated 4/24/12 through 4/28/12, were reviewed. There is documentation, from a hospital physician, that R1 has a left femoral head subluxation. An orthopedic consultation is recommended if R1's physician agrees.

E4 (LPN) was interviewed on 5/16/12 regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 81 the documentation that R1 has a left femoral head subluxation. E4 was asked if R1 had an orthopedic consult regarding this diagnosis. E4 stated that she did not know if an orthopedic consult was obtained. E4 stated that she is not responsible for reviewing the hospital information. E1 (QMRP) was interviewed on 5/17/12 at 12:30pm. E1 was asked if the facility expects nursing to review the hospital information that is received when a client returns to the facility. E1 stated the nurse should review the hospital information when a client returns from a hospital visit or admit. 2b) Review of R1's May 2012 POS (Physician's Order Sheet) noted that R1 has the following dietary order: "G-tube Feeding Isosource 1.5 at 60ML / HR (hour) X 18 hours - On 2:30pm, Off 8:30am." On 5/18/12 E1 (QMRP) presented, to surveyor, a copy of the facility's undated "Feeding Pump Operation" information. E1 reviewed this information and identified that unlicensed direct care staff can complete the following: - Turn machine off and on - If machine alert sounds, staff check and clear tubing - Troubleshoot, including disconnecting to remove kinks from the line and make sure that formula is flowing freely. E1 stated that nursing starts R1's feedings. E9 (direct care) was interviewed on 5/16/12 at 3:05pm. E9 was asked if she has any responsibility regarding R1's G-tube feedings during the night time. E9 stated that sometimes	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 82	W9999		

R1's G-tube feeding alarm will sound and she checks to see if something is clogged. E9 stated she will usually just shake the feeding and then the alarm stops. E9 stated this happens approximately once a month. E9 verified there is no nurse on duty during the night (3rd shift).

3) R4, per review of the facility roster dated 5/15/12, is a 51 year old male whose diagnoses include Profound Mental Retardation.

On 4/29/12 the facility notified IDPH (Illinois Department of Public Health) of a change in R4's condition. The facility noted: "In the evening and night of 4/28/12 and early morning of 4/29/12 (R4), a resident of (facility), has been vomiting. ... The transfer took place at 8:15am (4/29/12) ... At approximately 1:00pm, on 4/29/12 (R4) was admitted for observation.... "

R4's nursing progress notes identify that R4 was admitted to the hospital on 4/29/12 and returned to the facility on 5/2/12 at 3:35pm. E3 (LPN) documented, on 5/2/12 at 3:35pm, that R4 was diagnosed with Duodenitis.

E1 (QMRP) provided a copy of R4's hospital records, including the ER (Emergency Room) report. The ER report notes R4 arrived at the hospital on 4/29/12 at 09:32am. The ER report includes the following: "Presenting complaint: EMS (Emergency Medical Services) states: called to (facility) nursing home for c/o (complaint of) pt (patient) having vomiting with coffee ground emesis since last noc. (night) unable to ask pt regarding history due to hx (history) of Profound Mental Retardation, pt non-verbal.... "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 83	W9999		

R4's nursing progress notes were reviewed. E3 (LPN) documented the following: "4/29/12 7am Sent resident to (hospital). Notified from staff, resident vomited 4/28/12 and during Noc. (night) (and) early this AM - Dr (dark) Brown emesis. Family notified. Supervisor notified."
Prior to 4/29/12 the last nursing note is dated 4/24/12 at 5:00pm. There is no nursing note that R4 had vomited on 4/28/12, during the day or during the evening.

E9 (direct care) was interviewed on 5/17/12 at 2:08pm. E9 stated that on 4/28/12 she worked the hours of 8:30am until 8:30pm. E9 stated that R4 had vomited a couple of times. E9 stated that R4 "was miserable, he didn't feel good." E9 was asked if she notified the nurse about R4's condition. E9 stated that she told the nurse (an agency nurse). E9 stated, however, the nurse seemed pre-occupied. E9 stated she believes the nurse may have looked at R4, but she is not sure.

R4's nursing noted were reviewed. There is no documentation, by nursing, that R4 was assessed on 4/28/12.

4) R3, per review of his May 2012 POS (Physician's Order Sheet), is a 49 year old male diagnosed with Profound Mental Retardation and Cerebral Palsy. R3, observed on 5/15/12 at 4:10pm is non-ambulatory and essentially non-verbal.

The facility's Incident Reports were reviewed. On 3/31/12 at 6:27pm R3 was noted with the following injury of unknown origin: " ... staff observed blood to right foot baby toe (with) part of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 84 his toe nail missing." The facility notified IDPH (Illinois Department of Public Health) of R3's injury of unknown origin on 4/1/12. The notification included the following: On 3/31/12 at 6:27pm R3's injury of unknown was reported to the supervisor on duty. R3 was assessed and then transferred to the hospital for evaluation at approximately 7:00pm. R3 returned to the facility at approximately 11:30pm with a diagnosis of Foot Contusion/Foot Abrasion. On 4/1/12, E14 (Supervisor) was notified that R3's X-Ray results noted a "Non - Displaced Fracture to right 5th toe." On 3/31/12 R3 was discharged with a medication order for Bactroban 2/% Topical Ointment. The Bactroban is to be applied to the affected area every 12 hours. E4 (LPN - Licensed Practical Nurse) documented 4/2/12 at 9:30am, in nursing progress notes, R3's order for Bactroban was noted and fax'd to the pharmacy. R3's April 2012 MAR (Medication Administration Record) notes R3's Bactroban was initiated on 4/3/12 at 7:00pm. Review of the nursing progress notes and April 2012 MAR, note that R3's medication Bactroban (ordered on 3/31/12) was not initiated until 7:00pm on 4/3/12. R3 did not receive 5 scheduled doses of this medication. E4 was interviewed on 5/16/12 at 1:50pm. E4 verified that R3's medication order for Bactroban was not initiated until 4/3/12 at 7:00pm. E4	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	16220 PARKER ROAD LOCKPORT, IL 60441

(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
W9999	Continued From page 85	W9999		

Continued From page 85

verified that this medication was ordered on 3/31/12. E4 stated she found the prescription on 4/2/12.

E2 was interviewed on 5/18/12 at 12:40pm. E2 verified that R3's physician was not notified that R3 did not receive his medications as ordered.

E1 (QMRP) was interviewed on 5/16/12 at 9:55am. E1 was asked if the facility had reported any medication errors to the physician during the months of April 2012 and May 2012. E1 stated there were no reports, from nursing, of any medication errors during these 2 months. E1 stated their were no medication errors reported to the physician.

5) R5, per review of her May 2012 POS (Physician's Order Sheet), is a 56 year old female whose diagnoses include Profound Mental Retardation, Seizure Disorder and Autism.

On 5/15/12 at 10:30am E1 (QMRP) told surveyor that an investigation was in progress as R5 was diagnosed with a fractured arm on 5/14/12.

E1 completed an investigation (undated) and noted that the cause of R5's injury remains unknown. The following information is based on E1's investigation:
R5 was sent to the local hospital on 5/14/12 and was diagnosed with a right ulnar shaft fracture.
Z1 (Occupational Therapist) was interviewed by E1 and stated that around 4:00pm on 5/14/12 he noticed swelling from R5's elbow to her wrist with bruising on her right forearm. Z1 notified E13 (Supervisor) at this time.
E4 (LPN) was interviewed by E1 and stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD LOCKPORT, IL 60441**

(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
W9999		W9999		

Continued From page 86
she was not notified of R5's injury until 6:00pm on 5/14/12. After E4 was notified of R5's injury of unknown origin, R5 was sent out to the local hospital.

E4 documented, in nursing progress notes, the following:
"5/14/12 ... 6pm Supervisor reports incident from 5/12/12 Bil (bilateral) knees (with) bruises (right) knee 3 cm (centimeter) green purple bruise (and) (left) knee 3 cm faded green bruise also (right) forearm (with) lateral side (with) 10 cm X 9 cm purple / red bruise. Swelling to site (and) wrist, resident keeps fingers clenched (and) yells out "huh" when checking site - area also warm to touch staff to take to (local) hosp. (hospital) ER (Emergency Room) for eval."
"5/15/12 8:30am Notified from QMRP of (Rt.) ulna fx (fracture), splint and (compression) wrap intact to (right) arm, fingers pink / warm, slightly swollen. Sitting up in (wheelchair) (no) discomfort noted."

R5's Discharge Instructions, dated 5/14/12, from the urgent care center identified, "Tylenol as needed for pain."

R5's nursing notes, dated 5/14/12 thru 5/15/12, were reviewed. There is no documentation by nursing as to when R5 returned to the facility and if nursing assessed R5 for pain and the need for pain management.

E3 (LPN) was interviewed on 5/15/12 at 4:02pm. E3 was asked how she assessed R5 to determine if she is in pain. E3 stated that she cannot tell if R5 is in pain because she is non-verbal. E3 was asked if the nurse assessed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G356	A. BUILDING ______ B. WING ______	C 06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY OAKS WEST	**16220 PARKER ROAD** **LOCKPORT, IL 60441**

(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
W9999	Continued From page 87 R5 when she returned from the urgent care with a diagnosed fractured ulna. E3 stated there is no nurse available to assess and administer pain medication during the night time. The Incident Report, dated 5/12/12, that E4 referenced in the 5/14/12 nursing progress notes was reviewed. The Incident Report notes staff observed a bruise on R5's right and left knee and right forearm top side. The Incident Report notes that the nurse was notified on 5/12/12 at 7:09pm. However, review of R5's nursing notes identified there is no nursing progress note for the date of 5/12/12. There is no documentation that nursing physically assessed R5 after staff observed bruises to R5's knees and right forearm. Nursing assessed R5's 5/12/12 injuries of unknown origin on 5/14/12. (B)	W9999		