STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	14G039		B. WING		C 05/01/2013		
	NAME OF PROVIDER OR SUPPLIER BROTHER JAMES COURT			REET ADDRESS, CITY, STATE, ZIP CODE 2508 ST. JAMES ROAD SPRINGFIELD, IL 62707	1 03/0	J1/2013	
(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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
W 368	the nurse and taker nurse.	ge 17 ng station in the morning by n off each evening by the eay Training Staff) on 4/15/13	W 368				
	at 1:15pm, Z1 state	d that she is unaware that R1 does not attend day training					
	4/22/13 at 1:21pm, wears the elastic typon the unit have been	Direct Care Supervisor) on E4 stated that R 1 rarely on wraps. E4 stated that staff en responsible for wrapping are kept only in the					
	there is no documed January. In the mort wraps were documed	atment Sheet since 1/23/13, ntation for the last 7 days of ath of February the elastic type ented on the 2nd, 3rd, 16th, arch the elastic type wraps mes.					
W9999	nurses are respons physician orders of	2 on 4/15/13 at 2:35, the ible for carrying out the the applying and removing the and documenting on the	W9999				
	LICENSURE VIOL	ATIONS					
	350.620a) 350.620b)6) 350.1210b) 350.1220j) 350.1230b) 350.1230d)2)						

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

NAME OF PROVIDER OR SUPPLIER BROTHER JAMES COURT X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAGS PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W9999 Continued From page 18 W9999 Section 350.3240a) Section 350.620 Resident Care Policies 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. b) These policies shall include: 6) A written statement for resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, polarmaceutical services, dietary services, social services, resident records, dental services, and diagnostic	C / 01/2013
NAME OF PROVIDER OR SUPPLIER BROTHER JAMES COURT X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAGS PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W9999 Continued From page 18 W9999 Section 350.3240a) Section 350.620 Resident Care Policies 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. b) These policies shall include: 6) A written statement for resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, polarmaceutical services, dietary services, social services, resident records, dental services, and diagnostic	70172010
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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. b) These policies shall include: 6) A written statement for resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, resident records, dental services, and diagnostic	
service (including laboratory and x-ray). Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1220 Physician Services	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		14G039	B. WING	i			01/ 2013		
NAME OF PROVIDER OR SUPPLIER BROTHER JAMES COURT				2	EEET ADDRESS, CITY, STATE, ZIP CODE 508 ST. JAMES ROAD PRINGFIELD, IL 62707		.,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
W9999	j) The facility shall rof any accident, injucondition that threat welfare of a resident the presence of inciulcers or a weight to more within a period Section 350.1230 Nb) Residents shall be services, in accordady Direct care personare not limited to, the 2) Basic skills requiand problems of the Section 350.3240 Ab a) An owner, license	notify the resident's physician ary, or change in a resident's tens the health, safety or at, including, but not limited to, pient or manifest decubitus ass or gain of five percent or ad of 30 days. Itursing Services The provided with nursing ance with their needs. The following: The following: The domest the health needs are residents. The provided with nursing ance with their needs. The following: The following: The following is the health needs are residents. The following is the health needs are residents. The following is the health needs are residents.	W99	999					
	Based on interview failed to ensure time medical treatment for the sample with a from the facility fail								
		y has a system in place that I verbal communication							

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	14G039			i		C 05/01/2013		
NAME OF PROVIDER OR SUPPLIER BROTHER JAMES COURT				2	EEET ADDRESS, CITY, STATE, ZIP CODE 508 ST. JAMES ROAD PRINGFIELD, IL 62707	00/	1,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
W9999	between the direct nursing staff with the B. Provide a nursing documents based upon C. Ensure timely for by the physician and change in conditions. D. Ensure appropriates appropriates appropriates appropriates appropriates appropriates appropriates appropriates appropriates appropriates. E. Provide the accordance of the appropriate appropriates and appropriates appropriates. E. Provide the accordance appropriates and appropriate appropriates and appropriate appropriates appropri	care staff and nursing and the physician. g assessment with appropriate upon a change of condition allow up care and assessment deformation and the documents, including gerin condition to physicians are urate information to Direct responsible for taking the visician. (Individual Program Plan) are 75 year old male, verbal, assistance of a wheel walker) are severe range of Intellectual ditional diagnoses of Seizures,	W99	999				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		(X3) DATE SURVEY COMPLETED			
14G039			B. WING			C 05/01/2013		
NAME OF PROVIDER OR SUPPLIER BROTHER JAMES COURT				2	EET ADDRESS, CITY, STATE, ZIP CODE 508 ST. JAMES ROAD PRINGFIELD, IL 62707		.,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
W9999	was hurting and it a informed her super needed to transfer I Interview with E4 (E Supervisor) on 4/22 she was told by E9 problems bearing w down to inform the took several contact came down to the u instructed to place at the right leg. E4 statinstructed to wrap F never received any	as complaining that his leg ppeared to be swollen. E9 visor (E4) that 2-3 people were	W99	999				
	E4 stated that on 3/problems of bearing staff to transfer him nursing station and concerns with R1's nurse on 3/5/13. Th nursing note, that R on 3/5/13. E4 stated the last few days or falls. E4 stated that there of when and what i staff to the nursing system to ensure the care concerns The supervisors on concerns to the Res reports concerns to	25/13, R1 was still having g weight and it took up to 3 at time. E4 went to the informed E3 about the leg. R1 was not seen by the ere is no evidence of a at was assessed by the nurse d she did not witness R1 fall in receive any reports on any a is no documentation written is reported by the direct care department. There is no be nurse responds to the direct the unit are to report sident Service Director, who the Director of Nursing. lack of respect between the						

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	14G039			;		C 05/01/2013		
NAME OF PROVIDER OR SUPPLIER BROTHER JAMES COURT				2	EEET ADDRESS, CITY, STATE, ZIP CODE 508 ST. JAMES ROAD PRINGFIELD, IL 62707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
W9999	Any staff can write is that particular shift iget distributed to the follow up. Per interview with Emorning nurses are the elastic type wra complies). E3 state was having problem to assess him and the evaluated. E3 state discoloration in the There is no evidency treatment sheets the pain or that E3 attended to verify if he was resident having difficult with 3+ edema note (Typed as written). Nursing Note of 183 leg-2+ edema, whe elevated in chair.	-		999				
	nurse contacted him elbow on 3/2/13.	erns for R1's leg when the n about an injury to R1's right						
	in regards to reside	/13 (1315pm), states faxed Dr. nt being unable to bear weight ty, with swelling noted to calf						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER BROTHER JAMES COURT			ı	2	REET ADDRESS, CITY, STATE, ZIP CODE 508 ST. JAMES ROAD PRINGFIELD, IL 62707		.,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE	
W9999	at knee. Requesting tomorrow or x-ray to awaiting on response There is no evidence the fax on 3/3/13. Interview with E8 (E4/15/13 at 2:14pm, instructed to escort E8 continue to say work with R1 on a response the physician utilizing given any specific in the nursing staff regweight to his right le E8 states at the visic his leg but was obsective was not observe type wrap to the right physician office. The physician seem (Urinary Tract Infect leg. E8 stated that we to the physician, she with the physician. Interview with E8, dabout R1's non-weight about R1's non-weight region of the Phys 3/4/12, under the region of the Phys 3/4/12, under the region of the physician of the Phys 3/4/13. The primary to a possible UTI. Z swelling was notice	g to have primary PCP see or rule out any fracture, see. (3/3/13 is a Sunday). See that physician responded to Direct Support Person) on E8 stated that she was R1 to the physician on 3/4/13. That she does not normally egular basis. R1 was taken to no a wheelchair. E8 was not instructions or information from garding R1's inability to bear	W99	999				

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NAME OF PROVIDER OR SUPPLIER BROTHER JAMES COURT				2	EET ADDRESS, CITY, STATE, ZIP CODE 508 ST. JAMES ROAD PRINGFIELD, IL 62707		.,	
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W9999	of pain. Review of the Asse Physician for the 3/-Urinary incontinence culture and sensitive double strength twice push fluid. -Bilateral lower legelevated, monitor. -History of seizures check level. Will alse Profile) and CBC (Odifferential. Instruct any changes. Followsooner if needed. Nursing Note of 3/5 with transfers (Typelevidence that nursing 3/5/13. Interview with E4 (uconfirmed that E3 of 3/3/13. Nursing Note on 3/6 Bactrium DS dx right noted. Resident has extremity. Swollen I blue in color et residerainage or No week rule out medical. av Written) New orders were restudy. Biotech here	ssment and Plan by the	W9	999				

Facility ID: IL6001226

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	14G039		B. WING		C 05/01/2013			
	ROVIDER OR SUPPLIER			25	EET ADDRESS, CITY, STATE, ZIP CODE 508 ST. JAMES ROAD PRINGFIELD, IL 62707			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)			(X5) COMPLETION DATE	
W9999	Per interview with E 4/22/13 at 1:00pm, communication booresponded there is nurses, this is a sur The 24 hour log showith the residents. procedure of what i log. E4 emphasized Nursing Policies or E4 was asked when about a resident rechim and not weight expected by the nurwould expect a hea	E2 (Director of Nursing) on E2 was asked about a bk between the nurses. E4 a 24 hour log between the mmary of the nursing notes. buld include what is going on E4 stated there is no s to be written on the 24 hour d that the facility does not have	W99	999				