		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	0		E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	G			PLETED
		145906	B. WING _				C 1 3/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
DIXON R	EHAB & HCC			800 DIVISION STREET DIXON, IL 61021			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION FIVE ACTION SHOULD CED TO THE APPROP FICIENCY)	BE	(X5) COMPLETION DATE
F9999	FINAL OBSERVAT	IONS	F999	9			
	Licensure Violation	IS:					
	 a) The facility shall procedures governi facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall compl The written policies the facility and shall by this committee, or and dated minutes Section 300.1010 M i) At the time of an a statement of the statement	dvisory physician or the ommittee, and representatives r services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed of the meeting. Medical Care Policies accident or injury, immediate provided by personnel trained					

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		HAND HUMAN SERVICES				FORM	12/30/2013 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		145906	B. WING				C 13/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
DIXON R	EHAB & HCC				00 DIVISION STREET DIXON, IL 61021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From pa	ige 11	F99) 99			
	 a) Every facility shat to make decisions of treatment, including limit life-sustaining establish a policy of of such rights. Including establish a policy of of such rights. Including 4) procedures detail respect to the provi- treatment when a re- reject or limit life-su- resident has failed of opportunity to make 5) procedures for e- indirect care staff in specific provisions of responsible d) Any decision ma- a surrogate pursual Section must be re- medical record. Any 	Life-Sustaining Treatments all respect the residents' right relating to their own medical g the right to accept, reject, or treatment. Every facility shall oncerning the implementation uded within this policy shall be: iling staff's responsibility with ision of life-sustaining esident has chosen to accept, ustaining treatment, or when a or has not yet been given the e these choices; ducating both direct and n the application of those of the policy for which they are de by a resident, an agent, or nt to subsection (c) of this corded in the resident's y subsequent changes or also be recorded in the					
	resident, an agent, subsection (c) of th discriminate in the p basis of such decis accordance with the Attorney for Health Surrogate Act or the	honor all decisions made by a or a surrogate pursuant to is Section and may not provision of health care on the ion or will transfer care in e Living Will Act, the Powers of Care Law, the Health Care e Right of Conscience Act (III. 1. 111 ¹ / ₂ , pars. 5301 et seq.)					

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		I AND HUMAN SERVICES				FORM	12/30/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		145906	B. WING				C 1 3/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
DIXON R	EHAB & HCC				00 DIVISION STREET DIXON, IL 61021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From pa [745 ILCS 70]	ge 12	F99	999			
	of this Section, and physician's order to policy with respect life-sustaining treat such a decision is r	ment shall control until and if nade by the resident, agent, or ance with the requirements of					
	Nursing and Person a) Comprehensive with the participatio resident's guardian applicable, must de comprehensive car includes measurab meet the resident's and psychosocial n resident's compreh allow the resident to provide for discharg restrictive setting baneeds. The assess the active participat resident's guardian	General Requirements for hal Care Resident Care Plan. A facility, n of the resident and the or representative, as evelop and implement a e plan for each resident that le objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which o attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care ment shall be developed with tion of the resident and the or representative, as a 3-202.2a of the Act)					
	and services to atta	provide the necessary care in or maintain the highest I, mental, and psychological					

		HAND HUMAN SERVICES				FORM	12/30/2013 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		145906	B. WING	;			C 13/2013
NAME OF	PROVIDER OR SUPPLIER		-	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
DIXON R	REHAB & HCC				300 DIVISION STREET DIXON, IL 61021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F9999	 well-being of the research resident's complan. Adequate and care and personal of resident to meet the care needs of the research resident to meet the care needs of the research be knowledgeable arespective resident. Section 300.3240 A a) An owner, licens agent of a facility stresident. These requirements Based on interview failed to provide nuccardiopulmonary re7/28/2013, for a resected. The facility factor of 6 other residents The findings include R2 's Physician Trawas admitted to the transfer orders doct status as a full code The facility 's comp Order Sheet) of 7/2 resuscitation order. 	esident, in accordance with mprehensive resident care d properly supervised nursing care shall be provided to each e total nursing and personal esident. -giving staff shall review and about his or her residents' care plan. Abuse and Neglect see, administrator, employee or hall not abuse or neglect a ts are not met as evidenced by: and record review the facility prising services by not initiating esuscitation (CPR) on sident who chose to be a full failed to know the code status is in the facility. e: ansfer order sheet shows R2 e facility on 7/26/2013. The cument R2 ' s resuscitation		9999			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 145906 B. WING 08/13/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 DIVISION STREET **DIXON REHAB & HCC DIXON, IL 61021** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 14 F9999 Directive form giving physician orders for life-sustaining treatment. Nursing Notes (written by E4) of 7/28/2013 documents at 8:30 PM, E2 's respirations were 40 (breaths per minute) and labored, his temperature was 100.6. The notes show Z1 (Nurse Practitioner) and Z2 were notified of R2 's change in condition. The notes document at 9:20 PM the resident 's temperature was 99.2. The next entry in the nurse 's notes was at 10:00 PM. The notes state, "C.N.A. reported mucous at sides of mouth checked at this time expired also assessed by another nurse. (Z1) family notified and coroner called. " On 8/6/2013 at 3:30 PM, E6 (Social Services) said she did the admission paperwork for R2 at 6:30 PM on 7/26/2013. E6 said she asked Z2 (spouse) what R2 's code status was. Z2 said R2 had no Advanced Directives. E6 stated, " ... wife stated he was going to be a full code ...Paperwork was done and passed on to the nurses. They were given a 'heads up' that he was coming and he was a full code. " On 8/6/2013 at 2:30 PM, E4 (Licensed Practical Nurse) said when she came on her shift, on 7/28/2013, she was told R2 's condition had deteriorated. E4 said she did not know R2 's code status. She said she could not find R2 's code status. E4 said CPR was not initiated when R2 was found pulseless. E4 said, " If no DNR (Do not resuscitate) on chart, CPR should have been started. " E4 said she didn ' t find R2 's Full Code status until preparing paperwork for the coroner. On 8/6/2013 at 3:00 PM, E9 (LPN) stated in interview that E4 asked her to come to R2 's room and verify R2 had expired. E9 said, "We always have 2 nurses verify a death. I assumed she checked (R2's) code status. If the code

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		HAND HUMAN SERVICES				FORM	12/30/2013 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		145906	B. WING _				C 13/2013
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	REHAB & HCC				00 DIVISION STREET IXON, IL 61021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	status is not known resident ' s code sta the hard chart. " E vital signs, and she had expired. E9 sa assistance so I resi On 8/7/2013 at 10:2 said during interview from the day shift n condition update. A Z1 that R2 was a fu On 8/7/2013 from 4 - E13 (CNAs) and E Nursing) and E5 (LI found not breathing chart should be imr determine the resid the chart doesn ' t h resident is a full coo On 8/7/2013 the co 81 residents (accor of 8/6/2013) current the 81 residents, 6 12, &13) had conflic Physician orders fo (Uniform Do-Not-Re was not the same a physician orders sh Medication Review The facility ' s Adva policy and procedur to, or upon admissi designee or Admiss resident, and/or fan existence of any ad followed by Social S	a, CPR should be initiated. The atus should be in the front of E9 said R2 did not have any e concurred with E4 that R2 aid, " She (E4) did not ask for umed my duties. " 45 AM, Z1 (nurse practitioner) w that she had received a call nurse on 7/27/2013 with a At that time the nurse informed ull code. 4:15 PM through 4:30 PM, E10 E3 (Assistant Director of PN) all said if a resident is g/pulseless the front of the hard mediately checked to lent ' s code status. E5 said if nave a signed DNR, the de. ode status was reviewed for all rding to the Facility Data Sheet tly residing in the facility. Of of the residents (R7, 8, 10, 11, cting orders where the state or life-sustaining treatment esuscitate Advance Directive) as the resident ' s pharmacy neet or the electronic		99			

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	TH AND HUMAN SERVICES RE & MEDICAID SERVICES				FORM	12/30/2013 APPROVED 0938-0391
TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
	145906	B. WING	;			C 13/2013
ME OF PROVIDER OR SUPPLIE	R		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
XON REHAB & HCC			-	000 DIVISION STREET DIXON, IL 61021		
REFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
such directives be " The facility 's Abu of (5/2013) states mistreatment, neg also includes the including a careta necessary to attai and psychosocial physical harm, me illness.being " as the failure to p 300.610a) 300.1010h) 300.1210d)1)2)3) 300.1220b)2) 300.1610a)1) 300.1630d) 300.3220f) 300.3240a) Section 300.610 F a) The facility sha procedures gover facility. The writte be formulated by Committee consis administrator, the medical advisory of nursing and oth	sility will require that copies of e included in the medical record use, Prevention and Prohibition s, "This facility prohibits glect or abuse of residents. This deprivation by an individual aker, of good or services that are in or maintain physical, mental being, necessary to avoid ental anguish, or mental Neglect is defined in the policy rovide goods and services. (B)	F99	9999			

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		HAND HUMAN SERVICES				FORM	12/30/2013 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		145906	B. WING _				C 13/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
DIXON R	EHAB & HCC				00 DIVISION STREET IXON, IL 61021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F9999	the facility and shal by this committee, of and dated minutes	l be reviewed at least annually documented by written, signed	F99!	99			
	h) The facility shall 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 injury or change in a notification.	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 thin a period of 30 days. The and record the physician's plan or treatment of such accident, condition at the time of					
	treatment shall be p in first aid procedur	General Requirements for					
	care shall include, a and shall be practic seven-day-a-week	basis:					
		luding oral, rectal, hypodermic, ramuscular, shall be properly					

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		HAND HUMAN SERVICES				FORM	12/30/2013 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		145906	B. WING				C 13/2013
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DIXON R	EHAB & HCC				00 DIVISION STREET DIXON, IL 61021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F99999	Continued From pa 2) All treatments an administered as ord 3) Objective observ resident's condition emotional changes determining care re- further medical eva made by nursing st resident's medical r Section 300.1220 S Services b) The DON shall s nursing services of 2) Overseeing the of the residents' need defined conditions a sensory and physic status and requiren discharge potential, potential, rehabilitat and drug therapy. Section 300.1610 M Procedures a) Development of 1) Every facility sha procedures for prop	age 18 ad procedures shall be dered by the physician. vations of changes in a a, including mental and , as a means for analyzing and equired and the need for fluation and treatment shall be taff and recorded in the record. Supervision of Nursing supervise and oversee the the facility, including: comprehensive assessment of s, which include medically and medical functional status, cal impairments, nutritional nents, psychosocial status, dental condition, activities tion potential, cognitive status, Medication Policies and Medication Policies and berly and promptly obtaining,	F99			RIATE	DATE
	disposing of drugs a policies and proced	stering, returning, and and medications. These Jures shall be consistent with rt and shall be followed by the					

Facility ID: IL6005276

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		HAND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 12/30/2013 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT CON	TE SURVEY IPLETED
		145906	B. WING	;			C / 13/2013
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
DIXON R	EHAB & HCC				800 DIVISION STREET DIXON, IL 61021		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F9999		age 19 sies and procedures shall be in I applicable federal, State and	F99	999			
	Section 300.1630 A	Administration of Medication					
	medication order ca prescriber shall be reasonable, depend	n, a licensed prescriber's annot be followed, the licensed notified as soon as is ding upon the situation, and a ne resident's record.					
	Section 300.3220 N	Medical Care					
	administered as ord physician orders sh director of nursing of within 24 hours after	ment and procedures shall be dered by a physician. All new hall be reviewed by the facility's or charge nurse designee er such orders have been hacility compliance with such					
		Abuse and Neglect see, administrator, employee or hall not abuse or neglect a					
	These requirement	ts are not met as evidenced by:					
		and record review the facility is insulin as ordered for a					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 145906 B. WING 08/13/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **800 DIVISION STREET DIXON REHAB & HCC DIXON, IL 61021** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 20 F9999 resident with Diabetes. This failure contributed to a resident 's hyperglycemic state between 7/26/2013 7/28/2013. This applies to 1 of 3 residents (R2) reviewed for medications, in the sample of 13. The finding includes: R2 was admitted to the facility on 7/26/2013, according to the hospital transfer form. His 7/26/2013 Medication Review Report shows R2 ' s diagnoses includes Diabetes. On 8/7/2013 at 10:45 AM, Z1 (Nurse Practitioner) said R2 was admitted to the facility on Friday night (7/26/2013). Z1 said, "I began getting phone calls on him regarding elevated blood sugars. As I see it, (R2) was a sick man. He was discharged from the hospital too early. His blood sugars were all over the board. We couldn't get his blood sugars back under control. " Z1 said his blood sugars were running anywhere from 342 to 586. Z1 said she gave an order to a nurse (uncertain who) to administer 20 units Lantus subcutaneously for hyperglycemia. Z1 said the resident did not receive the insulin on 7/26/2013. Z1 said the nurse told her they did not have Lantus for R2 and cannot borrow from another resident. Z1 said they just kept chasing R2 's blood sugars, after missing his dose on 7/26/2013. We never did get them under control. A 7/26/2013 nurses notes, written by E4 (Licensed Practical Nurse) at 10:00 PM states Insulin Glargine 100u/ml (Lantus), inject 20 units subcutaneously at bedtime for prophylaxis. Waiting on supply. The medication administration record documents R2 did not receive any insulin until 10:19 AM on 7/27/2013. Nursing Notes (written by E4) of 7/28/2013 documents at 8:30 PM, E2 's respirations were 40 (breaths per minute) and labored, his temperature was 100.6. The notes show Z1

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		I AND HUMAN SERVICES				FORM	12/30/2013 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		145906	B. WING				C 13/2013
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	REHAB & HCC			-	00 DIVISION STREET DIXON, IL 61021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F9999	(Nurse Practitioner) change in condition PM the resident ' s next entry in the nu The notes state, " (sides of mouth che assessed by anothe and coroner called. On 8/7/2013 at 3:00 said the pharmacy ' gotten 24 hours a d local pharmacy ava medication. E2 was pharmacy emergen a copy of the label of facility did have 1 vi resident use. The facility ' s Medi Medication (1/1/13) facility has an inade administer, facility s initiate action to obt pharmacyIf the n delay or a missed of medication schedul) and Z2 were notified of R2's i. The notes document at 9:20 temperature was 99.2. The rse's notes was at 10:00 PM. C.N.A. reported mucous at cked at this time expired also er nurse. (Z1) family notified	F99	99			

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