STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145906	B. WING			08/1	C 13/2013
	PROVIDER OR SUPPLIER			80	TREET ADDRESS, CITY, STATE, ZIP CODE DO DIVISION STREET IXON, IL 61021	007	10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	FINAL OBSERVAT		F99	99			
	a) The facility shall procedures governi facility. The written be formulated by a Committee consisti						
	medical advisory co of nursing and othe policies shall compl The written policies the facility and shal	dvisory physician or the ommittee, and representatives or 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.					
	Section 300.1010 N	Medical Care Policies					
		accident or injury, immediate provided by personnel trained es.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		145906	B. WING				C 13/2013
	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE 800 DIVISION STREET DIXON, IL 61021		13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 11	F99	99			
	a) Every facility sha to make decisions of treatment, including limit life-sustaining to establish a policy co of such rights. Inclu 4) procedures detail respect to the provist treatment when a reflect or limit life-suresident has failed copportunity to make 5) procedures for exindirect care staff in specific provisions of responsible	ducating both direct and the application of those of the policy for which they are					
	a surrogate pursual Section must be red medical record. Any	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 thi discriminate in the plass of such decisi 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 111½, pars. 5301 et seq.)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		145906	B. WING		00	C / 13/2013		
	PROVIDER OR SUPPLIER	1.0000		STREET ADDRESS, CITY, STATE, ZIP CODE 800 DIVISION STREET DIXON, IL 61021		/13/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE		
F9999	Continued From pa [745 ILCS 70]	age 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 made by the resident, agent, or dance with the requirements of						
	Nursing and Person a) Comprehensive with the participation resident's guardian applicable, must decomprehensive car includes measurab meet the resident's and psychosocial in resident's comprehallow the resident to practicable level of provide for discharg restrictive setting beneds. The assess the active participar resident's guardian	General Requirements for nal Care Resident Care Plan. A facility, on of the resident and the or representative, as evelop and implement a re plan for each resident that ale objectives and timetables to a medical, nursing, and mental redeast that are identified in the rensive assessment, which or attain or maintain the highest independent functioning, and ge planning to the least assed on the resident's care ment shall be developed with tion of the resident and the or representative, as in 3-202.2a of the Act)						
	and services to atta	provide the necessary care ain or maintain the highest II, mental, and psychological						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145906	B. WING			C 08/13/2013		
	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE 800 DIVISION STREET DIXON, IL 61021	<u> </u>	13/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F9999	each resident's cor plan. Adequate and care and personal	esident, in accordance with imprehensive resident care diproperly supervised nursing care shall be provided to each e total nursing and personal	F99	99				
		-giving staff shall review and about his or her residents' care plan.						
	Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.							
	These requirement	ts are not met as evidenced by:						
	failed to provide nu cardiopulmonary re 7/28/2013, for a res	and record review the facility arsing services by not initiating esuscitation (CPR) on sident who chose to be a full failed to know the code status in the facility.						
	was admitted to the transfer orders doo status as a full cod. The facility 's comporter Sheet) of 7/2 resuscitation order.	ansfer order sheet shows R2 e facility on 7/26/2013. The cument R2 's resuscitation						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		145906	B. WING		30	C 3/ 13/2013	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 800 DIVISION STREET DIXON, IL 61021		713/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F9999	life-sustaining treating Nursing Notes (writt documents at 8:30 40 (breaths per mintemperature was 10 (Nurse Practitioner) change in condition PM the resident 's next entry in the nurthe notes state, "or sides of mouth cheassessed by another and coroner called. On 8/6/2013 at 3:30 said she did the add 6:30 PM on 7/26/20 (spouse) what R2 's had no Advanced Estated he was going Paperwork was denurses. They were was coming and he On 8/6/2013 at 2:30 Nurse) said when s 7/28/2013, she was deteriorated. E4 sa code status. She sa code status. E4 sa R2 was found pulse (Do not resuscitate) been started. "E4 Code status until procoroner. On 8/6/2013 at 3:00 interview that E4 as room and verify R2 always have 2 nurs	g physician orders forment. ten by E4) of 7/28/2013 PM, E2's respirations were tute) and labored, his 0.6. The notes show Z1 and Z2 were notified of R2's . 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 " 0 PM, E6 (Social Services) mission paperwork for R2 at 113. E6 said she asked Z2 s code status was. Z2 said R2 pirectives. E6 stated, "wife g to be a full code one and passed on to the given a 'heads up' that he	F99	99			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED		
		145906	B. WING			C 08/13/2013		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 800 DIVISION STREET DIXON, IL 61021	DE	00/10/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE			
F9999	resident's code stathe hard chart." Evital signs, and she had expired. E9 sa assistance so I resured on 8/7/2013 at 10:4 said during interview from the day shift not condition update. A Z1 that R2 was a furth on 8/7/2013 from 4 - E13 (CNAs) and EN ursing) and E5 (LI found not breathing chart should be immore determine the resident is a full coord on 8/7/2013 the coord 8/6/2013) current the 81 residents (accord 8/6/2013) current the 81 residents, 6 (12, &13) had conflice Physician orders for (Uniform Do-Not-Rewas not the same a physician orders she Medication Review The facility's Advarage or Admission or upon admission designee or Admission resident, and/or fame existence of any adfollowed by Social Stresident indicate the	CPR should be initiated. The atus should be in the front of 9 said R2 did not have any concurred with E4 that R2 id, "She (E4) did not ask for amed my duties." 5 AM, Z1 (nurse practitioner) with that she had received a call arse on 7/27/2013 with a stat that time the nurse informed II code. 15 PM through 4:30 PM, E10 is (Assistant Director of PN) all said if a resident is (Pulseless the front of the hard mediately checked to ent's code status. E5 said if ave a signed DNR, the le. de status was reviewed for all ding to the Facility Data Sheet thy residing in the facility. Of of the residents (R7, 8, 10, 11, cting orders where the state of life-sustaining treatment esuscitate Advance Directive) is the resident's pharmacy eet or the electronic	F99	99				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED		
		145906	B. WING			C / 13/2013		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 800 DIVISION STREET DIXON, IL 61021		710/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F9999	such directives be i " The facility 's Abus of (5/2013) states, mistreatment, negle also includes the de including a caretak necessary to attain and psychosocial be physical harm, mer illness.being " N	ty will require that copies of included in the medical record se, Prevention and Prohibition. This facility prohibits ect or abuse of residents. This eprivation by an individual er, of good or services that are or maintain physical, mental eing, necessary to avoid intal anguish, or mental seglect is defined in the policy evide goods and services. (B)	F99	99				
	a) The facility shall procedures govern facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall comp	esident Care Policies have written policies and ing all services provided by the policies and procedures shall Resident Care Policy ing of at least the idvisory physician or the parmittee, and representatives ar services in the facility. The ly with the Act and this Part. a shall be followed in operating						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145906	B. WING			C 08/13/2013	
	PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE 00 DIVISION STREET DIXON, IL 61021	00/	10/2313
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999		be reviewed at least annually documented by written, signed	F99	99			
	Section 300.1010 N	ledical Care Policies					
	of any accident, injuresident's condition safety or welfare of limited to, the prese decubitus ulcers or percent or more wit facility shall obtain a of care for the care	notify the resident's physician ary, or significant change in a that threatens the health, a resident, including, but not ence of incipient or manifest a weight loss or gain of five hin a period of 30 days. The and record the physician's plan or treatment of such accident, condition at the time of					
		accident or injury, immediate provided by personnel trained es					
	Section 300.1210 G Nursing and Persor	Seneral Requirements for nal Care					
		*					
		uding oral, rectal, hypodermic, ramuscular, shall be properly					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CON	COMPLETED			
		145906	B. WING				C 13/2013
	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE VISION STREET I, IL 61021	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F9999	administered as ord 3) Objective observes resident's condition emotional changes determining care refurther medical evaluate by nursing stresident's medical examples of the properties of the residents' need defined conditions sensory and physic status and required discharge potential potential, rehabilitation and drug therapy.	nd procedures shall be dered by the physician. vations of changes in a in including mental and in including mental and in including and equired and the need for including and treatment shall be aff and recorded in the	F99	999			
	Procedures a) Development of 1) Every facility sha procedures for prop dispensing, adminis disposing of drugs policies and procedures	Medication Policies All adopt written policies and Derly and promptly obtaining, Stering, returning, and and medications. These Alures shall be consistent with Art and shall be followed by the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145906	B. WING				C 13/ 2013
	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE 800 DIVISION STREET DIXON, IL 61021	00/	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999		ge 19 ies and procedures shall be in applicable federal, State and	F99	999			
	Section 300.1630 A	Administration of Medication					
	medication order ca prescriber shall be	n, a licensed prescriber's annot be followed, the licensed notified as soon as is ding upon the situation, and a e resident's record.					
	Section 300.3220 N	Medical Care					
	administered as ord physician orders sh director of nursing of within 24 hours after	nent and procedures shall be dered by a physician. All new hall be reviewed by the facility's or charge nurse designee or such orders have been cility compliance with such					
		Abuse and Neglect ee, administrator, employee or nall not abuse or neglect a					
	These requirement	s are not met as evidenced by:					
		and record review the facility s insulin as ordered for a					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED			
		145906	B. WING				C 13/2013
	PROVIDER OR SUPPLIER			800	REET ADDRESS, CITY, STATE, ZIP CODE DIVISION STREET (ON, IL 61021	<u> 00/</u>	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	resident with Diabe a resident 's hypery 7/26/2013 7/28/201 This applies to 1 of medications, in the The finding include: R2 was admitted to according to the ho 7/26/2013 Medicatis diagnoses include On 8/7/2013 at 10:4) said R2 was adminight (7/26/2013). In phone calls on him sugars. As I see it, discharged from the sugars were all overhis blood sugars were all overhis blood sugars was 342 to 586. Z1 said (uncertain who) to a subcutaneously for resident did not rec Z1 said the nurse to Lantus for R2 and cresident. Z1 said the blood sugars, after 7/26/2013. We never A 7/26/2013. We never A 7/26/2013 nurses (Licensed Practical Insulin Glargine 100 subcutaneously at Waiting on supply. administration recorreceive any insulin Nursing Notes (writt documents at 8:30 40 (breaths per miner supplements).	tes. This failure contributed to glycemic state between 3. 3 residents (R2) reviewed for sample of 13. 5: 1 the facility on 7/26/2013, spital transfer form. His on Review Report shows R2 'es Diabetes. 15 AM, Z1 (Nurse Practitioner tted to the facility on Friday Z1 said, "I began getting regarding elevated blood (R2) was a sick man. He was a hospital too early. His blood r the board. We couldn't get ick under control. " Z1 said ere running anywhere from a she gave an order to a nurse administer 20 units Lantus hyperglycemia. Z1 said the eive the insulin on 7/26/2013. Old her they did not have cannot borrow from another ney just kept chasing R2's missing his dose on are did get them under control. In notes, written by E4 Nurse) at 10:00 PM states ou/ml (Lantus), inject 20 units bedtime for prophylaxis.	F99	999			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION DING		COMPLETED		
		145906	B. WING				C 1 3/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 800 DIVISION STREET DIXON, IL 61021	CODE	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
F9999	change in condition PM the resident 's next entry in the nu The notes state, "or sides of mouth che assessed by another and coroner called. On 8/7/2013 at 3:00 said the pharmacy gotten 24 hours a docal pharmacy avant medication. E2 was pharmacy emergen a copy of the label of facility did have 1 viresident use. The facility 's Medication (1/1/13) facility has an inade administer, facility sinitiate action to obto pharmacyIf the nodelay or a missed of medication schedule.	and Z2 were notified of R2 's . 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	999			