PRINTED: 06/07/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145765	B. WING				C <b>01/2016</b>
	ROVIDER OR SUPPLIER W REHAB CENTER			5888	EET ADDRESS, CITY, STATE, ZIP CODE B NORTH RIDGE CAGO, IL 60660		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	Complaint Investigati	on					
F 157 SS=D	consult with the reside known, notify the residence or an interested family accident involving the injury and has the pot intervention; a signification of physical, mental, or produced the deterioration in health status in either life three clinical complications significantly (i.e., a new existing form of treatment); or a decist the resident from the §483.12(a).	iately inform the resident; ent's physician; and if dent's legal representative y member when there is an resident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a land), mental, or psychosocial seatening conditions or (i); a need to alter treatment the detect of the description of the descriptio	F	157			
	or interested family m change in room or roo specified in §483.15( resident rights under regulations as specified this section.  The facility must reco	ident's legal representative ember when there is a sommate assignment as e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of end and periodically update the number of the resident's in interested family member.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: IL6002315

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		145765	B. WING _			C <b>06/01/2016</b>	
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5888 NORTH RIDGE CHICAGO, IL 60660		00/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		SHOULD BE	(X5) COMPLETION DATE	
	by: Based on interview a failed to ensure that the an anticonvulsant me administered. This appears three residents (R1) in a sample of three.  Findings include:  According to R1's fact the facility on 1/11/20 diagnosis not limited to the facility on 1/11/20 diagnosis not limited	is not met as evidenced  and record review, the facility the physician was notified of dication that was not oplies to one resident out of eviewed for resident rights  esheet, R1 was admitted to 16 with the following to: other seizures.  an, R1 stated he did not edication, Keppra e following evenings: 4/15,  and 5/21. E2 stated she e) who said that she did not ecause R1 was sleeping. Aid that reads in part: E3] that worked the dates the informed writer that at's why he did not get his atticked.	F	157			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		145765	B. WING _			C 06/01/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5888 NORTH RIDGE CHICAGO, IL 60660	<b>'</b>	00/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 157		Report reads in part: Order	F 1	57			
		1/2016: Levetiracetam tablet Give 2 tablet by mouth every s.					
	administered levetira dates: 5/18/2016 at	/ 2016 reads in part that E3 cetam to R1 on the following 2100 (9PM) and 5/21/2016 6/1/2016 at 11:14am, E3 e didn't give [R1's]					
	medication when he doesn't know why it's didn't tell the doctor.	was sleeping and she s not documented and she E3 could not recall the date my times this happened.					
	Keppra twice a day. drawn before being a and the level was state aware of any missed stated that of course and if he was notified nurses to encourage						
	R1's summary order order: 5/26/2016 - K	report revealed in part a new eppra level					
		t reads in part: final reported .8 L (low), Reference Range- crogram/milliliter)					
	2/14 reads in part: If	ne licensed nurse will: d.					

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		145765	B. WING			C 06/01/2016
	ROVIDER OR SUPPLIER W REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5888 NORTH RIDGE CHICAGO, IL 60660	,	00/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157	Continued From pag	ge 3	F 15	7		
F 281 SS=D	This policy was not the 483.20(k)(3)(i) SERV PROFESSIONAL ST	VICES PROVIDED MEET	F 28	1		
		ed or arranged by the facility nal standards of quality.				
	by: Based on interview failed to ensure a re administered as orde	T is not met as evidenced and record review the facility sident's medication was ered by the physician for one at) reviewed for medications				
	Findings include:					
		cesheet, R1 was admitted to 016 with the following I to: other seizures.				
	did not receive his s (levetiracetam) on the 4/27, 5/18, 5/21. R1 with the nurse [E3/R give him his medical On 6/1/2016 at 9:04 stated on 5/23, she	am, R1 stated in part that he eizure medication, Keppra ne following evenings: 4/15, stated that he had to argue registered Nurse] on 4/15 to tion but the nurse wouldn't.  am, E2 (Director of Nursing) was notified that [R1] did not				
	she interviewed E3 ( not give the medicat sleeping. E2 presented a form Form" dated 5/23/16	n 5/18 and 5/21. E2 stated (nurse) who said that she did ion because R1 was a titled, "Concern/Compliment of that reads in part: [E3] that worked the dates				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		145765	B. WING		C 06/01/2016	
	ROVIDER OR SUPPLIER W REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  5888 NORTH RIDGE  CHICAGO, IL 60660	1 00/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 281	resident was sleep medication." E2 fur documented she ga didn't and should ha (medication adminis document the reasonote.  R1's MAR dated Ma administered levetir dates: 5/18/2016 a at 2100 (9PM). On stated in part that si when he was sleep it's not documented E3 could not recall many times this hap On 6/1/2016 at 4:34 R1 was not given mand May. Z3 stated acknowledged that medication and E3 happened the first that May when it happened that medication for seizure R1's Order Summa and Start date - 01/500mg (milligrams) 12 hours for seizure R1's care plan date Focus- Resident is (related to) a diagnor	that's why he did not get his ther stated that E3 are the medication when she are charted on the MAR stration record) as "other" and ons not given on a progress as 2016 reads: E3 accetam to R1 on the following to 2100 (9PM) and 5/21/2016 6/1/2016 at 11:14am, E3 the didn't give R1's medication ing and she doesn't know why and she didn't tell the doctor. The date of when and how opened.  Type, Z3 (Ombudsman) stated the facility told her that they an urse [E3] did not give R1's the facility told her that they are around and suspended in the dagain.  Ty Report reads in part: Order 11/2016: Levetiracetam tablet Give 2 tablet by mouth every est.  d 03/23/2016 reads in part: at risk for seizure activity R/T oses of seizure disorder.	F 28	31		
	with medication thro	izure activity will be controlled bugh next review. nister medication as directed eutical recommendations.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		145765	B. WING _			C 06/01/2016	
	ROVIDER OR SUPPLIER W REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5888 NORTH RIDGE CHICAGO, IL 60660		00/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 281	Keppra twice a day. drawn before being and the level was stated that of course and if he was notified nurses to encourage symptoms and maybe extra dose to give.  R1's summary order order: 5/26/2016 - ke R1's laboratory repoo 5/30/2016, Results 9 10.0-40.0 ug/mL (mi)  The facility's policy a "Medication Pass: Fedated 4/14 reads in administered in accorder. 9. a. Adminis with frequency preson This policy was not fed 483.25 PROVIDE County HIGHEST WELL BE  Each resident must provide the necessal or maintain the higher	6pm, Z1 (Attending I is compliant with story of seizures and takes [R1] had a Keppra level admitted to the nursing home able. Z1 stated he was not it doses of Keppra for R1. Z1 is he would want to be aware id, he would have told the emonitoring for signs and is he would have ordered an experience in part a new Keppra level and procedure titled, process and Procedure in part: Medication will be ordance with a physician's ster medication in accordance cribed by physician followed.  ARE/SERVICES FOR ING	F2				
	provide the necessa or maintain the high mental, and psychos	ry care and services to attain est practicable physical,					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		1.45765	B. WING			l	C
		145765	B. WING			06/	01/2016
	ROVIDER OR SUPPLIER W REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5888 NORTH RIDGE CHICAGO, IL 60660		
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	Continued From page	e 6	F	309			
	by: Based on interview a failed admistered a re medication (levetirace seizures, as ordered I failure affected one of reviewed for physicial three.  Findings include:  According to R1's fact the facility on 1/11/20 diagnosis not limited I According to R1's MD dated 2/25/2016 read Mental Status) = 15/1  On 5/26/2016 at 10ar did not receive his sei (levetiracetam) on the 4/27, 5/18, and 5/21. argue with the nurse I 4/15 to give him his m wouldn't. On 6/1/201 when he misses his e next morning he feels stated he starts to hav which are symptoms seizure. Once he get about two hours to kid relieve his symptoms.  On 6/1/2016 at 9:04a stated on 5/23, she w	esheet, R1 was admitted to 16 with the following to: other seizures. S (Minimum Data Set) s: BIMS (Brief Interview for 5, cognitively intact.  In, R1 stated in part that he fizure medication, Keppra e following evenings: 4/15, R1 stated that he had to (E3, Registered Nurse) on medication but the nurse 6 at 8:47am, R1 stated that evening dose of Keppra, the e that he is in withdrawal. R1 we tremors and feel dizzy, the feels before getting a s his morning dose, it takes ck in his system and to					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SUR' COMPLETE			
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	ROVIDER OR SUPPLIER W REHAB CENTER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE  5888 NORTH RIDGE  CHICAGO, IL 60660	1 00/01/2	.010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE CC	(X5) MPLETION DATE
F 309	not give the medicat sleeping. E2 presented a form Form" dated 5/23/16 "Identified the nurse [5/18 and 5/21]. Nur resident was sleep the medication." E2 furt she gave the medication record the reasons not give R1's MAR dated Maradministration record the reasons not give R1's MAR dated Maradministered levetiral dates: 5/18/2016 at at 2100 (9PM). On stated in part that showhen he was sleeping it's not documented E3 could not recall the many times this happed R1's Order Summary Start date - 01/11/20 500mg (milligrams) (12 hours for seizures) R1's care plan dated Focus- Resident is a (related to) a diagnor Goal- Residents' seizuith medication throughten for seizures. On 5/26/2016 at 4:44	titled, "Concern/Compliment that reads in part: [E3] that worked the dates rese informed writer that hat's why he did not get his her stated E3 documented ation when she didn't and on the MAR (medication d) as "other" and document in on a progress note.  19 2016 reads in part E3 rectam to R1 on the following 2100 (9PM) and 5/21/2016 reads in part E3 rectam to R1 on the following 2100 (9PM) and 5/21/2016 reads in part E3 redidn't give R1's medication in g and she doesn't know why and she didn't tell the doctor. The date of when and how pened.  10 Report reads: Order and 16: Levetiracetam tablet recommend in a cativity R/T reses of seizure activity R/T reses of seizure disorder. The sees of seizure disorder. The sees of seizure disorder recommendations recommendations.	F 30	09		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145765	B. WING				01/2016
	ROVIDER OR SUPPLIER W REHAB CENTER	1.0.00		STI 588	REET ADDRESS, CITY, STATE, ZIP CODE  88 NORTH RIDGE	<u> </u>	01/2016
				CH	HICAGO, IL 60660		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	a Keppra level drawn the nursing home and stated he was not aw Keppra for [R1]. Z1 swould want to be awawould have told the nmonitoring for signs a he would have ordered R1's summary order order: 5/26/2016 - Ke R1's laboratory report 5/30/2016, Results 9. 10.0-40.0 ug/mL (mic The facility's policy ar "Medication Pass: Pr dated 4/14 reads in padministered in accorder. 9. a. Administ with frequency prescr This policy was not for 483.75(I)(1) RES RECORDS-COMPLE LE  The facility must mair resident in accordance standards and practic accurately documents systematically organization to identify	eppra twice a day. [R1] had before being admitted to a the level was stable. Z1 are of any missed doses of stated that of course he are and if he was notified, he urses to encourage and symptoms and maybe and an extra dose to give.  Teport revealed in part a new eppra level  A reads in part: final reported 8 L (low), Reference Rangerogram/milliliter)  and procedure titled, rocess and Procedure" art: Medication will be dance with a physician's ter medication in accordance ibed by physician elibowed.  ETE/ACCURATE/ACCESSIB  Attain clinical records on each the with accepted professional test that are complete; and; readily accessible; and zeed.  Last contain sufficient to the resident; a record of the last; the plan of care and		514			

	TATEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED C			
		145765	B. WING		06/01/20	116
	ROVIDER OR SUPPLIER W REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  5888 NORTH RIDGE  CHICAGO, IL 60660	1 00/01/20	,10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COM	(X5) IPLETION DATE
F 514	and progress notes.  This REQUIREMEN by: Based on interview failed to accurately or given for one out of for medications in a  Findings include: On 5/26/2016 at 10a did not receive his so (levetiracetam) on the 4/27, 5/18, 5/21.  On 6/1/2016 at 9:04 stated on 5/23, she so get his medication on she interviewed E3 (19).	T is not met as evidenced and record review, the facility document medications not three residents (R1) reviewed	F 5'	,		
	Form" dated 5/23/16 "Identified the nurse [5/18 and 5/21]. Nur resident was sleep t medication." E2 furt she gave the medica should have charted administration record the reasons not give  R1's MAR dated Ma administered levetira dates: 5/18/2016 at	a titled, "Concern/Compliment of that reads in part: [E3] that worked the dates ree informed writer that that's why he did not get his ther stated E3 documented ation when she didn't and on the MAR (medication d) as "other" and document en on a progress note.  by 2016 reads in part that E3 acetam to R1 on the following 2100 (9PM) and 5/21/2016 6/1/2016 at 11:14am, E3				

	TEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		(X:	(X3) DATE SURVEY COMPLETED		
		145765	B. WING _			C
	ROVIDER OR SUPPLIER W REHAB CENTER	140700		STREET ADDRESS, CITY, STATE, ZIP COI 5888 NORTH RIDGE CHICAGO, IL 60660	DE	06/01/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 514	stated in part that she medication when he doesn't know why it's didn't tell the doctor. of when and how ma  The facility's policy tit 2/14 reads in part: 1 professional shall be own prompt, factual, appropriate, and legil f a medication is not licensed nurse will:  a. Enter initials in methe medication, b. Circle initials indic was not given, c. Provide written rat	e didn't give [R1's] was sleeping and she a not documented and she E3 could not recall the date ny times this happened.  Itled, "Documentation" dated . Each health care responsible for making their concise, complete, ble entries. administered, then the edication, space allocated for eating that the medication tionale regarding why the given or refused in the he MAR an when indicated	F	514		