							APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		14E361	B. WING			06/2	25/2015
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ASPEN F	REHAB & HEALTH C	ARE			03 9TH AVENUE LVIS, IL 61282		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	00			
F 155 SS=D	Annual Certification 483.10(b)(4) RIGH ADVANCE DIRECT	T TO REFUSE; FORMULATE	F 1	55			
	refuse to participate and to formulate an	e right to refuse treatment, to e in experimental research, a advance directive as aph (8) of this section.					
	specified in subpart related to maintaini procedures regardin requirements includ provide written infor concerning the righ or surgical treatmen option, formulate an includes a written d	mply with the requirements t I of part 489 of this chapter ng written policies and ng advance directives. These de provisions to inform and rmation to all adult residents t to accept or refuse medical nt and, at the individual's n advance directive. This escription of the facility's nt advance directives and v.					
	by: Based on record re failed to formulate a incorporate advanc care for one of 12	NT is not met as evidenced eview and interview, the facility advance directives and e directives into the plan of residents (R10) reviewed for in the sample of 12.					
		Advance Directive" dated					
LABORATOR	L Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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.

DEDADTMENT OF LIFALTLLAND LILINAAN CEDVICES

		AND HUMAN SERVICES			FORM): 06/29/2015 // APPROVED). 0938-0391	
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		14E361	B. WING _		06	/25/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ē		
ASPEN F	REHAB & HEALTH C	ARE		1403 9TH AVENUE SILVIS, IL 61282			
(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 CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 155	(revised 11/09/13) of admission each rest Attorney), guardian given written inform and advance direct resident/responsible furnish this facility v advance directives. facility, the Social S Administrator or de meet with the reside advance directives. of provided docume resident/responsible sent for appropriate made by the reside chart in the manner Code status shall a resident's Physician R10's facility form, documents that R11 on 02/23/15. This s "Advance Directives R10's medical reco state "Uniform Do N Form" under the "A R10's current Care the following "Probl Psychotropic Drugs Living) Rehab (Reh Medical Conditions Nutrition. R10's current Physic	directs staff, "At the time of sident, POA (Power of or responsible party shall be nation regarding resident rights ive. At this time, each e party will be requested to with copies of all existing . The day of admission to this Service Designee, signee at admission shall ent/responsible party to review . After confirming the accuracy ents with the e party, the document will be e signatures. Any decision int shall be indicated in the r easily understood by all staff. .lso be recorded on the n Order Sheet." "Profile Face Sheet" 0 was admitted to the facility ame form is blank under the s" tab, "Resuscitate". rd does not include a required Not Resuscitate (DNR) Order dvance Directives" tab. Plan, dated 03/12/15, includes ems": Cognition Loss, s, ADL (Activities of Daily habilitation), Continence, Falls, , Pressure Ulcers and ician's Order Sheet, dated t include a physician's order	F 15	55			

If continuation sheet Page 2 of 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES							APPROVED
	<u>SFOR MEDICARE</u> OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP			. 0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		14E361	B. WING			06/	25/2015
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ASPEN F	REHAB & HEALTH C	ARE			1403 9TH AVENUE SILVIS, IL 61282		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIC	N	(¥5)
(X4) ID PREFIX TAG			ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 155	Continued From pa	ge 2	F 1	155	5		
	Director) stated, "I o	45 A.M., E3 (Social Services don't handle DNR (Do Not Il codes on admission, nursing					
F 280 SS=D	confirmed there wa R10's chart, on R10 nor in R10's current "Nurses, on admiss Not Resuscitate)/ F The resident or thei decision and obtain 483.20(d)(3), 483.1 PARTICIPATE PLA	5 A.M., E2 (Director of Nurses) s not an advance directive on D's current physician's orders t care plan. E2 stated, sion, explain what DNR (Do full Code entails to residents. ir responsible party makes a the physician's order." 0(k)(2) RIGHT TO NNING CARE-REVISE CP the right, unless adjudged	F 2	280			
	incompetent or othe incapacitated under	erwise found to be r the laws of the State, to ing care and treatment or					
	within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	are plan must be developed the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after					

Facility ID: IL6008205

If continuation sheet Page 3 of 23

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLETED		
		14E361	B. WING			06/	25/2015	
NAME OF F	PROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, STATE, ZIP CODE			
ASPEN F	REHAB & HEALTH CA	ARE			403 9TH AVENUE SILVIS, IL 61282			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ON SHOULD BE COMPLÉTIC HE APPROPRIATE DATE		
F 280	Continued From pa	ge 3	F 2	280				
	by: Based on observat interview the facility to reflect the curren Living) status for or	NT is not met as evidenced ion, record review and failed to revise the careplan t ADL (Activities of Daily ne of 12 residents (R6) ans in a sample of 12.						
	Findings Include:							
	hallway walking with assistance of staff, chair with no specia	:15A.M. R6 was up in the n wheeled walker with no was able to sit in a regular al cushion in the chair and t assistance of staff.						
	assist and gait belt limited assist and g	d 2/4/2015, states, " Use 1:1 for all transfers. Uses 1:1 ait belt for all ambulation. device in wheelchair."						
	my own, transfer by	5 at 10:30 AM, "I can walk on myself to and from bathroom use a wheelchair or a special elchair."						
F 314	(Registered Nurse I Coordinator), stated updated to reflect c Living) status, (R6) by himself, does no staff, does not use cushion." 483.25(c) TREATM	d, "(R6's) careplan is not urrent ADL (Activities of Daily is up ambulatory with walker t need any assistance from a wheelchair or special ENT/SVCS TO	F 3	814				
SS=D	PREVENT/HEAL P	KESSUKE SOKES						

If continuation sheet Page 4 of 23

		AND HUMAN SERVICES				FORM	06/29/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14E361	B. WING _			06/:	25/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ASPEN F	REHAB & HEALTH C	ARE			403 9TH AVENUE ILVIS, IL 61282		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Based on the comp resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece services to promote prevent new sores This REQUIREMEN by: Based on observat interview, the facility over a pressure ulc for one of three re pressure ulcers in a FINDINGS INCLUE The facility policy, " Areas" dated (revis "Notify the Physicia Physician's orders s treatment, Frequen performed, How to application." On 06/23/15 at 3:25 Certified Nursing As transfer R11 from th Upon completion of R11's pants and ad amount of green, br R11's nate of the set of was in place. R11's Numerous, scattered	orehensive assessment of a r must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced tion, record review and y failed to maintain a dressing ser on two separate occasions esidents (R11) reviewed for a sample of 12.	F 3	14			

Facility ID: IL6008205

If continuation sheet Page 5 of 23

		AND HUMAN SERVICES			FORM	06/29/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14E361	B. WING		06/2	25/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 403 9TH AVENUE		
ASPEN I	REHAB & HEALTH C	ARE		SILVIS, IL 61282		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	stage 2 open area y buttocks. The press and white edges. E applied a thick past R11's entire buttock throughout the proo positioned R11 onto then left the room a resident room. On 06/24/15 at 8:58 Certified Nursing As R11 from the wheel completion of the tr pants and adult inco amount of green, b R11's buttocks. R1 ⁻ were reddened. A s pressure ulcer was covered in stool. No covering the wound care to R11. R11 ye the procedure. R11's "Nursing Adm 06/04/15 document CM open area press buttocks and a 2 Cl to the bottom of R1 R11's current Physi 2015 includes the fe "Cleanse wound to (water), pat dry, app pad) and cover with healed." R11's current care	was present on the left sure area had a yellow center 4 removed the stool and the of incontinence cream over (s. R11 yelled "Ouch, Ouch" cedure. E4 and E5 then to R11's left side. Both CNA's and proceeded into another 5 A.M., E6 and E7, both ssistants prepared to transfer I chair to the bed. Upon transfer, E7 removed R11's ontinence brief. A moderate rown liquid stool covered 1's buttocks and coccyx area stage 2, 3 CM (centimeter) present on the left buttocks, to pressure ulcer dressing was 4. E7 performed incontinence elled, "Ouch, Ouch" throughout thission Assessment" dated tis a 2.5 CM (centimeter) X 2 tent to the top of R11's left M X 1.5 CM open area present	F 314			

If continuation sheet Page 6 of 23

		AND HUMAN SERVICES			FORM	APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		14E361	B. WING _		06/25/2015		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-		
ASPEN F	REHAB & HEALTH C	ARE		1403 9TH AVENUE SILVIS, IL 61282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	(X5) COMPLETION DATE	
F 314	by the physician.	ge 6 00 A.M., E2 Director of Nurses	F 31	314			
F 329 SS=D	confirmed a dressir times to R11's butto 483.25(I) DRUG RE	ng should be in place at all ocks. EGIMEN IS FREE FROM	F 32	329			
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above.					
	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical its who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	by: Based on interview	NT is not met as evidenced and record review, the facility psychotropic assessment for					

If continuation sheet Page 7 of 23

	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/29/2015 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		14E361	B. WING		06 /;	25/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASPEN I	REHAB & HEALTH CA	ARE		1403 9TH AVENUE SILVIS, IL 61282		
(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 APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	one resident (R10), the administration of for two residents (R perform a gradual of psychoactive medic two of eight residen medications in the s FINDINGS INCLUE The facility policy, ti Policy" dated (revis "Initiate a Pre-Psyc Assessment (prior t Psychotropic medic or administered with the resident, the res authorized represer antipsychotic drugs reductions and beh clinically contraindid discontinue the drug 1.) R10's facility "Pr that R10 was admit R10's "Admission N 02/23/15 document medications include and Trazadone. R10's "Pharmacy C 04/01/15 includes th receives several ps signed/dated inform found in the resider R10's "Psychotropio	failed to obtain consent for of a psychotropic medication (2 and R10), and failed to dose reduction of a cation for one resident (R2), ints reviewed for psychoactive sample of 12. DE: tled" Psychotropic Medication ed 12/30/13) directs staff to, hotropic Medication to the start of therapy), cation shall not be prescribed hout the informed consent of sident's guardian, or other intative and Residents who use shall receive gradual dose avior interventions, unless cated, in an effort to gs." ofile Face Sheet" documents ted to the facility on 02/23/15. Medication Care Plan" dated s R10 's admission ed: Alprazolam, Risperidone	F 329			

If continuation sheet Page 8 of 23

STATE MEMOR OF CORRECTION (XY) PROVIDERSUPPLIER (XY) MULTIPLE CONSTRUCTION (XY) DATE SUPPLY COMPLETED AND PLAN OF CORRECTION 14E361 INING (XY) DATE SUPPLY COMPLETED (XY) DATE SUPPLY COMPLETED ASPEN REHAB & HEALTH CARE STREET ADDRESS, CITY, STATE, ZP CODE 1433 3TH AVENUE SULVIS, IL 61282 (XY) DATE SUPPLY COMPLETED MARE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 1433 3TH AVENUE SULVIS, IL 61282 (XY) DATE SUPPLY COMPLETED MARE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE (XY) AVENUE SULVIS, IL 61282 (XY) DATE SUPPLIER MARE OF PROVIDER VISION OF CORRECTION TAG CONTINUES (DENTIFYING INFORMATION) PRETX TAG (POOLDER PLAN OF CORRECTION (POOLDER PLAN OF CORRE		DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES O							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITV. STATE, ZIP CODE ASPEN REHAB & HEALTH CARE STREET ADDRESS, CITV. STATE, ZIP CODE IVANUE OF PROVIDER OF SUPPLIER SUMMARY STATEMENT OF DEPORENCES. IPHER TAX EACH DEPORENCE DE STULL POIL DE COORDECTIVE ACTION STATE DEPORENCE DE STULL PROVIDERS FLAV COORDECTION PHER TAX EACH DEPORENCE DE STULL REGULATORY OR LSC DENTIFYING INFORMATION) PARE F 329 Continued From page 8 dated 04/13/15 by R10'S Representative. R10's medical record also contained no psychotropic medication assessment F 329 On 06/23/15 at 2:15 P.M., E2 (Director of Nurses) confirmed the only signed consent forms for R10's psychotropic medication. Nurses are to obtain a consent form from a resident or a (residents)) responsible party when a Physician orders a psychotropic medication. Nurses are to obtain a consent form from a resident or a (residents)) responsible party when a Physician orders a psychotropic medication. Nurses are to abtion (miligram) anti-depresant take one tablet by mouth at bedtime. On 6/23/2015 at 12:45A.M., E2 RN DON (Registered Nurse Director of Nurses) states, "I could on find the consent for R2: Sy synchropic medication Amitriptyline *2. Synchropic medication Amitriptyline." 3. R2's Consultation Report dated October 1. 2014 thru October 2, 2014 recormendations: taper Amitriptyline to 25m gat bedtime for 7 days then discontinue, Again in December 1, 2014 the recommendation documents to consider tapering Amitriptyline to 25m gat bedtime for 7 days then discontinue, add Melatomi at bedtime. <td>STATEMENT</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td></td> <td></td> <td>LE CONSTRUCTION</td> <td colspan="2"></td>	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			LE CONSTRUCTION			
NME OF PROVIDER OR SUPPLER STREE TADDRESS. CITY. STATE. 2/P CODE ASPEN REHAB & HEALTH CARE IN 39 TH AVENUE (M) ID PREEIX TAG SUMMARY STATELENT OF DEFICIENCIES. (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULTIONY OF LSC DENTIFYING INFORMATION) IN PREEIX PREEIX RESULTIONY OF LSC DENTIFYING INFORMATION) IN PREEIX PREEIX TAG PROVIDER OF LAN OF CORRECTION (EACH OPERCIDEX AUST OF APERCENE BY FULL RESULTIONY OF LSC DENTIFYING INFORMATION) IN PREEIX PREEIX PREEIX TAG PROVIDER OF LAN OF CORRECTION (EACH OPERCIDEX AUST OF APERCENE BY FULL RESULTIONY OF LSC DENTIFYING INFORMATION) OW PREEIX PREEIX PREEIX TAG PROVIDER OF LAN OF CORRECTION (EACH OPERCIDEX AUST OF APERCIPANTE DEFICIENCY) OW PREEIX PREEIX PREEIX TAG OP PREEIX PRE			14E361	B. WING			06/:	25/2015	
ASPEN REHAB & I HEALTH CARE SILVIS, IL 61282 [W1]D PHEFK TAG SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST RE PRECEDED BY FULL RECOUNTORY OR LSC DENTIFYING INFORMATION D PHEFK TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIGT REPRECEDED BY FULL RECOUNTORY OR LSC DENTIFYING INFORMATION) D PHEFK TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) Continued From page 8 dated 04/13/15 by R10's Representative. F 329 F 329 Continued From page 8 dated 04/13/15 by R10's Representative. F 329 F 329 On 06/23/15 at 2:15 P.M., E2 (Director of Nurses) confirmed the only signed consent form Stores onfirmed the only signed consent form Stores accessent form from a resident or a (resident's) responsible party when a Physician orders a psychotropic medication. Nurses are to do (perform) a psychotropic assessment when a psychotropic decidation. Nurses are to do (perform) a psychotropic assessment when a psychotropic medication. Nurses are to do (perform) a psychotropic assessment when a psychotropic decidation. Nurses are to do (perform) a psychotropic assessment when a psychotropic decidation. Nurses are to do (perform) a psychotropic assessment when a psychotropic decidation. Nurses are to do (perform) a psychotropic dased 6/1/2015 thru 6/30/2015 documents Amitriptyline HCL 50 mg (milligram) anti-toppresent take one tablet by mouth at bedtime. On 6/22/2015 at 12:45A.M., E2 RN DON (Registered Nurse Director of Nurses) states, "1 could not find the consent for R2's Psychotropic medication Amitriptyline." 3. R2's Consultation Report dated October 1, 2014 thru October 2, 2014 recommendations: taper Amitriptyline to 25 mg at bedtime for 7 days then di	NAME OF F	PROVIDER OR SUPPLIER					•		
Pričejki TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PRĚTK TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS HEFERENCE TO THE APPROPRIATE COMMÉTION DATE F 329 Continued From page 8 dated 04/13/15 by R10's Representative. F 329 F 329 F 329 Continued From page 8 dated 04/13/15 by R10's Representative. F 329 F 329 On 06/23/15 at 2:15 P.M., E2 (Director of Nurses) confirmed the only signed consent forms for R10's psychotropic medications were dated 04/13/15. E2 also stated, "Nurses are to obtain a consent form from a resident or a (resident's) responsible party when a Physician orders a psychotropic medication. Nurses are to do (perform) a psychotropic assessment when a psychotropic medicine is ordered." 2. R2's Physician's Orders dated 6/1/2015 thru 6/30/2015 documents Amtripyline HCL 50 mg (milligram) anti-depressant take one tablet by mouth at bedfime. On 6/22/2015 at 12:45A.M., E2 RN DON (Registered Nurse Director of Nurses) states, "I could not find the consent for R2's Psychotropic medication Amtriptyline." 3. R2's Consultation Report dated October 1, 2014 thru October 2, 2014 recommendations: taper Amtriptyline." 3. R2's Consultation Report dated October 1, 2014 thru October 2, 2014 recommendations: taper Amtriptyline to 25 mg at bedtime for 7 days then discontinue. Again in December 1, 2014 the recommendation documents to consider tapering Amtiriptyline to 25 mg at bedtime in 7 days then discontinue, and add Melatoni at bedtime. In	ASPEN F	REHAB & HEALTH CA	ARE						
dated 04/13/15 by R10's Representative. R10's medical record also contained no psychotropic medication assessment On 06/23/15 at 2:15 P.M., E2 (Director of Nurses) confirmed the only signed consent forms for R10's psychotropic medications were dated 04/13/15. E2 also stated, "Nurses are to obtain a consent form from a resident or a (resident's) responsible party when a Physician orders a psychotropic medication. Nurses are to do (perform) a psychotropic assessment when a psychotropic medication. Nurses are to do (perform) a psychotropic assessment when a psychotropic medication. Nurses are to do (perform) a psychotropic assessment when a psychotropic medication. Nurses are to do (perform) a psychotropic assessment when a psychotropic medication. Nurses are to do (perform) a psychotropic assessment when a psychotropic medication. Nurses are to bot maint 0n 6/22/2015 documents Amitriptyline HCL 50 mg mouth at bedtime. 0n 6/22/2015 at 12:45A.M., E2 RN DON (Registered Nurse Director of Nurses) states, "I could not find the consent for R2's Psychotropic medication Amitriptyline." 3. R2's Consultation Report dated	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLÉTION	
recommends to taper Amitriptyline to 25 mg at	F 329	dated 04/13/15 by F R10's medical reco psychotropic medic On 06/23/15 at 2:15 confirmed the only s R10's psychotropic 04/13/15. E2 also s consent form from a responsible party w psychotropic medic perform) a psychotr psychotropic medic 2. R2's Physician's 6/30/2015 documer (milligram) anti-dep mouth at bedtime. On 6/22/2015 at 10 Psychotropic drug A the chart. On 6/23/2015 at 12 (Registered Nurse I could not find the co medication Amitript 3. R2's Consultation 2014 thru October 2 taper Amitriptyline to then discontinue. A recommendation do Amitriptyline to 25m discontinue, and ad March 1, 2015 the o	Allo's Representative. R10's Representative. rd also contained no ation assessment 5 P.M., E2 (Director of Nurses) signed consent forms for medications were dated tated, "Nurses are to obtain a a resident or a (resident's) hen a Physician orders a ation. Nurses are to do (ropic assessment when a ine is ordered." Orders dated 6/1/2015 thru trs Amitriptyline HCL 50 mg ressant take one tablet by :30A.M. the consent for the Amitriptyline was not found in :45A.M., E2 RN DON Director of Nurses) states, "I onsent for R2's Psychotropic yline." n Report dated October 1, 2, 2014 recommendations: o 25 mg at bedtime for 7 days gain in December 1, 2014 the ocuments to consider tapering ng at bedtime for 7 days then Id Melatonin at bedtime. In consultant report for R2	F3	329				

If continuation sheet Page 9 of 23

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		à		MPLETED
		14E361	B. WING		06	/25/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
ASPEN F	REHAB & HEALTH C	ARE		1403 9TH AVENUE SILVIS, IL 61282		
(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 S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 329	Continued From pa bedtime for 7 days	-	F 329			
F 334 SS=E	(Registered Nurse) expect the nurses t medication as direct	20A.M. E2, RN/DON /Director of Nurses), stated, "I o reduce the psychotropic eted by Physician." NZA AND PNEUMOCOCCAL	F 334	L		
	that ensure that (i) Before offering the each resident, or the representative rece- benefits and potent immunization; (ii) Each resident is immunization October annually, unless the contraindicated or the immunized during the (iii) The resident or representative has immunization; and (iv) The resident's re documentation that following: (A) That the resider representative was the benefits and po- immunization; and (B) That the resider	ives education regarding the ial side effects of the offered an influenza ber 1 through March 31 e immunization is medically he resident has already been his time period; the resident's legal the opportunity to refuse medical record includes indicates, at a minimum, the ent or resident's legal provided education regarding tential side effects of influenza ent either received the tion or did not receive the tion due to medical				
		evelop policies and procedures				

If continuation sheet Page 10 of 23

		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES					0938-0391	
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14E361	B. WING			06/;	25/2015	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ASPEN F	REHAB & HEALTH C	ARE			1403 9TH AVENUE SILVIS, IL 61282			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLÉTION DATE	
					DEFICIENCY)			
F 334	Continued From pa	uqe 10	F 3	221	1			
	(i) Before offering th	-	1.0	504	*			
		resident, or the resident's						
		e receives education regarding						
	the benefits and po immunization;	tential side effects of the						
		offered a pneumococcal						
		ss the immunization is						
		licated or the resident has						
	already been immu							
		the resident's legal the opportunity to refuse						
	immunization; and	the opportunity to relate						
	(iv) The resident's r	medical record includes						
		indicated, at a minimum, the						
	following: (A) That the reside	ent or resident's legal						
		provided education regarding						
	the benefits and po	tential side effects of						
	pneumococcal imm					l		
	()	ent either received the nunization or did not receive				l		
		immunization due to medical				l		
	contraindication or							
		e, based on an assessment						
		commendation, a second						
	years following the	nunization may be given after 5 first pneumococcal						
		ss medically contraindicated or						
	the resident or the r	resident's legal representative						
	refuses the second	immunization.						
	by:	NT is not met as evidenced						
		v, observation and record						
		ailed to document the status of						
		vaccine and/or influenza						

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	-	AND HUMAN SERVICES			FORM	06/29/2015 APPROVED 0938-0391
STATEM	IENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		14E361	B. WING		06/	25/2015
NAME	OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASPE	EN REHAB & HEALTH CA	ARE		403 9TH AVENUE SILVIS, IL 61282		
(X4) PREF TAC	IX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F3	 vaccine for ten of 1 immunization status R10, R13 and R14) residents. Findings include: The facility policy tif Residents' indicate residents) immuniz aid in the preventio Offer the Pneumon unless a second do resident's physiciar immunization annu March 31st (with ph the resident's Immu Order Sheet (POS) timing of previous v contraindications." On 06/23/15, during storage room, it wa medication refrigera pneumococcal or ir 1. R14's Admission R14 was admitted of administration seas Immunization Reco documentation of F or the pneumovac. R14's March and A Sheet (POS) indica standing orders, R1 pneumovac. 	2 residents reviewed for s (R2, R3, R4, R6, R7, R8, R9,), in the sample of 12 tled, "Immunization of the sthat the facility, "Will offer (to ations and vaccinations that n of infectious diseases.," ia vaccine as a one time dose ose is recommended by the n," "Offer the influenza ally from October 1st through hysician order)" and "Review unization Record, Physician and Consent form to verify vaccinations, allergies and g the tour of the medication is noted that the locked ator did not contain any vials of offluenza vaccines. n Data Sheet indicates that during the fluvac son on 03/19/15. R14's	F 334			

		AND HUMAN SERVICES				FORM	06/29/2015 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		14E361	B. WING			06/;	25/2015	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ASPEN F	REHAB & HEALTH CA	ARE			403 9TH AVENUE SILVIS, IL 61282			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 334	but contains no dat ever receiving or be pneumovac in that 2. R13's June 2018 (POS) indicates tha standing orders, R1 pneumovac. The facility provided immunization tracki residents. R13 was receiving or refusion R13's current media or documentation or offered the pneumor 3. Similar issues, a lack of documentat and/or failure to ma sheets for pneumov noted with R2, R3, also. On 06/23/15 at 1:50 (DON), stated that facility for the past or previous DON, "Wa the pneumococcal or serum when the pre- has not arrived as of P.M. E2 stated that influenza vaccines to (R6, R7, R8, R9,	 a short term stay of 29 days, ia, history or documentation of eing offered the fluvac or time frame. 5 Physician Order Sheet at, as part of the facility's 13 may receive the fluvac and d, on 06/23/15, an ing form for all current s not listed on this form as ig a pneumovac. cal record has no data, history of ever receiving or being ovac. as noted above, regarding the ion in current medical records aintain separate tracking vac and/or fluvac status were R4, R6, R7, R8, R9, and R10, 0 P.M., E2, Director of Nursing E2 had been working in the month. E2 stated that the as supposed to have ordered vaccination (pneumovac) evious DON had left, "But it of yet." On 06/24/15 at 1:30 t E2 did not know why (fluvac) had not been offered R10 and R14) during the 	F	334				
		ne facility's policy, but assigned art of the previous DON.						

Facility ID: IL6008205

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	A. BUILDING			COMPLETED	
		14E361	B. WING			06/;	25/2015	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
ASPEN F	REHAB & HEALTH C	ARE			1403 9TH AVENUE SILVIS, IL 61282			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETION DATE	
F 354 SS=C	()	-RN 8 HRS 7 DAYS/WK,	F 3	54	ŕ			
	this section, the fac	ed under paragraph (c) or (d) of cility must use the services of a r at least 8 consecutive hours ek.						
	this section, the fac	d under paragraph (c) or (d) of sility must designate a serve as the director of ne basis.						
		sing may serve as a charge e facility has an average daily fewer residents.						
	by: Based on record re failed to have the m Nurse hours for two	NT is not met as evidenced eview and interview the facility ninimum required Registered o of 14 consecutive days. This ential to affect all 46 residents						
	6/8/15 through 6/21 and 6/14/15, the fac Nurse scheduled in On 6/25/15 at 9:20 Nursing) verified the 6/13/15 and 6/14/15	red Nurse Staffing sheet from 1/15 indicated that on 6/13/15 cility did not have a Registered a 24 hour period. a.m. E2/ DON (Director of at in a 24 hour period on 5, the facility did not have working in the facility.						
	of Residents, Cente	esident Census and Conditions ers for Medicare and Medicaid dated 6/22/15, the facility's 6.						

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE SURVEY COMPLETED	
		14E361	B. WING	i		06/25/2015	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ASPEN F	REHAB & HEALTH CA	ARE			1403 9TH AVENUE SILVIS, IL 61282		
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 SS=E		I CONTROL, PREVENT	F 4	441			
	Infection Control Pros	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.					
	Program under whic (1) Investigates, con in the facility; (2) Decides what pr should be applied to	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective					
	determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact will tra (3) The facility must hands after each dir hand washing is ind professional practic (c) Linens Personnel must har	tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted					

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PRINTED: 06/29/2015

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14E361	B. WING			06/:	25/2015	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-		
ASPEN REHAB & HEALTH CARE					403 9TH AVENUE SILVIS, IL 61282			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441	by: Facility non-compli practices: A. Based on observery review, the facility factories between medication residents (R15, R16 wear protective per handling medication of seven residents of in a sample of 12. B. Based on observery review, the facility factories R11, two of seven resonance R11, two of seven res	NT is not met as evidenced ance resulted in two deficient vation, interview and record ailed to perform hand hygiene n administration for four 5, R17, and R18) and failed to sonal equipment while ns for one resident (R2), five reviewed for infection control vation, interview and record ailed to perform incontinence ss contamination for R7 and esidents reviewed for infection of 12. <i>y</i> , titled "Medication ed (revised 10/27/10) directs nand washing or use of an nust be performed throughout s. This should occur: Before n pass, After touching an oral administration. It is acceptable e gel type solution between	F 4	441				

Facility ID: IL6008205

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIENCLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUPPLIE A. BUILDING NAME OF PROVIDER OR SUPPLIER 14E361 B. WING 06/25/2019 ASPEN REHAB & HEALTH CARE STREET ADDRESS, CITY, STATE, ZIP CODE 1403 9TH AVENUE SILVIS, IL 61282 06/25/2019 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) 000 (22.5/2019 F 441 Continued From page 16 in the Medication Administer medication to R16. Without performing hand hygiene, E11 (LPN) continued to administer medication to R16, R17 and R18. F 441 F 441 On 06/22/15 at 2:15 P.M., E11 (LPN) stated, "I use sanitizer after every third administration." F 441 F 441 On 06/22/2015 at 11:40A.M. E10 LPN (Licensed Practical Nurse) did not wash hands before administering Hydro/Acetamin 5:325 Tab (tablet) po (by mouth) to R2. E10 punched the medication out of the bubble pack with bare fingers, and placed the medication in a small medication out of the pubble pack with bare fingers, and placed the medication in a small medication E10 then proceeded to administer the medication Image: Complexity of the medication			I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	06/29/2015 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ASPEN REHAB & HEALTH CARE 1403 9TH AVENUE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441 Continued From page 16 in the Medication Administration Record and then prepared to administer medications to R16, R17 and R18. F 441 On 06/22/15 at 2:18 P.M., E11 (LPN) continued to administer medications to R16, R17 and R18. F 411 On 06/23/15 at 2:15 P.M., E2 Director of Nurses stated, "It is acceptable to use hand gel between residents." On 6/22/2015 at 11:40A.M. E10 LPN (Licensed Practical Nurse) did not wash hands before administering Hydro/Accetamin 5-325 Tab (tablet) po (by mouth) to R2. E10 punched the medication out of the bubble pack with bare fingers, and placed the medication in a small medication cup. E10 then proceeded to administer the medication	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY	
ASPEN REHAB & HEALTH CARE 1403 9TH AVENUE SILVIS, IL 61282 (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 CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Comment Comment Deficiency F 441 Continued From page 16 in the Medication Administration Record and then prepared to administer medication to R16. Without performing hand hygiene, E11 (LPN) continued to administer medications to R16, R17 and R18. F 441 F 441 On 06/22/15 at 2:18 P.M., E11 (LPN) stated, "I use sanitizer after every third administration." On 06/23/15 at 2:15 P.M., E2 Director of Nurses stated, "It is acceptable to use hand gel between residents." On 6/22/2015 at 11:40A.M. E10 LPN (Licensed Practical Nurse) did not wash hands before administering Hydro/Acetamin 5:325 Tab (tablet) po (by mouth) to R2. E10 punched the medication out of the bubble pack with bare fingers, and placed the medication in a small medication cup. E10 then proceeded to administer the medication			14E361	B. WING		06/:	25/2015
ASPEN REHAB & HEALTH CARE SILVIS, IL 61282 (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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION & COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 441 Continued From page 16 in the Medication Administration Record and then prepared to administer medications to R16, R17 and R18. F 441 F 441 On 06/22/15 at 2:18 P.M., E11 (LPN) stated, "I use sanitizer after every third administration." On 06/23/15 at 2:15 P.M., E2 Director of Nurses stated, "It is acceptable to use hand gel between residents." On 6/22/2015 at 11:40A.M. E10 LPN (Licensed Practical Nurse) did not wash hands before administering Hydro/Acetamin 5-325 Tab (tablet) po (by mouth) to R2. E10 punched the medication out of the bubble pack with bare	NAME OF I	PROVIDER OR SUPPLIER					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE DATI F 441 Continued From page 16 in the Medication Administration Record and then prepared to administer medication to R16. Without performing hand hygiene, E11 (LPN) continued to administer medications to R16, R17 and R18. F 441 F 441 On 06/22/15 at 2:18 P.M., E11 (LPN) stated, "I use sanitizer after every third administration." F Image: Complete the the the the the the the the the	ASPEN F	REHAB & HEALTH C	ARE				
 in the Medication Administration Record and then prepared to administer medication to R16. Without performing hand hygiene, E11 (LPN) continued to administer medications to R16, R17 and R18. On 06/22/15 at 2:18 P.M., E11 (LPN) stated, "I use sanitizer after every third administration." On 06/23/15 at 2:15 P.M., E2 Director of Nurses stated, "It is acceptable to use hand gel between residents." On 6/22/2015 at 11:40A.M. E10 LPN (Licensed Practical Nurse) did not wash hands before administering Hydro/Acetamin 5-325 Tab (tablet) po (by mouth) to R2. E10 punched the medication out of the bubble pack with bare fingers, and placed the medication in a small medication cup. E10 then proceeded to administer the medication 	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
to R2. On 6/22/2015 at 11:50 A.M. E10 administered Lamotrigine 25 mg (milligrams) to R19 without washing hands before or after the administration of the medication. B. The facility policy, titled "Perineal Cleansing" dated (revised 9/21/10) instructs staff to, "Position resident on back with knees bent and slightly apart. Wet wash cloth with cleansing agent chosen. Wash pubic area including upper inner aspect of both thighs and frontal portion of perineum (as well as the penis and scrotum). Use long strokes from the most anterior down to the base of the labia.(For males, Retract foreskin and wash carefully, then wash under the scrotum.) Follow same sequence for rinsing area. Dry thoroughly. Instruct or assist resident to turn on	F 441	 in the Medication A prepared to administ Without performing continued to adminiand R18. On 06/22/15 at 2:18 use sanitizer after earlier of 0n 06/23/15 at 2:18 stated, "It is accept residents." On 6/22/2015 at 11 Practical Nurse) dia administering Hydropo (by mouth) to R2 out of the bubble paplaced the medicat E10 then proceede to R2. On 6/22/2015 at 11 Lamotrigine 25 mg washing hands befor of the medication. B. The facility policy dated (revised 9/21 resident on back wi apart. Wet wash clack with a spect of both thigh perineum (as well a long strokes from the base of the labia. (Final wash carefully, there Follow same sequered to sequere the sequered to the sequered to the labia. 	dministration Record and then ster medication to R16. g hand hygiene, E11 (LPN) lister medications to R16, R17 8 P.M., E11 (LPN) stated, "I every third administration." 5 P.M., E2 Director of Nurses table to use hand gel between 1:40A.M. E10 LPN (Licensed d not wash hands before o/Acetamin 5-325 Tab (tablet) 2. E10 punched the medication ack with bare fingers, and tion in a small medication cup. ed to administer the medication :50 A.M. E10 administered (milligrams) to R19 without ore or after the administration y, titled "Perineal Cleansing" /10) instructs staff to, "Position ith knees bent and slightly oth with cleansing agent ic area including upper inner ns and frontal portion of as the penis and scrotum). Use he most anterior down to the for males, Retract foreskin and n wash under the scrotum.) ence for rinsing area. Dry	F 441			

Facility ID: IL6008205

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		AND HUMAN SERVICES			FORM	: 06/29/2015 APPROVED : 0938-0391	
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		14E361	B. WING _		06/	25/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ASPEN F	REHAB & HEALTH C	ARE		1403 9TH AVENUE SILVIS, IL 61282			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 441	area thoroughly with base of the labia a buttocks (for males ending with center of area in the same set On 06/23/15 at 9:50 Certified Nursing As perform catheter ca pants and adult inco- end of a bath towel wall dispenser. E12 soapy towel to R7's then retracted R7's R7's penis in a circu- handed the bath tow this wet so I can cle stands up." E13 we water, and while ha the bath towel came in entire front of E12's On 06/13/15 at 10:0 need to be more ca On 06/24/15 at 8:55 Certified Nursing As perform incontinent applied gloves and wheel chair to the b and adult incontinent amount of green/br on (R11)'s skin. E7 soapy wash cloth in stool was removed R11 onto R11's bac	ghtly bent. Wash peri-anal h each stroke beginning at the nd extending up over the s, cleanse the anal area, of the anal area). Rinse entire equence. Dry area thoroughly. O A.M., E12 and E13 both ssistants (CNAs) prepared to are for R7. E12 removed R7's ontinence brief, then wet the with water and soap from a 2 CNA applied the end of the s scrotum and inner thighs, foreskin and wiped around ular motion. E12 CNA then wel to E13 and stated, "Get ean (R7)'s bottom when (R7) at the end of the towel with unding the towel back to E12, e unfolded and the used end nto direct contact with the s uniform top.	F 44	41			

Facility ID: IL6008205

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		AND HUMAN SERVICES				FORM	06/29/2015 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		14E361	B. WING			06/25/2015		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE			
ASPEN F	REHAB & HEALTH CA	ARE		1403 9TH AVENUE SILVIS, IL 61282				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 441 F 504 SS=D	thighs. On 06/24/15 at 2:15 confirmed incontine beginning with the of area. 483.75(j)(2)(i) LAB ORDERED BY PHY The facility must pro- services only when physician. This REQUIREMEN by: Based on record re- failed to perform a pro- monitoring for one of for careplans in a s Findings Include: The facility policy tit 01/02 documents u Blood Glucose will diabetics receiving physician."	A R11's peri area and inner A.M., E2/Director of Nurses ence care should be performed cleanest area to the dirtiest SVCS ONLY WHEN YSICIAN ovide or obtain laboratory ordered by the attending NT is not met as evidenced eview and interview the facility physician ordered laboratory resident (R6) of 12 reviewed	F 4.		DEFIGIENCY)			
	R6's Physician's Or	injections at bedtime. ders dated, 6/1/2015 thru FBS (Fasting Blood Sugar) to						

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	-	AND HUMAN SERVICES			FORM	06/29/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		14E361	B. WING		06/25/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASPEN F	REHAB & HEALTH CA	ARE		SILVIS, IL 61282		
(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
F 504	results for FBS sinc On 6/23/2015 at 12 (Registered Nurse/I FBS labs have not I	d contained no laboratory	F 504			
F 514 SS=D		LETE/ACCURATE/ACCESSIB	F 514			
	resident in accordation standards and prac	aintain clinical records on each nce with accepted professional stices that are complete; nted; readily accessible; and nized.				
	information to ident resident's assessm services provided; t	ening conducted by the State;				
	by: Based on observa interview the facility medication to the co for one resident (R1	NT is not met as evidenced ation, record review and ation, record review and ation, record review and alignment and review and alignment and review and alignment and review and ation at a set and ation at a set and at a set a set a set and at a set a set a set a set a set a set a set at a set a set at a set a set at a set				
	Findings Include:					
	pass, E10 LPN (Lic	:50A.M. during medication censed Practical Nurse) zolam 0.5mg (milligram) to				

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	-	AND HUMAN SERVICES	FORM APPROVED OMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14E361	B. WING _			06/:	25/2015	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ASPEN F	ASPEN REHAB & HEALTH CARE				103 9TH AVENUE ILVIS, IL 61282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 514	Continued From pa R19.	ge 20	F 5	14				
		Drders dated 5/27/2015 colam 0.5 mg at 8A.M. and		Ĩ				
		lecord dated 5/26/2015 colam 0.5 mg: give one every						
	R19's current Physi thru 6/30/2015 does Alprazolam 0.5 mg			Ĩ				
F 520 SS=C	(Registered Nurse/ didn't get the Alpraz current June's orde 483.75(o)(1) QAA	IBERS/MEET	F 5	20				
	assurance committe nursing services; a	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the						
	committee meets at issues with respect and assurance activ develops and imple	ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of entified quality deficiencies.						
		retary may not require cords of such committee						

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		AND HUMAN SERVICES				FORM	06/29/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14E361	B. WING			06/:	25/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ASPEN F	REHAB & HEALTH C	ARE			403 9TH AVENUE ILVIS, IL 61282		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
TAG F 520	Continued From pa except insofar as si compliance of such requirements of this Good faith attempts and correct quality of a basis for sanction This REQUIREMEN by: Based on interview failed to hold two of Assurance meeting failure has the pote facility's residents. Findings include: The facility policy for Committee was req on 06/25/15. On 06 stated that the (corp stated there was not Assurance Commit On 06/24/15, E1, A provide the sign-in si meetings. E1 state both the July 2014 a meetings had not b were no sign-in she verified that E1 was requirement.	age 21 uch disclosure is related to the committee with the s section. s by the committee to identify deficiencies will not be used as is. NT is not met as evidenced y and record review, the facility i the four quarterly Quality is over the past year. This ntial to affect all 46 of the or Quality Assurance (QA) quested on 06/24/15 and again 5/25/15 E1, Administrator, porate owner's main office) o policy specific to the Quality tee for all their facilities. dministrator, was asked to sheets for the quarterly QA ed that, for various reasons, and October 2014 QA een held and, therefore, there eets for those dates. E1 s aware this was a	F 5	20			
	of Residents, Cente	esident Census and Conditions ers for Medicare and Medicaid dated 6/22/15, the facility's 6.					

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DEPART	FORM	APPROVED					
	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) N			TIPLE CONSTRUCTION		0938-0391 E SURVEY	
			ING		IPLETED		
		14E361	B. WING		06/	06/25/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	25/2015	
ASPEN F	REHAB & HEALTH C	ARE		1403 9TH AVENUE SILVIS, IL 61282			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	ION	(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG			COMPLÉTION DATE	
			1				

Facility ID: IL6008205