DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY IPLETED
		14E572	B. WING		1:	2/08/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD		
				SKOKIE, IL 60076		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI		COMPLETION DATE
				DEFICIENCY)		
F 000	INITIAL COMMENTS	,	F 00	00		
	Annual Certification	-				
	Federal Oversight an An Extended Survey					
F 157	483.10(b)(11) NOTIF		F 15	57		
SS=G	(INJURY/DECLINE/R					
	consult with the resid known, notify the resi or an interested famil accident involving the injury and has the pol intervention; a signific physical, mental, or p deterioration in health status in either life thr clinical complications significantly (i.e., a ne existing form of treatr consequences, or to treatment); or a decis the resident from the §483.12(a).	nent due to adverse commence a new form of ion to transfer or discharge facility as specified in				
	and, if known, the rest or interested family m change in room or root specified in §483.15(resident rights under regulations as specifi- this section. The facility must reco- the address and phor	promptly notify the resident ident's legal representative member when there is a commate assignment as (e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of rd and periodically update ne number of the resident's or interested family member.				
	, DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE

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

(X6) DATE

PRINTED: 12/17/2014

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.

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	E SURVEY IPLETED	
		14E572	B. WING		12	2/08/2014	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SKOKIE M	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 157	Continued From page	e 1	F 15	57			
		is not met as evidenced					
	by: Based upon observa	tion, interview and record					
		led to notify and consult the					
	physician of a persist	ent complaint of pain and					
		ychiatrist of an onset and					
	U	vior for one resident (R7) in dents. Because of these					
	deficient practices, R						
	-	es and as a result, R7					
		imself and suffered decline					
		Daily Living) capabilities					
	and transfers.	, toileting, dressing, bathing					
	Findings include:						
	On 11/17/14, at 2:00F	PM, R7 was in his room and					
		se activities. On 11/17/14, at					
		Director stated R7 prefers to					
	his legs.	ause of complain of pain to					
	-	PM, R7 was on his bed, in a					
		R7 stated that he does not					
		esident morning meetings					
		d sore. R7 stated that he					
	told the nurse about I	nis complaint of pain. PM, R7 was on his bed, in a					
		R7 had difficulty changing his					
		to standing position. R7					
	moved slowly, with fa	icial grimacing, while					
		to grab his walker. R7 was					
	-	and stabilize himself in a walked approximately three					
		s bed to his dresser) with a					
	slow and wobbly gait						
	On 11/17/14, at 4:30	PM, R7 stated that he uses					
		is very difficult for him to go					

If continuation sheet Page 2 of 129

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	CON	IPLETED
		14E572	B. WING		1:	2/08/2014
NAME OF PI	ROVIDER OR SUPPLIER	·	•	STREET ADDRESS, CITY, STATE, ZIP COD	E	
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 157	Continued From page	e 2	F 15	7		
		ause of the pain to his neck,				
		vashroom is approximately				
		is bed. R7 stated that he is he walks to the washroom.				
	U 0	Am, R7 was in his room and				
		ot join the house activities				
		and pain to his legs, arms,				
		. R7 stated that it is difficult				
	- ·	o to smoke because of his				
		robably need a power chair				
		R7 stated that his inability to ys makes him sad and				
	angry.	ys makes him sau anu				
	•••	5AM, E9 RN (Registered				
		e doctor should have been				
	notified to obtain orde	er for pain relief when R7				
		E9 stated, " I am going to				
		v and will call the doctor. "				
		DAM, R7 was in his room. R7				
		ng activities. R7 stated that and upper back is worse and				
	-	ted his complaint of pain to				
	the nursing staff.					
	On 11/18/14, at 11:30	0Am, Z1 (Attending				
		t R7 has chronic pain				
		nritis. He stated that the				
	-	PRN pain medications for				
		s. Z1 stated that he depends y him if a resident complains				
		t he was not aware that R7				
	-	of pain. Z1 also stated that				
		ed pain medication for R7 if				
		r. Z1 also stated that he was				
		verall decline of condition.				
		DAM, E14 C.N.A. (Certified				
		ated that R7 cannot pull his tie his shoes. When asked				
		sonal hygiene and bathing,				
						1 I I I I I I I I I I I I I I I I I I I

Facility ID: IL6008643

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	CS FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		IO. 0938-039	
	F CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	IPLETED	
		14E572	B. WING		1:	2/08/2014	
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SKOKIE I	IEADOWS NURSING CE	NTERII		600 WEST GOLF ROAD KOKIE, IL 60076			
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE	
F 157	stated that " the only his teeth " when it co E14 stated that he tal out of 14 days. E14 a of pain six (6) or more he takes care of him. complains of pain wa E14 `does not know v informing them of R7 On 11/19/14, at 11:00 Director of Nursing) s shows decline of abili Living), the staff shou decline ", notify the of appropriate placemer On 11/19/14, at 1:056 Rehabilitation Service R7 is not attending ps not notify the psychia On 11/19/14, at 3:35F Rehabilitation Service is not aware that R7 s psychosocial groups psychiatrist should has stopped attending ps On 11/19/14, at 3:46F that R7 is being treate medications, but the provide psychosocial activities to R7 as a p treatment. Z2 stated s isolative behavior, o Daily Living) capabilit behavior. Z2 also stat aware by the facility s psychosocial groups	 thing (R7) can do is brush omes to personal hygiene. kes care of R7 ten (10) days also stated that R7 complains e days of the ten (10) days E14 stated that R7 's s reported to the Nurse but what the nurses did after 's pain. DAM, E3 ADON (Assistant stated that when a resident ities ADLs (Activities of Daily and determine the "kind of doctor, and discuss nt. DPM, E15 PRSC (Psychiatric es Coordinator) stated that sychosocial groups; E15 did strist about it. DM, E16 PRSD (Psychiatric es Director) stated that she stopped going to activities. E16 stated that the ave been called when R7 ychosocial group activities. DM, Z2 (Psychiatrist) stated ed biologically through facility services should programs and in-house part of his (R7) psychosocial that she is not aware of R7 ' decline in ADL (Activities of ties and decline in mood and ted that She was not made staff that R7 stopped going to and is not participating 2 stated that the isolative 	F 157				

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STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY	
and plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		14E572	B. WING		1:	2/08/2014	
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE			
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE	
F 157	Continued From page	e 4	F 15	7			
	monitor residents ' be monitoring tracking se can be created. Z2 st known about the char ADLs, she would hav hospitalization and fu R7 ' s Care Plan initia in part: (R7) has seve Intervention: Refer to worsening conditions inappropriate behavio Psychotropic Medicat dates documents in p exhibited- isolative, w exhibited - remains is There was no interve Admission/Initial MDS 12/17/2013 and Quar were reviewed. The C documents in part the in condition in the spe C- Presence of signs Inattention which was Admission/Initial com - Functional Status: d Bathing functions (R7 staff with Dressing an (12/17/13), R7 was in ADL (Activities of Dai supervision with Dress - Behavior/Potential in Delusion; Per Initial M	hat the nursing staff should ehavior using the behavior o an appropriate plan of care ated that if she should have inge in R7 's behavior and e ordered R7 for rther evaluation. ated on 9/18/14 documents ere mental illness; o MD (Medical Doctor) for ; Intervene when any or is observed. tion Record on the following wart: "9/30/14 Behavior vithdrawn; 10/31/14 Behavior olative and withdrawn. " intion documented. S (Minimum Data Set) dated terly MDS dated 9/17/14 Quarterly MDS dated 9/17/14 e following areas of decline ecific MDS sections: Section and symptoms of Delirium- s not present during the prehensive MDS; Section G lecline in Dressing and ') - needs assistance from and Bathing; Per Initial MDS idependent with all areas of ly Living) and only needed ising and Bathing; Section E indicator of Psychosis: - MDS (12/17/13) documents					
	Delusion; Per Initial M no potential indicator Mood: Emergence of interest or pleasure to sad, depressed and h	-					

Facility ID: IL6008643

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/17/2014 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		14E572	B. WING				12/	08/2014
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE	, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII			600 WEST GOLF ROAD KOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI D TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 157	score from zero to 13 R7 did not have any s Acute Care psychiatri instruction dated 12/4 Notify physician if exp following: Recurrence that led to hospitalizar yourself. Based on observation review, the facility fail with clinical changes (R9) of five residents medications in a sam facility failed to notify from a dialysis cathet (R13) reviewed for dia Findings include: During the initial tour 9:25am, R9 stated, "I' medication. Prolixin m decreased energy. To because I'm too tired. On 11/17/14 at 12:45p indicated that he felt m stated, "I told the nurs E24 (RN-Registered I pressure. R9 stated to performed R9's blood normal is 120/80 or 12 result: 92/60.	on things; total severity ; Per Initial MDS (12/17/13), cymptom of Mood problem. c hospital discharge /13 documents in part: periencing any of the of psychiatric symptoms tion; Inability to care for a, interview and record ed to notify the psychiatrist n condition for one resident reviewed for psychoactive ble of 18. In addition, the a physician of the drainage er site for one resident alysis in a sample of 18.	F	157				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/17/2014 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION		(X3) DATE	
		14E572	B. WING			_	12/	08/2014
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SKOKIE M	IEADOWS NURSING CEI	NTERII			1600 WEST GOLF ROAD SKOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	through 11/30/14 doci for a diagnosis of Par. R9's Psychiatric Prog documents that his Pr 17.5 mg at night. On 11/17/14 at 2:30pr on Prolixin 5 milligram 10 mg at night. I was Prolixin was changed sleepy and weak in th decreased my Prolixir and now I am on 17.5 will decrease again so before. I am still so we On 11/18/14 at 10:30a sleeping. At 12:05pm sleepy. I tell the nurse sleepy even though m When the Prolixin was day to 20 mg a day in sleepy and weak. I tol dose was too high." A complaining of dizzine R9's Psychiatric Prog documents that he rei decreased to 15 mg. 2 Prolixin but instead in monitored by staff and the medication if staff E24's Nurses' Progree 1:15pm documents thi notified regarding R9'	uments Prolixin medication anoid Schizophrenia. ress Note dated 11/13/14 rolixin was decreased to m, R9 stated, "I used to be ns (mg) in the morning and less sleepy. But then the to 20 mg at night. I was ne morning. The doctor n by 2.5 mg. I was at 20 mg 5 mg at night. And then she o I will be at 15 mg like eak and sleepy and dizzy." am, R9 was still in bed n, R9 stated, "I'm still so es all the time that I am ny Prolixin was decreased. s increased from 15 mg a the first week I was very Id (Z2-Psychiatrist) that the at 3:00pm, R9 was in bed ess and sleepiness. ress Note dated 10/10/14 quested to have his Prolixin Z2 did not decrease his dicated that R9 will be d will consider decreasing f agrees. ss Note dated 11/17/14 at nat Z1 (Physician) was s complaints of weakness, lood pressure. On 11/19/14	F	157				

Facility ID: IL6008643

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 12/17/2014 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY
		14E572	B. WING		_	12/0	08/2014
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII		600 WEST GOLF ROAD KOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	because I was focusin problems. I should've Especially because h dosage the week prio medical condition." On 11/19/14 at 11:40a they have symptoms, psychiatrist first becau meds. (R9) complaine sleepiness on/off." There is no documen notified of R9's on/off and sleepiness. On 11/19/14 at 3:41pt increased energy leve correlated to medicati to monitor him for ma attempted a further do medication had I know contacted earlier rega drowsiness and decre dose reduction on 11/ an additional dose red R9's Care Plan regard documents: Interventi of medication to appro The manufacturer spe (Fluphenazine Decan Reactions: Central Ne or lethargy, if they occ reduction in dosage.	 (Z1). (Z2) not notified ng more on medical called (Z2). I missed that. is Prolixin was decreased in r. I was focusing on his am, E9 (RN) stated, "When we usually call the use of the residents psych ed of weakness and tation indicating that Z2 was complaints of weakness m, Z2 stated, "I think his el could be directly fon reduction. But they need nia. I absolutely would have ose reduction of his Prolixin wn earlier or had been arding his sleepiness, eased energy level. I did a (13/14 but would have done duction had I known." 	F 157				

Facility ID: IL6008643

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	S FOR MEDICARE &					0.0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	PLETED	
		14E572	B. WING		12/	08/2014	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
SKOKIE N	IEADOWS NURSING CE	NTERII		600 WEST GOLF ROAD SKOKIE, IL 60076			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE	
F 157	Medication Reduction documents: Resident	n/Discontinuation Policy" will be observed, assessed, ppropriate behavioral or Psychiatrist will be lent is assessed and ychotropic med	F 157				
	admitted to the facility diagnoses include: Se Bi-Polar Type, Acute of Drug Abuse, Alcoh Esophageal Reflux D Hypertension, Syncop R13 's Physician Orc November 2014 deno week on Monday-We Dialysis Catheter Dre Needed. November POS does monitoring. On 11/19 seen in his room to h sites. One shunt in th sub-clavian port catho On 11/18/14 at 1:08p interview, surveyor of dressing from his left dressing had small an adhered to gauze dre	otes: Dialysis 3 Times per ednesday-Friday. Site: ess with Regular Gauze as a not denote any dialysis site 0/14 at 2:20pm R13 was ave two dialysis catheter e left arm and one eter. m during the group bserved R13 remove his arm dialysis site. The mount of dried exudates essing which he removed part that " I always remove					

Facility ID: IL6008643

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	-	D HUMAN SERVICES					FORM): 12/17/2014 APPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		14E572	B. WING				12/	08/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD	Έ		
SKOKIE M	IEADOWS NURSING CEI	NTERII			600 WEST GOLF ROAD KOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
F 157 F 166 SS=D	will be able to tolerate complications. Care I nursing will perform a return to the facility po not denote that dialys signs and symptoms of redness, drainage, pa and bleeding times 24 plan does not denote be checked for bruit a On 11/19/14 at 2:11pr asked about R13 's p stated in part they sho dialysis. It also does daily. Surveyor quest dressing or drainage I why exactly does he finotified. If there is a p then definitely the site signs and symptoms of monitored closely." 483.10(f)(2) RIGHT T RESOLVE GRIEVANG A resident has the righ facility to resolve griev have, including those of other residents. This REQUIREMENT by: Based upon interview facility failed to follow failed to respond prom regarding cable televi	 dialysis without any Plan does not denote that n overall assessment upon ost dialysis. Care Plan does is site will be monitored for of infection such as in, localized temperature hours post dialysis. Care that dialysis access site will nd thrill. m Z6 (Medical Doctor) was ost dialysis site care and Z6 ould not check it after every not need to be checked ioned Z6 what about a site noted and Z6 responded " have a dressing? I was not oroblem with the dressing e should be observed for of infection and be O PROMPT EFFORTS TO CES nt to prompt efforts by the vances the resident may with respect to the behavior is not met as evidenced v and record review, the their Grievance policy and nptly, resolve complaints sion made by one resident 18 and one resident (R49)		157				

Facility ID: IL6008643

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED
		14E572	B. WING		12/08/201	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 166	Continued From page	e 10	F 16	56		
	grievance resolution.					
	Findings include:					
		M, R49 stated that his DVD				
		nd a facility staff member				
	member 's name. R4	es not remember the staff				
		stated, "That's why I have				
		lock because I am afraid I				
	will lose my nice suits					
		PM, R6 stated that he wrote				
	letters of concerns ar	nd requests to the facility				
		ble television in the last few				
		d that it was reported during				
		the social worker when she				
		I what is going on. R6 stated news has been eliminated				
		as well as staff members				
	feel that it is unfair. R					
		e the facility should provide				
	cable stations that pr	ovide alternative shows				
		life experiences. R6 stated				
	-	tay in his room most of the				
		the change in cable service,				
		aying in his room anymore. PM, E16 PRSD (Psychiatric				
		es Director) stated she heard				
		g DVD player on 11/17/14 at				
		hat the report of the missing				
	DVD player was repo	orted to her by E17 Activity				
		2:05PM, when asked about				
		player, E17 stated that R49				
	is " having those mo					
		nce Book from 10/23/13 was				
		s no evidence of R49 ' s VD player documented. E16				
	-	tion on 11/18/14, at 2:05PM.				
		pPM, E11 RN (Registered				
		19 is alert and oriented X3 (to				
	person, time and plac					

Facility ID: IL6008643

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 12/17/2014 APPROVED . 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY
		14E572	B. WING		_	12/0	08/2014
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SKOKIE M	EADOWS NURSING CEI	NTERII		600 WEST GOLF ROAD KOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 166 F 224 SS=J	stated that R49 is con decision-making capa Cardex documents: " with a BIMS score is a progress notes docum and oriented in all sph The facility 's undated Policy and Procedure facility will make every satisfactorily resolve a grievance brought to t administration. This in concerning missing pr appropriate staff mem complainant to discus complaint, and will ac matter to the resident satisfaction. " The fac policy. 483.13(c) PROHIBIT MISTREATMENT/NET The facility must dever policies and procedur mistreatment, neglect and misappropriation	cerns appropriately. E 11 asistent with his acities. R49 ' s Care Plan ' alert and oriented x 3 " eleven (11), Social Service ments in part: " (R49) is alert heres. " d policy titled " Grievance " states in part: " This y effort to promptly and any complaint, concern or the attention of neludes grievances roperty. Procedure#1. The aber will meet with the ss the nature of the t promptly to resolve the or representative ' s cility failed to follow this GLECT/MISAPPROPRIATN elop and implement written es that prohibit c, and abuse of residents	F 166				
	assess R7 's complai	glected to comprehensively int of pain, provide on-going omplaint of pain., create					

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/17/20 FORM APPROVE MB NO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(3) DATE SURVEY COMPLETED
		14E572	B. WING				12/08/2014
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP COD	E	
		NTED I		46	00 WEST GOLF ROAD		
SNOKIE I	IEADOWS NURSING CE	NIERII		SK	(OKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 224	investigate R7 's refu psychosocial program isolative behavior, im who has diagnoses o of care to R7 's curre identify R7 's need for attention, notify the p of pain and decline in psychiatrist of R7 's i decline in overall func- change MDS (Minimu care to address signif As a result, R7 suffer outcomes and R7 cor and suffered decline in Living) capabilities re personal hygiene/gro bathing and transfers The facility 's failures jeopardy. The immed determined to have b doctor created a plan Therapy) for pain for assistance, neck and of care was not follow There is no evidence 8/27/14. On 11/20/14, at 11:15 notified of the immed determined that R7 p continued decline wa While the immediacy at 6:00 PM, the facilit at a Severity Level 2 educate their staff an from their abatement Findings include:	ss R7 ' s complaint of pain, usal to attend activities and nming, monitor R7 ' s plement Care Plan for R7 f Mental Illness, adapt plan ent level of functioning, or additional behavioral hysician of R7 ' s complaint overall function, notify the isolative behavior and ction, create a significant um Data Set) and plan of ficant decline of condition. ed negative psychosocial ntinued to isolate himself in ADL (Activities of Daily lated to ambulation, oming, toileting, dressing, a resulted in an immediate iate jeopardy was egun on 8/27/14 when R7 ' s for R7 to have PT (Physical flexibility, posture back exercises but the plan wed-up by the facility staff. that R7 received PT after 5 AM, E1 Administrator was iate jeopardy once it was ain and subsequent s not addressed. was removed on 11/20/14 y remains out of compliance as the facility continues to d implement interventions	F	224			

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 12/17/20 DRM APPROVE NO. 0938-039	
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION	(X3) D	ATE SURVEY OMPLETED	
		14E572	B. WING				12/08/2014	
NAME OF P	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP CO	DDE		
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 224	the facility on 12/4/13 hospital with diagnoss Schizoprenia, Hernia Decompression. R7 Screening/Mental He documents in part: S Observation by MD/F Doctor/Registered Ne monitoring, adjustme community re-integra Activities of Daily Livi and Mental Health Re acute acre psychiatri instruction dated 12/4 Notify physician if ex following: Recurrence that led to hospitaliza yourself." On 11/17/14, at 9:30 with E2 DON (Director room while the reside in progress. E2'state resident morning me room. On 11/17/14, at 2:00 did not attend in-hous On 11/17/14, at 3:07 stated R7 prefers to s complain of pain to h On 11/17/14, at 3:45 bent (fetal) position. If go to activities and re because he is stiff an told the nurse about 1 On 11/17/14, at 4:00 bent (fetal) position. If position from the bed moved slowly, with fa	 a from acute care psychiatric tees of Spine Injury, Paranoid teed cervical disk, C3-C4 's PAS/MH (Pre-admission ealth) dated 12/6/13 pecial Services- Professional RN (Medical urse) for medication ent and stabilization, ation activities, Instrumental ing training/reinforcement ehabilitation activities. The c hospital discharge 4/13 documents in part: " periencing any of the e of psychiatric symptoms ation; Inability to care for AM, during the initial tour for of Nursing), R7 was in his ents ' morning meeting was d that all residents attend eting every day in the front PM, R7 was in his room and se activities. PM, E12 Activity Director stay in the room because of is legs. PM, R7 was on his bed, in a R7 stated that he does not esident morning meetings and sore. R7 stated that he his complaint of pain. PM, R7 was on his bed, in a R7 had difficulty changing his it to standing position. R7 	F	224				

Facility ID: IL6008643

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							<u>IO. 0938-03</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		ISTRUCTION	· · ·	TE SURVEY MPLETED
		14E572	B. WING _			1	2/08/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		
SKOKIE M	EADOWS NURSING CE	NTERII	4600 WEST GOLF ROAD SKOKIE, IL 60076				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 224	Continued From page	2 14	F 2	24			
		and stabilize himself in a					
	stooping position. R7 walked approximately three feet distance (from his bed to his dresser) with a						
	slow and wobbly gait	,					
	On 11/17/14 at 4.30	PM, R7 stated that he uses					
		because it is very difficult for					
		room because of the pain to					
	his neck, legs and arr	•					
		et away from his bed. R7					
	stated that he is afraid	d he might fall if he walks to					
		Care Plan initiated on					
		part: " Urinals provided at					
		MD (Medical Doctor) for					
	-	" There is no evidence that					
	now uses the urinal a	d of the change - that R7					
		Am, R7 was in his room					
	and stated that he do						
		his aches and pain to his					
	legs, arms, neck and	upper back. R7 stated, "I					
	probably need a powe	er chair to be comfortable. "					
		s walking and he used to					
		ty when he " was not in so					
	-	ed that it is also difficult for					
		smoke because of his pain.					
		bility to do the things he d and angry. R7 stated, "I					
		of here and go to another					
	nursing home. "	of here and go to another					
		AM, E9 RN (Registered					
	Nurse) stated that R7						
		harted in the nurses ' notes.					
		s no Pain Assessment					
		hthly or quarterly after E9					
		E9 also stated that the					
		een notified to obtain order					
	when k/ complained	of pain. E9 checked the					

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		<u>D. 0938-039</u> E SURVEY
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	СОМ	PLETED
		14E572	B. WING		12	/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 224	confirmed that Motrin 11/15/14 without a do no documentation in the stated that the facility pain assessment but assessment not comp have a form that we up going to assess (R7) doctor. " On 11/18/14, at 10:20 R7 did not attend on- that the pain to his ne and R7 has already in to the nursing staff. On 11/18/14, at 11:30 Physician) stated that because of Osteoarth facility does not allow more than two weeks on the nurses to notif of pain. Z1 stated that was still complaining he would have ordere he was notified earlie not aware of R7 's ow	was administered to R7 on actor 's order and there was the nurses 'notes. E9 's policy was to complete a confirmed that pain bleted. E9 stated, "We use." E9 stated, "I am right now and will call the 0 AM, R7 was in his room. going activities. R7 stated eck and upper back is worse eported his complaint of pain	F 22	24		
	him; (R7) cannot even shoes; he used to. " grooming, personal h stated, " I do everyth that " the only thing (teeth " when it come stated that he takes c of 14 days. E14 also	ated, " I do everything for n pull his pants or tie his When asked about ygiene and bathing, E14 ing for him. " E14 stated R7) can do is brush his s to personal hygiene. E14 care of R7 ten (10) days out stated that R7 complains of ays of the ten (10) days he				

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	OF DEFICIENCIES	MEDICAID SERVICES		CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
		14E572	B. WING		1	2/08/2014
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII		500 WEST GOLF ROAD KOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		SHOULD BE	(X5) COMPLETIO DATE
F 224	Continued From page 16 complains of pain was always reported to the Nurse but E14 does not know what the nurses did		F 224			
	Director of Nursing) s shows decline of abili Living), the staff shou decline ", notify the of appropriate placement provide ADL (Activitie	AM, E3 ADON (Assistant tated that when a resident ties ADL's (Activities of Daily Id determine the "kind of				
	have that. " E3 stated does pertaining to AD the Care Plan. E3 als complaints of pain da nurses should call the There was no Care n decline of abilities to	d that anything that the staff DL should be documented in to stated, "We don't chart ily." E3 also stated that the e doctor if there is no relief. oted addressing R7's perform his ADL's. This				
	stated that when a re ADL functions, the fac approach. E1 further decline in condition st	by E3. PM, E1 (Administrator) sidents shows a decline of cility staff uses a holistic explained that a resident ' s hould be investigated and that if a resident needs PT				
	(Physical Therapy), th nursing facility for out resident can be admit facility and return whe On 11/19/14, at 1:05 Rehabilitation Service	ne resident can go a skilled patient therapy or the tted to a skilled nursing en the resident gets better. PM, E7 PRSC (Psychiatric es Coordinator) stated that sychosocial groups anymore.				
	When asked what was stated that she charter psychiatrist about it. It supposed to attend in	is done to address it, E7 ed it but did not notify the				

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		14E572	B. WING		12/08/2014	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET	
F 224	Continued From page	e 17	F 22	24		
		eeds intervention. E7 also ot aware if R7 was attending				
	On 11/19/14, at 1:36 PM, E3 (ADON) stated that R7 " can be isolative. " When asked if the					
	" Not really. " The Be	being monitored, E3 stated, ehavior monitoring Record ember, 2014 was blank. This				
	finding was confirmed On 11/19/14, at 3:35	d by E3. PM, E16 PRSD (Psychiatric				
	aware that R7 stoppe	es Director) stated she is not ed going to psychosocial S stated that the psychiatrist				
		out it. E16 also stated, " (R7				
		d that R7 should be in se activities if R7 is not going				
	that R7 was not atten	rams. E16 was not aware iding in-house activities.				
	8/15/14 documents in	itpatient Progress note dates n part: (R7) medical history:				
	(third 4th Cervical) de	ted Cervical disk s/p C3-C4 ecompression in 2007 will				
	defer pain control to I Doctor ' s Progress n					
	interferes with walk	ing. Depressed, Gait- orward flexed posture				
	Chronic Pain: Cons	sider PT (Physical Therapy) /) for flexibility, posture				
	evidence that R7 rec	k exercises. " There is no eived PT after 8/27/14. On , E3 ADON (Assistant				
	Director of Nursing) v	validated that the PT was not ursing staff. E3 confirmed				
	call the doctor about					
		ed 10/20/14 documents in n arms, legs and neck				

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUIT	IPLE CONSTRUCTION		O. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:	· ,	NG	· · ·	PLETED		
		14E572	B. WING _		12	2/08/2014		
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE			
SKOKIE M	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE		
F 224	Continued From page	e 18	F 2	224				
		There was no evidence of						
		complaint of pain. This						
	finding was validated by E3 on 11/18/14, at 10:25 AM.							
	Per MAR (Medicatior	Administration Record)						
		gust, 2014, September, 2014						
		nere is no evidence of pain						
		er, 2014 documents that the						
	-	Motrin once to R7 - 10/20/14,						
		e is no date or time when R7 er pain medication was						
	administered.	a pair medication was						
		to address R7 's complains						
		nedical record. On 11/18/14,						
		dinator stated validated the						
		I will create a Care Plan for						
	pain today. "							
	Pain Assessment/Ma	nagement undated facility						
		part: "Policy#1. A clinical						
		dmission, monthly when pain						
		ure #2. Formulate care plan						
	•••••••	nysician when nursing red medical intervention are						
	not sufficient.	ed medical intervention are						
		nmary from July to October,						
		For both months of July and						
	August, 2014, the rec							
		and steady with behavior as						
		Monthly Nursing Summary						
	dated 9/12/14 docum							
		and paranoid. Monthly						
		ted 10/24/14 documents: or: Delusional and Paranoid.						
		that the changes in gait and						
	behavior were addres							
		tion Record on the following						
		part: 9/30/14 documents in						
	part. Rehavior exhibit	ed- isolative, withdrawn.				1		

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STATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	PLETED
		14E572	B. WING		12	/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SKOKIE N	IEADOWS NURSING CE	NTERII	4600 WEST GOLF ROAD SKOKIE, IL 60076			
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 224	10/31/14 documents remains isolative and evidence that the ons isolative and withdraw addressed by the faci Psychiatric progress and 10/24/14 did not withdrawn behavior. T that Z2 was notified of behavior of R7. Psychotropic Care PI documents intervention occurrence of for targ document per facility behavioral tracking st specific behavioral co address mood/behav The facility 's Behavi from February, 2014 reviewed. The followi uncoded (No specific March, 2014, April, 20 and November, 2014 E3 (ADON) stated that tool is used to track re facility 's monitoring to changes of behavior. from the Behavior Mo when planning the ca for a resident. The facility 's undate Medications policy do #11. Documentation of which includes sympt psychotropic medicat permanent or transien	in part: Behavior exhibited - withdrawn. There is no set and persistence of wn behaviors were ility. notes dated 8/25/14, 9/26/14 identify R7 ' s isolative and There is no documentation of the isolative and withdrawn an initiated 9/18/14 ons in part: " Monitor/record yet behavior symptoms and protocol; Update and code neets as indicated; Offer bunseling and intervention to	F 224			

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		MEDICAID SERVICES		E CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,			MPLETED
		14E572	B. WING		1	2/08/2014
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SKOKIE M	EADOWS NURSING CE	NTERII		1600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 224	Behavior Monitoring F antidepressant, antips sedative-hypnotic, mo anticonvulsant medica medications to record appropriate diagnosis and side effects. Social Service Progree 11/7/14 were reviewe reviewed did not iden Withdrawn behaviors Initial Activity History 12/12/13 documents to time, place and per interests include mus and being outdoors, t movies, social events resident ' s council, in Activity Progress Note in part: Resident had in bed. There is no ev created to address R ² in bed. " R7 ' s Care Plan date part: R7 ' s Care Plan documents in part: (R illness; Intervention: <i>A</i> activities to go to. Inter inappropriate behavior has demonstrated soc Long Term Placemen involved in programs resident group or acti Activity dated 9/24/14	blicy documents in part: Record is used for sychotic, psycho-stimulant, bod stabilizing and ations, anti-anxiety I target behaviors, a, interventions, outcomes ess Notes from 5/21/14 - d. The documentation tify R7 's Isolation and and Assessment dated that R7 is alert and oriented rson and R7 's activity ic, reading, writing, walking alking or conversing, //parties, organization like ttellectual games and trivia. es dated 9/24/14 documents been spending a lot of time ridence of a care plan being 7 's "spending a lot of time d 9/18/14 documents in i initiated on 9/18/14 47) has severe mental Assign (R7) to group or ervene when any or is observed. Focus - (R7) me difficulty adjusting to t; Intervention: Get resident and activities. Assign the vities to go to. Care Plan 4 documents in part: (R7 's) poor functioning with peers.	F 224			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	3	· /	PLETED
		14E572	B. WING		12	/08/2014
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 224	 224 Continued From page 21 level of function/condition. On 11/19/14 @ 2:05 PM, E12 (Activity Director) validated the absence of plan of care to address R7 's activity needs. E12 stated, "I missed it." Facility 's undated policy, titled "Activities " documents in part: The facility shall provide an on-going program of activities to meet the interests and preferences and the physical, mental and psychosocial well-being of each resident. (e) Activities shall be adapted, as needed, to provide for maximum participation by individual residents. If a particular resident does not participate in at least an average of four (4) activities per day over one week period, the unit director shall evaluate the resident 's participation and have the available activities modified and/or consult with the interdisciplinary team. Mental Health Progress notes dated 9/2/14 documents R7 's is not attending Anger, Men's Health and Stress programs. Men's ' group was documented as " discontinued " but there was 		F 22	24		
	no documentation of evidence of the psych The facility 's undate Management and Be documents in part: " identify residents who chaotic, and disorgar demonstrate greater de-compensation incl oneself and/or other p may need additional medication managem their behavioral treats	the reason. There was no niatrist being notified. d policy titled Behavior havior Health policy Overview: It 's purpose is to o demonstrate unstable, nized behavior who may potential for luding aggression towards persons. These residents psychiatric consultation, nent and/or modifications in ment plan. Problem-solve mptoms are communicating. olvement in on-going				

Facility ID: IL6008643

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						RINTED: 12/17/2014 FORM APPROVED MB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION		(3) DATE SURVEY COMPLETED
		14E572	B. WING				12/08/2014
NAME OF P	ROVIDER OR SUPPLIER	1		STR	EET ADDRESS, CITY, STATE, ZIP CO	DE	
	IEADOWS NURSING CE			460	0 WEST GOLF ROAD		
SKUKIE	EADOWS NORSING CE	NIEKII		SK	OKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 224	implements plans of a safety living environm services/training, more implemented change revisions to the action primarily through the clinical social work co- identifying residents in behavioral attention. the staff addressed R behavioral attention. Psychiatric Rehabilitation. Psychiatric Rehabilitation. Psychiatric Rehabilitation. Po- response shall includ counseling about the personal consequence poor engagement. " appropriate education when R7 stopped part programming. House Rules & Beha documents in part: Re- out of bed in the more physically ill by medice evidence of any type relation to R7 's bein morning and not atter meetings. Quarterly MDS (Minin 3/17/14 documents th (in comparison with A 12/17/2013): ADL fur and Bathing; new ons Frequency document in behavior which wa	nanagement challenges and action to promote a safe and nent, stressing educational nitoring the effect of s and making needed n care plans. The IDT, social services staff and onsultant are responsible for n need of additional " There is no evidence that ation Services policy date n part: " Program goal: resident in his/her recovery or Participation: Staff e appropriate education and value of interventions and ces the resident faces for There is no evidence that n and counseling was done tricipating in psychosocial vioral Expectations esidents are expected to be ning unless evaluated as cal personnel. There is no of evaluation performed in g not being out of bed in the nding residents ' morning mum Data Set) dated he following areas of decline admission/Initial MDS dated hertion- decline in Dressing	F	224			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		14E572	B. WING			12/	/08/2014
NAME OF PI	ROVIDER OR SUPPLIER		- 1		STREET ADDRESS, CITY, STATE, ZIP CODE		
					4600 WEST GOLF ROAD		
SKOKIE N	IEADOWS NURSING CEI	NTERII			SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 224	 & delusion; Emergeno which included the fol feeling down, sad, de feeling tired and havir about himself; trouble There was no Signific completed. On 11/19/ MDS/CP (Minimum D Coordinator validated MDS was not comple significant change ME comprehensive asses done. E8 stated, " W stated that a significan done if there is a char and ADL's (Activities of Immediate Jeopardy V 6:00 PM. E1 was notified interviewing of staff an effectiveness of the need to interviewing of staff an effectiveness of the per The facility submitted 1. The facility notified and obtained an orde Motrin to 800 mg (mill (Three Times a Day) physician planned to 2. The facility notified 11/20/14 and was sch 11/20/14. A significant char assessment will be co (Assessment Reference) 	cc of sad or anxious mood lowing documentation: pressed and helpless; ng less energy, feeling bad concentrating on things. ant Change MDS 14, a 11:06 AM, E8 ata Set/Care Plan) that Significant Change ted. E8 stated that a DS (Minimum Data Set) asment should have been e have criteria for that. " E8 nt change MDS should be nge in behavior, cognition of daily Living). was removed on 11/20/14 at fied. However, the facility ompliance at severity level 2 to allow for complete nd to evaluate the lan of correction. the following plan: ed the attending physician r on 11/20/14 to increase the ligrams) from 600 mg TID for weeks. The attending see R7 on 11/21/14. ed the psychiatrist on heduled to see R7 on t was completed on mge comprehensive ompleted with an ARD	F	224	4		

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		14E572	B. WING		12/08/2014		
AME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP C	•		
	IEADOWS NURSING CE	INTER I I		00 WEST GOLF ROAD (OKIE, IL 60076			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 224	was initiated on 11/20 7. Care Plan was a performance deficits with a goal for R7 to decline in ADL function 8. (Activity) Care F symptom of isolation impairment was initia 9. Care Plan was u addressed R7 's isol included Intervention limited to: Do informa Invite (R7) to activitie groups. Encourage (I 10. Care Plan addre Term Care placement adding a new interve an activity, (R7) can attends activity. 11. The facility 's Par revised which include Pain level is re-asses (30) minutes to one (of the ordered medic relieved, the MD (Me by the nurse for a cha- increase in dose. For physician for further 12. R7 was referred was evaluated by PT 11/20/14.	essing R7 's complain of pain 0/14. addressing R7 's self-care was initiated on 11/20/14 " not show any further on." Plan addressing R7 's , psychosocial/psychiatric ted on 11/20/14. updated on 11/20/14 that ative behavior which s which includes but not al one to ones with resident. es if (R7) does not attend R7) to attend activities. essing adjustment to Long t was updated on 11/20/14 ntion: Personal invite R7 to have a reward after he ain Management Policy was es but not limited to: #6 e. essed and documented thirty 1) hour after administration ation. If the pain is not edical Doctor) will be notified ange in medication or r continued pain, alert the orders. " to PT (Physical Therapy). R7 (Physical Therapy) on made an appointment for R7 rsical Medicine and	F 224				
F 226	,		F 226				

Facility ID: IL6008643

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CENTER STATEMENT C AND PLAN OF NAME OF PP	MENT OF HEALTH AN S FOR MEDICARE & I OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER BEADOWS NURSING CEI	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E572	· <i>`</i>	NGS	TREET ADDRESS, CITY, STATE		FORM OMB NC (X3) DATE COMP): 12/17/2014 1 APPROVED 0. 0938-0391 SURVEY LETED 08/2014
				S	KOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 226	policies and procedur mistreatment, neglect and misappropriation This REQUIREMENT by: Based on observation review, the facility failur regarding the staff 's suspected crime. Findings Include: During the environme started at 2:00 PM, the information regarding report a suspected crime or 11/19/14 at 3:16 P stated in part that the information for staff to suspected crime, in the failed to identify where the facility. On 11/19/14 at 3:40 P stated in part that the information for staff to suspected crime, in the provided staff training suspected crime. The facility 's undated Program Facility Proc and training of employ part the following:	lop and implement written es that prohibit , and abuse of residents of resident property. is not met as evidenced n, interview, and record ed to post information obligation to report a ntal tour on 11/19/14 that ere was no posting, with the staff ' s obligation to me, in the staff ' s locker M, E26 (Dietary Aide) re is no posting with follow to report a ne staff ' s locker room. E26 e the posting was located in M, E1 (Administrator) re is no posting with follow to report a ne facility. E1 has not regarding how to report a	F	226				
	obligation for reporting how to file such a report	g a suspected crime and ort without retaliation.						

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		MEDICAID SERVICES				0.0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION	(X3) DATE COMP	SURVEY		
		14E572	B. WING		12/08/2014			
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE				
SKOKIE M	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETIO DATE		
F 241	Continued From page	e 26	F 241					
F 241 SS=D			F 241					
	manner and in an en	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.						
	by: Based on observatio failed to provide a dig	 is not met as evidenced n and interview, the facility infied dining experience for 18 residents reviewed for 18. 						
	Findings include:							
	table with six residen R44, R45) waiting for	Certified Nurse Assistant) n to pass trays to the						
	R40 received his tray R41 received his tray R42 received his tray R43 received his tray R44 received his tray R45 received his tray	at 12:08pm at 12:10pm at 12:09pm at 12:10pm						
	R45 began to eat. At "I'm hungry." E22 sta yet." At 12:15pm, R4 came down to the dir been waiting for 15 m	R41, R42, R43, R44 and 12:10pm, R4 stated to E22, ted, "You're tray is not ready stated to the surveyor, "I ning room at 12:00pm. I've ninutes. It bothers me that s the only thing to look						

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If continuation sheet Page 27 of 129

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/17/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		14E572	B. WING		12/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•
	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD	
		ATEMENT OF DEFICIENCIES		SKOKIE, IL 60076	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 241	Continued From page	e 27	F 24	41	
	R41, R42, R43, R44	at 12:16pm. By then, R40, and R45 were already d and leaving the table.			
	R4's tray was deliver	pm, E22 was asked why ed later than the others' ecause some trays were not			
F 248 SS=D			F 24	48	
	of activities designed the comprehensive a	vide for an ongoing program to meet, in accordance with ssessment, the interests and and psychosocial well-being			
	by: Based upon observa review, the facility fail resident 's activity pa modify activities to m	is not met as evidenced ition, interview and record led to plan and evaluate articipation and failed to eet the needs, abilities and esident (R7) in the sample			
	on-going in-house ac On 11/17/14, at 2:30F stated that R7 does r On 11/17/14, at 3:07F stated R7 prefers to s complain of pain to h	Pm, E32 (Activity Staff) not attend group activities. PM, E12 (Activity Director) stay in the room because of			

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						<u>0. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	· · · ·	E SURVEY PLETED
		14E572	B. WING		12/08/2014	
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CEI	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIOI DATE
F 248	Continued From page	28	F 24	48		
	go to activities and the					
	because he is stiff and	v				
		Am, R7 was in his room and				
		participate in the house				
	legs, arms, neck and	his aches and pain to his				
		AM, R7 did not attend				
	on-going activities.					
		and Assessment dated				
		that R7 is alert and oriented				
		rson and R7 ' s activity ic, reading, writing, walking				
	and being outdoors, ta					
	-	/parties, organization like				
		tellectual games and trivia.				
		es dated 9/24/14 documents ad been spending a lot of				
	-	s no evidence of a care plan				
		ified to address R7 's "				
	· •	in bed. "R7's Activity				
		/14 did not document any				
		no evidence of one-to-one . On 11/19/14, at 2:05PM,				
) validated these findings.				
F 274	· · ·	PREHENSIVE ASSESS	F 27	74		
SS=G	AFTER SIGNIFICAN	T CHANGE				
	A facility must conduc	at a comprohensive				
	A facility must conduct assessment of a resid	dent within 14 days after the				
		should have determined,				
	that there has been a	significant change in the				
		mental condition. (For				
		n, a significant change le or improvement in the				
		will not normally resolve				
		ntervention by staff or by				
	implementing standar	d disease-related clinical				
	interventions, that has	an impact on more then	1			1

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUTIPI	E CONSTRUCTION		O. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:				IPLETED		
		14E572	B. WING		1:	12/08/2014		
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE				
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE			
F 274	one area of the reside	e 29 ent's health status, and ary review or revision of the	F 274					
	by: Based upon observa review, the facility fail comprehensive asses significant decline of of (R7) in the sample of resulted in R7 negative increased isolation ar daily living (ADL) relat incontinence, dressin Findings include: On 11/17/14, at 2:00F did not attend in-hous 3:07PM, E12 Activity stay in the room becat his legs. On 11/17/14, at 3:45F bent (fetal) position. F to activities and the m he is stiff and sore. R nurse about his comp On 11/17/14, at 4:00F bent (fetal) position. F position from the bed moved slowly, with fa changing his position able to get out of bed stooping position. R7 feet distance (from hi slow and wobbly gait.	essment to address condition for one resident 18 residents. This failure we phychosocial outcome, nd decline in activities of ted to ambulation, g, bathing and transfers. PM, R7 was in his room and se activities. On 11/17/14, at Director stated R7 prefers to nuse of complain of pain to PM, R7 was on his bed, in a R7 stated that he cannot go norning meetings because 7 stated that he told the plaint of pain. PM, R7 was on his bed, in a R7 had difficulty changing his to standing position. R7 cial grimacing, while to grab his walker. R7 was and stabilize himself in a walked approximately three s bed to his dresser) with a						

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/17/2014 FORM APPROVED MB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		3) DATE SURVEY COMPLETED
		14E572	B. WING				12/08/2014
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
	IEADOWS NURSING CE	NTED I		46	00 WEST GOLF ROAD		
SKOKIE N	EADOWS NORSING CE	NIERII		SK	(OKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 274	he might fall if he wal On 11/18/14 at 10:00 stated that he cannot activities because of legs, arms, neck and is difficult for him to g because of his pain. If a power chair to be co- his inability to do the sad and angry. On 11/18/14, at 10:05 Nurse) stated that the notified to obtain orde pain. E9 stated, " I al now and will call the co- On 11/18/14, at 10:20 did not attend on-goin the pain to his neck a R7 has already repor the nursing staff. On 11/18/14, at 11:30 Physician) stated that because of Osteoarth facility does not allow more than two weeks aware that R7 was st also stated that he wa decline of condition. On 11/19/14, at 11:00 Director of Nursing) s shows decline of abili Living), the staff shou decline ", notify the co appropriate placemer On 11/19/14, at 10:50	ed. R7 stated that he is afraid ks to the washroom. Am, R7 was in his room and participate in the house his aches and pain to his upper back. R7 stated that it o the patio to smoke R7 stated, " I probably need omfortable. " R7 stated that things he enjoys makes him 5AM, E9 RN (Registered e doctor should have been er when R7 complained of m going to assess (R7) right doctor. " DAM, R7 was in his room. R7 ng activities. R7 stated that thind upper back is worse and ted his complaint of pain to DAm, Z1 (Attending t R7 has chronic pain nritis. He stated that the v PRN pain medications for a. Z1 stated that he was not ill complaining of pain. Z1 build have ordered pain te was notified earlier. Z1 as not aware of R7 ' s overall DAM, E3 ADON (Assistant tated that when a resident tites ADLs (Activities of Daily uld determine the " kind of doctor, and discuss	F	274			

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	S FOR MEDICARE &				OMB NO. 0938-			
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		14E572	B. WING		12/08/2014			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ε			
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076				
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLE			
F 274	Continued From page	e 31	F 27	74				
		tie his shoes. When asked sonal hygiene and bathing,						
		erything for him. " E14 [,] thing (R7) can do is brush						
		omes to personal hygiene. kes care of R7 ten (10) days						
	· ·	Ilso stated that R7 complains e days of the ten (10) days						
	he takes care of him.	E14 stated that R7 's s reported to the Nurse but						
	E14 `does not know	what the nurses did after						
	informing them of R7	ˈs pain. ∂Pm, E15 PRSC (Psychiatric						
		es Coordinator) stated that						
		sychosocial groups; E15 did						
	not notify the psychia	itrist about it. PM, E16 PRSC (Psychiatric						
		es Director) stated she is not						
		ed going to psychosocial						
		stated that the psychiatrist						
		lled when R7 stopped						
	attending psychosoci	PM, Z2 (Psychiatrist) stated						
		ed biologically through						
		facility services should						
		programs and in-house						
		part of his (R7) psychosocial						
		that she is not aware of R7 '						
		decline in ADL (Activities of ties and decline in mood and						
		ted that she was not made						
		staff that R7 stopped going to						
		and is not participating						
		2 stated that the isolative						
	behavior should have	-						
	monitored because o							
		ude SAD (Schizo-Affective						
	Disorder) 72 stated (that the nursing staff should						

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	460		(X3) DATE SURVI COMPLETED			
NTER I I	STF 460					
ATEMENT OF DEFICIENCIES	460		12/08/20)14		
ATEMENT OF DEFICIENCIES		REET ADDRESS, CITY, STATE, ZIP CODE				
	50	4600 WEST GOLF ROAD SKOKIE, IL 60076				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COM	(X5) IPLETIO DATE		
e 32 o an appropriate plan of care iated that if she should have inge in R7 's behavior and e ordered R7 for rther evaluation. ated on 9/18/14 documents ere mental illness; o MD (Medical Doctor) for ; Intervene when any or is observed. tion Record on the following part: "9/30/14 Behavior vithdrawn; 10/31/14 Behavior solative and withdrawn." intion documented. 5 (Minimum Data Set) dated terly MDS dated 3/17/14 Quarterly MDS dated 3/17/14 e following areas of decline ecific MDS sections: Section : decline in Dressing and Y) - needs assistance from and Bathing; Per Initial MDS independent with all areas of ly Living) and only needed asing and Bathing; Section J eview: (R7) complained of y: occasionally; Per Initial imented " No Pain " ; 'Potential indicator of ation & delusion; Per Initial iments no potential indicator D - Mood: Emergence of : feeling down, sad,	F 274					
	an appropriate plan of care ated that if she should have inge in R7 's behavior and e ordered R7 for rther evaluation. ated on 9/18/14 documents ere mental illness; b MD (Medical Doctor) for ; Intervene when any br is observed. tion Record on the following part: "9/30/14 Behavior vithdrawn; 10/31/14 Behavior iolative and withdrawn." intion documented. 5 (Minimum Data Set) dated terly MDS dated 3/17/14 Quarterly MDS dated 3/17/14 Quarterly MDS dated 3/17/14 cecific MDS sections: Section : decline in Dressing and ?) - needs assistance from ad Bathing; Per Initial MDS idependent with all areas of ly Living) and only needed asing and Bathing; Section J eview: (R7) complained of y: occasionally; Per Initial imented " No Pain " ; Potential indicator of ation & delusion; Per Initial iments no potential indicator D - Mood: Emergence of	b an appropriate plan of care ated that if she should have inge in R7 's behavior and e ordered R7 for rther evaluation. ated on 9/18/14 documents are mental illness; o MD (Medical Doctor) for ; Intervene when any or is observed. tion Record on the following wart: "9/30/14 Behavior vithdrawn; 10/31/14 Behavior iolative and withdrawn. " intion documented. S (Minimum Data Set) dated terly MDS dated 3/17/14 Quarterly MDS dated 3/17/14 e following areas of decline ecific MDS sections: Section : decline in Dressing and Y) - needs assistance from id Bathing; Per Initial MDS idependent with all areas of ly Living) and only needed assing and Bathing; Section J eview: (R7) complained of y: occasionally; Per Initial imented " No Pain " ; Potential indicator of ation & delusion; Per Initial iments no potential indicator D - Mood: Emergence of : feeling down, sad, ass; feeling tired and having ad about himself; trouble gs; total severity score from	F 274 a 32 b an appropriate plan of care ated that if she should have nge in R7 's behavior and e ordered R7 for ther evaluation. ated on 9/18/14 documents are mental illness; b MD (Medical Doctor) for ; Intervene when any or is observed. tion Record on the following arat: "9/30/14 Behavior olative and withdrawn." ntion documented. 5 (Minimum Data Set) dated terly MDS dated 3/17/14 polative and withdrawn." ntion documented. 6 (Minimum Data Set) dated terly MDS dated 3/17/14 polative and withdrawn. c following areas of decline actific MDS sections: Section : decline in Dressing and ') - needs assistance from id Bathing; Per Initial MDS dependent with all areas of ly Living) and only needed using and Bathing; Section J eview: (R7) complained of y: occasionally; Per Initial ments no potential indicator D - Mood: Emergence of : feeling down, sad, ses; feeling tired and having ad about himself; trouble gs; total severity score from	P 32 P 32		

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STATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY		
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	. ,		COMF	PLETED		
		14E572	B. WING		12/	12/08/2014		
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE				
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE		
F 274	Meeting Signature sh documents eight facil includes E16 PRSD (Services Director) an Nursing Assistant) wh signifying attendance This information was (Minimum Data Set/C 11/18/14 at 10:25AM On 11/19/14 at 10:25AM On 11/19/14 at 11:06 Data Set/Care Plan) hardly have those kin asked about (SCSA) Assessment. E8 state Status Assessment s a decline in behavior, further stated that an should have been do the Quarterly, and the	re noted in the MDS ' 4 and 9/17/14. hary Team Care Plan) eet dated 3/20/14 ity staff 's signature which Psychiatric Rehabilitation d a E14, C.N.A. (Certified no takes care of R7 signed to the Care Plan meeting. validated by E8 MDS/CP Care Plan) Coordinator on	F 274	4				
	were not modified act decline. Long Term Care Faci Instrument User 's M update) documents in determining a signific status: If the condition (2) weeks, staff shoul Change in Status Ass On 11/20/14, at 5:30F Data Set/Care Plan) significant change co will be completed with Reference Date) of 1	cording to the areas of lity Resident Assessment lanual, (October, 2014 n part: "Guidelines for ant change in residents ' n has not resolved within two ld begin a SCSA (Significant sessment). " PM, E8 MDS/CP (Minimum Coordinator stated that a mprehensive assessment n an ARD (Assessment						

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION		10. 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				MPLETED
		14E572	B. WING		1	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP COD	DE	
SKOKIE N	IEADOWS NURSING CE	NTERII		600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 274	Continued From page	e 34	F 274			
	to an acute care hosp					
	behavioral symptoms	-	F 070			
F 279 SS=D			F 279			
ti c		e results of the assessment d revise the resident's of care.				
	plan for each residen objectives and timeta medical, nursing, and	elop a comprehensive care t that includes measurable bles to meet a resident's I mental and psychosocial ied in the comprehensive				
	to be furnished to atta highest practicable pl psychosocial well-bei §483.25; and any ser be required under §4 due to the resident's					
	by: Based on observatio review, the facility fail three residents (R7, F reviewed which addre loss, and ADL (activit Findings include: On 11/18/14, at 9:40a	is not met as evidenced n, interview and record ed to develop a care plan for R10, R12) in a sample of 18 essed psychosocial, weight ies of daily living) needs. am, record review of R10's es R10 did not have a care				

Facility ID: IL6008643

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		MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVE		
	F CORRECTION	IDENTIFICATION NUMBER:	· /	G	COMPLETED	I	
		14E572	B. WING		12/08/2014		
NAME OF F	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
SKOKIE I	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE COMP	X5) PLETIO ATE		
F 279	groups and 1:1 sessii (Psycho-social Rehal 9:51am, E16 (PRSD) is supposed to go to Impulse, Interpersona Relapse Prevention go to groups and has po not attend groups. I do what groups he's sup I have a care plan that groups and 1:1's." During the first three walking around the fat brassiere. An attempt was made 11/17/14 at 3:30pm. If talk to you or talk abo On 11/19/14 at 12:13 bra but it's uncomfort On 11/18/14 at 1:20p Assistant-CNA) state bra. It's been awhile. she always refuses. I I don't ask her." On 11/18/14 at 1:30p (MDS) Coordinator) s behavior/refusal rega (Activities of Daily Liv should be care planne provide intervention." On 11/18/14 at 2:15p Rehabilitation Service stated, "I've known he wears a bra. Only wh It's not care planned. If you want a care pla	ons with his PRSD o Services Director). At stated the following: "(R10) Stress Reduction, Anger & al 2, Self-Esteem, and groups. He is very resistant or impulse control. He does don't have a care plan on posed to attend. Neither do at states he is refusing days of the survey, R12 was acility without wearing a e to speak to R12 on R12 stated, "I don't want to out anything." pm, R12 stated, "I put on a able. I need a bigger bra." m, E23 (Certified Nurse d, "She refuses to wear a If you tell her to wear one, 'm not sure why she refuses. m, E8 (Minimum Data Set stated, "If someone has a rding medications, ADL's ring), if behavior is constant ed. If care plan, then able to m, E7 (Psychosocial es Coordinator-PRSC) er for 10 years. She barely en family comes into town. I think it's a personal choice.	F 21	79			

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		ND HUMAN SERVICES			FO	ED: 12/17/20 RM APPROVE
TATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY MPLETED
		14E572	B. WING		1	2/08/2014
	ROVIDER OR SUPPLIER	NTER I I		STREET ADDRESS, CITY, STATE, ZIP COI 4600 WEST GOLF ROAD	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	SKOKIE, IL 60076 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 279 F 280 SS=E	wearing a bra. R12's initiated date of 11/18 On 11/19/14, at 12:13 Nurse) stated that R2 dining room. E24 sta food from the vending were reviewed. R12 R12 's eating habits. by E8 MDS/CP (Mini Coordinator on 11/19 R12 's documented limited to: Psychosoo There was no plan de validated by E12 (Ac 2:05PM. Per weight sheet for (9) lbs. (pounds) in a not address. There is plan to prevent further An undated facility per "Comprehensive/Qua documents: 2. Care p will be formulated. 3. resident's medical, m needs. 483.20(d)(3), 483.10 PARTICIPATE PLAN The resident has the incompetent or other incapacitated under to participate in plannin changes in care and A comprehensive care within 7 days after th comprehensive asse	care plan documents an B/14. 3PM, E24 RN (Registered 12 does not eat lunch in the ted that R12 eats a lot of g machine. 12 ' s Care Plans ' s care plans do not address . The finding was validated mum Data Set/Care Plan) b/14, at 11:06AM. needs include but not cial/psychiatric impairment. ocumented. This finding was tivity Director) on 11/19/14, at the year 2014, R7 lost nine month. The weight loss was s no measurable objective or er weight loss. olicy titled, arterly Care Plan" olan goals and interventions A care plan will meet ursing and psychosocial (k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged wise found to be the laws of the State, to g care and treatment or treatment. re plan must be developed	F 27			

Facility ID: IL6008643

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		14E572	B. WING			12/	08/2014
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
SKOKIE N	IEADOWS NURSING CE	NTERII			600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	for the resident, and o disciplines as determinand, to the extent pra the resident, the resid legal representative; a	e 37 Id nurse with responsibility other appropriate staff in ined by the resident's needs, acticable, the participation of dent's family or the resident's and periodically reviewed n of qualified persons after	F	280			
	by: Based on interview a failed to revise care p individualized psycho and toileting for 4 resi	is not met as evidenced and record review, the facility plan interventions related to p-social, dietary, activities idents(R15,R7,R12,R1) of a reviewed for resident					
	with diagnoses that in Disorder, Hepatitis C, alcohol abuse, and hi On 11/19/14 at 12:59 he currently has psyc at the facility. R15 gc men ' s health, and st groups at the facility. stress reduction group health topics are inter attend psychosocial p community anymore. psychosocial program 6 months.	male admitted to the facility include: Bipolar Affective spinal stenosis, history of story of prostate cancer PM, R15 stated in part that shosocial groups scheduled bes to anger management, tress reduction psychosocial Anger management and ps are helpful. Men 's resting. R15 doesn 't't brogramming in the R15 has had scheduled inming at the facility for about					

Facility ID: IL6008643

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	S FOR MEDICARE &					10. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		FE SURVEY MPLETED
		14E572	B. WING		1	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COD	E	
SKOKIE I	IEADOWS NURSING CE	NTERII		00 WEST GOLF ROAD KOKIE, IL 60076		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 280	that he had radiation started at the beginni was scheduled for ps community, but he did because of his radiati assigned to psychoso when he was schedu psychosocial groups. radiation treatments, 't't feel good, he doesn psychosocial groups days when R15 feels scheduled psychosoc On 11/20/14 at 12:19 Rehabilitation Service that R15 was dropped groups in the commu attend the groups wh treatments (5X/week) attending his schedul the facility. E7 has sp the scheduled facility On 11/24/14 at 11:21 that she has encoura scheduled psychosoc visits with R15 and di psychosocial groups discussed in the group the 1:1 visits. The inf encourage residents psychosocial groups On 11/24/14 at 11:21 Rehabilitation Service that R15 has not att	treatments for 26 weeks that ng of the year, 2014. R15 ychosocial groups in the d not attend the groups fon treatments. R15 was not ocial groups at the facility led for the community Since R15 completed the he has days when he doesn e days when R15 doesn ' t ' ' t ' t go the scheduled in the facility and on the good, he attends the cial groups. PM, E7 (Psychosocial es Coordinator) stated in part d from the psychosocial nity because he didn ' t en he started his radiation b. R15 has not been ed psychosocial groups at poken to R15 about going to psychosocial groups. AM, E7 also stated in part ged R15 to attend his cial groups. E7 has had 1:1 scussed attending the but did not review the topics ps that R15 missed, during formal 1:1 visits are to to attend the scheduled and are not documented. AM, E16 (Psychosocial ports) stated in part ended his psychosocial porths. R15 was encouraged	F 280			

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/17/20 FORM APPROV OMB NO. 0938-03
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		14E572	B. WING		12/08/2014
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CO	
	IEADOWS NURSING CE		4	600 WEST GOLF ROAD	
SKUKIE IV	IEADOWS NURSING CE		5	SKOKIE, IL 60076	
(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 280	Continued From non	- 20	F 000		
F 200	Continued From pag		F 280		
		during the 1:1 visits. The			
	-	nentation regarding R15 's			
	1:1 visits.	undete deted 9/21/14			
		update dated 8/21/14 as poor judgment, delusional			
		coping skills, poor verbal			
		of daily living, difficulty			
	-	ears disheveled. R15 has			
		e paranoid and irrational			
	-	e facility environment. R15			
	has a history of aggr	essive, inappropriate			
	behavior due to para	noia and poor social skills.			
		les self-harmful ideation and			
		ession as well as threats			
	towards others.				
		lated 9/29/14 indicates that			
	-	and doesn't't come out of			
		neals and medications and			
	has poor hygiene pra	lated 10/21/14 indicates that			
	E7 spoke to R15 abo				
	-	and will encourage R15 to			
	attend activities durir	-			
	On 11/24/14, R15 ' s				
		ere requested for June to			
		n 11/24/14, E7 presented the			
		dance sheets for R15:			
	- ·	Control - one/time week -			
		5 attended one of three			
	available sessions of				
		time/week - October, 2014 -			
		f five available sessions and 5 attended zero of three			
	available sessions				
		ne time/week - September			
		R15 attended zero of five			
	-	nd November, 2014, R15			
		e available sessions			
		th progress notes from July			

Facility ID: IL6008643

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IAME OF PRO IAME OF PRO IXA) ID PREFIX TAG F 280 (t a (t t t t t t	ORRECTION WIDER OR SUPPLIER ADOWS NURSING CEN SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page o November, 2014 in attend any psychosoc Dctober, 2014. The p hat R15 attended one	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 40 dicate that R15 did not	· /	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 WEST GOLF ROAD SKOKIE, IL 60076 PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLET
(X4) ID PREFIX TAG F 280 (t a (t	ADOWS NURSING CEN SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page o November, 2014 in attend any psychosoc October, 2014. The p hat R15 attended one	ATER I I ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 40 dicate that R15 did not	ID PREFIX TAG	4600 WEST GOLF ROAD SKOKIE, IL 60076 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	ON (X5) D BE COMPLET
(X4) ID PREFIX TAG F 280 (t a (t	ADOWS NURSING CEN SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page o November, 2014 in attend any psychosoc October, 2014. The p hat R15 attended one	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 40 dicate that R15 did not	PREFIX TAG	4600 WEST GOLF ROAD SKOKIE, IL 60076 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLET
(X4) ID PREFIX TAG F 280 C t a C t	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page o November, 2014 in attend any psychosoc October, 2014. The p hat R15 attended one	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 40 dicate that R15 did not	PREFIX TAG	SKOKIE, IL 60076 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLET
F 280 (t a f t a f t a	(EACH DEFICIENCY REGULATORY OR L Continued From page o November, 2014 in attend any psychosoc October, 2014. The p hat R15 attended one	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 40 dicate that R15 did not	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLET
t a C t	o November, 2014 in attend any psychosoc October, 2014. The p hat R15 attended one	dicate that R15 did not	F 28		
a C t	attend any psychosoc October, 2014. The p hat R15 attended one			30	
t	hat R15 attended one	attend any psychosocial groups from July to October, 2014. The progress notes also indicate			
ł	that R15 attended one stress and one men ' s health group in November, 2014. R15 was				
0	Care plan initiated on	the scheduled groups. 8/21/14 indicates that R15			
i	rrational perceptions	, paranoid thoughts and and interpretations of his			
c	difficulty forming interp	impaired social skills and personal relationships with			
a	address his issues (in	luled for therapy groups to cluding Anger and Impulse			
a	avoid group. Impleme	 p). R15 makes excuses to ented interventions include: itation Services Coordinator 			
(•	cate with group leader			
a	attendance and partic	ipation; Staff will give the lendar and encourage			
r	esident to participate	in activities; Try to motivate and out of his room during			
r	ounds/spontaneous	-			
F	R15 ' s lack of psycho	ed, interventions to address social group attendance			
0	On 12/3/14 at 2:50 PM	Jalized psychosocial needs. <i>I</i> , E7 stated in part that she			
i	nterventions that add	ating R15 ' s care plan ress R15 ' s psychosocial ad rovicos R15 ' s care plan			
i	needs. E7 updates and revises R15 ' interventions on a quarterly basis. On 12/3/14 at 2:50 PM, E16 stated in	arterly basis.			
(Psychosocial Rehabi				
Ę	osychosocial groups i E16 have care plan m	n the facility. E4, E7, and leetings on Tuesdays and ly discuss issues/incidents			

Facility ID: IL6008643

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/17/2014 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	
		14E572	B. WING				12/	08/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE	E, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII			600 WEST GOLF ROAD SKOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 280	issues discussed vert R15 's care plan inter revised during the 11/ The facility 's undated Care Plan policy does plan interventions sho R7 's Care Plan docu provided at HS (at nig documents in part: " On 11/17/14, at 4:30F the urinal all the time him to go to the wash his neck, legs and arr approximately five fee stated that he is afraid the washroom. There and revision of the ca R7 's current condition R12 's Dietary Care F was documented as 7 updated on 10/9/14 a R12 's Activity Care F revision was document was not updated on 1 R1 's Dietary Care Pl revision was document was not updated on 1 R1 's Activity Care Pl revision was document updated on 10/08/14 policy; These finding were co Director on 11/18/14,	attend the groups. The bally are not documented. rventions should have been /20/14 care plan review. d Comprehensive/Quarterly s not indicate when care build be revised/updated. uments in part: " Urinals ght)" . Intervention Provide urinals at night. " PM, R7 stated that he uses because it is very difficult for room because of the pain to ms. The washroom is et away from his bed. R7 d he might fall if he walks to is no evidence of review the interventions to address on. Plan last review and revision 7/9/14; the care plan was not s scheduled. Plan the last review and nted as 7/8/14; the care plan 0/08/14 as scheduled. lan the last review and nted as 7/9/14; the care plan 0/9/14 as scheduled. lan the last review and nted as 7/7/14; the was not as required by the facility onfirmed by E12 Activity at 1:30PM and validated by m Data Set/Care Plan)	F	280				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 12/17/2014 DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		14E572	B. WING			12/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,		
	A STATE AND A S	NTERII		4600 WEST GOLF ROAD)	
				SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page	e 42	F:	281		
F 281 SS=E		ICES PROVIDED MEET ANDARDS		281		
	The services provided or arranged by the facility must meet professional standards of quality.					
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to obtain a physician's order prior to administering medication, failed to follow physician's orders/manufacturer specifications when administering insulin and failed to communicate with a dialysis center. These deficient practices affected three residents (R1, R7, R13) in the sample of 18 reviewed for quality of care and three residents (R19, R20, R47) in the supplemental sample.					
	4:52pm, R20's blood (milligrams per decilit Nurse-LPN) administ Novolog Aspart insuli scale. R20 did not red 6:10pm. On 11/17/14 at 5:00p was 142 mg/dl. E20 (five units of Novolog not receive his dinner Physician Order Shee through 11/30/14 doc inject 5 units subcuta with meals. R47's Ca	n Pass task, on 11/17/14 at sugar result was 269 mg/dl ere). E20 (Licensed Practical ered R20's seven units of n according to his sliding ceive his dinner tray until m, R47's blood sugar result LPN) administered R47's insulin via flex pen. R20 did r tray until 6:10pm. R47's et (POS) dated 11/1/14 suments: Novolog Flex pen neously three times daily re Plan documents: es medication as ordered by				

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						<u>NO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
		14E572	B. WING		1	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 281	Continued From page	2 43	F 2	81		
		am, R19's blood sugar result				
	was 232 mg/dl. E9 (R	•				
		s going to administer three				
		Ilin according to R19's				
		units of Humalog insulin				
		ly scheduled insulin with				
		ed 15 units of Humalog				
		at 11:52am. R19's POS nents: Increase Humalog 12				
		busly) with lunch. R19 did not				
	-	al until 12:15pm. R19's Care				
	Plan documents: Inte	rventions: Diabetes				
	medication as ordered	-				
		am, R1's blood sugar result				
		N) indicated that she was				
		ovolog insulin four units ing scale plus Novolog				
		was his regularly scheduled				
		als. E9 administered 26 units				
	of Novolog insulin to I	R1 via flex pen at 11:54am.				
	E9 did not prime the i	nsulin pen before dialing it				
		s. E9 did not keep the				
		nen holding the insulin pen				
		n for seven seconds. R1 did meal until 12:13pm. R1's				
		: Interventions: Diabetes				
	medication as ordered					
	On 11/19/14 at 12:55	-				
		, "Insulin should be given				
	with meals or directly	after meals. By the time the				
		n, the trays should be up				
	here already. Resider	nt could experience				
	hypoglycemia."	m E24 (PN) stated				
	On 11/20/14 at 9:45a	sulin is fast acting so we				
		minutes before meals or				
		Id happen? Blood sugar				
		E24 stated, "With the insulin				
	flex pen, you should l		1			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/17/2014 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	
		14E572	B. WING		_	12/	08/2014
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	needle in the skin. If y pen, the needle won't get all of insulin." An undated facility po Subcutaneous" docur medication order befo sheet with medication and dosage. The manufacturer spe insulin documents: Be rapid onset and a sho human regular insulin immediately (within 5 The manufacturer spe FlexPen insulin docur small amounts of air r during normal use. To ensure proper dosing to select 2 units G. Ke upwards, press the pu The dose selector ret should appear at the needle and repeat the times. Step 13: Press button until the dose of	r. That's what keeps the you let go of the end of the be in skin. Resident won't licy titled, "Injections, ments: Procedure: 1. Check ore preparing drug. a. Order a sheet for correct time, drug ecification for Novolog ecause Novolog has a more orter duration of activity than a, it should be injected -10 minutes) before a meal. ecifications for Novolog ments: Before each injection may collect in the cartridge o avoid injecting air and to : E. Turn the dose selector eep the needle pointing ush button all the way in. urns to 0. A drop of insulin needle tip. If not, change the e procedure no more than 6 and hold down the dose counter shows "0". Keep the ter the dose counter has	F 28				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
		14E572	B. WING		12/0	08/2014
NAME OF P	ROVIDER OR SUPPLIER	·	S	STREET ADDRESS, CITY, STATE, ZIP COD	Ε	
SKOKIE N	IEADOWS NURSING CE	NTERII		600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 281	diagnoses: Schizo-Af Type, Acute Psychoti Abuse, Alcohol Deper Hypertension, Syncop R13 's Physician Ord November 2014 dend week on Monday-We Dialysis Catheter Dre Needed. On 11/19/14 at 9:30ar was asked about corr and dialysis center. E dialysis center sends and facility communic notes. " E24 stated i checked once in a wh document that. " Sur shunt site dressing is and E24 stated " son " Facility 's Policy titled Residents On Dialysis facilitate care of resid designated dialysis cer residents return to the will do an overall asse Dialysis site will be m symptoms of infection pain, localized tempe hours post dialysis. Contract for Skilled N Outpatient Dialysis Se facility and local dialy Services Provided by	er Sheet (POS) denotes fective Disorder Bi-Polar c Episode, History of Drug ndence, Diabetes Mellitus, pe and Hydronephrosis . der Sheet (POS) for otes: Dialysis 3 Times per dnesday-Friday. Site: .ss with Regular Gauze as m E24 (Registered Nurse) munication between facility E24 stated in part that "yes, laboratory values routinely cates in house in nurses in part " bruit and thrill is hile but we don ' t really rveyor asked E24 if dialysis being checked regularly netimes, when he asks for it. d Policy And Procedure Of s states: Purpose: To lents receiving dialysis in a enter. Procedure: 4. Upon e facility, the nurse on duty essment of the resident. 5. ionitored for signs and n such as redness, drainage, rature and bleeding times 24	F 281			

Facility ID: IL6008643

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(¥3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED
		14E572	B. WING		12	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CEI	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 281	Facility information or management of the re provision of dialysis s on management of m emergencies, includir bleeding/hemorrhage of dialysis success sit access site. R13 's Dialysis Care with a target date of 1 will be able to tolerate complications. Care I nursing will perform a return to the facility por not denote that dialys signs and symptoms of redness, drainage, pa and bleeding times 24 plan does not denote be checked for bruit a On 11/19/14 at 1:10pt DON stated that R13 pressure to be taken and takes no informat the records there. " facility there is no clin	5. D. To provide the Nursing a all aspects of the esidents care related to the ervices, including directions edical and non- medical g but not limited to, , infection/bacteria, and care e and disinfection of dialysis Plan initiated 10/14/2014 /15/2015 denotes that R13 e dialysis without any Plan does not denote that n overall assessment upon ost dialysis. Care Plan does is site will be monitored for of infection such as ain, localized temperature 4 hours post dialysis. Care that dialysis access site will	F 2	81		
	stated in part that the with resident to the di sent back with him. V results to the facility fo (Nurse/Manager) stat	ed that facility should be I thrill daily and after every				

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12 FORM API OMB NO. 09	PROVE
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURV COMPLETE	
		14E572	B. WING		12/08/20	014
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CO	DE	
SKOKIE N	IEADOWS NURSING CE	NTERII		0 WEST GOLF ROAD OKIE, IL 60076		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COM IE APPROPRIATE	(X5) MPLETIO DATE
F 281	Continued From page	e 47	F 281			
F 282 SS=D	gave him Motrin a co (MAR) Medication Ac month of November, was given to R7 on 1 order. There was no ' notes about the Mo 11/15/14. There was assessment being co POS (Physician Orde of Motrin 600mg for t This doctor ' s order of On 11/18/14, at 10:00 Nurse) confirmed that nurse to R7 on 11/15 and there was no doo notes. E9 stated that complete a pain asse completed. E9 stated use. " E9 stated, " I right now and will cal 483.20(k)(3)(ii) SERV PERSONS/PER CAF The services provide must be provided by accordance with each care. This REQUIREMENT by: Based on observatio review, the facility fai identified plan of care	ompleted at that time. Per er Sheet), Z1 gave an order wo (2) weeks on 10/20/14. expired on 11/03/14. DAM, E9 RN (Registered th Motrin was given by a /14 without a doctor ' s order cumentation in the nurses ' the facility policy was to essment but that was not I, " We have a form that we am going to assess (R7) I the doctor. " /ICES BY QUALIFIED RE PLAN d or arranged by the facility qualified persons in h resident's written plan of f is not met as evidenced on, interview and record led to implement an	F 282			

Facility ID: IL6008643

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 12/17/2014 APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		14E572	B. WING				12/	08/2014
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
SKOKIE M	IEADOWS NURSING CEI	NTERII			600 WEST GOLF ROAD SKOKIE, IL 60076			
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 282	position. R7 changed position slowly, with fa grabbing onto his wal stabilize himself in a su use of his walker. R7 feet distance (from his slow and wobbly gait claimed that he report pain to the nursing stat On 11/17/14, at 4:30F the urinal because it it to the washroom beca- legs and arms. The w five feet away from hi afraid he might fall if f On 11/18/14 at 10:00/ stated that he does no because of his aches neck and upper back. for him to go the pation pain. R7 stated, " I put to be comfortable. " F do the things he enjoy angry.	Assessment. PM, R7 had difficulty from the bed to standing position: from bed to sitting acial grimacing, while ker to standing position. R7 stooping position with the walked approximately three is bed to his dresser) with a using his walker. R7 ted about his complaint of aff. PM, R7 stated that he uses is very difficult for him to go ause of the pain to his neck, vashroom is approximately is bed. R7 stated that he is ne walks to the washroom. AM, R7 was in his room and ot join the house activities and pain to his legs, arms, R7 stated that it is difficult to to smoke because of his robably need a power chair R7 stated that his inability to ys makes him sad and	F	282	DEFICIENCY)			
	Nursing Assistant) sta pants and R7 cannot about grooming, pers E14 stated, "I do eve	AM, E14 C.N.A. (Certified ated that R7 cannot pull his tie his shoes. When asked onal hygiene and bathing, erything for him. " E14 thing (R7) can do is brush						

Facility ID: IL6008643

If continuation sheet Page 49 of 129

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		14E572	B. WING			12/	08/2014
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
SKOKIE N	IEADOWS NURSING CEI	NTERII			600 WEST GOLF ROAD KOKIE, IL 60076		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 282 F 309 SS=J	his teeth " when it co E14 stated that he tak out of 14 days. E14 a of pain six (6) or more he takes care of him. complains of pain was E14 'does not know v informing them of R7 Nurses ' Notes dated went for PM & R (Phy Rehabilitation) appoin hospital. R7 returned of orders. PM & R Doo 8/27/14 documents in over "interferes witt spastic/scissor gait, fo Chronic Pain: PT (F the facility) for flexibili neck/back exercises. There is no evidence On 11/19/14, at 1:36F Director of Nursing) v receive PT the plan w nursing staff. 483.25 PROVIDE CA HIGHEST WELL BEIN Each resident must re provide the necessary or maintain the highes mental, and psychoso	mes to personal hygiene. kes care of R7 ten (10) days lso stated that R7 complains e days of the ten (10) days E14 stated that R7 's s reported to the Nurse but what the nurses did after 's pain. 18/27/14 documents that R7 vsical Medicine and thment at an acute care with orders. Z1 was notified ctor 's Progress notes dated part: (R7) c/o pain " all h walking. Depressed, Gait- orward flexed posture Physical Therapy) for pain (at ty, posture assistance, that R7 was referred to PT. PM, E3 ADON (Assistant alidated that R7 did not ras not followed-up by the RE/SERVICES FOR NG eceive and the facility must y care and services to attain st practicable physical,		282			

Event ID: RPQ011

Facility ID: IL6008643

If continuation sheet Page 50 of 129

	-	ND HUMAN SERVICES MEDICAID SERVICES					INTED: 12/17/2014 FORM APPROVEI IB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		14E572	B. WING				12/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	IEADOWS NURSING CE	NTERII		460	00 WEST GOLF ROAD		
				SK	OKIE, IL 60076		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	by: 1) Based upon obse review, the facility fai Management Policy; assess complaint of on-going monitoring of to create plan of care pain; failed to evaluat	✓ is not met as evidenced T is not met as evidenced rvation, interview and record led to follow their Pain failed to comprehensively pain; failed to provide of complaint of pain; failed to address complaint of te and modify plan of care to tion; failed to notify the	F 3				
	overall function; failed condition; failed to co significant change MI plan of care to addres condition for 1 reside reviewed for quality of As a result, R7 suffer outcomes and R7 con	ed negative psychosocial ntinued to isolate himself					
	Living) capabilities re personal hygiene/gro bathing and transfers The facility 's failures jeopardy. The immed determined to have b doctor created a plan	oming, toileting, dressing, s resulted in an immediate liate jeopardy was legun on 8/27/14 when R7 ' s for R7 to have PT (Physical					
	of care was not follow There is no evidence 8/27/14. On 11/20/14, at 11:15 notified of the immed	back exercises but the plan ved-up by the facility staff. that R7 received PT after 5 AM, E1 Administrator was					
	6:00 PM. While the ir	nmediacy was removed, the f compliance at level two as to implement their					

Facility ID: IL6008643

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		14E572	B. WING			12/	08/2014
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SKOKIE N	IEADOWS NURSING CEI	NTERII			4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	the facility on 12/4/13 hospital with diagnose Schizoprenia, Herniat Decompression. R7 ' Screening/Mental Hea documents in part: Sp Observation by MD/R Doctor/Registered Nu monitoring, adjustmer community re-integra Activities of Daily Livia and Mental Health Re acute acre psychiatric instruction dated 12/4 Notify physician if exp following: Recurrence that led to hospitalizar yourself. " On 11/17/14, at 9:30 / with E2 DON (Director room while the reside in progress. E2'stated resident morning mee room. On 11/17/14, at 2:00 / did not attend in-hous On 11/17/14, at 3:07 / stated R7 prefers to s complain of pain to hi On 11/17/14, at 3:45 / bent (fetal) position. F go to activities and re because he is stiff and told the nurse about h On 11/17/14, at 4:00 / bent (fetal) position. F	esident who was admitted to from acute care psychiatric es of Spine Injury, Paranoid ted cervical disk, C3-C4 's PAS/MH (Pre-admission alth) dated 12/6/13 becial Services- Professional CN (Medical trse) for medication nt and stabilization, tion activities, Instrumental ng training/reinforcement enabilitation activities. The c hospital discharge /13 documents in part: " beriencing any of the e of psychiatric symptoms tion; Inability to care for AM, during the initial tour or of Nursing), R7 was in his nts ' morning meeting was d that all residents attend eting every day in the front PM, R7 was in his room and se activities. PM, E12 Activity Director stay in the room because of s legs. PM, R7 was on his bed, in a R7 stated that he does not sident morning meetings d sore. R7 stated that he	F	309			

Facility ID: IL6008643

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		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 12/17/20 ORM APPROVE NO: 0938-039
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		INSTRUCTION	(X3) I	DATE SURVEY COMPLETED
		14E572	B. WING _				12/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CO	DDE .	
SKOKIE N	IEADOWS NURSING CE	NTERII			WEST GOLF ROAD KIE, IL 60076		
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 309	moved slowly, with fachanging his position able to get out of bed stooping position. R7 feet distance (from hi slow and wobbly gait On 11/17/14, at 4:30 the urinal all the time him to go to the wash his neck, legs and an approximately five fee stated that he is afrait the washroom. R7 's 9/18/14 documents in HS (at night). Refer to worsening conditions the doctor was notifie now uses the urinal a On 11/18/14 at 10:00 and stated that he do activities because of legs, arms, neck and probably need a pow R7 stated that he like walk around the facili much pain. " R7 statt him to go the patio to R7 stated that his ina enjoys makes him sa just want to move out nursing home. " On 11/18/14, at 10:05 Nurse) stated that R7 sometimes and it is of E9 stated that there i completed for R7 mo checked R7 's chart.	acial grimacing, while to grab his walker. R7 was and stabilize himself in a walked approximately three s bed to his dresser) with a using his walker. PM, R7 stated that he uses because it is very difficult for mom because of the pain to ms. The washroom is et away from his bed. R7 d he might fall if he walks to a Care Plan initiated on n part: " Urinals provided at o MD (Medical Doctor) for " There is no evidence that ed of the change - that R7 all the time. Am, R7 was in his room res not join the house his aches and pain to his upper back. R7 stated, " I er chair to be comfortable." s walking and he used to ty when he " was not in so ed that it is also difficult for s moke because of his pain. bility to do the things he d and angry. R7 stated, " I to fhere and go to another 5 AM, E9 RN (Registered	F	309			

Facility ID: IL6008643

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		14E572	B. WING		12/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076	
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETI
F 309	when R7 complained MAR (Medication Adr confirmed that Motrin 11/15/14 without a do no documentation in t stated that the facility pain assessment but assessment not comp have a form that we u going to assess (R7) doctor. " On 11/18/14, at 10:20 R7 did not attend on- that the pain to his ne and R7 has already re to the nursing staff. On 11/18/14, at 11:30 Physician) stated that because of Osteoarth facility does not allow more than two weeks on the nurses to notiff of pain. Z1 stated that was still complaining he would have ordere he was notified earlie not aware of R7 's ow On 11/19/14, at 10:50	of pain. E9 checked the ninistration Record) and was administered to R7 on octor 's order and there was the nurses 'notes. E9 's policy was to complete a confirmed that pain bleted. E9 stated, "We use." E9 stated, "I am right now and will call the 0 AM, R7 was in his room. going activities. R7 stated eck and upper back is worse eported his complaint of pain 0 Am, Z1 (Attending t R7 has chronic pain writis. He stated that the 0 PRN pain medications for . Z1 stated that he depends y him if a resident complains t he was not aware that R7 of pain. Z1 also stated that he was verall decline of condition.	F 30		
	him; (R7) cannot even shoes; he used to. " grooming, personal h stated, " I do everyth that " the only thing (teeth " when it comes stated that he takes of	ated, " I do everything for n pull his pants or tie his When asked about ygiene and bathing, E14 ing for him. " E14 stated R7) can do is brush his s to personal hygiene. E14 care of R7 ten (10) days out stated that R7 complains of			

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	OF DEFICIENCIES					0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPLI	
		14E572	B. WING		12/0	8/2014
NAME OF PR	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP COD	E	
SKOKIE M	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 309		lays of the ten (10) days he	F 309			
	pain six (6) or more days of the ten (10) days he takes care of him. E14 stated that R7 ' s complains of pain was always reported to the Nurse but E14 does not know what the nurses did after informing them of R7 ' s pain.					
	Director of Nursing) s shows decline of abili Living), the staff shou) Am, E3 ADON (Assistant stated that when a resident ities ADL's (Activities of Daily ild determine the " kind of				
	decline ", notify the doctor, and discuss appropriate placement. When asked if the facility provide ADL (Activities of Daily Living) programs to prevent ADL decline, E3 stated, "We don 't	nt. When asked if the facility as of Daily Living) programs				
	does pertaining to AD the Care Plan. E3 als complaints of pain da	DL should be documented in so stated, " We don ' t chart illy." E3 also stated that the				
	There was no Care n	e doctor if there is no relief. oted addressing R7 ' s perform his ADL's. This d by E3.				
	On 11/19/14 at 12:07 stated that when a re ADL functions, the fac	PM, E1 (Administrator) sidents shows a decline of cility staff uses a holistic				
approach. E1 further explained that a resident 's decline in condition should be investigated and addressed. E1 stated that if a resident needs PT						
	nursing facility for out resident can be admi	he resident can go a skilled tpatient therapy or the tted to a skilled nursing en the resident gets better.				
	On 11/19/14, at 1:05 Rehabilitation Service	PM, E7 PRSC (Psychiatric es Coordinator) stated that sychosocial groups anymore.				
	÷ .	as done to address it, E7				

Facility ID: IL6008643

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						0. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE COMP	LETED
		14E572	B. WING			08/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
SKOKIE M	EADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETIO DATE
F 309	Continued From page	9 55	F 3	09		
		of R7 's ADL decline of	_			
		is the one who makes the				
		eeds intervention. E7 also				
	stated that she was n	ot aware if R7 was attending				
	in-house activities.					
		PM, E3 (ADON) stated that				
	R7 " can be isolative					
		eing monitored, E3 stated,				
	•	havior monitoring Record				
	finding was confirmed	ember, 2014 was blank. This				
		PM, E16 PRSD (Psychiatric				
		es Director) stated she is not				
		d going to psychosocial				
		stated that the psychiatrist				
		out it. E16 also stated, " (R7				
	's) isolative Behavior	should have been				
	monitored. E16 stated	d that R7 should be in				
	00	e activities if R7 is not going				
		ams. E16 was not aware				
		ding in-house activities.				
		PM, Z2 stated that R7 is				
	being treated biologic					
		also need psychosocial ould get through facility				
		chosocial programs and				
		2 stated that she is not				
		ve behavior, decline in ADL				
		ing) capabilities, stopped				
	going to psychosocial					
		activities. Z2 stated that the				
		ould be monitored because				
		iagnoses which include SAD				
		order). Z2 stated that the				
	-	nonitor residents ' behavior				
		onitoring tracking so an				
		are can be created. Z2				
	stated that if she above	uld have known about the				

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		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 12/17/20 ORM APPROVE 3 NO: 0938-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		14E572	B. WING				12/08/2014
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	. <u> </u>	
SKOKIE N	A STATE AND A S		4600 WEST GOLF ROAD				
				S	KOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 309	Continued From pag	e 56	F	309			
	have ordered R7 for	hospitalization and further		000			
	evaluation.	utrationt Program note datas					
		utpatient Progress note dates n part: (R7) medical history:					
		ated Cervical disk s/p C3-C4					
	,	ecompression in 2007 will					
	defer pain control to	-					
	Doctor 's Progress r						
		' (R7) c/o pain "all over" king. Depressed, Gait-					
		forward flexed posture					
		sider PT (Physical Therapy)					
		y) for flexibility, posture					
		ck exercises. " There is no					
		ceived PT after 8/27/14. On					
		I, E3 ADON (Assistant					
	• ·	validated that the PT was not ursing staff. E3 confirmed					
		rred for PT. E3 stated, "I will					
	call the doctor about						
	Pain Assessment da	ted 10/20/14 documents in					
	part: Frequent pain o	on arms, legs and neck					
		There was no evidence of					
		complaint of pain. This					
	AM.	d by E3 on 11/18/14, at 10:25					
		n Administration Record)					
	-	gust, 2014, September, 2014					
	-	here is no evidence of pain					
	management. Octob	er, 2014 documents that the					
		Motrin once to R7 - 10/20/14,					
		e is no date or time when R7					
	was re-assessed after administered.	er pain medication was					
	-	n to address R7 ' s complains					
	-	medical record. On 11/18/14,					
		S/CP (Minimum Data					
		dinator stated validated the					
	initialing and stated, "	I will create a Care Plan for					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES			PRINTED: 12/17/201 FORM APPROVE OMB NO. 0938-039		
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVE COMPLETED	EY	
14E572	B. WING		12/08/20	014	
•	ST	TREET ADDRESS, CITY, STATE, ZIP C	•		
	46	600 WEST GOLF ROAD			
	S	KOKIE, IL 60076			
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE COM HE APPROPRIATE	(X5) IPLETIO DATE	
e 57 nagement undated facility part: "Policy#1. A clinical dmission, monthly when pain ure #2. Formulate care plan hysician when nursing red medical intervention are mary from July to October, For both months of July and cords documents and steady with behavior as Monthly Nursing Summary tents Gait: Unsteady; and paranoid. Monthly ted 10/24/14 documents: or: Delusional and Paranoid. that the changes in gait and seed by the facility. tion Record on the following part: 9/30/14 documents in ted- isolative, withdrawn. in part: Behavior exhibited - Withdrawn. There is no set and persistence of wn behaviors were ility. notes dated 8/25/14, 9/26/14 identify R7 's isolative and There is no documentation of the isolative and withdrawn an initiated 9/18/14 ons in part: "Monitor/record get behavior symptoms and protocol; Update and code	F 309				
	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E572 NTER II ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) = 57 nagement undated facility part: "Policy#1. A clinical dmission, monthly when pain ure #2. Formulate care plan hysician when nursing red medical intervention are mary from July to October, For both months of July and cords documents and steady with behavior as Monthly Nursing Summary ents Gait: Unsteady; and paranoid. Monthly ted 10/24/14 documents: or: Delusional and Paranoid. that the changes in gait and seed by the facility. tion Record on the following part: 9/30/14 documents in ed- isolative, withdrawn. in part: Behavior exhibited - withdrawn. There is no set and persistence of vn behaviors were ility. notes dated 8/25/14, 9/26/14 identify R7 ' s isolative and There is no documentation of the isolative and withdrawn an initiated 9/18/14 ons in part: "Monitor/record jet behavior symptoms and	MEDICAID SERVICES (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (x2) MULTIPLE A. BUILDING 14E572 B. WING	MEDICAID SERVICES (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A. BUILDING 14E572 B. WING TREE I STREET ADDRESS, CITY, STATE, ZIP CL 4600 WEST GOLF ROAD SKOKIE, IL 60076 NTER I I STREET ADDRESS, CITY, STATE, ZIP CL 4600 WEST GOLF ROAD SKOKIE, IL 60076 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ID PREFIX TAG CROSS-REFERENCED TO TI DEFICIENCE 2 57 F 309 F 309 REFICENCE CROSS-REFERENCED TO TI DEFICIENCE 2 57 F 309 F 309 nagement undated facility part: "Policy#1. A clinical dmission, monthly when pain ure #2. Formulate care plan sysician when nursing red medical intervention are F 309 mmary from July to October, For both months of July and cords documents and steady with behavior as Aonthly Nursing Summary ents Gait: Unsteady; and paranoid. Monthly ted 10/24/14 documents: or: Delusional and Paranoid. that the changes in gait and ssed by the facility. ion Record on the following vart: "30/14 documents in ed- isolative, withdrawn. in part: Behavior exhibited - withdrawn. There is no et and persistence of wn behavior symptoms and protocol; Update and code teb bavior symptoms and protocol; Update and code tebes as indicated; Offer	MEDICALD SERVICES OMB NO. 033 (x1) PROVIDERSUPPLERCLIA IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A BUILDING (x3) DATE SURV COMPLETED 14E572 B. WING	

Facility ID: IL6008643

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		14E572	B. WING			12	/08/2014
NAME OF P	ROVIDER OR SUPPLIER		I	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII			4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	The facility 's Behavior from February, 2014 f reviewed. The followin uncoded (No specific March, 2014, April, 20 and November, 2014. E3 (ADON) stated that tool is used to track re- facility 's monitoring f changes of behavior. from the Behavior Mo- when planning the ca- for a resident. The facility 's undated Medications policy do #11. Documentation of which includes sympt psychotropic medicati permanent or transier causes of the behavior effects to the psychot The facility 's undated Monitoring Record Po Behavior Monitoring F antidepressant, antips sedative-hypnotic, mo anticonvulsant medica medications to record appropriate diagnosis and side effects. Social Service Progref 11/7/14 were reviewe reviewed did not iden Withdrawn behaviors. Initial Activity History 12/12/13 documents to to time, place and per	or Monitoring Records dated to November, 2014 were ng records were blank and Behavior being monitored): 014, May, 2014, July, 2014 On 11/19/14, at 1:36 PM, at the behavior monitoring esident 's behavior and the ool to determine significant E3 stated that information nitoring Records is used re or behavior management d policy titled Psychotropic cuments in part: Guideline of behavioral monitoring oms requiring the use of ion, if the symptoms are nt, other reason as potential or and monitoring of the side ropic medication. d policy titled Behavior blicy documents in part: Record is used for sychotic, psycho-stimulant, bod stabilizing and ations, anti-anxiety target behaviors, o, interventions, outcomes ess Notes from 5/21/14 - d. The documentation tify R7 's Isolation and and Assessment dated that R7 is alert and oriented rson and R7 's activity ic, reading, writing, walking	F	309			

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		MEDICAID SERVICES				<u>O. 0938-03</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	IPLE CONSTRUCTION	. ,	E SURVEY PLETED
		14E572	B. WING _		•	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
SKOKIE M	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETIC DATE
F 309	Continued From page	59	E 3	309		
		/parties, organization like				
		itellectual games and trivia.				
		es dated 9/24/14 documents				
		been spending a lot of time				
		vidence of a care plan being				
		7's "spending a lot of time				
	in bed. "					
	R7 ' s Care Plan date	d 9/18/14 documents in				
	part: R7 ' s Care Plan	initiated on 9/18/14				
	documents in part: (R					
		Assign (R7) to group or				
	activities to go to. Inte	-				
		or is observed. Focus - (R7)				
		me difficulty adjusting to				
	-	t; Intervention: Get resident and activities. Assign the				
		vities to go to. Care Plan				
	- ·	documents in part: (R7 ' s)				
		poor functioning with peers.				
		on/approach documented.				
	There is no plan to ac					
		to adapt to R7 ' s current				
		ition. On 11/19/14 @ 2:05				
	PM, E12 (Activity Dire	ector) validated the absence				
		ress R7 ' s activity needs.				
	E12 stated, " I misse					
		olicy, titled "Activities "				
		ne facility shall provide an				
	on-going program of a					
	-	nces and the physical,				
	resident. (e) Activities	cial well-being of each				
		r maximum participation by				
		f a particular resident does				
		ast an average of four (4)				
		r one week period, the unit				
	director shall evaluate	-				
		e the available activities				
		ult with the interdisciplinary				1

Facility ID: IL6008643

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	S FOR MEDICARE &					IO. 0938-039
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	E SURVEY IPLETED
		14E572	B. WING		12	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII		600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 309	documents R7 's is n Health and Stress pro documented as "dise no documentation of evidence of the psych The facility 's undate Management and Bel documents in part: " identify residents who chaotic, and disorgan demonstrate greater p de-compensation incl oneself and/or other p may need additional p medication managem their behavioral treatr what the behavior syr Evaluate resident invo psychiatric, psycholog Function: The staff co potential behavioral n implements plans of a safety living environm services/training, mor implemented changes revisions to the action primarily through the clinical social work co identifying residents in behavioral attention. ' the staff addressed R behavioral attention. Psychiatric Rehabilita 5/11/12 documents in	ss notes dated 9/2/14 not attending Anger, Men's ograms. Men's ' group was continued " but there was the reason. There was no niatrist being notified. d policy titled Behavior havior Health policy Overview: It 's purpose is to o demonstrate unstable, nized behavior who may potential for uding aggression towards bersons. These residents osychiatric consultation, nent and/or modifications in ment plan. Problem-solve mptoms are communicating. olvement in on-going gical. Structure and opperatively works to identify nanagement challenges and action to promote a safe and nent, stressing educational nitoring the effect of s and making needed n care plans. The IDT, social services staff and onsultant are responsible for	F 309			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY		
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		14E572	B. WING		12/08/2014		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076			
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLI		
F 309	counseling about the personal consequence poor engagement. " appropriate education when R7 stopped par programming. House Rules & Behar documents in part: Re out of bed in the morr physically ill by medic evidence of any type relation to R7 's bein morning and not atter meetings. Quarterly MDS (Minir 3/17/14 documents th (in comparison with A 12/17/2013): ADL fun and Bathing; new ons Frequency document in behavior which was of potential indicators & delusion; Emergent which included the for feeling down, sad, de feeling tired and havin about himself; trouble There was no Signific completed. On 11/19/ MDS/CP (Minimum D Coordinator validated MDS was not comple significant change MI comprehensive asses done. E8 stated, " W	value of interventions and tees the resident faces for There is no evidence that and counseling was done ticipating in psychosocial vioral Expectations esidents are expected to be hing unless evaluated as cal personnel. There is no of evaluation performed in g not being out of bed in the nding residents ' morning num Data Set) dated he following areas of decline dmission/Initial MDS dated totion- decline in Dressing set of pain - 6/10 with ed as: occasionally; Change is documented as new onset of psychosis - hallucination ce of sad or anxious mood llowing documentation: pressed and helpless; ng less energy, feeling bad e concentrating on things. cant Change MDS (14, a 11:06 AM, E8 bata Set/Care Plan) that Significant Change ted. E8 stated that a DS (Minimum Data Set) ssment should have been e have criteria for that. " E8 nt change MDS should be	F 30				

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						FORM	
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMP	LETED
		14E572	B. WING			12/	08/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		NTED I		4	4600 WEST GOLF ROAD		
SKOKIE IV	IEADOWS NURSING CE	NIERII		5	SKOKIE, IL 60076		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX							COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	IAG		DEFICIENCY)	AIE	Ditte
			-				
F 309	Continued From page	IDENTIFICATION NUMBER: A BUILDING COMPLETED 14E572 B. WING 12/08/2014 IFR STREET ADDRESS, CITY, STATE, ZIP CODE 4600 WEST GOLF ROAD SKOKIE, IL 60076 NG CENTER II ID PREFIX PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE 000000000000000000000000000000000000					
1 000				009			
		· · ·					
		•					
	-						
	1. The facility notifie	ed the attending physician					
	and obtained an orde	r on 11/20/14 to increase the					
	•						
		neduled to see R7 on					
	11/21/14.						
	3. Pain Assessmen 11/20/14.	t was completed on					
		ago comprohonsivo					
	was initiated on 11/20						
	7. Care Plan was a	ddressing R7 ' s self-care					
	performance deficits	was initiated on 11/20/14					
	-	-					
	decline in ADL function						
	• • •	•					
		-					

Facility ID: IL6008643

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	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:				FOR	M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		14E572	B. WING			12	/08/2014
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII			4600 WEST GOLF ROAD SKOKIE, IL 60076		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	adding a new interver an activity, (R7) can h attends activity. 11. The facility 's Pa revised which include Pain level is re-asses (30) minutes to one (' of the ordered medica relieved, the MD (Me by the nurse for a cha increase in dose. For physician for further of 12. R7 was referred was evaluated by PT 11/20/14. 13. The facility staff to have PM & R (Phy	ntion: Personal invite R7 to nave a reward after he in Management Policy was is but not limited to: #6 e. sed and documented thirty 1) hour after administration ation. If the pain is not dical Doctor) will be notified ange in medication or continued pain, alert the orders. " to PT (Physical Therapy). R7 (Physical Therapy) on made an appointment for R7 sical Medicine and	F	309			
	facility failed to follow dialysis care and trea in a sample of 18 resi of care. Findings Include: Physician Order Shee admitted to the facility diagnoses include: So Bi-Polar Type, Acute of Drug Abuse, Alcoh Esophageal Reflux D Hypertension, Syncop R13 's Physician Ordon November 2014 dend	policy regarding post tment for 1 resident (R13), idents, reviewed for quality et (POS) denotes R13 was y on 6/27/2007. R13 ' s chizo-Affective Disorder Psychotic Episode, History ol Dependence, Gastro isease, Diabetes Mellitus, be and Hydronephrosis .					

Facility ID: IL6008643

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	S FOR MEDICARE &					10. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
		14E572	B. WING		1	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII		600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 309	Dialysis Catheter Dre Needed. November POS Does monitoring. On 11/19 seen to have two dial shunt in the left arm a catheter. On 11/19/14 at 9:30 a was asked about com and dialysis center. E dialysis center sends and facility communic notes. " E24 stated i checked once in a wh document that. " Su shunt site dressing is and E24 stated " son" " Facility ' s Policy titled Residents On Dialysis facilitate care of resid designated dialysis cor residents return to the will do an overall asso Dialysis site will be m symptoms of infection	ss with Regular Gauze as a not denote any dialysis site 0/14 at 2:20pm R13 was ysis catheter sites. One and one sub-clavian port am E24 (Registered Nurse) munication between facility E24 stated in part that " yes, laboratory values routinely cates in house in nurses in part " bruit and thrill is hile but we don ' t really rveyor asked E24 if dialysis being checked regularly netimes, when he asks for it.	F 309			
	facility and local dialy Services Provided by facility shall be respon- resident is medically transportation and for Renal Disease (ESRI	ervices Agreement between sis site denotes 3. Specific the Parties: The nursing nsible for ensuring that the stable to undergo such treatment at the End Stage D) Dialysis Unit. 5. D. To provide the Nursing				

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COMPLETED
		14E572	B. WING		12/08/2014
NAME OF PI	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE		ZIP CODE
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE IENCY)
F 309	Continued From page	e 65	F 3	309	
provision of dialysis services, including directions on management of medical and non- medical emergencies, including but not limited to, bleeding/hemorrhage, infection/bacteria, and car		nedical and non- medical ng but not limited to,			
	of dialysis success si access site.	e, infection/bacteria, and care te and disinfection of dialysis Plan initiated 10/14/2014			
	with a target date of will be able to tolerate	1/15/2015 denotes that R13			
	nursing will perform a return to the facility p	an overall assessment upon ost dialysis. Care Plan does sis site will be monitored for			
		of infection such as ain, localized temperature 4 hours post dialysis. Care			
	be checked for bruit a	that dialysis access site will and thrill. m E2 (Director of Nursing)			
	DON stated that R13 pressure to be taken	" has no orders for blood before leaving the facility			
	the records there. "	tion with him, they have all " When R13 returns back to nical assessment we just ask			
	notes. "	document that in the nursing m Z3 (Registered Nurse)			
	stated in part that the with resident to the d	re is no communication sent ialysis center and nothing is			
	results to the facility f	We do send monthly lab for their review. Z5 ted that facility should be			
		d thrill daily and after every returns to the facility.			
	interview, surveyor ol dressing from his left	bserved R13 remove his arm dialysis site. The			
		mount of dried exudates essing which he removed			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/17/2 FORM APPRO OMB NO. 0938-0
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		14E572	B. WING		12/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•
	EADOWS NURSING CE			4600 WEST GOLF ROAD	
SKOKIL				SKOKIE, IL 60076	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 309	Continued From pag	e 66 part that "I always remove	F 30	9	
	the dressing myself. On 11/19/14 at 2:11p asked about R13 's stated in part they sh dialysis. It also does daily. Surveyor ques dressing or drainage why exactly does he notified. If there is a then definitely the sit signs and symptoms monitored closely. " On 11/19/14 at 4:50p and E3 (Assistant Dia asked if staff had had medical emergencies complications and E3	m Z6 (Medical Doctor) was post dialysis site care and Z6 ould not check it after every not need to be checked stioned Z6 what about a site noted and Z6 responded " have a dressing? I was not problem with the dressing e should be observed for of infection and be m E2 (Director of Nursing) rector of Nursing) were d any formal training on			
F 310 SS=G	stated, "We only have dialysis. That's (R13 from dialysis, I just as don't assess his shur bruits or thrills. We he the nursing home or do if there's an emery But if there was bleed pressure with a steril	om, E27 (Registered Nurse) ve one resident that goes to). When (R13) comes back sk him how he is doing. We nt or site. We don't check for have not got any training from the dialysis center on what gency with the shunt or site. ding at the site, I would apply e dressing or call 911." DO NOT DECLINE UNLESS	F 31	0	
	resident, the facility r	chensive assessment of a nust ensure that a resident's of daily living do not diminish			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/17/2014 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		14E572	B. WING			12/	/08/2014
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				4	4600 WEST GOLF ROAD		
SKOKIE M	EADOWS NURSING CE	NTERII		5	SKOKIE, IL 60076		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 310	condition demonstrate unavoidable. This inc to bathe, dress, and g ambulate; toilet; eat; a or other functional con This REQUIREMENT by: Based upon observa review, the facility fail clinical condition and maximize the level of toileting, dressing, ba resident (R7) in the sa reviewed for ADL(Act failures resulted in de capabilities related to dressing, bathing and Findings include: On 11/17/14, at 9:30 J with E2 DON (Directo his room and did not a morning meeting. E2 ² attend resident mornin front room. On 11/17/14, at 4:00 I bent (fetal) position. F position from the bed moved slowly, with fa changing his position able to get out of bed stooping position. R7 feet distance (from his slow and wobbly gait	 a of the individual's clinical a that diminution was cludes the resident's ability groom; transfer and and use speech, language, mmunication systems. ⁻ is not met as evidenced tion, interview and record ed to investigate changes of implement interventions to function in ambulation, thing and transfers for one ample of 18 residents, ivities of Daily Living) These terioration in R7 ambulation, toileting, I transfers. Am, during the initial tour or of Nursing), R7 stayed in attend the residents ' stated that all residents ng meeting every day in the PM, R7 was on his bed, in a R7 had difficulty changing his to standing position. R7 cial grimacing, while to grab his walker. R7 was and stabilize himself in a walked approximately three s bed to his dresser) with a 	F	310			
		because it is very difficult for					

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						IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
		14E572	B. WING		12	2/08/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
SKOKIE N	EADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 310	Continued From page	e 68	F 3 ⁻	10		
	•	nroom because of the pain to ms. The washroom is				
app state 9/18 HS wor: On Nur: som	approximately five fee	et away from his bed. R7 d he might fall if he walks to				
	the washroom. R7 ' s	Care Plan initiated on part: "Urinals provided at				
	HS (at night). Refer to	o MD (Medical Doctor) for				
	worsening conditions On 11/18/14, at 10:05	5 AM, E9 RN (Registered				
	Nurse) stated that R7	complains of pain				
	(R7) right now and wi	d, "I am going to assess ill call the doctor."				
	On 11/18/14, at 11:30) Am, Z1 (Attending				
	•	t R7 has chronic pain nritis. He stated that the				
		PRN (as needed) pain				
	medications for more	than two weeks. Z1 stated				
	•	he nurses to notify him if a f pain. Z1 stated that he was				
		as still complaining of pain.				
		e would have ordered pain				
	medication for R7 if h	ne was notified earlier.				
		O AM, E14 C.N.A. (Certified				
	÷ .	ated, " I do everything for n pull his pants or tie his				
	shoes; he used to. "					
		ygiene and bathing, E14				
		ning for him. " E14 stated (R7) can do is brush his				
		s to personal hygiene. E14				
		ains of pain during ADL				
		ving) care and E14 always nt of pain to the Nurse.				
) AM, E3 ADON (Assistant				
	• /	stated that when a resident				
	shows decline of abil	ities ADL's the staff should	1			1

Facility ID: IL6008643

If continuation sheet Page 69 of 129

						0. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	IPLE CONSTRUCTION	· · ·	E SURVEY PLETED
		14E572	B. WING		12	/08/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
SKOKIE M	EADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 310	Continued From page	e 69	F 3	310		
		ppropriate placement.				
	•	cility provide ADL (Activities				
		ams to prevent ADL decline,				
		't have that. " E3 stated				
	that anything that the	staff does pertaining to ADL				
		ed in the Care Plan. E3 also				
		hart complaints of pain				
	•	d that the nurses should call				
		no relief. There was no Care				
	-	's decline of abilities to				
	E3.	his finding was confirmed by				
		DM E1 (Administrator)				
		PM, E1 (Administrator) sidents shows a decline of				
		cility staff uses a holistic				
		explained that a resident 's				
		hould be investigated and				
		that if a resident needs PT				
	(Physical Therapy), th	ne resident can go a skilled				
	nursing facility for out	patient therapy or the				
		tted to a skilled nursing				
		en the resident gets better.				
		imary records from July to				
		eviewed: For both months of				
		4, the records documents and steady. Monthly Nursing				
	Summary dated 9/12/					
		ursing Summary dated				
		Gait: Wobbly. R7 's wobbly				
		the surveyor. There is no				
		inge in gait was addressed				
	by the facility.	-				
		6 (Minimum Data Set) dated				
		ts in part:: Section G -				
		was independent with all				
		es of Daily Living) and only				
	-	vith Dressing and Bathing.				
	IVIDS dated 3/1//14 s	howed a decline in Dressing	1			1

Facility ID: IL6008643

If continuation sheet Page 70 of 129

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		14E572	B. WING			12/	08/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII			600 WEST GOLF ROAD KOKIE, IL 60076		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 310 F 319 SS=G	from staff with Dressii functional decline were completed on 6/17/14 evidence of any type R7 's ADL decline. The of care being created capabilities and there 's attempt to prevent 11/19/14, at 11:06 AM Data Set/Care Plan) of findings. On 11/18/14, at 11:30 Physician) stated that overall decline of com- makes rounds in the fa- should have notified fa- further stated that he comes to informing hi his residents in the fa- Director of Nursing) s to an acute care hosp behavioral symptoms 483.25(f)(1) TX/SVC MENTAL/PSYCHOSO Based on the compre- resident, the facility m who displays mental of difficulty receives app services to correct the This REQUIREMENT by:	ng and Bathing. Similar re noted in the MDS ' and 9/17/14. There was no of investigation/evaluation of here is no evidence of plan to address R7 ' s decline of is no evidence of the facility further ADL decline. On A, E8 MDS/CP (Minimum Coordinator validated these Am, Z1 (Attending the was not aware of R7 ' s dition. Z1 stated that he facilities but the facility staff nim of R7 ' s decline. Z1 depends on the staff when it im of what is going on with cility. Am, E3 ADON (Assistant tated that R7 was admitted bital for evaluation of and pain. FOR DCIAL DIFFICULTIES thensive assessment of a nust ensure that a resident or psychosocial adjustment oropriate treatment and e assessed problem.		310			
	by:	tion, interview and record					

Event ID: RPQ011

Facility ID: IL6008643

If continuation sheet Page 71 of 129

						10.0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
		14E572	B. WING		12/08/2014	
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII	4			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE
F 319			F 319			
	interventions consiste programming needs a capabilities for one re 18 residents. This fail	and current level of sident (R7) in the sample of ure resulted in decreased ion and continued isolation,				
	with E2 DON (Director room while the resider in progress. E2`stated	AM, during the initial tour or of Nursing), R7 was in his ents ' morning meeting was d that all residents attend eting every day in the front				
	did not attend in-hous 3:07 PM, E12 Activity to stay in the room be his legs. On 11/17/14	PM, R7 was in his room and se activities. On 11/17/14, at Director stated R7 prefers ecause of complain of pain to , at 3:45 PM, R7 was on his				
	does not go to activiti meetings because he that he told the nurse On 11/18/14 at 10:00	bosition. R7 stated that he es and resident morning is stiff and sore. R7 stated about his complaint of pain. Am, R7 was in his room				
	legs, arms, neck and probably need a pow R7 stated that he like	his aches and pain to his upper back. R7 stated, " I er chair to be comfortable. " s walking and he used to				
	much pain. " R7 stat him to go the patio to R7 stated that his ina	ty when he " was not in so ed that it is also difficult for smoke because of his pain. bility to do the things he d and angry. R7 stated, " I				
	just want to move out nursing home. "	AM, R7 was in his room.				

Facility ID: IL6008643

If continuation sheet Page 72 of 129

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		10. 0938-03 FE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	, ,			MPLETED	
		14E572	B. WING		1	12/08/2014	
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E		
SKOKIE M	EADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076			
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 319	Continued From page	e 72	F 31	9			
		eck and upper back is worse					
	•	eported his complaint of pain					
	to the nursing staff.						
	On 11/19/14, at 1:05	PM, E7 PRSC (Psychiatric					
	Rehabilitation Service	es Coordinator) stated that					
	R7 is not attending pa	sychosocial groups anymore.					
		as done to address it, E7					
		ed it but did not notify the					
	psychiatrist about it.						
		h-house activities. E7 stated					
		of R7 's ADL decline of					
	-	is the one who makes the eeds intervention. E7 also					
		ot aware if R7 was attending					
	in-house activities.	iot aware in ter was attending					
		PM, E3 (ADON) stated that					
	•	. When asked if the					
	isolative behavior is b	peing monitored, E3 stated,					
	" Not really. " The Be	havior monitoring Record					
		ember, 2014 was blank. This					
	finding was confirmed						
		PM, E16 PRSD (Psychiatric					
		es Director) stated she is not					
		ed going to psychosocial					
	•	stated that the psychiatrist out it. E16 also stated, " (R7					
	's) isolative Behavior	-					
	,	d that R7 should be in					
		se activities if R7 is not going					
		ams. E16 was not aware					
		ding in-house activities.					
		PM, Z2 stated that R7 is					
	being treated biologic						
		also need psychosocial					
		ould get through facility					
		chosocial programs and					
1	in house activities 7	2 stated that she is not					

Facility ID: IL6008643

If continuation sheet Page 73 of 129

	-	ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/17/2014 FORM APPROVED MB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X	(3) DATE SURVEY COMPLETED	
		14E572	B. WING				12/08/2014	
NAME OF PI	ROVIDER OR SUPPLIER			S	EET ADDRESS, CITY, STATE, ZIP CODE			
	IEADOWS NURSING CE			46	600 WEST GOLF ROAD			
		NIEKII		S	KOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 319	going to psychosocia participating in-house isolative behavior sho of R7 's psychiatric of SAD. Z2 stated that t monitor residents 'b monitoring tracking si can be created. Z2 st known about the chai ADL's, she would hav hospitalization and fu Psychiatric progress and 10/24/14 did not withdrawn behavior. that Z2 was notified of behavior of R7. Monthly Nursing Sum October, 2014 were r July and August, 201 behavior as quiet and Summary dated 9/12 delusional and paran Summary dated 10/2 Delusional and Parar that the changes in b the facility. Psychotropic Medicai dated documents in p part: Behavior exhibit 10/31/14 documents remains isolative and evidence that the ons isolative and withdraw addressed by the fac	ring) capabilities, stopped I groups and not e activities. Z2 stated that the build be monitored because liagnoses which include he nursing staff should ehavior using the behavior to an appropriate plan of care tated that if she should have inge in R7 's behavior and ve ordered R7 for rther evaluation. notes dated 8/25/14, 9/26/14 identify R7 's isolative and There is no documentation of the isolative and withdrawn mary records from July to reviewed: For both months of 4, the records documents d pleasant. Monthly Nursing /14 documents Behavior: oid. Monthly Nursing 4/14 documents: Behavior: noid. There is no evidence ehavior were addressed by tion Record on the following part: 9/30/14 documents in red- isolative, withdrawn. in part: Behavior exhibited - withdrawn. There is no set and persistence of wn behaviors were	F	319				
	12/12/13 documents to time, place and pe	that R7 is alert and oriented rson and R7 ' s activity ic, reading, writing, walking						

Facility ID: IL6008643

If continuation sheet Page 74 of 129

		MEDICAID SERVICES					NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,			· · · ·	TE SURVEY MPLETED
		14E572	B. WING			1	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	Ē	
SKOKIE N	IEADOWS NURSING CE	NTERII			WEST GOLF ROAD KIE, IL 60076		
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 319	Continued From page	e 74	F 3	19			
	and being outdoors, t			,10			
	-	s/parties, organization like					
		ntellectual games and trivia.					
		es dated 9/24/14 documents					
		been spending a lot of time					
		vidence of a care plan being					
		7 's "spending a lot of time					
	in bed. "	d 0/19/14 decuments in					
	part: R7 's Care Plan date	ed 9/18/14 documents in					
		R7) has severe mental					
		Assign (R7) to group or					
	activities to go to. Inte						
	inappropriate behavio	or is observed. Focus - (R7)					
		me difficulty adjusting to					
		t; Intervention: Get resident					
		and activities. Assign the					
		ivities to go to. Care Plan 4 documents in part: (R7 ' s)					
		poor functioning with peers.					
		on/approach documented.					
	There is no plan to a						
		to adapt to R7 ' s current					
		lition. On 11/19/14 @ 2:05					
		ector) validated the absence					
		lress R7 's activity needs.					
	E12 stated, " I misse House Rules & Beha						
		esidents are expected to be					
	-	ning unless evaluated as					
		cal personnel. There is no					
		of evaluation performed in					
		g not being out of bed in the					
	morning and not atter meetings.	nding residents 'morning					
	Quarterly MDS (Minir	num Data Set) dated					
		ne following areas of decline					
		dmission/Initial MDS dated					

Facility ID: IL6008643

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		14E572	B. WING			12/	08/2014
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
SKOKIE N	IEADOWS NURSING CEI	NTERII			00 WEST GOLF ROAD KOKIE, IL 60076		
(X4) ID PREFIX TAG	(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 SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 319 F 323 SS=E	documented as new of of psychosis - hallucin Emergence of sad or included the following down, sad, depressed and having less energy himself; trouble conce 11/19/14, at 11:06 AM Data Set/Care Plan) of comprehensive assess done to address the of 483.25(h) FREE OF A HAZARDS/SUPERVI The facility must ensu- environment remains as is possible; and ea	onset of potential indicators nation & delusion; anxious mood which documentation: feeling d and helpless; feeling tired gy, feeling bad about entrating on things. On 1, E8 MDS/CP (Minimum Coordinator validated that a assment should have been lecline. ACCIDENT SION/DEVICES are that the resident as free of accident hazards	F 3				
	by: Based on observatio review, the facility fail disposable lighter whi cause an accident/ha R13) in the sample of accidents/hazards an R36, R39, R46, R47) Findings include: On 11/17/14 at 9:45 at the 100 unit with E24	is not met as evidenced n, interview and record ed to properly secure a ich has the potential to zard for two residents (R8, 18 residents reviewed for d six residents (R32, R33, in the supplemental sample.					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		14E572	B. WING			12/	08/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
SKOKIE N	IEADOWS NURSING CEI	NTERII			600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323 F 325 SS=D	should be kept locked removed the lighter. On 11/17/14 at 9:48 a in a cool place. It's su locked place." R13 in how long the lighter w On 11/17/14 at 2:45pt Rehabilitation Service stated, "Lighters shou people may come and locked or in a safe pla On 11/17/14 at 3:30pt can have parapherna assessed. Items have On 11/18/14, the facil titled, "List of Consum Impaired Cognition"." R32, R33, R36, R39, An undated facility po documents: Residents themselves and other may have their cigare removed from them a location for safety, un demonstrates respons compliance with facilit 483.25(i) MAINTAIN I	dents are taught that lighters I." E24 immediately Im, R13 stated, "Store them pposed to be kept in a dicated that he did not know vas on his bedside table. Im, E4 (Psychosocial es Coordinator-PRSC) Id not be out. Confused d pick it up. They should be ace." Im, E7 (PRSC) stated, "They lia if they are appropriately e to be secured." ity submitted a document hers with Moderately The document listed: R8, R46, R47. licy titled, "Smoking Policy" is who may pose a hazard to is with smoking materials tte, lighters and matches nd kept at a designated til such time as the resident sible smoking habits in ty safety rules. NUTRITION STATUS BLE is comprehensive		323			

Facility ID: IL6008643

If continuation sheet Page 77 of 129

	-	ND HUMAN SERVICES MEDICAID SERVICES				F	ITED: 12/17/20 ORM APPROVE NO: 0938-039	
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14E572	B. WING				12/08/2014	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP COD	E		
SKOKIE N	IEADOWS NURSING CE	INTERII	4600 WEST GOLF ROAD SKOKIE, IL 60076					
	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	31	PROVIDER'S PLAN OF CO	PRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO	
F 325	Continued From pag	o 77		225				
1 525	1.0		F	325				
		able parameters of nutritional weight and protein levels,						
	unless the resident's	÷ .						
		is is not possible; and						
		peutic diet when there is a						
	nutritional problem.							
	This REQUIREMEN	T is not met as evidenced						
	by:							
		ation, interview and record						
		to prevent significant weight esidents (R2), in a total						
	sample of 18 reviewe							
	Findings include:							
		r Sheet (POS) denotes						
		Schizoaffective Chronic						
		I Abuse, Hepatitis B, Anxiety,						
	Prostate Cancer and Pulmonary Disease.	Chronic Obstructive						
		ber 2014 denotes R2 ' s diet						
		ease Caffeine Intake, and						
		Lunch and Dinner. Six						
		dtime Snack. On the						
	October POS telepho							
	sleep (HS).	neat sandwich at the hour of						
		om E13 (Registered Nurse)						
		fusing or giving away his						
		n was noticed by the certified						
		three or four instances " and						
	E13 requested that the discontinued	ne sandwich be						
		weight history is as follows:						
		, February 171 lbs, March						
		s, May 166 lbs, June 165 lbs,						
		160 lbs, September 155 lbs,						

Facility ID: IL6008643

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					NOTOLOTION		NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		NSTRUCTION	· · · ·	ATE SURVEY
		14E572	B. WING				2/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP COD	Ε	
SKOKIE N	IEADOWS NURSING CE	NTERII			WEST GOLF ROAD KIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 325	Continued From page	e 78	F	325			
	_	ember 155 lbs. Overall R2					
	has lost 24 pounds ye						
		Note dated 3/10/14 identifies					
		triggering a 10.9 percent					
		s at six months. Dietitian					
		be a good weight for R2 and					
	stated to continue pre interventions noted.	esent diet plan. No					
		Note dated 10/13/14 denotes					
		ches; Ideal Body Weight					
	•	or minus 10 percent for an					
	ideal body weight ran	ige (IWBR) of 155 pounds to					
	189 pounds.						
	Nutritional progress N						
	•	nt of 152 lbs triggered a					
		weight loss at six months. who stated in part that " I					
		Dietitian explained that R2					
		e " and needed to gain					
	weight. Dietitian Fo	llowed up with R2 's food					
	-	t made no recommendations					
		d / caloric content of R2 ' s					
	diet.	of what his ideal hady					
	-	of what his ideal body be is not evident in R2 ' s					
	-	Dietitians note 3/10/14					
		70 lbs is a good weight for					
		dated 10/13/14 states in					
		lose weight. " Monthly					
	-	s (V/S) and Weights for 2014					
		er weight 152 lbs; 3 lbs					
	-	ight Range 155 to 189					
	pounds. Minimum Data Set (N	IDS) for R2 ' Brief Interview					
	-	IMS) assessment with					
	-	/14 denotes a summary					
		cognition as moderately					
	impaired.						
	D2 ' a Social Services	s care plan initiated 11/13/14	1				

Facility ID: IL6008643

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		10. 0938-03 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· /			MPLETED	
		14E572	B. WING		1	2/08/2014	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
SKOKIE M	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 325	Continued From page	e 79	F 32	.5			
	with a target date 2/1	2/15 states: R2 has severe					
	cognitive impairment	as it relates to thought					
	process and decision						
	motivation and is resi						
		s note from 8/12/14 states in s good but does not like the					
		Physicians same note states					
		58 pounds " perfect for me "					
	•	want to be on the Remeron					
	as he was gaining we	eight. Monitor for further					
	weight loss.						
		s note 8/29/14 states in part					
		to decline. Latest weight is) continues to exhibit poor					
		ed with the patient, in great					
		aintain adequate oral intake.					
		low up with psychiatrist					
	regarding his psychia						
		n adequate oral intake					
		s note from 9/28/14 states					
	-	es to have poor oral intake. Inds. Patient lost 24 pounds					
		bly refuses to eat. Strongly					
	-	with diet. Maintain normal					
	oral intake. "						
		pm Z7 (Consultant Dietitian)					
	•	y ' s dietitian who was					
		part that her stance would					
	be that the weight los resident noted in a nu	-					
		am R2 stated that his					
		that he doesn ' t ' t like the					
	food. He did like the	chocolate ice cream					
		R2 stated he doesn ' t ' t like					
		s to drink, likes yogurt and					
	would eat more. He of						
	hungry in the morning	ually eat breakfast I am not					
	On 11/20/14, after int						

Facility ID: IL6008643

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/17/2014 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE	
		14E572	B. WING		_	12/	08/2014
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
SKOKIE N	IEADOWS NURSING CEI	NTERII		600 WEST GOLF ROAD KOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325 F 328 SS=D	R2 and discussed nut advance residents we residents ' Ideal Body was willing to try doub and dinner. Dietitian assure needs. 483.25(k) TREATMEN NEEDS The facility must ensu proper treatment and special services: Injections; Parenteral and entera Colostomy, ureterosto Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT by: Based on observation review, the facility fail CPAP (Continuous Po machine for one resid residents, reviewed fo Findings include: On 11/17/14, at 9:20 / with E2 DON (Directo (Continuous Positive / was noted exposed, u dresser. The machine The mask was visibly	te by Z7 states Z7 met with ritional approaches to sight toward the mid-point of y Weight Range. Resident ble portions of meat at lunch will also add multi vitamin to NT/CARE FOR SPECIAL are that residents receive care for the following al fluids; omy, or ileostomy care; is not met as evidenced h, interview and record ed to follow their policy on ositive Airway Pressure) ent (R1) in a sample of 18	F 325				
	brown discoloration a	nd was placed on top of the					

Facility ID: IL6008643

If continuation sheet Page 81 of 129

		ID HUMAN SERVICES				FORM): 12/17/2014 I APPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		14E572	B. WING		_	12/0	08/2014
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
SKOKIE M	IEADOWS NURSING CEI	NTERII		600 WEST GOLF ROAD KOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 328 F 329 SS=D	and dusty; the tubing dangling on the side of E2 stated that it should use. E2 stated that R staff should take care staff is responsible for The facility 's undated Cleaning Instructions Headgear documents should be cleaned at or as needed. Unused back in plastic bag that resident 's name and 483.25(I) DRUG REG UNNECESSARY DRU Each resident's drug nunnecessary drugs. A drug when used in ex duplicate therapy); or without adequate mor indications for its use; adverse consequence should be reduced or combinations of the re Based on a comprehe resident, the facility m who have not used ar given these drugs und therapy is necessary as diagnosed and door record; and residents drugs receive gradual behavioral interventio	raps were also visibly dirty was visibly dirty and was of the dresser. Id be bagged when not in 1 probably forgot, but the of it. E2 also stated that the r cleaning the machine. d policy titled CPAP for Masks and Tubing & in part: "These items a minimum of once a week d CPAP shall be placed at is labeled with the room number. " BIMEN IS FREE FROM UGS regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate g or in the presence of es which indicate the dose discontinued; or any easons above. ensive assessment of a nust ensure that residents ntipsychotic drugs are not ess antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic I dose reductions, and	F 328				

Event ID: RPQ011

Facility ID: IL6008643

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	-	D HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COMP	LETED
		14E572	B. WING _			12/	08/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII			600 WEST GOLF ROAD KOKIE, IL 60076		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
			-		DEFICIENCY)		
F 329	Continued From page	82	F3	329			
	This REQUIREMENT	is not met as evidenced					
	by:	- interview and accord					
		n, interview and record ed to identify and monitor a					
	resident's side effects						
	resident (R9) of five re	cient practice affected one esidents reviewed for					
	psychoactive medicat	ions in a sample of 18.					
	Findings include:						
	During the initial tour	of the facility on 11/17/14 at					
		'm sleepy because of my nakes me sleepy and I have					
		day, I'm not going to groups					
	because I'm too tired.	n					
		om, R9 was still in bed and					
		eally weak and sleepy. R9 se." At 1:20pm, R9 asked					
	E24 (RN-Registered I	Nurse) to take his blood					
	-	DE24, "I feel weak." As E24 pressure he stated, "My					
	normal is 120/80 or 1	20/75." His blood pressure					
F 332	result: 92/60. 483 25(m)(1) FREE (OF MEDICATION ERROR	F3	332			
SS=E				202			
	The facility must ensu	ire that it is free of					
		s of five percent or greater.					

Facility ID: IL6008643

If continuation sheet Page 83 of 129

		MEDICAID SERVICES			OMB NO. 0938-0
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		14E572	B. WING		12/08/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076	
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETI E APPROPRIATE DATE
F 332	This REQUIREMENT	e 83 Γ is not met as evidenced	F 3	32	
	review, the facility fail				
	residents (R1, R19, F eight residents obser	Ilin medications to four R20, R47) in the sample of ved during medication pass.			
		cation errors among 32 g a medication error rate of			
	Findings include:				
		n Pass task, on 11/17/14 at			
		sugar result was 269 mg/dl ter). E20 (Licensed Practical			
		ered R20's seven units of			
		n according to his sliding			
		ceive his dinner tray until			
	6:10pm.				
		m, R47's blood sugar result			
		(LPN) administered R47's insulin via flex pen. R20 did			
		r tray until 6:10pm. R47's			
		et (POS) dated 11/1/14			
		uments: Novolog Flex pen			
		neously three times daily			
	with meals. R47's Ca Interventions: Diabete doctor.	re Plan documents: es medication as ordered by			
		am, R19's blood sugar			
		. E9 (Registered Nurse-RN)			
		s going to administer			
	•	e units according to R19's			
		malog insulin 12 units which			
		eduled insulin with meals. Inits of Humalog Lispro			
		2 am. R19's POS dated			
		Increase Humalog 12 units			
		with lunch. R19 did not			
	receive his lunch mea	al until 12:15pm. R19's Care			

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				E CONSTRUCTION		10.0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · /	TE SURVEY MPLETED
		14E572	B. WING		1	2/08/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 332	Continued From page	e 84	F 332			
	Plan documents: Inte			-		
	medication as ordere					
	On 11/19/14 at 11:52	am, R1's blood sugar result				
		RN) indicated that she was				
		ovolog insulin four units				
		ling scale plus Novolog				
		was his regularly scheduled als. E9 administered 26 units				
		R1 via flex pen at 11:54 am.				
		insulin pen before dialing it				
	-	s. E9 did not keep the				
	injector depressed wh	nen holding the insulin pen				
	-	n for seven seconds. R1 did				
		meal until 12:13pm. R1's				
		s: Interventions: Diabetes				
	medication as ordere On 11/19/14 at 12:55					
		, "Insulin should be given				
		after meals. By the time the				
		n, the trays should be up				
	here already. Resider	nt could experience				
	hypoglycemia."					
	On 11/20/14 at 9:45 a					
		sulin is fast acting so we				
) minutes before meals or Ild happen? Blood sugar				
		drops or if meals are not				
		it already received insulin				
		observe." At 12:55pm, E24				
	stated, "With the insu	lin flex pen, you should keep				
		d of the pen, the injector.				
		e needle in the skin. If you let				
		en, the needle won't be in				
	skin. Resident won't g	commendation for Novolog				
		ecause Novolog has a more				
		orter duration of activity than				
	human regular insulir	-				

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 12/17/2014 RM APPROVED O. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		14E572	B. WING		12	2/08/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	
SKOKIE M	EADOWS NURSING CE	NTER II		4600 WEST GOLF ROAD		
				SKOKIE, IL 60076		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 332 F 333 SS=E	FlexPen insulin docu small amounts of air during normal use. To ensure proper dosing to select 2 units G. Ku upwards, press the p The dose selector ref should appear at the needle and repeat the times. Step 13: Press button until the dose needle in your skin af returned to "0" and sl An undated facility po Procedures of Flex P policy of the facility to insulin with the use o prescribed by a physi When flex pen is orde follow the following p Hold the syringe with gently to remove air to down on your syringe drop of insulin appea pressing the button a needle for at least 6 s insulin. 483.25(m)(2) RESIDI SIGNIFICANT MED F The facility must ensu any significant medic	ecifications for Novolog ments: Before each injection may collect in the cartridge o avoid injecting air and to y: E. Turn the dose selector eep the needle pointing ush button all the way in. furns to 0. A drop of insulin needle tip. If not, change the e procedure no more than 6 a and hold down the dose counter shows "0". Keep the fter the dose counter has owly count to 6. Dicy titled, "Policy and en Use" documents: It is the o ensure safe delivery of f the flex pen when it is ician to a particular resident. ered, the staff nurse shall rocedure: 4. Dial 2 units. 5. needle pointing up and tap pubbles. 6. Press the button e as far as it will go until a rs. 9. Inject the insulin by II the way in. Leave the seconds after injecting the ENTS FREE OF ERRORS ure that residents are free of ation errors.	F 33			
	Based on observatio	n, interview and record				

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Facility ID: IL6008643

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		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/17/20 FORM APPROVE MB NO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X	(3) DATE SURVEY COMPLETED
		14E572	B. WING				12/08/2014
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
SKOKIE N	IEADOWS NURSING CE	INTERII					
	CUMMADY C	TATEMENT OF DEFICIENCIES		or	OKIE, IL 60076 PROVIDER'S PLAN OF COR		
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 333	Continued From pag	e 86	F	333			
	review, the facility fai	iled to ensure that residents					
	-	ant medication errors for one					
	resident (R1) in a sau	R47) in the supplemental					
		ceiving insulin injections. The					
		nister insulin injections at the					
		ed to follow manufacturer's nas the potential to affect the					
		g insulin injections in the					
	facility.	J					
	Findings include:						
	During the Medicatio	n Pass task, on 11/17/14 at					
	4:52pm, R20's blood	sugar result was 269 mg/dl					
		ter). E20 (Licensed Practical					
	,	tered R20's seven units of in according to his sliding					
	0 1	ceive his dinner tray until					
	6:10pm.						
		om, R47's blood sugar result (LPN) administered R47's					
	-	insulin via flex pen. R20 did					
	not receive his dinne	r tray until 6:10pm. R47's					
	-	et (POS) dated 11/1/14					
		cuments: Novolog Flex pen aneously three times daily					
	with meals. R47's Ca						
		es medication as ordered by					
	doctor.	am B10's blood sugar					
) am, R19's blood sugar . E9 (Registered Nurse-RN)					
	indicated that she wa	as going to administer three					
		ulin according to R19's					
		units of Humalog insulin Irly scheduled insulin with					
		red 15 units of Humalog					
	Lispro insulin to R19	at 11:52 am. R19's POS					
	dated 11/17/14 docu	ments: Increase Humalog 12					

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			0.00				NO. 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		STRUCTION	· · ·	TE SURVEY
		14E572	B. WING _				2/08/2014
NAME OF PF	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		
SKOKIE M	EADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 333	Continued From page	2 87	F 3	33			
		ously) with lunch. R19 did not		.00			
	•	al until 12:15pm. R19's Care					
	Plan documents: Inte	•					
	medication as ordered	d by doctor.					
		am, R1's blood sugar result					
	0 (N) indicated that she was					
		ovolog insulin four units					
	•	ing scale plus Novolog					
		was his regularly scheduled als. E9 administered 26 units					
		R1 via flex pen at 11:54 am.					
		nsulin pen before dialing it					
		s. E9 did not keep the					
	injector depressed wh	nen holding the insulin pen					
	-	n for seven seconds. R1 did					
		meal until 12:13pm. R1's					
		: Interventions: Diabetes					
	medication as ordered On 11/19/14 at 12:55	•					
		, "Insulin should be given					
		after meals. By the time the					
	•	n, the trays should be up					
	here already. Resider						
	hypoglycemia."						
	-	m, Z4 (Pharmacy Manager)					
	stated, "Within 10 to "						
		sidents should be eating.					
	Ideally, immediately a On 11/20/14 at 9:45 a						
		sulin is fast acting so we					
		minutes before meals or					
		ld happen? Blood sugar					
	drops." At 12:55pm, E	24 stated, "With the insulin					
		keep your thumb on the end					
	· ·	r. That's what keeps the					
		ou let go of the end of the					
		be in skin. Resident won't					
1	get all of insulin."						

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						NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION		TE SURVEY MPLETED
		14E572	B. WING _		1	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		DE	
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 333	"Novolog and Humale Should be given befo 30 minutes. It it's orde insulin should be give before. The insulin wor is delayed, then blood rapidly." The manufacturer rec insulin documents: Be rapid onset and a sho human regular insulir immediately (within 5 The manufacturer spe FlexPen insulin docu small amounts of air during normal use. To ensure proper dosing to select 2 units G. Ko upwards, press the p The dose selector ret should appear at the needle and repeat the times. Step 13: Press	e 88 bg are short acting insulin's. re meals but not more than ered with meals then the en with the meals, not ill work within 15 minutes. It's rks in 15 minutes and meal d sugar will begin to drop commendation for Novolog ecause Novolog has a more orter duration of activity than h, it should be injected -10 minutes) before a meal. ecifications for Novolog ments: Before each injection may collect in the cartridge o avoid injecting air and to g: E. Turn the dose selector eep the needle pointing ush button all the way in. surns to 0. A drop of insulin needle tip. If not, change the e procedure no more than 6 a and hold down the dose counter shows "0". Keep the	F 3	333		
	returned to "0" and sl An undated facility po Procedures of Flex P policy of the facility to insulin with the use of prescribed by a physi When flex pen is order follow the following po Hold the syringe with gently to remove air b down on your syringe drop of insulin appea	fter the dose counter has owly count to 6. olicy titled, "Policy and en Use" documents: It is the o ensure safe delivery of f the flex pen when it is ician to a particular resident. ered, the staff nurse shall rocedure: 4. Dial 2 units. 5. needle pointing up and tap oubbles. 6. Press the button e as far as it will go until a rs. 9. Inject the insulin by II the way in. Leave the				

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				CONSTRUCTION		10. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		14E572	B. WING		1	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP COD	E	
SKOKIE I	MEADOWS NURSING CE	NTERII		500 WEST GOLF ROAD KOKIE, IL 60076		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 333	needle for at least 6 seconds after injecting the		F 333			
F 364 SS=F	insulin. 483.35(d)(1)-(2) NUT	RITIVE VALUE/APPEAR,	F 364			
	Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.					
	by: Based on observatio review, facility failed t holding of cooked foo recipes, and serve foo temperature. This fai affect all 90 residents Findings include: On Monday 11/17/14 Meal included: Fish S Red Bean Salad, Cre Peaches and Pears, I Choice of Beverage. On 11/17/14 at 2:30p supper meal were ob thirds full, full size six in a combination over temperature was take noted the temperature Fahrenheit. In anothe another full size stear of cooked fish sticks	en by E25 (am cook) who e to be 207 degrees er standard oven was m table pan three quarter full which were 148 degrees r inquired of E17 (Dietary				

Event ID: RPQ011

Facility ID: IL6008643

If continuation sheet Page 90 of 129

	-	ID HUMAN SERVICES			FOR	ED: 12/17/2014 MAPPROVED
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DAT	O. 0938-0391 E SURVEY IPLETED
		14E572	B. WING		1:	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP COD)E	
				4600 WEST GOLF ROAD		
SKOKIE N	IEADOWS NURSING CE	NTERII	:	SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 364	inquired if the cook dr cooked and E17 state depends on how the of how much work they if The supper menu call Salad to be prepared mayonnaise type sala prepared was bow tie salad for supper mea recipe called for medi mayonnaise type sala the recipe. For this re- were omitted and a vi was substituted for a dressing. On 11/18/14 at 2:20p E19 (PM cook) decide because they were ou dressing for both recip no hard cooked eggs Red Bean Salad recipe had told anyone at the had substituted recipe " no. " On 11/17/14 at 3:00p observed the Macaroo stored in the walk in c size six inch deep ste very top with the prep with plastic film. E17 macaroni salad which Fahrenheit and same was a temperature of A second pan with m be 73.4 degrees Fahr stated that he had pre-	red four hours. "Surveyor rives the time the food is ed 'yes." E17 stated "it cook's day is going and have to do. " led for Creamy Macaroni with elbow pasta and ad dressing. What was e pasta with a vinegar and oil e recipe for the Red Bean al was not followed. This ium hard cooked eggs and a ad dressing to be included in ecipe, the hard cooked eggs inegar and oil salad dressing mayonnaise type salad om E17 stated in part that ed to adjust the recipe ut of mayonnaise type salad pes and because there were available to include in the be. Surveyor inquired if E19 e time of preparation that he e ingredients and E17 stated m with E17, Surveyor ni Salad for the Supper meal cooler. There were two full am table pans filled to the pared salads and covered took the temperature of the	F 364			

Facility ID: IL6008643

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/ FORM APP MB NO. 093	ROVE
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION		K3) DATE SURVE COMPLETED	ΞY
		14E572	B. WING				12/08/20)14
NAME OF PF	OVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	E		
	EADOWS NURSING CE			46	00 WEST GOLF ROAD			
		NIEKTI		SK	(OKIE, IL 60076			
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COM	(X5) IPLETION DATE
F 364 F 371 SS=L	temperatures were ta meal being served. On 11/17/14 at E10 (I took the macaroni sa noted to be 69.2 degre thermometer and Sur registered 65.0 degre bean salad was noted Fahrenheit with Surve thermometer. Facility policy titled: F Prepared Foods from March, 2014 states: at the destination kitc their temperature take below the baseline te above the baseline te quick chilled to the pr immediately. Facility undated, Star states: It is the policy utilize standardized ro the delivery of consis 483.35(i) FOOD PRC STORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and	to the receiving kitchen, iken again prior to the dinner Food Service Supervisor) alad temperature which was rees Fahrenheit with a digital revors stem thermometer ees Fahrenheit. The red d to be 48 degrees evors metal stem Procedure for Transferring Kitchen to Kitchen dated Procedure: 7. When arriving then cold foods will have en to ensure they started imperature. If they are emperature, the foods will be toper temperature indardized Recipe Policy of the Dietary Department to ecipes as a means to ensure tent food products. DCURE, ERVE - SANITARY		3364				

Event ID: RPQ011

Facility ID: IL6008643

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
		14E572	B. WING		12	/08/2014
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SKOKIE N	IEADOWS NURSING CE	NTERII		600 WEST GOLF ROAD KOKIE, IL 60076		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 371	by: Based on observatio review facility failed to assure that potentially properly cooled down of micro-organisms ', equipment and food p follow policy 's for ta	is not met as evidenced n, interview and record p implement procedures to y hazardous foods (PHF) are to prevent the rapid growth sanitize food preparation preparation surfaces and king food temperatures. lementing procedures for	F 371			
	potentially hazardous policies, all 90 resider meal were at risk for a This was identified as 11/17/14 at 5:00pm. informed of the Imme immediacy was remo the facility remains ou Severity Level 2 as th	food (PHF) cool down nts who were to receive the a food borne illness. a n Immediate Jeopardy on E1 (Administrator) was diate Jeopardy. While the ved on 11/17/14 at 5:20 PM,				
	at 5:20 PM, the facilit at a Severity Level 2 implement their abate Findings include: On 11/17/14 at 3:00p (Dietary Manager) off	site kitchen were checking				
	that was prepared on (PM Cook) earlier in t being stored in six in steel pans. Both pan filled to the very top a E17 checked the tem salad with the facilitie Two temperature read	o pans of macaroni salad 11/17/14 at 1:15pm by E19 he day. Macaroni salad was ch deep full size stainless s of macaroni salad were ind covered with plastic film. perature of the macaroni s' digital thermometer. dings in one pan were 76.3 ind 74.7 degrees Fahrenheit.				

Facility ID: IL6008643

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					OMB NO. 0938-0	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14E572	B. WING		12/08/2014	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
SKOKIE I	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLET	
F 371	E25 (AM Cook) " got now ", " that 's been E25 placed the whole freezer that was full w delivery earlier in the that the freezer was fil limited air circulation a which was placed dira frozen food. Surveyor was going to make it? below before serving " he (E19) knows the t 't pay attention to th bean salad was on th dinner meal. E19 (PM bean salad was prepa On 11/17/14 at 1:55pi (Dietary Manager) ab the lunch menu today beef had been cooker E18 (AM Cook). Surv utilized and documen for Potentially Hazard stated " No we don ' we? E17 indicated th Roast Beef and Corno on the four week cycl day prior to being ser Surveyor inquired reg Critical Control Point the two-stage cool do in part that the proces and that E17 didn 't ' documentation accura E17 if he had any rec	bo high. " E17 instructed to get it in the freezer right a sitting way too long." e pan into the reach in with boxes of food from a day. Surveyor observed illed and that there was around the full size pan ectly on top of a box of rinquired if E17 thought it ? Meaning 41 degrees or time 5:00pm and E17 stated procedure, cooks just didn ' he clock. In addition, a red e supper menu for the M Cook) stated that the red ared at 1:00pm on 11/17/14. m Surveyor inquired E17 out the roast beef served on W. E17 stated that the roast d on Sunday 11/16/14 by weyor questioned E17 if they ted any cool down activities lous Foods (PHF) and E17 t keep any records; should hat Roast Pork, Pork Loin, ed Beef were items served e menu and all cooked the ved. garding the Hazard Analysis (HACCP) documentation for wn process, and E17 stated as was documentation heavy t trust staff to complete the ately. Surveyor questioned ords of any Potentially F) cool down activities in the	F 37			

Facility ID: IL6008643

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	S FOR MEDICARE & I				OMB NO. 0938	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14E572	B. WING		12/08/2014	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
SKOKIE M	EADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPL THE APPROPRIATE DA	
F 371	Continued From page	94	F 3	71		
		the cook staff regarding the				
		he undated Two Step Cool				
		es: Cooked food will be				
	cooled down from 130 degrees Fahrenheit to 70					
	degrees Fahrenheit within two hours and from 70 degrees Fahrenheit to 41 degrees Fahrenheit or					
		rs (or within a total of 6 d comes out of the oven, or				
	,	steam-table, use an active				
		ich 135 degrees Fahrenheit.				
	-	m, both hot and cold food				
	prepared for the dinner meal was transported to					
	the facility kitchen from the offsite kitchen in a					
	plastic thermal cabine					
		ken by E10 (Food Service				
	Supervisor) using a d Surveyor using a calil	igital thermometer and by				
		temperature was 69.2				
	degrees Fahrenheit a					
	thermometer reading					
	Fahrenheit. The meta	al stem thermometer				
	reading for the red be	an salad was 48 degrees				
	Fahrenheit.					
		f the temperatures were				
	-	stated " of course they are should be less than 40				
		E10 stated I am going to				
	-	ut it in the freezer until we				
	serve. "					
		m both prepared salads had				
	been in the Danger Z					
	-	or more than four hours with				
		n of harmful pathogens.				
		January 27, 2014 for both ed bean salad state: Danger				
		ods between 41 degrees				
		egrees's Fahrenheit longer				
	than four hours.	- <u>-</u>				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		14E572	B. WING			12/	/08/2014
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SKOKIE N	IEADOWS NURSING CE	NTERII			4600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 371	 While the immediacy at 5:20 PM, the facility at a Severity Level 21 for complete interview evaluate the effective correction for F-371. The facility submitted 1. The food left out salad) were discarded Staff was in-serviced Food Temperature Pr 2. Daily temperature Pr 2. Daily temperature file for one year. 3. Cooks will use the and will complete the Log. 4. The food temperation kitchens and will be sitem is being served. 5. The facility Admini- list of all foods that wi and schedule self to oprocess is being perfor 6. Administrator has Monitoring of Cooling one times weekly for weekly for one month thereafter. 7. Dietary consultar during their monthly v 8. Food Preparation Policy will be discussed Assurance Meeting. Although the immedia remains at the second can be in-serviced. 	was removed on 11/17/14 y remains out of compliance because of the need to allow ving of dietary staff and to ness of the plan of the following plan: (bean salad and pasta d on 11/17/14 at 5:20pm. on Cool Down Policy and ocedure. e logs for food will be kept on e two step cool down label Food Temperature Cooling ature cooling log will serve document between the two ent to the facility when such histrator will obtain a weekly II be cooled down properly observe that the cool down ormed accurately. s developed a form for Down which will be done one month, two times and then monthly hts will be observing staff risits. n and Food temperature ed in the Quarterly Quality	F	371			

Event ID: RPQ011

Facility ID: IL6008643

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DAT	E SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED	
		14E572	B. WING		1:	2/08/2014	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
SKOKIE N	IEADOWS NURSING CE	NTERII		00 WEST GOLF ROAD COKIE, IL 60076			
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE COMPLET		
F 371	sanitizer bucket and o less than 10 parts per Facility policy for Cher Cloths states: Wiping a bucket of water at 7 the following concent On 11/17/14 at 2:20p kitchen along with E2 bucket sanitizing solu E17 stated that they of the thermometers ' in taking food temperatur he understood that if down tables that it leas stated that using bleat idea than using a aloc the thermometer prote water for sanitizing te part, there ' s barely a million. Undated Food Temper Fill sanitizing bucket sanitizing solution and the way. 3. using a of thermometer, take the food placed in the stat temperature on the D proper location. Rins thermometer probe a On 11/17/14 at 2:25p four quart measuring	bd preparation surface determined that it was at or r million (ppm). emical Sanitizing For Wiping g cloths should be stored in 75 degrees Fahrenheit with rations: Chlorine 100 ppm. m Surveyor and E17 offsite 25 (am cook) checked the atton in the cook ' s area. Use that bucket to sanitize netal probes in between ures. E17 stated in part that alcohol was used to wipe aves a residue behind and ach water would be better obol swab cloth to sanitize one. E25 tested the bleach emperature probes stated in anything, maybe 20 parts per erature Procedure states: 2. with proper mix of water and d place on rear table out of digital probe-type e temperature of the first evantable. Record the value table. The process is the aves and sanitize the	F 371				

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							10.0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		NSTRUCTION		FE SURVEY MPLETED
		14E572	B. WING _			1	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII			WEST GOLF ROAD KIE, IL 60076		
						TION	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 371	Continued From page	97	F 3	371			
		time. Facility presented a					
		torage Policy on 11/18/14.					
	On 11/17/14 at 2:45pm observed E19 (PM cook)						
	washing pots and pans in the three compartment						
	sink. Observed the immersion time to be less						
	than 10 seconds, E19 was continuously moving						
	pans from the rinse to	o through the sanitizer to the					
	drain board without re	equired sanitizer contact					
	time.						
	-	m off site kitchen, Surveyor					
		the two step cool down					
		asta. E25 stated in part that					
	you would wait two hours for the product to be 40 degrees Fahrenheit. If not 40 degrees, separate						
	into smaller portions						
	container with ice to c						
		ig a meat item and E25					
	-	ernal temperature of 145 to					
		neit. Then cut in half and					
	cool to 70 degrees in						
	degrees, cut into qua	rters, put in cooler or on ice					
	until 41 to 40 degrees	Fahrenheit. E25 stated "					
		ple process, yes to get the					
	right temperature. "						
		m Surveyor asked E19 to					
		cool down process for roast					
	-	art, to remove from oven at					
		ahrenheit. Put roast beef in					
	-	ol down for 3 hours at room ut into four to six pieces to					
	cool, then just put in c						
		emperature logs for 2014					
		and November showed that					
		ing 21 meals where no food					
		corded, October noted 25					
	-	ratures and November					
		I with no temperatures					
	documented.						
	Eacility Procedure for	Transferring Prepared					

Facility ID: IL6008643

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/17 FORM APPRO OMB NO. 0938-	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• • •	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		14E572	B. WING		12/08/2014	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
SKOKIE M	EADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD		
				SKOKIE, IL 60076		
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLE THE APPROPRIATE DATE	
F 371	Continued From page	e 98	F 3	71		
		o Kitchen, dated March,				
	2014 states: 1. When	n picking up hot foods the				
		aken to ensure that they are				
		temperature of 140 degrees ey must be reheated to				
		ahrenheit before leaving the				
	kitchen.	3				
		perature Logs for November				
		Up temperatures noted for				
	and 11/10/2014.	1/1, 11/2, 11/4, 11/6, 11/7,				
	Facility Policy dated I	March, 2014 states:				
		When arriving at the				
		ot foods will have their				
	temperature taken to	ransfer. If there is heat loss,				
	the food will be re he					
	temperature immedia					
		: When arriving at the				
		old foods will have their ensure they started below				
		ture. If they are above the				
	•	e, the foods will be quick				
		emperature immediately.				
F 372	()()	E GARBAGE & REFUSE	F 3	72		
SS=F	PROPERLY					
	The facility must disp	ose of garbage and refuse				
	properly.					
		Γ is not met as evidenced				
	by:	tion and uppend and include				
		ation and record review rly contain and cover refuse				
		e dumpster. This has the				
	potential to affect all	90 residents in the facility.				
	Findings include:					

Facility ID: IL6008643

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/17/20 [;] RM APPROVE IO. 0938-039
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		14E572	B. WING		1:	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CO	•	
SKOKIE N	IEADOWS NURSING CE	NTERII		600 WEST GOLF ROAD KOKIE, IL 60076		
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 372 F 406 SS=G	On 11/17/14 at 8:50 a overflowing with accu and refuse. The lid to propped open two or because of the volum The undated facility p and Recycle Materia leases (1) one 8 yard disposal. Pick up is a through Saturday. S (3) three recycle bins which will be picked of pickups are due by 8 483.45(a) PROVIDE/ REHAB SERVICES If specialized rehabilit not limited to, physica pathology, occupation health rehabilitative s and mental retardation resident's comprehene must provide the req required services from accordance with §48 provider of specialized This REQUIREMENT by: 1) Based upon obse review, the facility fail underlying factors of failed to identify need attention for one resir residents. This failure	e 99 am the facility dumpster was unulated bags of garbage o the refuse dumpster was more feet into the air ne of refuse in the dumpster. bolicy titled: Policy for Trash ls states: Skokie Meadows d dumpster (trash / waste) six days a week, Monday Skokie Meadows also leases a (for papers / cardboard's) up one time a week. Both :00 am on scheduled days. /OBTAIN SPECIALIZED itative services such as, but al therapy, speech-language nal therapy, and mental services for mental illness on, are required in the nsive plan of care, the facility uired services; or obtain the m an outside resource (in 3.75(h) of this part) from a ed rehabilitative services. T is not met as evidenced rvation, interview and record led to identify and treat behavioral changes and d for additional behavioral dent (R7) in a sample of 18 e resulted in decreased tion and continued isolation,	F 372			

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		ID HUMAN SERVICES MEDICAID SERVICES				l	NTED: 12/17/2014 FORM APPROVED B NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		14E572	B. WING				12/08/2014
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	I	
SKOKIE N	IEADOWS NURSING CE	NTEDII		46	600 WEST GOLF ROAD		
SNORIE	IEADOWS NORSING CE	NIEKII		S	KOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 406	Continued From page	e 100	F	406			
	diagnoses of Spine Ir Herniated cervical dis R7 's PAS/MH (Pre-a Health) dated 12/6/13 Services- Professiona (Medical Doctor/Regi monitoring, adjustme community re-integra Activities of Daily Livi and Mental Health Re acute acre psychiatric instruction dated 12/4 Notify physician if exp following: Recurrence that led to hospitaliza yourself. " On 11/17/14, at 9:30 with E2 DON (Director room while the reside in progress. E2'stated resident morning mee room. On 11/17/14, at 2:00 did not attend in-hous On 11/17/14, at 3:07 stated R7 prefers to s complain of pain to hi On 11/17/14, at 3:45 bent (fetal) position. F go to activities and re because he is stiff an told the nurse about H On 11/18/14 at 10:00 and stated that he do	tion activities, Instrumental ng training/reinforcement ehabilitation activities. The c hospital discharge l/13 documents in part: " beriencing any of the e of psychiatric symptoms tion; Inability to care for AM, during the initial tour or of Nursing), R7 was in his ents ' morning meeting was d that all residents attend eting every day in the front PM, R7 was in his room and se activities. PM, E12 Activity Director stay in the room because of is legs. PM, R7 was on his bed, in a R7 stated that he does not esident morning meetings d sore. R7 stated that he his complaint of pain. Am, R7 was in his room					

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						10.0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	FE SURVEY MPLETED
		14E572	B. WING		1	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE I	IEADOWS NURSING CE	NTERII		600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 406	legs, arms, neck and probably need a pow R7 stated that he like walk around the facili much pain. " R7 stat him to go the patio to R7 stated that his ina enjoys makes him sa just want to move out nursing home. " On 11/18/14, at 10:20 R7 did not attend on- that the pain to his ne and R7 has already r to the nursing staff. On 11/19/14 at 12:07 stated that a resident should be investigate On 11/19/14, at 1:05 Rehabilitation Service R7 is not attending p When asked what was stated that she charte psychiatrist about it. If supposed to attend in that she is not aware function, but Nursing determination if R7 n stated that she was n in-house activities. On 11/19/14, at 1:36 R7 " can be isolative isolative behavior is to " Not really. " The Be	upper back. R7 stated, " I er chair to be comfortable. " es walking and he used to ty when he " was not in so ed that it is also difficult for smoke because of his pain. bility to do the things he d and angry. R7 stated, " I t of here and go to another D AM, R7 was in his room. going activities. R7 stated eck and upper back is worse eported his complaint of pain PM, E1 (Administrator) c's decline in condition ed and addressed. PM, E7 PRSC (Psychiatric es Coordinator) stated that sychosocial groups anymore. as done to address it, E7 ed it but did not notify the	F 406			

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						<u>NO. 0938-03</u>
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	IPLE CONSTRUCTION		TE SURVEY MPLETED
		14E572	B. WING		1	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	θE	
SKOKIE M	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 406	Continued From page	e 102	F4	.06		
	aware that R7 stoppe	d going to psychosocial				
	groups activities. E16 stated that the psychiatrist					
	should have been about it. E16 also stated, " (R7					
	's) isolative Behavior should have been monitored. E16 stated that R7 should be in					
	engaged with in-house activities if R7 is not going					
		ams. E16 was not aware				
		ding in-house activities.				
		PM, Z2 stated that R7 is				
	being treated biologic	ally through R7 ' s				
		also need psychosocial				
	treatment that R7 should get through facility services such as psychosocial programs and					
		chosocial programs and 2 stated that she is not				
		ve behavior, decline in ADL				
		ing) capabilities, stopped				
	going to psychosocial					
		activities. Z2 stated that the				
		ould be monitored because				
		iagnoses which include SAD				
		order). Z2 stated that the				
		nonitor residents ' behavior onitoring tracking so an				
		are can be created. Z2				
		uld have known about the				
	change in R7 ' s beha	avior and ADL's, she would				
	have ordered R7 for hevaluation.	nospitalization and further				
		mary records from July to				
		eviewed: For both months of				
		4, the records documents I pleasant. Monthly Nursing				
		/14 documents Behavior:				
	delusional and parane					
		4/14 documents: Behavior:				
		oid. There is no evidence				
	-	ehavior were addressed by				
	the facility.					
	Psychotropic Medicat					

Facility ID: IL6008643

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				PRINTED: 12/17/20 FORM APPROV OMB NO. 0938-03
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	14E572	B. WING		12/08/2014
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP C	•
		40	600 WEST GOLF ROAD	
SKOKIE MEADOWS NURSING CE		s	KOKIE, IL 60076	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETIC HE APPROPRIATE DATE
part: Behavior exhibit 10/31/14 documents remains isolative and evidence that the ons isolative and withdraw addressed by the fac Psychiatric progress and 10/24/14 did not withdrawn behavior. that Z2 was notified of behavior of R7. Psychotropic Care Pl documents interventi occurrence of for targ document per facility behavioral tracking si specific behavioral oc address mood/behav The facility ' s Behavi from February, 2014 reviewed. The followi uncoded (No specific March, 2014, April, 2 and November, 2014 E3 (ADON) stated that tool is used to track r facility ' s monitoring changes of behavior. from the Behavior Mo when planning the ca for a resident. Social Service Progre	part: 9/30/14 documents in ted- isolative, withdrawn. in part: Behavior exhibited - d withdrawn. There is no set and persistence of wn behaviors were sility. notes dated 8/25/14, 9/26/14 identify R7 ' s isolative and There is no documentation of the isolative and withdrawn lan initiated 9/18/14 fons in part: "Monitor/record get behavior symptoms and protocol; Update and code heets as indicated; Offer bunseling and intervention to vioral issues. " ior Monitoring Records dated to November, 2014 were ing records were blank and e Behavior being monitored): 014, May, 2014, July, 2014 b. On 11/19/14, at 1:36 PM, at the behavior monitoring resident ' s behavior and the tool to determine significant . E3 stated that information ponitoring Records is used are or behavior management ess Notes from 5/21/14 - ed. The documentation ntify R7 ' s Isolation and	F 406		

Facility ID: IL6008643

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STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		MPLETED
		14E572	B. WING		1	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	Ē	
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET	
F 406	Continued From page	e 104	F 40	06		
		ic, reading, writing, walking				
	and being outdoors, talking or conversing,					
		/parties, organization like				
		ntellectual games and trivia.				
		es dated 9/24/14 documents				
		been spending a lot of time vidence of a care plan being				
		7's "spending a lot of time				
	in bed. "	7 3 spending a lot of time				
		ed 9/18/14 documents in				
	part: R7 ' s Care Plar	n initiated on 9/18/14				
		R7) has severe mental				
		Assign (R7) to group or				
	activities to go to. Inte	-				
		or is observed. Focus - (R7) me difficulty adjusting to				
		it; Intervention: Get resident				
		and activities. Assign the				
		ivities to go to. Care Plan				
	Activity dated 9/24/14	4 documents in part: (R7 ' s)				
		poor functioning with peers.				
		on/approach documented.				
	There is no plan to a					
		to adapt to R7 ' s current lition. On 11/19/14 @ 2:05				
		ector) validated the absence				
		lress R7 's activity needs.				
	E12 stated, "I misse					
		olicy, titled "Activities "				
	-	he facility shall provide an				
	on-going program of					
	-	nces and the physical,				
		ocial well-being of each s shall be adapted, as				
		r maximum participation by				
		f a particular resident does				
		east an average of four (4)				
	activities per day ove	r one week period, the unit				
	director shall evaluate					

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		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 12/17/20 FORM APPROVE B NO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í			(X3)	DATE SURVEY COMPLETED
		14E572	B. WING				12/08/2014
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				4	600 WEST GOLF ROAD		
SKOKIE IV	IEADOWS NURSING CE	INTERTI		s	KOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 406	10		F	406			
		e the available activities oult with the interdisciplinary					
	documents R7 ' s is i	ess notes dated 9/2/14 not attending Anger, Men's					
	documented as " dis	ograms. Men's ' group was continued " but there was the reason. There was no					
	evidence of the psyc	hiatrist being notified. ad policy titled Behavior					
	Management and Be						
	identify residents who	o demonstrate unstable, nized behavior who may					
	demonstrate greater	-					
	· ·	luding aggression towards persons. These residents					
		psychiatric consultation, nent and/or modifications in					
		ment plan. Problem-solve					
		mptoms are communicating. olvement in on-going					
	psychiatric, psycholo	gical. Structure and					
		ooperatively works to identify management challenges and					
	-	action to promote a safe and					
		nent, stressing educational					
	services/training, mo	nitoring the effect of s and making needed					
		n care plans. The IDT,					
		social services staff and					
	clinical social work co identifying residents	onsultant are responsible for					
		" There is no evidence that					
		R7 's need for additional					
	behavioral attention.						
	5/11/12 documents ir	ation Services policy date					
	engagement of each	resident in his/her recovery					

Facility ID: IL6008643

If continuation sheet Page 106 of 129

		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/17/2 FORM APPRO VB NO. 0938-0	VED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		3) DATE SURVEY COMPLETED	
		14E572	B. WING				12/08/2014	
NAME OF PI	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	IEADOWS NURSING CE			4	600 WEST GOLF ROAD			
SNORIE	IEADOWS NORSING CE	NIERII		s	KOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETI DATE	
F 406	response shall includ counseling about the personal consequence poor engagement. " appropriate education when R7 stopped par programming. Quarterly MDS (Minir 3/17/14 documents th (in comparison with A 12/17/2013): Change documented as new of of psychosis - hallucin Emergence of sad or included the following down, sad, depressed and having less energy himself; trouble conce was no Significant Ch 11/19/14, at 11:06 AN Data Set/Care Plan) comprehensive asses done. On 11/24/14, at 9:30 Director of Nursing) s to an acute care hosp behavioral symptoms 2) Based on observat review, the facility fail (R2, R10, R15), in a s psychosocial rehabiliti specified intervention individualized mental Findings Include: R15 is a 58 year old n	or Participation: Staff e appropriate education and value of interventions and ses the resident faces for There is no evidence that n and counseling was done ticipating in psychosocial num Data Set) dated ne following areas of decline admission/Initial MDS dated in behavior which was onset of potential indicators nation & delusion; anxious mood which g documentation: feeling d and helpless; feeling tired gy, feeling bad about entrating on things. There hange MDS completed. On <i>A</i> , E8 MDS/CP (Minimum Coordinator validated that a assment should have been AM, E3 ADON (Assistant tated that R7 was admitted bital for evaluation of a and pain. tion, interview, and record led to ensure that 3 residents sample of 18, reviewed for tative services, received s to address their	F	406				

If continuation sheet Page 107 of 129

		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/17/2014 FORM APPROVED MB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		ONSTRUCTION		(3) DATE SURVEY COMPLETED
		14E572	B. WING				12/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CO	DE	
	IEADOWS NURSING CE			460	0 WEST GOLF ROAD		
				SK	OKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 406	Disorder, Hepatitis C, alcohol abuse, and hi On 11/19/14 at 12:59 he currently has psyc at the facility. R15 gc men 's health, and st groups at the facility. stress reduction grou health topics are inter attend psychosocial p community anymore. psychosocial program 6 months. On 11/24/14 at 9:42 A that he had radiation started at the beginni was scheduled for ps community, but he did because of his radiati assigned to psychoso when he was schedu psychosocial groups. radiation treatments, 't ' feel good. On the feel good, he doesn ' psychosocial groups days when R15 feels scheduled psychosoc On 11/20/14 at 12:19 Rehabilitation Service that R15 was dropped groups in the commu attend the groups wh treatments (5X (5 tim been attending his sc groups.	spinal stenosis, history of istory of prostate cancer PM, R15 stated in part that chosocial groups scheduled bes to anger management, tress reduction psychosocial Anger management and ps are helpful. Men 's resting. R15 doesn 't' orogramming in the R15 has had scheduled nming at the facility for about AM, R15 also stated in part treatments for 26 weeks that ng of the year, 2014. R15 ychosocial groups in the d not attend the groups ion treatments. R15 was not ocial groups at the facility led for the community Since R15 completed the he has days when he doesn e days when R15 doesn 't' t' go the scheduled in the facility and on the good, he attends the	F	406			

Facility ID: IL6008643

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/17/201 FORM APPROVE OMB NO. 0938-039
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		14E572	B. WING _		12/08/2014
NAME OF P	ROVIDER OR SUPPLIER	•	-	STREET ADDRESS, CITY, STATE, ZIP	•
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O	CTION SHOULD BE COMPLETIO D THE APPROPRIATE DATE
F 406	that she has encoura scheduled psychosoo visits with R15 and di psychosocial groups discussed in the grou the 1:1 visits. The infe encourage residents psychosocial groups On 11/24/14 at 11:21 Rehabilitation Service that R15 has not att groups for several me to attend his schedul 1:1 visits. The topics psychosocial groups, discussed with R15 of facility has no docum 1:1 visits. Psychosocial annual indicates that R15 ha thoughts, ineffective skills, poor activities of showering, and appe also expressed some perceptions about the has a history of aggre behavior due to parai R15 's history includ verbal/physical aggre towards others. Social service note d R15 is very isolative a his room except for m has poor hygiene pra Social service note d E7 spoke to R15 abo	iged R15 to attend his cial groups. E7 has had 1:1 iscussed attending the but did not review the topics ups that R15 missed, during ormal 1:1 visits are to to attend the scheduled and are not documented. AM, E16 (Psychosocial es Director) stated in part ended his psychosocial onths. R15 was encouraged ed psychosocial groups via discussed in the that R15 missed, were not during the 1:1 visits. The mentation regarding R15 ' s update dated 8/21/14 is poor judgment, delusional coping skills, poor verbal of daily living, difficulty ars disheveled. R15 has e paranoid and irrational e facility environment. R15 essive, inappropriate noia and poor social skills. es self-harmful ideation and ession as well as threats ated 9/29/14 indicates that and doesn ' t come out of neals and medications and actices. ated 10/21/14 indicates that out attending the and will encourage R15 to ng the day.	F 4		

If continuation sheet Page 109 of 129

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI E	CONSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
		14E572	B. WING		1	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER		ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE I	IEADOWS NURSING CE	NTERII		500 WEST GOLF ROAD KOKIE, IL 60076		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 406	attendance sheets we November, 2014. Or following group attend Anger and Impulse C November, 2014, R1 available sessions on Men's Health - one f R15 attended zero of November, 2014, R1 available sessions Stress Reduction - or and October, 2014, R1 available sessions an attended zero of three Monthly mental health to November, 2014 in attend any psychosod October, 2014. The that R15 attended on health group in Novel encouraged to attend Care plan initiated on expresses debilitating irrational perceptions environment and has difficulty forming inter others. R15 was sch address his issues (in Control, Men's Grou avoid group. Implem Psychosocial Rehabi (PRSC) will communi regular to discuss res attendance and partic resident an activity ca	ere requested for June to a 11/24/14, E7 presented the dance sheets for R15: ontrol - one/time week - 5 attended one of three a 11/19/14 time/week - October, 2014 - five available sessions and 5 attended zero of three a time/week - September R15 attended zero of five ad November, 2014, R15 e available sessions h progress notes from July adicate that R15 did not cial groups from July to progress notes also indicate e stress and one men 's mber, 2014. R15 was the scheduled groups. a 8/21/14 indicates that R15 g, paranoid thoughts and and interpretations of his impaired social skills and personal relationships with eduled for therapy groups to acluding Anger and Impulse up). R15 makes excuses to ented interventions include: litation Services Coordinator icate with group leader	F 406			

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		MEDICAID SERVICES				O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	e survey Ipleted
		14E572	B. WING		12	2/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE M	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 406	Continued From page	e 110	F 40	06		
	-	sed, interventions to address				
		osocial group attendance				
		ualized psychosocial needs.				
		M, E7 stated in part that she lating R15 ' s care plan				
		fress R15 's psychosocial				
		ind revises R15 's care plan				
	interventions on a qu	arterly basis.				
		M, E16 stated in part that E4				
	(Psychosocial Rehab					
		I E16 conduct all of the in the facility. E4, E7, and				
	E16 have care plan meetings on Tuesdays and					
		Ily discuss issues/incidents				
	that occur with reside	ents and concerns with any				
		attend the groups. The				
		bally are not documented. rventions should have been				
		/20/14 care plan review.				
		d Comprehensive/Quarterly				
	Care Plan policy doc	uments in part:				
		n will be assessed and				
		epending on change of level				
	of care.	ndicate when care plan				
	interventions should l	-				
	On 11/18/14. at 9:51	am, E16 (Psycho-social				
		ctor) stated the following:				
	"(R10) is supposed to	o go to Stress Reduction,				
		erpersonal 2, Self-Esteem,				
		ion groups. He is very				
		nd has poor impulse control. roups. I don't have a care				
		he s supposed to attend.				
		are plan that states he is				
	refusing groups and '					
		r sheet denotes in part the				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 12/17/2014 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	_	(X3) DATE	
		14E572	B. WING			12/	08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CEI	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORE	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 406	following diagnoses: I Depression. Record of chart indicates lack of R10 to try alternative psychosocial groups. 1:1's documented any (R10) in my office and Facility's policy titled of Protocol: Structured Format denotes in pa provide a personalize specific psychosocial appropriate for group behavioral, and/or ext withdrawal, mood stat Recommended schere are 1-3x (3 times) /we On 11/9/14 at 10:30 a stated, "The PRSC's Services Counselor) a documenting their 1:1 residents are required are not required to go groups, the PRSC's a 1:1's." At 10:52 am, F stated, "The PRSC a encouraging the resid go to groups. They a	Bipolar Disorder and review of R10's medical f interventions to encourage strategies in place of E16 stated, "I don't have where for (R10). I do see 1 talk to him occasionally." One to One Intervention Professional Counseling rt: "The purpose is to d forum for residents with needs who are not intervention due to medical, treme psychosocial te-related problems. duled therapeutic sessions sek." um, E1 (Administrator) (Psycho-social Rehab and PRSD should be 's in a timely manner. The d to go to groups, but they to activities. If they refuse and PRSD should be doing E2 (Director of Nursing) nd PRSD should be lents to get out of bed and	F 4	06			

Facility ID: IL6008643

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	-	ID HUMAN SERVICES MEDICAID SERVICES					PRINTED: FORM A OMB NO. (PPROVE
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14E572	B. WING				12/08	/2014
NAME OF PI	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CO	DDE		
	IEADOWS NURSING CE	NTERII			0 WEST GOLF ROAD			
				SK	OKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE		(X5) COMPLETION DATE
F 406	Continued From page	e 112	F4	406				
	diagnoses to include Schizoaffective Chron Abuse, Hepatitis B ar On 11/17/14 at 12:55 has formal programm no Monday groups. " asked R2 about group know. " R2 was in at reduction. R2 's Mental Health months of September that R2 has six forma Cessation, Stress rec II, Self Esteem, Men Impulse Managemen each program genera month. Attendance a R2 did not attend any time in the month of S On 12/3/14 at 11:50 a Rehabilitation Service that if residents refus rehabilitative program encouragement throu resident is encourage bed, be active and sc activities which are lis calendar. E16 indicated that the programming was no only encouragement some meaningful acti R2 's Social services to 2/12/15 states that	pm R2 stated in part that he ing three times a week, " On 11/18/14 at 10:30 am ps and he stated " don ' t tendance for stress progress Note for the r and October 2014 denotes all programs listed: Smoking duction, Interpersonal Skills ' s health and Anger and t. E16 stated in part that ally meets four times a and Participation denote that v formal programs at any September and October. am E16 (Psychological es Director) stated in part e to attend their formal ming, they receive basic ugh a one to one where each ed get up, possibly out of bocialize, attend leisure sted on the monthly and daily e content of the formal t reviewed in the one to one, to be engaged and active in						

Facility ID: IL6008643

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/17/2014 APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	ECONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		14E572	B. WING		_	12/	08/2014
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	FATE, ZIP CODE		
SKOKIE M	IEADOWS NURSING CEI	NTERII		600 WEST GOLF ROAD SKOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 406 F 441 SS=F	receive those benefic attend formal program t cover any of the form 483.65 INFECTION C SPREAD, LINENS The facility must estal Infection Control Prog safe, sanitary and cor to help prevent the de of disease and infection (a) Infection Control F The facility must estal Program under which (1) Investigates, contr in the facility; (2) Decides what proc should be applied to a (3) Maintains a record actions related to infe (b) Preventing Spread (1) When the Infection determines that a resi prevent the spread of isolate the resident. (2) The facility must p communicable diseass from direct contact wii direct contact will tran (3) The facility must re	hs do not denote how R2 will ial services if he does not ming and one to ones don ' mal program content. CONTROL, PREVENT blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on. Program blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ctions. d of Infection in Control Program ident needs isolation to 'infection, the facility must prohibit employees with a se or infected skin lesions th residents or their food, if ismit the disease. equire staff to wash their ct resident contact for which iated by accepted	F 406				
	(c) Linens						

Event ID: RPQ011

Facility ID: IL6008643

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 12/17/201 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		14E572	B. WING			12/08/2014
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CIT	Y, STATE, ZIP CODE	
	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROA	AD	
				SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COI	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIA DEFICIENCY)	
F 441	transport linens so as infection.	e 114 lle, store, process and s to prevent the spread of is not met as evidenced	F 4	41		
	review, the facility fail infection control pract sanitize blood glucose hygiene during medic administration/distribu proper hand sanitizat deficient practices aff R8, R14) of 18 reside for infection control at R21, R22, R23, R24, R30, R31, R32, R33, R47, R48) in the supp addition, the facility fa linen properly. This de potential to affect all 9 Findings include: On 11/17/14 at 4:38p Practical Nurse) was perform R20's blood 9 that she had to retriev machine from a locke With her gloves on, E pocket for the keys at did not remove her gl perform R20's blood 9 During blood glucose 11:42 am, E9 (RN-Re sanitizer, rubbed her seconds and gloved.	tices by failing to: properly e machines, perform hand cation ution of meals and perform ion with hand gel. These fected three residents (R1, ents in the sample reviewed and 22 residents (R19, R20, R25, R26, R27, R28, R29, R34, R36, R37, R38, R39, oblemental sample. In ailed to store/handle clean eficient practice had the 20 residents in the facility. m, E20 (LPN-Licensed gloved and prepared to glucose test. E20 realized ve R20's blood glucose ed compartment on the cart. i20 reached into her uniform and unlocked the cart. E20 oves. E20 continued to				

Facility ID: IL6008643

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		ND HUMAN SERVICES MEDICAID SERVICES				F	ITED: 12/17/20 ORM APPROVE NO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		DNSTRUCTION	(X3) [OATE SURVEY OMPLETED
		14E572	B. WING				12/08/2014
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CC	DDE .	
				4600) WEST GOLF ROAD		
SKOKIEN	IEADOWS NURSING CE	NIERII		SKC	DKIE, IL 60076		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
	E9 did not clean R38 after use. E9 used he dirty machine on the E9 indicated that she machines after she p At 11:46 am, R19 ent glucose test. E9 used her hands for two sed hands, E9 gloved and glucose test. With ba dirty machine on the R38's dirty machine a did not clean R19's m am, E9 hand gelled for administered R19's H	her hands for two seconds. 's blood glucose machine er bare hands to place R38's cart next to R19's monitor. e cleans all the blood glucose erforms all the testing. tered the room for his blood d hand sanitizer and rubbed conds. With visibly wet d performed R19's blood re hands, E9 placed R19's clean surface in between and R1's clean machine. E9 nachine after use. At 11:52 or two seconds, gloved and dumalog insulin.					
	glucose test. E9 used her hands together for immediately and perf test. E9 removed her hands for four second placed R1's dirty mor between R19's dirty r machine. E9 applied Novolog insulin via for	d hand sanitizer and rubbed or three seconds. E9 gloved formed R1's blood glucose gloves and sanitized her ds. With bare hands, E9 hitor on the clean cart in machine and R39's clean gloves to administer R1's ex pen. E9 removed her					
	At 11:58 am, E9 glov blood glucose test. E hand sanitizer and ru two seconds. At 12:00pm, E9 bega machines for R1, R19 R39's machine with a minute. E9 did not all R39's blood glucose placed it in a black zi E9 repeated the sam	her hands for three seconds. ed and performed R39's 9 removed her gloves, used bbed her hands together for in to clean the blood glucose 9, R38 and R39. E9 rubbed a disinfectant cloth for one low time for air drying. With machine visibly wet, E9 pper case. e process for R1, R19 and machines. E9 stored the					

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				PRINTED: 12/17/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		14E572	B. WING		12/08/2014
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	•
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION OTHE APPROPRIATE DATE
F 441	allowing time for the i On 11/18/14 at 8:35 a Pass task, E9 applied of hand hygiene prior Advair oral inhalation Advair diskus up to R An undated facility po documents: 2. If hand alcohol-based water routinely decontamine clinical situations. So between patients, be taking off gloves, and indwelling catheter ar pass. 1. The CDC (C guidelines on Hand H recommendations for Using a waterless alc adequate volume of a 15 - 25 seconds for h to palm of one hand a Cover all surfaces of Continue to rub until An undated facility po and Nasal) Administr documents: Procedur Cleanse hands befor administration. On 11/24/14 at 11:10 Director of Nursing) s be cleaned immediate been inserviced."	hes while visibly wet, not machines to air dry. am, during the Medication d gloves without the benefit to administering R14's medication. E9 held the R14's mouth while he inhaled. olicy titled, "Hand Hygiene" ds are not visibly soiled, use ess antiseptic agent for ating hands in all other me of these situations are fore putting gloves on, after d before handling an hd in between medication enter for Disease Control) dygiene gave the following thand hygiene technique: 1. cohol-based agent - if an agent is used, it should take hands to dry. a. Apply product and rub hands together. b. hands and fingers. c. hands are dry. olicy titled, "Inhalations (Oral	F 4	41	

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					OMB NO. 093	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		14E572	B. WING		12/08/20)14
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE I	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COM	(X5) IPLETIO DATE
F 441	blood glucose meters Caring for your Blood (Long Term Care) Se thoroughly; the treate visibly wet for 2 full m disinfection. 6. Air dry completely before the On 11/17/14 at 12:18 Nurse Assistant) was towards the back of th arms crossed and pur uniform pockets. E21 hygiene prior to the p process was to serve the dining room and t residents simultaneou handled R21's dirty tr lunch tray. There was between contact with At 12:22pm, E21 scra his cheek. At 12:23pr mug by the rim and s 12:28pm, E21 handle At 12:30pm, E21 serve E21 took R8's dirty tra E21's left thumb camo of R23's cup. At 12:39 lunch tray. On 11/18/14 at 5:05p against a wall with his E31 touched his hair retrieve the dinner ca hallway. E31 did not p	iginal container. fications document for the a used in the facility denotes: Glucose Meter in a LTC tting: 4. Wipe the meter ad surface must remain inutes to attain complete of the meter to sanitize e next use. pm, E21 (CNA-Certified in the dining room located he facility. E21 stood with his t his hands in/out of his did not perform hand assing of lunch trays. E21's residents as they came to o receive dirty trays from usly. At 12:18pm, E21 ay and handed R24 his is no hand hygiene in a dirty tray and clean tray. atched his ear and touched n, E21 grabbed R21's coffee erved him coffee. At ed R36 and R1's dirty trays. ved R22 coffee. At 12:37pm, ay and served coffee to R23. e into contact with the inside 9pm, E21 served R25 his m, E31 (CNA) leaned is hands behind his back. and nose. E31 ran to rt and wheeled it down the perform hand hygiene prior passed dinner trays from	F 44			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		SURVEY PLETED
		14E572	B. WING			12	08/2014
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SKOKIE N	IEADOWS NURSING CE	NTERII			600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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	R36, R37, R47 and R (PRSC-Psychosocial Coordinator) entered office. E7 did not perf grabbing R26 and R3 filling it with water. At dirty tray. E31 did not before opening R22's the spout. E31 then h opened R26's carton On 11/19/14 at 2:30pr should leave the dirty gel before giving clea and forth to wash han places to wash hands between taking dirty t On 11/24/14 at 10:555 Director of Nursing) s not multitask while pa hand sanitization was On 11/18/14 at 2:30pr E22 (CNA) and E30 (unloading the clean lii and placing in a linen standing closest to the were simultaneously large bin. As E5 and I to take linens from the remove clean linens a arms. Then clean line with their uniforms. E5 blankets in half and d the grey bin. The outs visibly dirty. An undated facility po documents: 7) Linens	A48. At 5:12pm, E7 Rehabilitation Services the dining room from her form hand hygiene prior to 2's glasses by the rim and 5:15pm, E31 handled R31's perform hand hygiene milk carton and touching andled R8's dirty tray and of milk. m, E21(CNA) stated, "I trays, wash hands or hand n trays. It's hard to run back ids. There's not enough 5. Maybe I could hand gel in rays and giving clean trays." am, E3 (ADON-Assistant tated, "The CNA's should issing trays. Inservice on 5 done." m, E5 (CNA), E21 (CNA), CNA Support) were nen from a large grey bin closet. E21 and E30 were e closet. All four employees removing linens from the E22 waited for E21 and E30 em, they continued to and drape them over their ons were coming in contact 5 and E22 were folding large raping them over the side of side of the grey bin was	F	441			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED MB NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION		K3) DATE SURVEY COMPLETED
		14E572	B. WING			12/08/2014
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 441	were noted between clean linens and towe clean linens and towe carts containing soile be laundered. E2 (DC indicated that the clea separated from the di immediately separate the dirty linen carts. E to send the linens tha carts to the laundry. An undated facility po documents: 10) The o placed in the area wh and soiled linens is p	AM, three (3) dirty linen veen two (2) large linen and towels. The carts contact with the d linens and other items to DN-Director of Nursing) an linen carts should be rty linen carts. E2 d the clean linen carts from 22 also informed E21 (CNA) it were in the clean linen blicy titled, "Linen" clean linen carts must not be here contact between clean basible.	F	441		
	contact with the carts	containing soiled linens and idered. E2 DON (Director of				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
14E572		B. WING			12/	08/2014	
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE M	IEADOWS NURSING CEI	NTERII			00 WEST GOLF ROAD KOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441 F 458 SS=E	should be separated to proceeded to separate the dirty linen carts. E (Certified Nursing Ass that were in the clean The facility 's undated documents in part: " linen carts must not b contact between clean possible. " 483.70(d)(1)(ii) BEDF LEAST 80 SQ FT/RE Bedrooms must meas per resident in multipl least 100 square feet This REQUIREMENT by: Based on observation failed to provide the re- resident for 12 out of 105, 106, 108, 110, 11 ,and 120) Findings Include: During the environme started at 2:00 PM, 12 were noted to have two	at the clean linen carts from the dirty linen carts. E2 e the clean linen carts from i2 also informed E21 C.N.A. sistant) to send the linens linen carts to the laundry. d policy titled Linen Policy Procedure #10. The clean e placed in the area where n and soiled linens is		ł41 ł58	DEFICIENCY)		
	in part that there are	M, E1 (Administrator) stated 16 rooms on there 100 esident beds in a linear					

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	-	D HUMAN SERVICES				FORM	2: 12/17/2014 APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		14E572	B. WING		_	12/0	08/2014
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CE	NTERII		000 WEST GOLF ROAD KOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 458 F 465 SS=F	position that measure living space per reside multi-resident rooms of square feet of living s private rooms on the is square feet of living s the rooms not meeting requirements in the re- 483.70(h) SAFE/FUNCTIONAL/ E ENVIRON The facility must prov- sanitary, and comforts residents, staff and the This REQUIREMENT by: Based on observation failed to maintain the and sanitary manner hazardous material (c have the potential to a R10) in the sample of R27, R32, R33, R36, R50, and R51) in the Findings Include: On 11/19/14 at 2:00 FR Supervisor) stated in outstanding repairs, the The environmental to 11/19/14 at 2:00 PM, the following areas we repair: 1. In room 122 - the floor tiles between R4	 56 to 74 square feet of ent. None of the on the 200 corridor have 80 pace per resident. The 200 corridor don't have 100 pace either. E1 is aware of g the square footage esident rooms. 'SANITARY/COMFORTABL ide a safe, functional, able environment for re public. ' is not met as evidenced n and interview, the facility environment in a functional and safely secure charcoal). These failures affect 3 residents (R3, R8, 18 and 12 residents (R24, R39, R46, R47, R48, R49, supplemental sample. PM, E28 (Maintenance part, that the facility has no hat he knows of. 	F 458				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14E572	B. WING			12/	08/2014	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-		
SKOKIE N	IEADOWS NURSING CEI	NTERII			600 WEST GOLF ROAD SKOKIE, IL 60076			
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 465 F 514 SS=E	R49 's bed was push on 4 floor tiles at the f ceiling vent above R1 accumulation of dust. 3. In rooms 118, 10 ceiling vents above R s, R8 's, and R24 's accumulation of dust: 4. In the women 's corridor - there was a of two shower rods. In the unlocked storag there was one opener ½ full and one unoper charcoal. The unsect the potential to affect residents: R8, R32, F R47. On 11/19/14 at 2:36 F the housekeeping dep cleaning ceiling vents On 11/19/14 at 5:05 F stated in part that the responsible for cleani residents ' rooms. Th ceiling vents every 2 - housekeepers see tha 483.75(I)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance standards and practice	ed in, there were gray stains foot of R10's bed, and the 0's bed contained an 9, 107, 206, and 215 - the 50's, R27's, R3's, R51' beds contained an shower room in the 100 brown discoloration on one ge closet next to room 200, d 20 pound bag of charcoal, ned 20 pound bag of ured hazardous material has all 7 moderately impaired R33, R36, R39, R46, and PM, E28 stated in part that partment is responsible for in the residents ' rooms. PM, E29 (Housekeeper) housekeepers are ng the ceiling vents in the ne housekeepers clean the - 3 months and when the at the vents are dusty. TE/ACCURATE/ACCESSIB		465				

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DICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
14E572	B. WING _		12/08/2014
		STREET ADDRESS, CITY, STATE,	•
RII		4600 WEST GOLF ROAD	
		SKOKIE, IL 60076	
ST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) EACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE CIENCY)
resident; a record of the he plan of care and sults of any onducted by the State; not met as evidenced and interview, the facility ment behavior sychosocial group ents (R7,R15,R10,R2) ents, reviewed for onitoring Records from ber, 2014 were ere blank and not coded a documented) for the April, 2014, May, 2014, ; 2014. E3 ADON (Assistant ated this information. E3 nonitoring tool is used to vior is increasing or ng tool is used to nges of behavior. E16 PRSD (Psychiatric irector) stated that the important when ups and when creating Plan initiated on 9/18/14	F 5		
	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN 14E572 B. WING	PROVIDER/SUPPLER/CLIA (x2) MULTIPLE CONSTRUCTION A BUILDING

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14E572	B. WING			12/	08/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SKOKIE N	IEADOWS NURSING CE	NTERII			600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 514	occurrence of target t Update/code behavio indicated. On 11/17/14, at 3:07 I stated R7 was receivin There was no docume pertaining to the one- completed. The facility 's undate Medications policy do no. 11: Document bel includes symptoms re psychotropic medicat permanent or transier causes of the behavio effects to the psychot The facility 's undate Monitoring Record Po Behavior Monitoring F antidepressant, antips sedative-hypnotic, mo anticonvulsant medica medications to record appropriate diagnosis and side effects. The facility 's undate documents in part: Th current records of res activity program. Findings Include: R15 is a 58 year old r with diagnoses that in Disorder, Hepatitis C, alcohol abuse, and hi On 11/20/14 at 12:19 Rehabilitation Service	pehavior symptoms. ral tracking sheets as PM, E12 Activity Director ng one-to-one activities. entation presented to-one activities being d policy titled Psychotropic focuments in part: Guideline havioral monitoring which equiring the use of ion, if the symptoms are nt, other reason as potential or and monitoring of the side ropic medication. d policy titled Behavior blicy documents in part: Record is used for sychotic, psycho-stimulant, bod stabilizing and ations, anti-anxiety	F	514			

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		ND HUMAN SERVICES				F	NTED: 12/17/20 ORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3)	NO. 0938-039 DATE SURVEY COMPLETED	
		14E572	B. WING				12/08/2014
NAME OF PROVIDER OR SUPPLIER SKOKIE MEADOWS NURSING CENTER I I				4600	EET ADDRESS, CITY, STATE, ZIP CO) West Golf Road) Xie, IL 60076	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIOI DATE
PRÉFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)F 514Continued From page 125 groups in the community because he didn 't't attend the groups when he started his radiation treatments (5X/week). R15 has not been attending his scheduled psychosocial groups at the facility. E7 has spoken to R15 about going to the scheduled facility psychosocial groups. On 11/24/14 at 11:21 AM, E7 also stated in part that she has encouraged R15 to attend his scheduled psychosocial groups. E7 has had 1:1 visits with R15 and discussed attending the psychosocial groups but did not review the topics discussed in the groups that R15 missed, during the 1:1 visits. The informal 1:1 visits are to encourage residents to attend the scheduled psychosocial groups and are not documented. On 11/24/14 at 11:21 AM, E16 (Psychosocial Rehabilitation Services Director) stated in part that R15 has not attended his psychosocial groups for several months. R15 didn 't feel good most of the time. R15 was encouraged to attend his scheduled psychosocial groups via 1:1 visits. The topics discussed in the psychosocial groups, that R15 missed, were not discussed with R15 during the 1:1 visits. The facility has no documentation regarding R15 's 1:1 visits. Review of R15 's medical record indicated no documentation of R15 's 1:1 visits with E7 or E16.		F	514				
	medical chart did not documentation for R E16 (Psycho-social I stated the following:	am, record review of R10's contain any 1:1 10. On 11/18/14, at 9:51 am, Rehab Services Director) "(R10) is supposed to go to nger & Impulse, Interpersonal					

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		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/17/201 FORM APPROVE /IB NO. 0938-039
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION				TIPLE C		3) DATE SURVEY COMPLETED	
		14E572	B. WING				12/08/2014
NAME OF PR	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CO	DE	
				460	00 WEST GOLF ROAD		
SKOKIE M	EADOWS NURSING CE	NIERII		SK	OKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 514	He is very resistant to impulse control. He of R10's physician orde following diagnoses: Depression. Record chart indicates lack of R10 to try alternative psychosocial groups. 1:1's documented an (R10) in my office an Facility's policy titled Protocol: Structured Format denotes in pa provide a personalize specific psychosocial appropriate for group behavioral, and/or ex withdrawal, mood sta Recommended scher are 1-3x/week." On 11/9/14 at 10:30 a stated, The PRSC's (Services Counselor) documenting their 1:: residents are required are not required to go groups, the PRSC's a 1:1's." At 10:52 am stated, "The PRSC's a encouraging the resid go to groups. They a	Relapse Prevention groups. o groups and has poor does not attend groups." r sheet denotes in part the Bipolar Disorder and review of R10's medical f interventions to encourage strategies in place of E16 stated, "I don't have ywhere for (R10). I do see d I talk to him occasionally." One to One Intervention Professional Counseling art "The purpose is to ed forum for residents with I needs who are not intervention due to medical, treme psychosocial te-related problems. duled therapeutic sessions am, E1 (Administrator) (Psycho-social Rehab and PRSD should be 1's in a timely manner. The d to go to groups, but they to to activities. If they refuse and PRSD should be doing , E2 (Director of Nursing) and PRSD should be dents to get out of bed and	F	514			
		et (POS) denotes R2 ' s but not limited to Paranoid					

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		MEDICAID SERVICES				NO. 0938-03
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED	
		14E572	B. WING		1	2/08/2014
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE N	IEADOWS NURSING CEI	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 514	Continued From page	• 127	F 5	14		
	-	nic Type, History Alcohol	1.5			
	Abuse, Hepatitis B an					
	R2 's Mental Health I					
		and October 2014 denotes				
	that R2 has six formal programs listed: Smoking					
		luction, Interpersonal Skills				
		s health and Anger and				
	Impulse Management					
	On 11/17/14 at 12:55pm R2 stated in part that he has formal programming three times a week, "					
		On 11/18/14 at 9:30 am				
		at on. Surveyor asked R2				
		nd he stated " don ' t know.				
	" On 11/18/14 at 10:3	30 am R2 was in attendance				
	for his stress reductio					
		m E16 (Psychosocial				
		es Director) PSRD stated in m generally meets four				
		hly Mental Health Progress				
		pliance indicates " poor				
		ance and Participation				
	denote that R2 did no	t attend any formal				
		in the month of September				
	and October.					
		am E16 (Psychological				
		es Director) stated in part e to attend their formal				
		iming, they receive basic				
		gh a one to one where each				
		d get up, possibly out of				
	bed, be active and so	cialize, attend leisure				
		sted on the monthly and daily				
	calendar.					
		am E16 indicated that the				
	content of the formal					
		o one, only encouragement ctive in some beneficial or				
	meaningful activity.					
	R2 's Social services					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	2: 12/17/2014 APPROVED 2: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14E572	B. WING				12/	08/2014
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP COD)E		
SKOKIE N	IEADOWS NURSING CE	NTERII			600 WEST GOLF ROAD KOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 514	to 2/12/15 states that house psychological Care plan intervention receive those benefic	R2 would benefit from in social rehabilitative groups. ns do not denote how R2 will ial services if he does not nming and one to ones don '	F	514				

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