| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 | | |
|--|--|---|-------------------|--|--------------------------------------|-------|----------------------------|--|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | TIPLE CONSTRUCTION | (X3) DATE SU COMPLE | JRVEY | | | |
| | | | A. BU | | | | | | |
| | | 145413 | B. WI | NG _ | | 03/1 | 6/2012 | | |
| NAME OF F | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| ASTA CA | RE CENTER OF TOL | UCA | | 101 EAST VIA GHIGLIERI TOLUCA, IL 61369 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREF TAG | FIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION DATE | | |
| F 512 | Continued From page 35 three lumps in my breast. One of the vans broke down so I wasn't able to get the biopsy done. The facility then canceled again because they weren't able to find someone to drive the van. They told me they weren't going to reschedule the biopsy and I should have my family take me. My husband can't take me because he lives in Wisconsin." | | F | 512 | 2 | | | | |
| | Nursing) stated that transport R15 to he because the van wa | | | | | | | | |
| F9999 | FINAL OBSERVATI | IONS | F99 | 999 | 9 | | | | |
| | LICENSURE VIOL | ATIONS | | | | | | | |
| | 300.1050d)1) 300.1210b) 300.1210d)2) 300.3240a) | | | | | | | | |
| | Section 300.1050 D | Dental Standards | | | | | | | |
| | | | | | | | | | |
| | | General Requirements for | | | | | | | |

PRINTED: 07/11/2012

| DEPART | MENT OF HEALTH | AND HUMAN SERVICES | | | | | APPROVED |
|--|--|---|------|-------------------|---|---------|----------------------------|
| | | & MEDICAID SERVICES | | OMB NO. | 0938-0391 | | |
| STATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAAND PLAN OF CORRECTIONIDENTIFICATION NUMBER: | | | | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | | | A. BUILDING | | | |
| 145413 | | B. WI | √G | | 03/16/2012 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| ASTA CA | RE CENTER OF TOL | UCA | | | 01 EAST VIA GHIGLIERI FOLUCA, IL 61369 | | |
| | | | ID | | PROVIDER'S PLAN OF CORRECT | | (NE) |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREF | | (EACH CORRECTIVE ACTION SHOL | JLD BE | (X5) COMPLETION DATE |
| TAG | | SC IDENTIFYING INFORMATION) | TAG | 1 | CROSS-REFERENCED TO THE APPR DEFICIENCY) | JPRIATE | 57.12 |
| | | | r | | | | |
| F9999 | Continued From pa | .ge 36 | F9 | 999 | | | |
| | | | I | | | | |
| | b) The facility shall | provide the necessary care | I | | | | |
| | and services to atta | ain or maintain the highest | 1 | | | | |
| | | I, mental, and psychological sident, in accordance with | 1 | | | | |
| | | nprehensive resident care | 1 | | | | |
| | | properly supervised nursing | 1 | | | | |
| | | care shall be provided to each e total nursing and personal | I | | | | |
| | care needs of the re | e 1 | I | | | | |
| | | | I | | | | |
| | | | I | | | | |
| | | section (a), general nursing | I | | | | |
| | care shall include, a and shall be practic | at a minimum, the following | I | | | | |
| | seven-day-a-week l | | I | | | | |
| | | | l | | | | |
| | | nd procedures shall be dered by the physician. | l | | | | |
| | | | l | | | | |
| | Section 300.3240 A | Abuse and Neglect | l | | | | |
| | Section 500.5240 P | ibuse and Negleci | 1 | | | | |
| | | | 1 | | | | |
| | | ee, administrator, employee or hall not abuse or neglect a | 1 | | | | |
| | resident. (Section 2 | | 1 | | | | |
| | _ , , , | | 1 | | | | |
| | These requirements | s are not met as evidenced by: | 1 | | | | |
| | | | 1 | | | | |
| | | and record review the facility | 1 | | | | |
| | | of one resident (R15) in the sidents and one resident | I | | | | |
| | (R18) on the supple | emental sample with obtaining | I | | | | |
| | transportation to me | edical appointments. This | I | | | | |
| | 1 | | | | | | 1 |

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PRINTED: 07/11/2012

| DEPART CENTEF | PRINTED: 07/11/2012 FORM APPROVED OMB NO. 0938-0391 | | | | | | | |
|----------------------------|---|--|-------------------|------|---|-------------------------------|----------------------------|--|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 145413 | B. WI | NG _ | | 03/16/2012 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | | |
| ASTA CARE CENTER OF TOLUCA | | | | | 101 EAST VIA GHIGLIERI TOLUCA, IL 61369 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| F9999 | failure resulted in or four months for a de replacement surger affects the resident ability to walk. Findings include: 1. The face sheet f diagnoses: depress arthritis. Physician Note date orthopedic physicia history of rheumato having a lot of pain injections in the pas have not helped late concessions in activitimes. She has pai from a seated posit causing her to be d moderate limp. Re- support. Plan: Sch arthroplasty as soon get dental clearance the procedure." Doctor's orders and for R18 from the pap patient to a rheuma treatment of her set Note: This MUST b | ne resident (R18) waiting for ental clearance prior to knee ry, resulting in severe pain that 's psychological status and for R18 includes the following sive disorder and rheumatoid ed 11/11/11 for R18 from the n states, "She (R18) has a id arthritis. She has been lately. She has had Cortisone st with some relief but they elyHer pain requires vity and can be severe at n at night and when arising ion. Her present condition is epressed. She walks with a quires a cane or walker for hedule a right knee total n as possible. The patient will e first then contact us to set up d progress notes dated 1/6/12 ain clinic states, "Please refer tologist for evaluation and vere rheumatoid arthritis. | F99 | 999 | | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 07/11/2012 APPROVED 0938-0391 | |
|---|--|--|-------------------|--|---|-------------------------------|-------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
| | | 145413 | B. WI | NG _ | | 03/16/2012 | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | | |
| ASTA CARE CENTER OF TOLUCA | | | | | 101 EAST VIA GHIGLIERI TOLUCA, IL 61369 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| F9999 | Physician Notes da rheumatologist state replacement surger from a dental stand Physician Order Sh R18 indicate R18 ta for pain manageme (milligram) PO (by r mg take six tablets Prednisone 5 mg P tablet (with 30 mg ta 90 mg) PO daily. Doctor's Orders and for R18 from the pa (Morphine) 15 mg tr for breakthrough pa Controlled Substan- indicate R18 receiv 30 mg in January 2 Morphine 30 mg in of Morphine 30 mg breakthrough pain. On 3/16/12 at 8:45 last appointment wi dental work finished surgery done. My s December to do my work wasn't comple because of the pair appointment about been rescheduled b | ted 1/30/12 for R18 from the es, "She needs right knee ry and is waiting to be cleared lpoint." neets dated March 2012 for akes the following medications ent: Meloxicam 15 mg mouth) daily, Methotrexate 2.5 every week on Thursday, O daily, Morphine 60 mg ablet to total 90 mg) PO daily, blet (with 60 mg tablet to total d Progress notes dated 1/6/12 ain clinic states, "MSIR wo PO TID (three times a day) ain." ce Proof of Use Sheets ed thirteen doses of Morphine 012, sixty-seven doses of February 2012, and ten doses currently in March 2012 for AM, R18 stated "I need my th the dentist so I can get my d so I can get my right knee surgeon was all set in y knee surgery but my dental eted. I can barely walk n. They canceled my dental a month ago and it hasn't because the van broke down. ecause of the pain. I just want | F9! | 999 | | | | |

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| | | AND HUMAN SERVICES | | | | FORM | : 07/11/2012 APPROVED 0938-0391 | |
|--|--|--|-------------------|--------------------|---|------------|---------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) M A. BU | | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
| | | 145413 | B. WI | NG _ | | 03/16/2012 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | | |
| ASTA CA | RE CENTER OF TOL | UCA | | | 101 EAST VIA GHIGLIERI TOLUCA, IL 61369 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| F9999 | Continued From pa | ige 39 | F9 | 999 | 9 | | | |
| | Nursing) stated that | AM, E2/DON (Director of t the facility was unable to er dental appointments as broke. | | | | | | |
| | diagnoses: depres | or R15 includes the following sion with suicide attempt, order and a history of cervical | | | | | | |
| | (appointment) with mammogram on 2/ 2/6/12 at 10:00 AM order from (physicia mammogram due t | d 1/18/12 for R15 states, "Has (physician) for annual 1/12." Nurses Notes dated for R15 states, "Telephone an)-schedule diagnostic to calcifications." Nurses Notes 15 PM for R15 states, mmogram." | | | | | | |
| | 2/27/12 for R15 sta Breast Calcification After Visit Summary dated 2/27/12 for R Appointments 3/1/1 Center." There is n | d Progress Notes dated tes, "General Surgery. Left is. Plan/Stereotactic biopsy." y from physician office visit 15 states, "Future 2 at 2:00 PM at Breast to evidence in R15's clinical s present for the March 1 | | | | | | |
| | clinical record for R original date of Mar 14 has been writter is no evidence in R | Breast stereotactic biopsy in 15 list a date of March 1. The rch 1 is crossed out and March in above original date. There 15's clinical record that she March 14 appointment. | | | | | | |

Facility ID: IL6006308

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| | | AND HUMAN SERVICES | | | | FORM | 07/11/2012 APPROVED 0938-0391 |
|---|---|--|-------------------|--------------------|---|--------|-------------------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) N A. BUI | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
| | | 145413 | B. WI | √G | | 03/1 | 6/2012 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | EET ADDRESS, CITY, STATE, ZIP CODE | | |
| ASTA CA | RE CENTER OF TOL | UCA | | | OLUCA, IL 61369 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F9999 | three lumps in my b down so I wasn't ab The facility then can weren't able to find They told me they w biopsy and I should husband can't take Wisconsin." On 3/16/12 at 9:45 Nursing) stated tha | PM, R15 stated, "They found oreast. One of the vans broke ble to get the biopsy done. Inceled again because they someone to drive the van. weren't going to reschedule the have my family take me. My me because he lives in AM, E2/DON (Director of t the facility was unable to er breast appointments | F9 | 9999 | | | |

Facility ID: IL6006308