		AND HUMAN SERVICES			FORM	07/11/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		145311	B. WING _			ך 1∕ <b>2012</b>
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRE	ST NURSING & REH	AB CTR		777 DRAPER JOLIET, IL 60432		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 315}	showed that R11 's	ge 4 rine return." This record also "suprapubic catheter was oving 50 cc of water from	{F 315}			
F9999	FINAL OBSERVAT	IONS	F9999			
	Licensure Violatior	IS:				
	300.1210 b)					
	Section 300.1210 C Nursing and Persor	General Requirements for nal Care				
	and services to atta practicable physica well-being of the re each resident's con plan. Adequate and care and personal of resident to meet the care needs of the re	provide the necessary care in or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to each to total nursing and personal esident. Restorative measures ninimum, the following				
	This Regulation wa	s not met as evidence by:				
	review, the facility facility facility for skin monitoring and for preventative ski seven residents (RS	on, interview and record ailed to implement an ongoing failed to revise interventions n care . This applies to one of 5) reviewed for risk of erations in a total sample of				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	ULTI	PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
AND FLAN C	F CORRECTION	IDENTIFICATION NOMBER.	A. BU	LDIN	G		R
		145311	B. WI	IG			` 1/2012
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRE	ST NURSING & REH	AB CTR			77 DRAPER OLIET, IL 60432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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	Continued From pa	ge 5	F9	999			
	Findings include:						
	to include chronic s dependent diabetes and anxiety. Review of nursii 2/7/2012 showed th high risk) for Nortor Assessment to Dete Developing Pressur scored 14 (moderat Review of R5's 2/8/2012 and 2/28/2 " Problem: (R5) imp Right heel. Related	r old with multiple diagnoses chizophrenia, insulin s mellitus(IDDM), depression ng documentation dated tat R5 scored 11 (0 to 12= n Risk Score (Nursing ermine Resident at Risk for re Ulcer). On 2/8/2012, R5 te risk) for Norton Risk Score. current care plan dated 2012 reads: pairment of skin integrity : to : Diabetes Mellitus, s, Incontinence of Bowel,					
	Decreased safety a Diabetic ulcer to rig "Approach: Nurses: and note any chang	wareness. Manifested by :					
		POS (Physician order sheet) R5's whole body to be rizer twice daily.					
	(TAR) for the month	nt Administration Record of March 2012 showed the signed by staff to indicate it ered.					
	practical nurse/treat	:00 A.M., E13 (licensed tment nurse) stated R5 is high own or alteration. E13 also					

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		AND HUMAN SERVICES				FORM	07/11/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE	TED
		145311	B. WI	NG _			R <b>1/2012</b>
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRE	EST NURSING & REH	AB CTR			777 DRAPER JOLIET, IL 60432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	stated that R5's dia heel was recently h further stated that F done daily and that shower check form times a week - Wee shift), TAR, and nur At 11:15 A.M., a ski to R5. R5 was in be removed R5's shoe extremities, noticea redness was noted all the way to the ar foot ulcer site was a redness. R5 stated having pain on my r walk." When aske the swelling/rednes that she was not aw looks like a cellulitis On 3/15/2012 at 11 nurse assistant), E4 both stated that the any potential proble the swelling and red Review of nursing of 2/28/2012, shower March 1 to 15, 2012 1,-15, 2012 showed documentation rega monitoring to addre problems. E13, E4 validated th documentation for N shower and a skin of	betic foot ulcer to the right ealed on 2/28/2012. E13 R5's skin check should be skin check be documented on (R5's shower schedule two d. day shift, Saturday evening rsing documentation. in assessment was requested ed in his room. As E13 es and exposed R5's lower able swelling and inflamed on R5's right leg mid calf area nkle. R5 's healed diabetic adjacent to the swelling and "May I have a wheelchair, I'm right leg/foot and I can't hardly d, R5 cannot remember when s /pain started. E13 stated vare of this skin problem, " it s, I will call the doctor now." :30 A.M., E12 (CNA- certified 4(Licensed practical nurse) by have not check R5's skin for ems nor they were aware of dness. documentation from schedule for the month of 2, TAR for the month of March d that there was no arding an ongoing skin ess R5's potential skin	F9	999			

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		AND HUMAN SERVICES				FORM	07/11/2012 APPROVED 0938-0391
STATEMENT	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		145311	B. WI	NG			R <b>1/2012</b>
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRE	EST NURSING & REH	AB CTR			77 DRAPER OLIET, IL 60432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	TAR and nursing no skin check was dor that was mentioned Review of R5's " Cf ADL (Activities of D the month of March bathing/shower " di 1-15,2012. E13, E4 validated th for March 1-15, 20 was done to R5. E was no documentar notes that would ind done to R5 for the t mentioned. E13 ar must have refused there was no revision shower had not bee Review of POS sho	otes that would indicate R5's ne to R5 for the time period d. NA- (Certified Nurse Assistant) Daily Living) Tracking Form for h 2012 showed that R5 d not occur " from March here was no documentation 12 shower and a skin check 13 also validated that there tion on the TAR and nursing dicate R5's skin check was time period that was nd E4 also stated that "R5 his shower." E14 validated on of skin care plan when R5	F9	999			

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
			A. BU B. WI			ſ	R
		145311	D. WI	_		03/2	1/2012
	ROVIDER OR SUPPLIER	AB CTR		7	TREET ADDRESS, CITY, STATE, ZIP CODE 777 DRAPER JOLIET, IL 60432		
(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 APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	a) The facility sha procedures, govern the facility which sh	esident Care Policies Il have written policies and ing all services provided by all be formulated by a	F9	999	)		
	least the administra the medical advisor representatives of r the facility. These p with the Act and all These written polici operating the facility least annually by th	cy Committee consisting of at ator, the advisory physician or by committee and hursing and other services in policies shall be in compliance rules promulgated thereunder. les shall be followed in y and shall be reviewed at is committee, as evidenced by dated minutes of such a					
	<ul> <li>h) The facility is physician of any according in a resider health, safety or we but not limited to, the manifest decubitus of five percent or me The facility shall ob plan of care for the</li> </ul>	Medical Care Policies shall notify the resident's cident, injury, or significant nt's condition that threatens the elfare of a resident, including, ne presence of incipient or ulcers or a weight loss or gain ore within a period of 30 days. tain and record the physician's care or treatment of such shange in condition at the time					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SU COMPLE	JRVEY
		445044	A. BU B. WI				R
NAME OF P	ROVIDER OR SUPPLIER	145311		_	REET ADDRESS, CITY, STATE, ZIP CODE	03/2	1/2012
HILLCRE	ST NURSING & REH	AB CTR			777 DRAPER JOLIET, IL 60432		
(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	Continued From pa	ge 9	F99	999	)		
	Section 300.1210 G Nursing and Persor	General Requirements for nal Care					
	care and services to practicable physical well-being of the re- each resident's com- plan. Adequate and care and personal of resident to meet the care needs of the re- measures shall incl following procedure 2) All treatment administered as orco f) All medical treatment administered as orco physician orders shall director of nursing of	nts and procedures shall be dered by the physician.					
	orders. (Section 2-1 Section 300.3240 A						

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		AND HUMAN SERVICES			FORM	: 07/11/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		145311	B. WING _			R <b>1/2012</b>
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRE	EST NURSING & REH	AB CTR		777 DRAPER JOLIET, IL 60432		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	a) An owner, licens	ee, administrator, employee or hall not abuse or neglect a	F9999	9		
	Based on observati review, the facility fiphysician order and proper care of a sureviewed for bladded This failure resulted R11 was sent to the evaluation of supra Findings include: R11 is a 35 yea to include schizoaff seizure, CVA (cerek and diabetes melliti (Physician Order SI showed that R11 ha 16 with 30 cc balloo Review of curr showed that R11 ha to traumatic hyposp neurogenic bladder plan also indicated catheter as follows: observe, assess a odor, clarity, volume	d in R11's excruciating pain. e hospital due to pain and pubic catheter. ar old with multiple diagnoses fective affective disorder, oral vascular disorder), obesity us. Review of current POS heet) dated March 2012 as a suprapubic catheter, size on. rent care plan dated 3/15/2012 as a suprapubic catheter due badia, hemiparesis and spastic r. Review further of the care for nurses to address R11's : nd evaluate urine for color,				

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		AND HUMAN SERVICES				FORM	07/11/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		145311	B. WIN	IG			R 1/ <b>2012</b>
NAME OF P	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HILLCRE	EST NURSING & REH	AB CTR			77 DRAPER OLIET, IL 60432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	infection -assess for abdomi of bladder feeling fu - notify physician as On 3/20/2012 observed alert and suprapubic cathete drainage bag. Surve in the catheter tubir was blood tinged in R11 stated " I was s because of an excr catheter(suprapubic the tubing. The nurs night because I was catheter. My pain g flushed my catheter the hospital, there w removed from the s E3(Director of view R11's urine ou 11:40 A.M. E3 confi hospital because of E7(licensed practic suprapubic catheter of the following me suprapubic catheter - failed to follow fac supervisor/Director complained of supr bladder - failed to notify phy - should have not ir catheter	nal pain distention, sensation all s indicated at 11:30 A.M., R11 was oriented X 3. R11 has a r connected to a urinary eyor observed few blood clots ing and noted that the urine color. During this observation, sent to the hospital last night uciating pain from my c) and there was also blood in se flushed my catheter last s having pain from my ot worst after the nurse r." R11 also stated while at was a 50 cc amount of water suprapubic catheter balloon. of Nursing) was prompted to tiput on 3/20/2012 at around irmed R11 was sent to the f increased pain after al nurse) irrigated R11's r. E3 also stated E7 failed to easures to ensure proper r care: iility policy to notify nurse of Nursing when R11 apubic pain/ feeling of full	F99	999			

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		AND HUMAN SERVICES				FORM	07/11/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		145311	B. WI	NG			R <b>1/2012</b>
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HILLCR	EST NURSING & REH	AB CTR			77 DRAPER IOLIET, IL 60432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	and what measures E3 also stated there removed from the s when R11 was at the hospital. As E3 indi wrong entry port by of using the port for Review of facilit Catheter Care " sho indicate that his or I she needs to void, is supervisor." On 3/20/2012 a physician) stated he when R11 complain also stated that if he would NOT order to catheter. Z1 added R11 to be sent to the follow up. Z1 furthe the catheter balloor if the balloon was o stated that the poss nurse used the wro balloon port when the irrigated. Review of the 3/20/2012 showed a s if in pain and R1 is turning inside out indicated there was	s were taken e was a 50 cc of water suprapubic catheter balloon ne emergency room at the icated, E7 must have used the r using the balloon port instead	F9	999			

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		AND HUMAN SERVICES				FORM	07/11/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		145311	B. WI	NG			ך 1/ <b>2012</b>
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 77 DRAPER		
HILLCRI	EST NURSING & REH	AB CTR			OLIET, IL 60432		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	1:10 A.M. and retur A.M. Review further showed the 3-11 P. catheter because (I (R11's) was hurting catheter, but worse There was no d 3/19/2012 to indicat irrigation, assessme to ensure proper cat Review of the M Record (MAR) for t 3/20/2012 showed scale (excruciating Review of hosp 3/20/2012 indicated tried to flush suprap increased and no u showed that R11 's	to the hospital on 3/20/2012 at med back to the facility at 4:25 er of this documentation M. nurse (E7) "flushed (R11's R11) was complaining of pain. prior to (E7) flushing the n after being flushed." locumentation made by E7 on te details regarding the ent and any measures taken are for suprapubic catheter. Medication Administration he shift of 11-7 shift on R11 scored 10/10 for pain	F9	999			

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