Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PR

1	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000467			C 09/25/2014
NAME OF PROVIDER OR SUPPLIER	STREET A	DORESS, CITY, S	STATE, ZIP CODE	1 03/23/2014
APPLEWOOD REHABILITATIO		OSTNER AVE		
(X4) ID SUMMARY STAT	EMENT OF DEFICIENCIES	ON, IL 60443		
PREFIX (EACH DEFICIENCY)	MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY)	HOLLID BE COMPLET
S9999 Final Observations		S9999		
LICENSURE FINDIN	GS	Addition to the second		
300.1210a) 300.1210b) 300.1210d)6) 300.3240a)				
a) Comprehensive Re with the participation or resident's guardian or applicable, must development to a meet the resident's meand psychosocial need resident's comprehensive care pland psychosocial need resident's comprehensiallow the resident to at	sident Care Plan. A facility, of the resident and the representative, as op and implement a lan for each resident that objectives and timetables to edical, nursing, and mental is that are identified in the live assessment, which tain or maintain the highest ependent functioning, and lanning to the least don the resident's care			

(X6) DATE 10/20/14

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6000467	B. WING		1	C	
	OF PROVIDER OR SUPPLIER EWOOD REHABILITATION	N CENTER 21020 K	DDRESS, CIT OSTNER A' ON, IL 604		<u> </u>	25/2014	
(X4) I PREF TAG	IX : (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
S999	99 Continued From page	ge 1	S9999				
	care shall include, at and shall be practice seven-day-a-week b 6) All necessary pred assure that the resid as free of accident had nursing personnel ship that each resident reand assistance to present of a facility shall resident. (Section 2-1) THESE REGULATION EVIDENCED BY: Based on observation review, the facility failed provide adequate super (R1,R3,R4,R6) review 8. This failure resulted wheelchair, sustaining and bleeding in the brack brack brack with a chair hallway across from the There were no staff med minutes. R3 had a fall of On 9/23/14 at 11:15am wheelchair with a chair	cautions shall be taken to ents' environment remains azards as possible. All all evaluate residents to see ceives adequate supervision event accidents. use and Neglect a, administrator, employee or ll not abuse or neglect a 07 of the Act) NS WERE NOT MET AS a, interview and record ed to follow their policy and ervision for 4 of 6 residents ed for falls in the sample of in R1 falling from the a laceration to the head ain. 3 sat leaning forward in the alarm in place in the enurse station on side 1. embers in the hallway for 6 on 8/8/14. R6 sat up in the alarm in place in the					
is Denarti	ment of Public Health	nurse station on side 2.			11111		

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	IL6000467	B. WING			C	
NAME OF PROVIDER OR SUPPLIER APPLEWOOD REHABILITATION	311(EE174)	DORESS, CITY, S	STATE, ZIP CODE	1 09/	25/2014	
	MATTES	ON, IL 60443				
TAG REGULATORY OR L	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
S9999 Continued From page	ge 2	S9999			 	
within a 5 minute per at the nurse station stated R6 is brought because staff does in unattended. The characteristic of the state of the control of the cont	air alarm will sound if R6 es to get out of the chair. am, R4 sat in a wheelchair tached, across from the e 3. R4 had a fall on 9/4/14. e gets up when she's not f does not leave her alone, her wheelchair out at the					
falls at home. Minimulation documents R1 had a admission to the facilifor the mental status deficits. R1 does not I Notes for 8/2/14, 8/3/was brought out to the 11pm-7am shift for clobed alarm being activa 8/6/14 at 6:50am, R1 while sitting at the nursulation likely and the near R1. R1 was transwas diagnosed with a bleeding on the brain. 8/6/14 documents an a subdural hematoma m millimeters(mm) in wid shift. Emergency Roomalert and oriented to pe	ecuments staff was in other end of the hallways, not sferred to the hospital and laceration to the head and Hospital radiology report acute on chronic right					

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PR

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	
	IL6000467	B. WING		COMP	LETED
NAME OF PROVIDER OR SUPPLIER				09/2	5/2014
			STATE, ZIP CODE		
APPLEWOOD REHABILITATION	ON CENTER 21020 KC	STNER AVE	NUE		
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ON, IL 60443			
TAG REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
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eyes spontaneously confused, and moto Physician Certification clinical personnel or resources unavailab transferred to another appropriate medical Certification 8/6/14, If trauma hospital due possible surgical inter No return phone calls 9/23/14 for Z4(Emergy Z5(Trauma Surgeon, Transfer Emergency document R1 now has shallow breathing, and still localizes pain 8/6/14 on arrival R1 bedue to the altered medion a ventilator to help poor prognosis, family placed R1 on hospice.	er hospital to receive treatment. Nurse R1 is being transferred to a to bleeding in the brain and revention by a neurosurgeon. Is from messages left on gency Room Physician), and Z6(Neurosurgeon). Room Records 8/6/14 is a GCS of 7 out of 15, id low oxygenation. R1 does less not respond verbally, it. History and Physical reathing is compromised intal status. R1 was placed her breathe; due to the withdrew life support and				
a chair alarm. E6 hear see R1 on the ground. at night. She brings R1 to "keep an eye on her On 9/24/14 at 1pm, E5	(Restorative Nurse) stated				
in the room, and bring to station to monitor. E5 s have more people wate On 9/24/14 at 1:10pm, stated the residents are	nd bed alarms, low beds, don't leave resident alone hem out to the nurse's tated supervision means h the resident				

Illinois Department of Public Health

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/X2\ MUII TIPI	E CONSTRUCTION		
ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:				E SURVEY MPLETED
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ME OF PROVIDER OR SUPPLIER	STREET A	DOBESS CITY S	STATE, ZIP CODE	[09/	/25/2014
PLEWOOD REHABILITATION		OSTNER AVE			
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4) ID SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	(D)	PROVIDER'S PLAN OF CO	RRECTION	· · · · · · · · · · · · · · · · · · ·
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			DEFICIENCY)	EAPPROPRIATE	DATE
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care plan is initiated	. Staff moved R1 to the	And Annual Annua			
nurse's station at nig	ght to monitor her more				San Control of the Co
closely, R1 was gett	ing out of bed, staff wanted to				
prevent a fall from the	ne bed. E2 stated there isn't	TO VALUE OF THE PARTY OF THE PA			
nurse's station to wa	nt, so they put R1 out at the attention that	AMPRICATION CONTRACTOR			
R1 did not have a ca	ire plan for falls and did not	CORNADA MARIA			
nave floor mats orde	red.	We do not not not not not not not not not no			
On 9/24/14 at 1:25pr	m, Z2(Trauma Surgeon)			20	
over the old area. Th	area of bleeding in the brain is new area caused the brain			and the second of the second o	
to be pushed over to	the side, creating pressure	a de la companya de l			
inside the skull. It wa	s this pressure that caused	To the second se			
from the first hospital	eriorate during the transfer . Z2 stated this injury is	THE PERSON NAMED IN COLUMN TO PE			
associated with R1's	head trauma from the fall.			White problem	
On 9/25/14 at 1:20pm	1. Z1(Physician) stated that it				
would have been bett	er if someone was there to	VALUE		Action and the second	
someone stay at the	ntion could be to have			and the state of t	
residents that are put	there.			907 ilmenens	
	**************************************			MACOUNT COMME	
Fall Reduction Policy	- The program will include	and the same of th			
of each resident by as	mine the individual needs sessing the risk of falls,	m ut voca de manue			
and implementation of	f appropriate interventions			the many print and	
to provide necessary s	supervision and assistive				
devices are utilized as	necessary. All assigned			No. of Contract of	
ongoing precaution are	responsible for ensuring	0000			
consistently maintaine	d.	nammon processing		W	
Post Fall Investigation	policy - Any new			00.00	
information and/or inte	rventions will be reflected			Transmin	
the investigation.	plan at the conclusion of				
	Plans policy - A preliminary			Will A Danison	
plan is developed upon	the resident's admission.	Ariel married small		fi-	
	The state of the s	Batch many op. 15.		Ì	I
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PRINTED: 10/14/2014 Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C IL6000467 B. WING 09/25/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 21020 KOSTNER AVENUE APPLEWOOD REHABILITATION CENTER MATTESON, IL 60443 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID in PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Final Observations S9999 LICENSURE FINDINGS 300.1210a) 300.1210b) deleted per Domments 300,12105)3) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care

resident to meet the total nursing and personal Illinois Department of Public Health

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

plan. Adequate and properly supervised nursing care and personal care shall be provided to each

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) D	(X3) DATE SURVEY	
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	are needs of the re	_	direcceditaaageg	39999				
3) er inc ap uri no pe wh ca clir cat d) car	All nursing persor acourage residents continent of bowel propriate treatmer inary tract infection rmal bladder functions and enters the facilitatheter is not cathet pical condition demander the content of the content of the content of the condition was not condition.	annel shall assist and a so that a resident wand/or bladder recent and services to proper and to restore as and to restore as a possible. All rest residents so that any without an indwellisterized unless the reponstrates that necessary. Ction (a), general nuaminimum, the followed on a 24-hour.	ives the event much nursing resident's					
ass as f nurr that and Sec a) A	ture that the reside free of accident hat sing personnel shat each resident recit assistance to prediction 300.3240 Abuston owner, licensee, and of a facility shall	ise and Neglect , administrator, empl not abuse or neglec	mains III Is to see ervision					
THE EVIE Base revie provi	dent. (Section 2-10) SE REGULATION DENCED BY: ed on observation, ew, the facility failed ide adequate supe	O7 of the Act) IS WERE NOT MET interview and record to follow their police rivision for 4 of 6 resed for falls in the same	AS t y and idents					

Illinois Department of Public Health

AND PLAI	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, 5	STATE, ZIP CODE	1 03/	23/2014
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(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ON, IL 60443			
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Committee of the commit	wheelchair, sustaining and bleeding in the t	ng a laceration to the head brain.				The second secon
· ·	Findings include:		deliconomical			S common
in C win E si R ni	hallway across from There were no staff r minutes. R3 had a fa On 9/23/14 at 11:15a wheelchair with a chahallway across from t E3(Nurse) was at the within a 5 minute periat the nurse station wastated R6 is brought opecause staff does not unattended. The chair moves around or tries on 9/23/14 at 11:25ar with a chair alarm attainurse station on side (E4(Nurse)) stated R4 gupposed to, so staff of the station.	im, R6 sat up in the air alarm in place in the the nurse station on side 2. desk but left several times od. There was no one elsewhen E3 left. At 11:20am, E3 but to the nurse's station of like to leave her alarm will sound if R6 to get out of the chair. In, R4 sat in a wheelchair inched, across from the 3. R4 had a fall on 9/4/14. Gets up when she's not does not leave her alone, her wheelchair out at the				
fa fa do ac for de No wa	ign risk for falls on ad alls at home. Minimum ocuments R1 had a fad mission to the facility or the mental status in efficits. R1 does not had tes for 8/2/14, 8/3/14 as brought out to the ipm-7am shift for clos	ents R1 was assessed as a mission due to previous a Data Set (MDS) 8/6/14 all with major injury prior to and was not appropriate terview due to cognitive ave a fall care plan. Nurse 4, 8/4/14, and 8/6/14, R1 nurse's station on the monitoring due to the ed by the resident. On				

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PRINTED: 10/14/2014 Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED IL6000467 C B. WING 09/25/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 21020 KOSTNER AVENUE APPLEWOOD REHABILITATION CENTER MATTESON, IL 60443 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5)TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 while sitting at the nurse's station. Fall Investigation 8/6/14 documents staff was in other rooms or down at the end of the hallways, not near R1. R1 was transferred to the hospital and was diagnosed with a laceration to the head and bleeding on the brain. Hospital radiology report 8/6/14 documents an acute on chronic right subdural hematoma measuring 7 millimeters(mm) in width causing a 5 mm midline shift. Emergency Room History 8/6/14, R1 was alert and oriented to person, which is a normal assessment for her. R1's Glasgow Coma Scale (GCS) 8/6/14, which assesses neurological response, score R1 13 out of 15. R1 opened her eyes spontaneously, verbal response was confused, and motor response localized pain. Physician Certification 8/6/14 documents qualified clinical personnel or service unavailable; hospital resources unavailable; R1 needs to be transferred to another hospital to receive appropriate medical treatment. Nurse Certification 8/6/14, R1 is being transferred to a trauma hospital due to bleeding in the brain and possible surgical intervention by a neurosurgeon. No return phone calls from messages left on 9/23/14 for Z4(Emergency Room Physician), Z5(Trauma Surgeon, and Z6(Neurosurgeon). Transfer Emergency Room Records 8/6/14 document R1 now has a GCS of 7 out of 15. shallow breathing, and low oxygenation. R1 does not open her eyes, does not respond verbally, and still localizes pain. History and Physical 8/6/14 on arrival R1 breathing is compromised due to the altered mental status. R1 was placed

a chair alarm. E6 heard the alarm and turned to Illinois Department of Public Health

placed R1 on hospice.

on a ventilator to help her breathe; due to the poor prognosis, family withdrew life support and

On 9/23/14 at 1:40pm, E6(Nurse) stated R1 had

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AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		E SURVEY
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JAME OF	PROVIDER OR SUPPLIER				09/	25/2014
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-				DEFICIENCY)	CAPPROPRIATE	DATE
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			danaaaaa			
	at night. She brings	ind. E6 stated R1 gets restless R1 out to the nurse's station	MANIFERENCE			
	to "keep an eve on	her" and prevent falls.	a managara			
	On 9/24/14 at 1nm	E5(Restorative Nurse) stated				
And A feet of the second	residents assessed	as high risk for falls have	and the contract of the contra			
	interventions of cha	ir and bed alarms, low beds,	and the second s			
	floor mats, supervis	ion, don't leave resident alone	Will A Annua in c			
}	in the room, and bri	ng them out to the nurse's				
Ì	station to monitor. E	5 stated supervision means			1	
-	nave more people v	vatch the resident	miny managers			
	On 9/24/14 at 1:10p	m. E2(Director of Nursing)	na Arriva			
	stated the residents	are assessed for fall risk on	7000			
	admission, intervent	ions are put into place, and a			Printer and the second	
1	care plan is initiated	. Staff moved R1 to the	Try Anderson		90.1	
	closely P1 was gott	th to monitor her more	Addressment of their			1
	prevent a fall from the	ing out of bed, staff wanted to bed. E2 stated there isn't	Angle Processors			
í	as much staff at nigh	nt, so they put R1 out at the			And the second second	
r	nurse's station to wa	tch her. E2 confirmed that			de seus acción	
F	R1 did not have a ca	re plan for falls and did not	man provided design			
r	ave floor mats orde	red.	THE STATE AND ADDRESS OF THE STATE ADDRESS OF THE STATE ADDRESS OF THE ADDRESS OF THE STATE AND			
(On 9/24/14 at 1:25pr	n, Z2(Trauma Surgeon)	VPA-AA A			1
S	tated R1 had a new	area of bleeding in the brain			***	
0	ver the old area. Th	is new area caused the brain			124	
to	be pushed over to	the side, creating pressure	TIAMANAMANA			1
ır	iside the skull. It wa	s this pressure that caused	Try same a plane.			1
H	T's condition to dete	riorate during the transfer	r de la companya de l			
Ir	om the first hospital	. Z2 stated this injury is				1
a	ssociated with R1's	head trauma from the fall.	donor		000 mg	
U	11 9/25/14 at 1:20pm	, Z1(Physician) stated that it	of homograph & as and		All Andrews	
VV	ould have been bett	er if someone was there to	in the delicated points.			
VV.	menne stav at the	ition could be to have	Annie de Santiere de La Constitución de La Constitu		-	1
re	omeone stay at the o sidents that are put	there	Malabel debenoues.		Publish non value	
		in the state of th	vamme) Octobro-Opto		the control of the co	
Fa	II Reduction Policy	The program will include	African manufacture of the state of the stat		www.monaldida.	
m	easure s which deter	mine the individual needs			V and a second s	
of	each resident by as	sessing the risk of falls	To Commentation of		V.A.—OAA	
an	a implementation of	appropriate interventions	Depleted on the second			
to	provide necessary s	upervision and assistive			and the same of th	1

Illinois Department of Public Health

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PRINTED: 10/14/2014 Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: ___ COMPLETED C IL6000467 B. WING 09/25/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 21020 KOSTNER AVENUE APPLEWOOD REHABILITATION CENTER MATTESON, IL 60443 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) \$9999 Continued From page 5 S9999 devices are utilized as necessary. All assigned nursing personnel are responsible for ensuring ongoing precaution are put into place and consistently maintained. Post Fall Investigation policy - Any new information and/or interventions will be reflected on the resident's care plan at the conclusion of the investigation. Comprehensive Care Plans policy - A preliminary plan is developed upon the resident's admission.

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