Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY	
DENTI TOATION NOWIDER.		A. BUILDING:		COMPLETED	
				l c	
		IL6005714	B. WING		07/09/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE	
		2308 011	D HICKS RO		
ALDEN	LONG GROVE REHAI	R XHC CIR	ROVE, IL 60		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES			A.V.
PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	
				DEFICIENCY)	
S9999	Final Observations		S9999		
	Statement of Licen	sure Violations :			
	300.610a)				
	300.1210b)		Anna de Contra d	Committee	
	300.1210c)				
	300.1210d)6) 300.3240a)				
	300.3240a)		Article sensessed		
	Section 300.610 Re	esident Care Policies	and the state of t		
		have written policies and			
	procedures governi	ing all services provided by the			
		policies and procedures shall		99 000	
		Resident Care Policy			
	Committee consisti				
		dvisory physician or the			
		ommittee, and representatives r services in the facility. The		And the same of th	
		ly with the Act and this Part.			
		shall be followed in operating			
	the facility and shall	be reviewed at least annually			
		documented by written, signed		The second secon	
	and dated minutes				
		-			
	A // A				
		General Requirements for		***************************************	
	Nursing and Personal Care				,
b) The facility shall provide the necessary care and services to attain or maintain the highest					
		, mental, and psychological		Attachment A	
		sident, in accordance with			
		prehensive resident care		Statement of Licensure	IVIQUVIIO
-	plan. Adequate and properly supervised nursing care and personal care shall be provided to each				
j					
	resident to meet the	total nursing and personal			
	care needs of the re				
		giving staff shall review and			
		about his or her residents'			
	respective resident	care plan.			ļ

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

TITLE

(X6) DATE

08/03/15

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

			(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :		(X3) DATE SURVEY COMPLETED	
				7. DOLDING	Medical prince of the contraction appear in this representation of the contraction and contraction appearance.		С	
IL6005714				B. WING 07/09/2015				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
ALDEN	LONG GROVE REHAB	&HC CTR		O HICKS RO ROVE, IL 60				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
\$9999	Continued From part of Pursuant to subscare shall include, a and shall be practiced seven-day-a-week to All necessary preassure that the residual free of accident in nursing personnel such that each resident reand assistance to provide the section 300.3240 All	ection (a), general a minimum, the don a 24-hour pasis: ecautions shall be dents' environment azards as poshall evaluate reservent accident buse and Neglese, administrate all not abuse of the were not met a servent according paralys of the service of 3. The service of 3 residents (R2 apple of 3. The service of 3 residents according to the server according to the service of 3 residents (R2 apple of 3. The service of 3 residents (R2 apple of 3 residents (R2 a	the following r, the following r, the taken to the facility the facili	S9999	DEFICIENCY)			
	Nurse 's notes dated June 8, 2015 showed that R2 is alert and oriented with confusion and needed a two person assist. Nursing post occurrence documentation dated							
	ivursing post occurre	ence document	ation dated					

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		СОМ	E SURVEY IPLETED	
		IL6005714		B. WING		1	C 09/2015
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From partial June 16, 2015 shown Nursing Assistant (a) Nurse) after lunch of left upper arm lump tender, no redness like water crackles. Called Z1 (Nurse Pland ordered venous Doppler result came symptoms was gett June 16, 2015. R2 hwith bruise present. The movement on left are extension on elbown adduction on left are extension on elbown adduction on left are and arm. X-ray was fracture of mid humordered to send R2 treatment. The Nurses notes dated showed that R2 was confusion. R2 had a PM. R2 was noted varm, lump with minimand feel like water opain with touch, no repractitioner) was call Doppler on left upper Nurses notes dated alert x1 with confusionshift with getting wor arm. R2 has swelling lump with no redness 2015. Today (June 19 left arm, with bruise complained of pain of by pillow and applied by pillow and applied to the state of the	ved " E7 CNA (Conotified E6 RN (Fon June 14,2015 to noted, swelling vor bruise noted word actitioner) on June 16 Doppler on left actitioner on l	Registered that R2 had with mild with touch feel lize pain. E6 ne 14, 2015 arm. Venous alt but R2's N saw R2 on all left arm, of pain with flexion and bduction and bduction and bduction and by Z1 on left shoulder came with result and result a	S9999			

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	1 ' '	(X3) DATE SURVEY	
ANDILA	OF CONNECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMF	COMPLETED	
		IL6005714	B. WING		I	C 09/2015	
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ALDEN	LONG GROVE REHA	D & FILL LIK	ROVE, IL 60				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	OPPECTION		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From pa	age 3	S9999				
\$9999	arm. R2 has good elbow, limited addu PRN pain medicati was seen by NP to ordered STAT x-ray R2's x-ray result re humerus. NP saw to hospital for furthe 7:30 PM from unit.' On July 1, 2015 at went to checked R2 that she heard crace E6 assessed R2 ar swelling with tender like water crackles. moaning. E6 called condition as swoller water crackles on levenous Doppler. E6 PM -7 AM E8 (nurs R2 had a crackling further stated that s Z1 and ordered ver the following day a E6 said that she water that she water crackles are swelling and bruises upper arm. Z1 was morning and ordered arm and whole arm afternoon and resul PM with left arm huminformed of the X-ray results.	flexion and extension on action and abduction. R2 took on Tylenol with good effect. R2 day in the morning and she on left shoulder and left arm. ceived with fracture of mid he result and order to send R2 er evaluation. R2 left around					
2	PM. E6 was asked i R2 on June 14, 201 on June 15, 2015. T	f she did pain assessment on 5. E6 said No, but it was done here was no documentation of monitored by the nursing					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION		E SURVEY PLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		00/2010
ALDEN	LONG GROVE REHAE	3 &HC CTR 2308 OLI	HICKS RC	DAD		
		LONG GR	ROVE, IL 60	047		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	staff between 7PM 2016.	June 14 to 7AM June 16,	PPOROMORE III DALINGGADADA GARNONA			

Illinois Department of Public Health

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SAME OF PROVIDER OR SUPPLIER ILBOST14 ABULDING: B. WING	Illinoi	s Department of Public	<u>Health</u>				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2308 OLD HICKS ROAD LONG GROVE REHAB &HC CTR 2308 OLD HICKS ROAD LONG GROVE, IL. 60047 PREPIX TAG SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICENCY MIST BE PRECEDED BY PILL) TAG SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICENCY MIST BE PRECEDED BY PILL) TAG SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICENCY MIST BE PRECEDED BY PILL) TAG SPRETIX TAG SPRETIX TAG CROSS.REFERENCE TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 5 stated that she's been taking care of R2 for a couple of week and when R2 was in previous facility. Z3 said that on Sunday June 14, 2015, she sat up R2 in bed for breakfast. During lunch time R2 needed to get up but R2 was dead weight. Z3 said she put R2's head of the bed up and E7 was behind helping R2 to sit up. Z3 said that she was on R2's left shoulder around R2's waits L3 stated E7 went around to R2's sight side and transferred R2 to the wheel chair. Z3 said that R2 helped very little and they (E7 and Z3) held onto the back part of R2's sweat pants and transferred R2 to the wheel chair. Z3 said that P2 helped very little and they (E7 and Z3) held onto the back part of R2's sweat pants and transferred R2 to the wheel chair. Z3 said that R2 helped very little and they (E7 did he nurse, 22 was asked if they use a gait belt when they transfer R2. Z3 said I cannot remember, I didn't have my gait belt at that time. I was just there to assist with bath and care. On June 16, 2015 Z1 documented left upper arm swelling, pain and bruises, pain with abduction of left upper arm, positive crepitus, and decreased range of motion Z1 ordered a stat. X-ray. The X-ray showed Acute overlapping comminuted fracture of mid humerus. Review of current care plan (date initiated June 9, 2015) showed that R2 requires the use of a mechanical lift for transfer related to muscle weakiness and Parkinsons. This was not followed when R2 was transferred from be to wheel chair or June 14, 2015. Facility's policy and procedure date							
ALDEN LONG GROVE REHAB &HC CTR 2308 OLD HICKS ROAD LONG GROVE, It 60047 (X4) ID (X4) ID (X5) ID (X6)		IL6005714		B. WING		1	-
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ILONG GROVE, IL. 60047 SUMMARY STATEMENT OF DEFICIENCIES TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROULATORY OR LSC IDENTIFYING INFORMATION) PREETX TAG PROVIDERS PLAN OF CORRECTION DEFICIENCY S9999 Continued From page 5 Stated that she's been taking care of R2 for a couple of week and when R2 was in previous facility. Z3 said that on Sunday June 14, 2015, she sat up R2 in bed for breakfast. During lunch time R2 needed to get up but R2 was dead weight. Z3 said that she called E7 CNA (Certified Nursing Assistant) for assistance in transfer. Z3 said she put R2's head of the bed up and E7 was behind helping R2 to sit up. Z3 said that she was on R2's left side, put her arm under R2's left shoulder around R2's waist. Z3 stated E7 went around to R2's right side and transferred R2 to the wheel chair. Z3 said that R2 helped very little and they (E7 and Z3) held onto the back part of R2's sweat pants and transferred him this way without a gait belt. Z3 said a half hour later she noticed a bump on R2's left upper arm. Z3 said she told E7 and E7 told the nurse. Z3 was asked if they use a gait belt when they transfer R2. Z3 said that that time. I was just there to assist with bath and care. On June 16, 2015 Z1 documented left upper arm swelling, pain and bruises, pain with abduction of left upper arm, positive crepitus, and decreased range of motion. Z1 ordered a stat X-ray. The X-ray showed Acute overlapping comminuted fracture of mid humerus. Review of current care plan (date initiated June 9, 2015) showed that R2 requires the use of a mechanical lift for transfer related to muscle weakness and Parkinsons. This was not followed when R2 was transferred from bed to wheel chair on June 14, 2015. Facility's policy and procedure dated 05/10 on			2308				
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transfer technique showed - to place gait belt		couple of week and facility. Z3 said that on Sun R2 in bed for break needed to get up by said that she called Assistant) for assist put R2's head of the helping R2 to sit up left side; put her arraround R2's waist. R2's right side and chair. Z3 said that (E7 and Z3) held or pants and transferre belt. Z3 said a half on R2's left upper a E7 told the nurse. Z belt when they transremember, I didn't h was just there to as On June 16, 2015 Z swelling, pain and b left upper arm, posit range of motion. Z1 X-ray showed Acute fracture of mid hum. Review of current ca 2015) showed that I mechanical lift for the weakness and Park This was not follower from bed to wheel company the said that I was not follower from bed to wheel company the said that I was not follower from bed to wheel company the said that I was not follower from bed to wheel company the said that I was not follower from bed to wheel company the said that I was not follower from bed to wheel company the said that I was not follower from bed to wheel company the said that I was not follower from bed to wheel company the said that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from bed to wheel company that I was not follower from the fol	d when R2 was in previous anday June 14, 2015, she sat sfast. During lunch time R2 ut R2 was dead weight. Z3 is E7 CNA (Certified Nursing tance in transfer. Z3 said see bed up and E7 was behind. Z3 said that she was on R1 under R2's left shoulder Z3 stated E7 went around the transferred R2 to the wheel R2 helped very little and the notate back part of R2's sweed him this way without a gastern. Z3 said she told E7 and Z3 was asked if they use a gaster R2. Z3 said I cannot have my gait belt at that times is sist with bath and care. Z1 documented left upper and the provinces, pain with abduction at the coverlapping comminuted between the coverlapping comminuted between the coverlapping comminuted between the coverlapping comminuted between R2 requires the use of a cansfer related to muscle chair on June 14, 2015. Procedure dated 05/10 on	t up the d 22's o ley eat ait mp d gait e. I rm of d			

Illinois Department of Public Health

around resident's waist unless contraindicated.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED					
Table						С				
		IL6005714	B. WING		i i	09/2015				
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
ALDEN	ONG GROVE REHAE	SAHCCIR	OVE, IL 60							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE				
S9999	- Note: Depending a required, the nurse resident on his/her of the resident. Sup of a waist belt. Do not the arms as this prehis/her unaffected eresident to put arms. The facility does no givers assist in trans. Z3 and E7 were not	upon the amount of assistance may either support the affected side of stand in front port may be provided by use not support the resident under events the resident from using extremity. Do not allow a around your neck.	S9999							

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