

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145825	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/01/2016
NAME OF PROVIDER OR SUPPLIER SOUTH ELGIN REHAB & HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 746 WEST SPRING STREET SOUTH ELGIN, IL 60177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 323 SS=G	<p>Complaint Investigation 1672921/1185839</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide supervision during a meal for 1 resident (R1) with cognitive impairment known to eat quickly and require cueing to slow her intake down. As a result of this failure, R1 choked while eating a sandwich and expired. This failure involved 1 resident (R1) out of 3 reviewed for choking.</p> <p>Findings include:</p> <p>On 6/1/16 at 9:30 am, Z1 (Coroner's Office Personnel) stated that R1's cause of death was choking.</p> <p>Progress note of 5/24/16 timed at 8:00 PM states that R1 was observed eating quickly and choking on a sandwich in the dining room. She was also observed to put a large piece of food in her mouth which she attempted to swallow. The author of the note (E4-LPN) documented that she attempted to remove some food doing a finger</p>	F 323			

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

TITLE

(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145825	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/01/2016
NAME OF PROVIDER OR SUPPLIER SOUTH ELGIN REHAB & HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 746 WEST SPRING STREET SOUTH ELGIN, IL 60177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 1</p> <p>sweep of R1's mouth. She also attempted the Heimlich maneuver. R1 became unresponsive so E4 called for help and placed R1 on the floor and CPR was started. (911 was called, arrived and continued resuscitation efforts and transported R1 to the hospital. The facility learned later from the hospital that R1 had expired.</p> <p>R1's 3/14/16 MDS (Minimum Data Set) scores R1 as a "1/1" for eating, which indicates R1 requires tray set up and supervision for eating. R1's BIMS score (brief interview for mental status) is a "00" indicating cognitive impairment. R1's diagnoses include Vascular Dementia, Anxiety, Cerebral Palsy, Diabetes and Cognitive Deficit. POS (Physician Order Sheet) of 5/1/16 reflects that R1 was on a regular, low concentrated sweet, no added salt diet.</p> <p>On 6/1/16 at 12:45 PM, E7 (CNA) stated she was working the evening shift of 5/24/16 stated that residents are to be monitored during while eating. A CNA is to remain present at mealtime. E7 stated that the Group 4 CNA on their schedule is responsible for passing snacks and supervising the residents during snack time. E7 stated she was the CNA who passed snacks that evening. She stated that they usually try to have help when passing snacks, so someone can supervise while the other person continues to pass snacks. E7 stated she began passing snacks around 7:45 PM and E9 (CNA) helped her for a while, but then he had to leave to assist another staff person with resident care. She began passing snacks in the 100 dining room, then went to the main dining room, then the 300 hall and then the 200 hall. She recalled R1 being in the main dining room and giving R1 2 cookies and juice. She stated she offered R1 a sandwich but she didn't want it.</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145825	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/01/2016
NAME OF PROVIDER OR SUPPLIER SOUTH ELGIN REHAB & HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 746 WEST SPRING STREET SOUTH ELGIN, IL 60177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 2</p> <p>E7 stated she gave the man next to R1 (R2) a peanut butter and jelly sandwich stated that she did not remain in the dining room after passing snacks there because she had more snacks to pass. R1 was eating the cookies when E7 left the dining room. E7 stated she believed she saw E4 go to get something out of her medication cart but does not know if E4 stayed in the dining room. E7 stated that while she continued to pass snacks, she heard a code blue called in the main dining room and when she arrived there, R1 was on the ground and nurses were doing CPR (cardiopulmonary resuscitation).</p> <p>On 6/1/16 at 11:00 AM E4 stated she was familiar with R1 and she was alert and oriented. She could make her needs known and currently resided on the Alzheimer's wing. She was able to eat on her own but required tray set-up and supervision. According to E4, there is always to be a CNA in the dining room when residents are eating, and nurses are also in and out of the dining room. R1 ate in the main dining room which is the dining room used for more independent residents. E4 stated she worked the evening of 5/24/16 usually 2 CNAs pass snacks, with 1 usually remaining in the dining room for supervision while the residents are eating.</p> <p>On 6/1/16 at 12:32 PM, E4 stated she left the nursing office located off of the main dining room to begin doing treatments at about 7:00 pm; 7:00 PM was the last time she was in the office where she could see the main dining room. She was doing a treatment in a 400 wing room at approximately 7:45 PM. When she left to do treatments at 7:00 PM, snacks hadn't been passed yet. She stated that somewhere around 8:00 PM she had returned to the station from</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145825	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/01/2016
NAME OF PROVIDER OR SUPPLIER SOUTH ELGIN REHAB & HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 746 WEST SPRING STREET SOUTH ELGIN, IL 60177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 3</p> <p>doing the treatment and observed R1 across the dining room eating a sandwich very quickly. E4 stated she began walking towards R1 and verbally reminded R1 to eat more slowly. R1 did not make any response and did not slow her eating down. Before E4 reached R1, she saw R1 stuff the remaining piece of her sandwich in her mouth. E4 estimates that the piece of sandwich was about 1 and 1/2 inches in width. At that point, E4 reached R1 and R1 began to gag and put her hands up to her throat. E4 stated she called for help and performed a mouth sweep with her finger and got out about 3 pieces of food. R1 was still gagging and had her hands up to her throat and appeared pale at that point. E4 then performed a Heimlich maneuver but got no more food out. E4 stated that was no staff in the dining room when she returned from doing her treatment; she could not say why.</p> <p>E4 stated that E3 (ADON) arrived when she was doing the Heimlich maneuver. By then, R1 was cyanotic and not responding, so they laid her down on the floor and they began doing CPR. E4 did compressions and E3 got an ambu and did respirations. Other staff arrived and called 911. The paramedics arrived very quickly and took over resuscitative efforts and transported R1 to the hospital. E4 stated that she heard the paramedics say that R1 had a pulse when they were ready to transport her to the hospital. E4 later learned that R1 had expired in the hospital.</p> <p>On 6/1/16 at 2:50 PM, E14 (CNA) stated she worked the evening of 5/24/16. She was familiar with R1, who required assistance with ADLs (Activities of Daily Living) and ate independently but with tray set up and supervision. Sometimes R1 ate fast and would gulp her food but she</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145825	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/01/2016
NAME OF PROVIDER OR SUPPLIER SOUTH ELGIN REHAB & HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 746 WEST SPRING STREET SOUTH ELGIN, IL 60177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 4</p> <p>usually responded to directions to slow her eating down. Residents are to be monitored during meals and snack time, according to E14. E14 also stated that when snacks are passed, they should start from the back of the building and work their way to the front, so they end with the dining room and can remain there for supervision. E14 stated she did not pass snacks that evening because it was not her assignment and she did not provide any supervision in the main dining room after snacks were passed, as she was working with other residents. After this incident, E3 met with the CNAs to see where they had been and to remind them to do their assignments and provide supervision at meals and snack time.</p> <p>On 6/1/16 at 2:10 PM, E13 (CNA) stated she worked the evening shift on 5/24/16 and had cared for R1 in the past several weeks. R1 ate independently but required tray set up and supervision. According to E13, residents are to be monitored when eating. E13 did not provide any monitoring/supervision in the main dining room for any meals or snacks for that shift as that was not her assignment. Although she assisted passing trays at dinner, she did not remain in the dining room to monitor and did not pass snacks. When she passes snacks, she makes the dining room her last stop so she is able to stay in the dining room to monitor. The person who passes the snacks is to supervise in the main dining room. E13 was just finishing a resident shower when she heard the code blue called. After the incident, E3 talked to all the CNAs working that night to find out where they had been and to remind them to do their assignments and to monitor during eating.</p> <p>On 6/1/16 at 12:00 noon, E6 (CNA) stated that</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145825	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/01/2016
NAME OF PROVIDER OR SUPPLIER SOUTH ELGIN REHAB & HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 746 WEST SPRING STREET SOUTH ELGIN, IL 60177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 5</p> <p>R1 required tray set up and supervision. E6 stated that she would sometimes have to remind R1 to slow her eating down.. E6 stated that there is always to be staff in the dining room when residents are eating. E6 stated that she was in a resident room transferring a resident to bed when she heard the code blue called. After the choking incident involving R1, E3 met with the CNAs to find out where each of them had been and to remind them to to their assigned tasks.</p> <p>On 6/1/16 at 1:30 PM, E9 (CNA) stated he worked the evening of 5/24/16 and he believes that the CNA assigned to monitor in the dining room for meals in the one who would be responsible for monitoring during snacks. E9 stated he initially was helping E7 pass snacks, but he had to leave to assist with a resident, so E7 continued to pass snacks by herself. E9 was in a resident room and denies supervising in the main dining room after snacks were passed. According to E9, it would either have been E7 or E14 who would have been responsible for supervising in the dining room for snacks. E9 was completing a transfer when he heard the code blue called. E9 confirmed the conversation with E3 afterwards when she reminded the CNAs to do their assignments and supervise residents during snack time.</p> <p>On 6/1/16 at 2:15 PM, E11 (CNA) stated she worked the evening of 5/24/16 and is familiar with R1. R1 requires supervision and tray set up. Residents are to be monitored when they eat. E4 was just returning from break when she heard the code blue called. According to E11, there is always a CNA assigned to the dining room when residents eat. E11 did not provide any supervision in the main dining room that evening as she had</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145825	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/01/2016
NAME OF PROVIDER OR SUPPLIER SOUTH ELGIN REHAB & HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 746 WEST SPRING STREET SOUTH ELGIN, IL 60177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 6 other duties including passing room trays.</p> <p>On 6/1/14 at 3:00 Pm, E10 (RN) stated she was familiar with R1, who required tray set up and supervision at meals. All residents are to be supervised during meals and snacks. While nurses and CNAs can provide monitoring at meals, nurses are not assigned to dining rooms, as they are in and out of the room more so than the CNAs. R1 occasionally ate too fast but would usually respond to redirection to slow her eating down. She had never choked prior to this incident. E10 was not working on the 400 wing that shift and is not sure who was providing supervision in that dining room. She is aware that E4 was in the area doing treatments.</p> <p>On 6/1/16 at 11:45 AM, E5 (RN) stated she was working in the 300 hall that shift, and knew that R1 ate in the main dining room. She required tray set up and there is always to be staff in the dining room when residents are eating.. Both CNAs and nurses can monitor during meals. The CNA passing the snacks is to provide supervision in the dining room . R1 would occasionally eat quickly but she responded to redirection to slow down. E5 was in the main dining room during dinner but not after snacks were passed. At dinner, there had been nothing unusual about R1.</p> <p>On 5/28/16 at 10:55 AM, E3 stated that she was still in the building on the evening shift of 5/24/16. She stated she was in the E2's (DON) office when she heard E4 call for help. When she went to investigate, E4 was doing the Heimlich on R1; R1's eyes were closed and she was not responding. R1's hands were bluish, her face was pale and she had no pulse.. E3 also called for help; 2 nurses arrived and one called 911, the</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145825	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/01/2016
NAME OF PROVIDER OR SUPPLIER SOUTH ELGIN REHAB & HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 746 WEST SPRING STREET SOUTH ELGIN, IL 60177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 7</p> <p>other got the crash cart. CPR was begun. The paramedics arrived very quickly and took over the code and then transported R1 to the hospital where she later died.</p> <p>On 6/1/16 at 11:30 AM, E3 stated that 1 CNA is assigned to each dining room during meals and snacks, and nurses can also monitor but they are in and out of the room. There is to be staff in the dining room when residents are eating. E3 stated she discussed with all the CNAs working that shift their whereabouts. E3 stated that 2 were helping other residents, some were showering and all were doing direct care with other residents. The CNA passing the snacks is to stay with residents while they eat. She instructed the CNAs to remain in the dining room or resident room when snacks are passed.</p> <p>On 6/1/16 at 3:40 PM, R4 stated he eats in the main dining room. He stated he was in the dining room when R1 began to choke. According to R4, there was a time when staff were not in the room; he could not say how long. R1 stated staff came in quickly when R1 started to choke.</p> <p>E2 was asked about the facility policy on supervision during meals on 6/1/16 and provided a copy of a policy entitled "Supervision at mealtime". This policy says , "to provide adequate supervision at mealtime for residents who require assistance and supervision". It further states that Nurses and CNAs will provide help to resident in the small dining room during meals. Resident who require assistance will eat in the small dining room with supervision and assistance, as well as residents with swallowing problems. E2 was questioned what supervision was provided in the main dining room, where R1 ate. On 6/1/16 at</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145825	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/01/2016
NAME OF PROVIDER OR SUPPLIER SOUTH ELGIN REHAB & HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 746 WEST SPRING STREET SOUTH ELGIN, IL 60177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 8</p> <p>3:25 PM, E2 stated that they do provide monitoring in the main dining room but the people eating in the small dining room require more physical assistance than those in the main dining room. E2 agreed that all residents require supervision at meals and that there should be staff present when residents are eating, regardless of what dining room they are in.</p> <p>No staff interviewed reported monitoring or providing supervision in the dining room while residents were eating their snacks, up until the time E4 walked back into the dining room and observed R1 already stuffing food into her mouth. E7 adamantly stated that she gave R1 2 cookies and juice for a snack and yet R1 choked on a sandwich, according to E4.</p> <p>Additionally, several of the staff noted that R1 had a habit of eating too fast and requiring cueing to slow her eating down. However, despite this known behavior on the part of R1, there was no plan of care developed for this behavior.</p> <p>R1's entire care plan was reviewed, and while there was some behavioral care plan in place, none addressed the behavior of eating too quickly. The inappropriate behavior identified was resisting care and yelling. R1 was identified as having impaired communication and risk factors that required monitoring and intervention to reduce the potential for self-injury related to falls. R1 was also care planned for impaired cognition and was noted that R1 needed adequate time to respond to questions and make her needs known. R1's current care plan for Nutrition indicates R1 is to be fed. On 6/1/16 at 1:30 Pm, E8 (MDS Coordinator) states that R1 is able to eat independently and she was not aware that her</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145825	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/01/2016
NAME OF PROVIDER OR SUPPLIER SOUTH ELGIN REHAB & HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 746 WEST SPRING STREET SOUTH ELGIN, IL 60177		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 9 care plan says that she should be fed. According to E8, that is not accurate. E8 stated resident care plans get updated each quarter and they read them quickly and if no changes, sign the bottom and put a new date on it. The date of 3/7/16 on the bottom of the care plan indicates a review date and E8 stated that they must not have noted that it said R1 was to be fed.	F 323			