

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2020
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NAME OF PROVIDER OR SUPPLIER BERKELEY NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6909 WEST NORTH AVENUE OAK PARK, IL 60302
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S 000	<p>Initial Comments</p> <p>Annual Licensure and Certification Survey</p> <p>Complaint Investigation(s): #2096254/IL125592 #2097623/IL127177 #2096257/IL125582</p> <p>Licensure Findings</p>	S 000		
S9999	<p>Final Observations</p> <p>Licensure Violations</p> <p>One of Three Violations</p> <p>300.610a) 300.1210b) 300.1210d)2) 300.1210d)5) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed</p>	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1 and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to follow physician orders for wound care and treatment for one resident (R58) reviewed for pressure ulcers. This failure resulted in R58 developing an unstageable (deteriorated from Stage 2) sacral wound, which also became infected.</p> <p>10/20/20 at 3:57 PM, V6 (Wound Care Nurse/Nursing Supervisor) stated that V15 (Wound Care Doctor) assessed R58 on 9/16/20 and noted her wound was infected and deteriorated. She ordered antibiotics and labs but on 9/18/20, R58 was sent to the hospital due to the wound on her sacrum. V15's note on 9/16/20 stated that wound on sacrum was there for 27</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>days and unstageable. The wound was black (necrosis), had an odor, a moderate amount of purulent drainage and was deteriorating. Upon review of weekly wound evaluation, on 8/10/20, there was documentation stating that R58 had 2 skin tears on sacrum. 2 days later, on 8/12/20, skin note stated that she developed to stage 2 pressure sore on sacrum. A hydrocolloid dressing was applied until waiting wound care doctor evaluation.</p> <p>Review of progress notes, physician orders and treatment administration record notes there was no wound care administered from 8/12/20-8/19/20. Progress notes also show there is no documentation of turning and repositioning during this time frame.</p> <p>V6 went on to state that R58 was seen by V15 (Wound Care Doctor) on 8/19/20 and dressing was changed to Calcium alginate every 72 hours and as needed for stage 2 pressure ulcer of sacrum. Interventions recommended by V15 included turning and repositioning every 2 hours. On 9/2/20 (2 weeks later), R58's wound was now unstageable (100% dead tissue), was larger in size and showed a yellow and brown color. V15 removed the damaged tissue (debrided) the wound this day and changed the treatment and dressing to santyl (debriding medication) to be changed daily.</p> <p>Review of progress notes from 9/6/20-9/16/20 do not state intervention of repositioning being followed.</p> <p>V6 went then on to state that my note on 9/16/20, notes unstageable ulcer still, a moderate amount of thick drainage and is foul smelling. V15 debrided the wound again and changed the</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>treatment orders to dakins solution and to change daily and as needed. Interventions still include turning and repositioning every 2 hours.</p> <p>10/20/20 at 4:46 PM, V3 (Nursing Supervisor) stated that there should be an order to turn and reposition every 2 hours so it alerts the CNA's (Certified Nursing Assistants) when caring for her. This was an oversight. I see that the bed mobility section the CNA's document on, notes once that she was repositioned once a shift and that there are several days and times with no documentation of turning, so there is no proof. R58 required total assistance for turning in bed and repositioning from staff and she was incontinent of bowel and bladder. There were days when I did her wound care and she did not have a dressing on. I would just go ahead and put the dressing on. I do not know how long it was off or what happened. I see on the treatment administration record from 8/19/20-9/2/20 that it is blank. When a nurse changes a dressing, it should be documented. In September, On 9/5/20-9/13/20 the treatment for the wound care was santyl to sacrum once a day. This was not documented as done. When I was here during the week, I did the dressing change. On the weekends or when I was not here, a nurse should do the dressing and chart it. V3 went on to state that the CNA's were supposed to chart turning and reposition at least every shift and that was not done. If there was an order for repositioning every 2 hours, then it would show up on the task for the CNA to chart every 2hours.</p> <p>10/21/20 at 11:46 AM, V15 (Wound Care Physician) stated that R58's wound deteriorated quickly in a week or two. I did a deep debridement the week before she went to the hospital since it had an odor and showed signs of</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>infection in the wound. She was immobile, contracted, incontinent and confused, I ordered labs and antibiotics but she did not get better and she was sent to the hospital. If the dressing was not done or recommendations not followed, it could make the wound worse. My recommendations including turning every 2 hours in addition to the wound care.</p> <p>V15's note on 9/16/20 R58 has an unstageable wound to sacrum that is necrotic and has moderate amount of purulent (thick drainage associated with infection). It is deteriorating and has an odor. Recommendations include to off-load the wound, reposition per facility protocol and add antibiotics.</p> <p>Review of ADL report from 8/18/20-9/16/20 shows lack of documentation for turning and repositioning on 19 of 30 days.</p> <p>Review of Physician orders and progress notes from 8/12/20 to 8/19/20, after the stage 2 wound was identified did not show any treatment orders or dressing completed.</p> <p>Review of Treatment Administration record from 8/19/20 to 9/16/20 note treatment was only charted as completed on 4 of 13 days.</p> <p>R58's care plan initiated 9/4/20 states she has an alteration in skin integrity as evidenced by a unstageable pressure ulcer to her sacrum and is at risk for additional and or worsening of skin related to impaired cognition, incontinence of bowel and bladder and impaired mobility. Interventions include: Reposition resident frequently, monitor for signs and symptoms of infection, administer wound care treatments as physician orders.</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>R58's care plan dated 9/16/20 states she is receiving antibiotics related to unstageable, infected pressure ulcer to sacrum.</p> <p>R58's functional status on 7/30/20 notes she requires extensive assistance for bed mobility and is incontinent of bowel and bladder.</p> <p>Facility skin care and prevention policy states to establish an individualized turning and reposition schedule if the resident is immobile. While in bed, not to exceed 2 hours and while in sitting position not to exceed 1 hour.</p> <p>(B)</p> <p>Licensure Violations Two of Three</p> <p>300.610a) 300.1210b)6) 300.1210c) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed</p>	S9999		
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S9999	<p>Continued From page 7 and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>Section 300.3240 Abuse and Neglect</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to follow care plan interventions for two residents (R36 and R48) assessed as high risk for falls and with a history of falls. This failure resulted in both R36 and R48 sustaining fractures which required hospitalization and surgery.</p> <p>Findings include:</p> <p>R36 is a 72 year old resident with diagnosis listed in part but not limited to Epilepsy, repeated falls, and hypothyroidism.</p> <p>R36's care plan dated 3/17/20 includes (but not limited to): The resident is high risk for falls related to diagnosis of schizophrenia with psychotic medication use per MD orders. Actual fall on 5/21/20-Resident tripped on bedside table. Interventions: After each meal while clearing the meal tray, aides on duty will move bedside table to a safe area to prevent further falls; Room will be clutter free; Call light will be placed within easy reach at all times; Anticipate and meet the resident's needs; Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>prompt response to all requests for assistance; Ensure that the resident is wearing appropriate footwear.</p> <p>Observations conducted on 10/19/20 at 11:40 AM show R36 in her room with two other residents cohabitating the same room. The room was arranged with two beds lined up parallel to the wall and the third bed parallel to the back window. The room appeared cluttered with wheelchairs, clothing hampers, and furniture arranged against the adjacent wall. R36 was observed sitting on her bed that was placed parallel to the wall while her nearest roommate was sitting in her wheelchair in the center of the room with a rolling tray table placed in front of her. There was a wet area in between R36 and her closest room mate. A rolling tray table was placed in front of R36 and call light was hanging against the wall but not near R36 to reach. R36 was sitting watching television at the edge of the bed fully dressed with feet dangling on the edge of the bed but wearing only socks and no shoes. Surveyor asked how she was doing, R36 stated, "I'm ok, who are you." Surveyor asked R36 if she was able to use the call light to ask for assistance, R36 turned around to view the call light and stated, "I guess not. It's all the way over there." Surveyor asked about her latest fall, R36 stated, "Oh yes, I had a cast on for awhile but I can't remember anymore how it happened but I do remember I was taken to the hospital and my arm hurt for awhile."</p> <p>10/19/20 at 1:20 PM, R36 was lying in bed with call light in the center of the room that was not within her reach and with rolling tray table adjacent to her bed.</p> <p>10/19/20 at 1:45 PM, V8 (Certified Nurses Aide) stated, What about her? She (R36) can do stuff</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>on her own. We don't help her much. Why do you ask? Is everything okay? Surveyor asked V8 when was the last time she saw R36 and V8 responded, I went in there and cleared her lunch tray when she finished. Asked if she did anything else for R36, V8 stated, No, she can do things pretty much herself.</p> <p>10/20/20 at 9:50 AM, R36 was observed in her room lying in bed with a rolling meal tray table placed against the bed. The call light was hanging against the wall and had fallen to the floor behind the bed.</p> <p>Review of R36's medical records document the following:</p> <p>5/22/20 at 1:24 PM written by V7 (LPN), "Resident observed on the floor in her room lying on the left side of her body, denies claims tripping over the bedside table while walking to the bathroom."</p> <p>Xray result dated 5/21/20 show "impacted distal radial fracture, acute to subacute."</p> <p>5/22/20 at 09:16 written by V19 (LPN), "Resident Left forearm demonstrates impacted distal radial fracture, acute/subacute. Resident left forearm feels warm, swollen, and bruised. MD notified with orders to send resident to hospital for evaluation."</p> <p>6/2/20 at 7:31 PM witten by V20 (LPN), "Resident readmitted to facility from hospital, alert, forgetful and verbally responsive. Diagnosis: Left radius closed displaced fracture. Skin: Per hospital record incision Left wrist ORIF (Open Reduction Internal Fixation) surgery 5/29, observed covered by cast, sling in place, resident</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>placed on contact, droplet isolation. Resident requires assistance with adls (activities of daily living), will continue to monitor."</p> <p>Prior to aforementioned fall, R36 required limited assistance with physical functioning related to bed mobility and transfers per MDS (Minimum Data Set) assessment dated 3/19/20. After R36's fall, bed mobility and transfer functioning declined to requiring extensive assistance from staff per MDS assessments dated 6/9/20 and most current MDS dated 9/7/20.</p> <p>10/22/20 at 12:10 PM R36 stated, "It took a long time to recover from that fall because I had a cast on. I couldn't unwrap things, or make my bed but thankfully I'm right handed or else it would have been really difficult. To this day, it's still a challenge to do things myself and you can see I still have a bandage on my wrist and I get aches on it. Asked if she uses the call light to ask for assistance, R36 stated, "I used to use it but it's hard enough getting help so I try to do it myself."</p> <p>R48 is a 70 year old resident listed in part but not limited to diagnosis of generalized muscle weakness, cognitive communication deficits, and repeated falls.</p> <p>R48's care plan dated 4/1/20 documents: Falls: High risk for more falls. Has history of repeated falls related to diagnosis of other lack of coordination, difficulty walking, muscle weakness, behavioral problems due to diagnosis of schizophrenia, use of psychotropic medications Actual fall on 3/22/20 in the bathroom. Fall on 5/21/20-Slipped while coming out of the bathroom while getting water. Fall on 6/9/2020-Transfer without assist in room, wheel chair unlocked.</p>	S9999		

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S9999	<p>Continued From page 12</p> <p>Fall on 7/19/2020-fell out of bed while trying to go to bathroom.</p> <p>Interventions: Call light within reach at all times; Resident will be reminded to call staff when she has urge to use the bathroom; Staff will provide extensive x 2 assist with toileting needs due to lack of coordination, muscle weakness; Resident will have helmet/hipster on at all times except while in bed as ordered; Floor mat at bedside, with bed in lowest position. Staff will anticipate needs and provide frequent roundings; Staff will continue to remind resident to lock wheelchair before transferring.</p> <p>R48's medical record includes note written by V3 (MDS Coordinator), which reads: Resident had a fall with injury on 7/19/2020 (Closed fracture of distal end of right radius) and laceration to right eye brow with 5 steri-strip in place. Right side of face with bruising. Has a soft cast in place. Has other diagnosis of lack of coordination, difficulty walking, generalized muscle weakness, dementia. Requires extensive assist with all adls at this time, due to presence of soft cast. Resident has poor impulse control with decreased safety awareness Related to diagnosis of dementia and continues to want to transfer/toilet without calling staff. Resident requires increased monitoring, reminders to use call light for assistance. Resident is currently on restorative toileting program. Plan of care at this time is to place her in restorative Transfer and bed mobility program for safe surface-surface transfer and on ROM exercises to LUE and BLE for flexibility, strength and to prevent loss of functional ability. Bed booster will be placed on mattress for safety. Resident has order for helmet on during the day and off at Hs. Due to recurrent falls and injury to head resident will wear helmet at all times, per Dr.s order. Staff will continue to</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2020
NAME OF PROVIDER OR SUPPLIER BERKELEY NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6909 WEST NORTH AVENUE OAK PARK, IL 60302		
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S9999	<p>Continued From page 13</p> <p>monitor right hand for circulation, motion and sensitivity.</p> <p>10/19/20 at 11:45 AM R48 was observed in her room that was located at the end of the hall furthest from the nursing station. She was seated in her wheelchair, fully dressed wearing tube socks but no helmet to protect her from a head injury per her plan of care. R48 appeared pleasantly confused and could not respond to any questions. R48's bed was placed parallel to the wall and she was sitting in her wheelchair with the call light hanging behind her bed against the wall far from her reach.</p> <p>10/20/20 at 10:20 AM, R48 was observed in bed, with no fall mats on the floor while she was in the bed as per her care plan.</p> <p>10/21/20 at 9:20 AM, R48 was observed in her room beside her bed sitting in her wheelchair with no helmet on as per her care plan.</p> <p>10/22/20 at 12:40 PM, V6 (LPN) was asked if R48 was able to use her call light or follow direction, V6 stated, (R48) is very confused; I don't think she can follow directions.</p> <p>(B)</p> <p>Licensure Violations Three of Three</p> <p>300.610a) 300.1210a)b) 300.1210d)3) 300.1220b)2)3) 300.3240a)</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2020
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NAME OF PROVIDER OR SUPPLIER BERKELEY NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6909 WEST NORTH AVENUE OAK PARK, IL 60302
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S9999	<p>Continued From page 14</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	S9999		
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2020
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NAME OF PROVIDER OR SUPPLIER BERKELEY NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6909 WEST NORTH AVENUE OAK PARK, IL 60302
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S9999	<p>Continued From page 15 applicable.</p> <p>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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive</p>	S9999		
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2020
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NAME OF PROVIDER OR SUPPLIER BERKELEY NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6909 WEST NORTH AVENUE OAK PARK, IL 60302
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S9999	<p>Continued From page 16</p> <p>assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to provide medically</p>	S9999		
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Illinois Department of Public Health

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NAME OF PROVIDER OR SUPPLIER BERKELEY NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6909 WEST NORTH AVENUE OAK PARK, IL 60302
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S9999	<p>Continued From page 17</p> <p>necessary social services to assist a resident in addressing mental and behavioral health needs for one resident (R47) reviewed for social services. This failure resulted in agitation of mood and behavior for R47; R47 subsequently obtained alcohol while in the facility and was sent to local hospital due to alcohol intoxication.</p> <p>Findings include:</p> <p>R47 is a 44 year old male admitted to the facility 07/01/20. R47 has a diagnosis history including alcohol use unspecified with alcohol induced psychotic disorder, anxiety disorder, schizoaffective disorder, major depressive disorder/severe with psychotic symptoms.</p> <p>10/21/20 09:29 AM V10 (Activities /Admissions Director) stated there has been no social services worker since September 17th approximately. V10 stated the facility uses a social services consultant in place of a social worker.</p> <p>10/21/20 12:09 PM V21 (Office Manager) stated the administrator wanted her to fill the role of a social service worker because they don't currently have one but she is not qualified to perform those duties. V21 stated that V22 (Social Services Consultant) has not been at the facility. V21 stated that R47 is allowed to go in and out of the building as he pleases. V21 stated that V2 (Director of Nursing) found beer cans and beer bottles behind R47's bed and pills in his drawer. V21 stated R47 has been drinking alcohol and not taking his meds. V21 stated that R47 had to be taken out of the facility 10/19/20 in restraints because he was intoxicated. V21 stated the administrator allows R47 to leave the facility and R47 became combative when the nurse on duty wouldn't allow him to leave the building on pass</p>	S9999		
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2020
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NAME OF PROVIDER OR SUPPLIER BERKELEY NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6909 WEST NORTH AVENUE OAK PARK, IL 60302
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S9999	<p>Continued From page 18</p> <p>during a time when the administrator was not in the facility.</p> <p>10/21/20 12:37 PM V3 (Minimum Data Set Coordinator) stated there is currently no social service worker for the facility.</p> <p>10/21/20 12:46 PM V22 (Social Services Consultant) stated he serves as a social services consultant for the facility and provides guidance to the facilities social worker on social service duties. V22 stated he had been working with V23 (Social Services Worker) and had last been in the facility in September. V22 stated he does not provide social service consultation services at the facility monthly but does so once a quarter or as needed. V22 stated he was not aware V23 was no longer working in the facility and if there was a change in social services he would expect to be notified. V22 stated he would serve as the facility's social service worker if it was requested but he was not asked to provide those services.</p> <p>10/21/20 01:24 PM, V1 (Administrator) stated that the facility currently uses a social services consultant. V1 stated he had to fire V23 (Social Services Worker) in September because she wouldn't follow instructions. V1 stated V22 (Social Services Consultant) comes in once a week and has remote access to perform duties. V1 stated that V22 is providing social services for the facility and a new social worker was just hired yesterday and will start on Monday. V1 stated V22 just "does his own thing" regarding providing social services. V1 could not clarify what social services V22 provides and stated V22 documents social service activities in the resident's medical records. V1 stated he could not afford to keep V22 on the payroll which is why he was hiring a social worker for the facility. V1 was asked to</p>	S9999		
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2020
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NAME OF PROVIDER OR SUPPLIER BERKELEY NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6909 WEST NORTH AVENUE OAK PARK, IL 60302
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S9999	<p>Continued From page 19</p> <p>provide a list of residents seen by V22 but did not provide one during the survey.</p> <p>10/21/20 03:00 PM V3 (Minimum Data Set Coordinator) stated on 10/05/20 when R47 returned from being out on pass she noticed R47 was singing and had blood tinged eyes and suspected he may be under the influence of a substance. V3 stated she asked R47 if he was ok then reported his condition to V1 (Administrator) and V2 (Director of Nursing).</p> <p>10/21/20 03:15 PM - 4:30 PM V2 (Director of Nursing) stated that the facility does not track outside pass privileges because residents are not allowed out on pass due to COVID. V2 stated that R47 was allowed to go out on pass with V1 (Administrator) permission. V2 stated that R47 had been found with full and empty containers of alcohol in his room. Observed 2 full cans, multiple empty cans, and one empty bottle of alcohol that V2 stated was confiscated from R47's room on 10/19/20. V2 stated that when R47 was suspected of being under the influence of a substance on 10/05/20 a urine sample had been taken from R47 by V4 (Registered Nurse) to be tested for substances but the sample went missing. V2 stated no other urine sample was taken from R47 and he was never tested for substance use that day. V2 stated she reported this to V24 (Physician) and V24 was upset that R47 was allowed out on pass. V2 stated that R47 receives an antipsychotic medication. V2 stated that R47 was again allowed to leave the facility on a pass 10/08/20 with V1's (Administrator) permission but V1 had instructed staff not to document this information. V2 stated that V25 (Licensed Practical Nurse) was upset when she became aware that R47 was allowed to go out on pass 10/08/20 unsupervised stating R47 could</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2020
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NAME OF PROVIDER OR SUPPLIER BERKELEY NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6909 WEST NORTH AVENUE OAK PARK, IL 60302
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S9999	<p>Continued From page 20</p> <p>have been hurt and this was during her shift. V2 stated that R47 hasn't had any visitors so he must have brought the alcohol in. V2 stated an investigation was not conducted to determine how R47 brought in the alcohol because the incident happened during the start of the annual survey. V2 stated V1 has had V16 (Activities Aid) escort R47 to the store and he may have accessed the alcohol while out of the facility but otherwise is not sure how R47 may have accessed the alcohol. V2 stated if a formal investigation was conducted she would have asked R47 how he accessed the alcohol. V2 stated V1 attempted to have a CNA (Certified Nursing Assistant) act as the social worker and questioned V1 on how a CNA is qualified to provide social services.</p> <p>10/22/20 01:20 PM R47 stated he was very unhappy with the care and services at the facility and wished to discharge but there has not been a social worker to assist him with his discharge goal of transitioning to his own apartment. R47 stated he had not seen V23 (Social Worker) since August and had not received social services such as discharge planning, counseling, or alcohol abuse therapy. R47 stated he needs these services.</p> <p>10/22/20 01:55 PM V1 (Administrator) stated V16 (Activities Aid) took R47 out of the facility last week to pay his phone bill and one other time. V1 stated that when staff escort residents out of the facility they sign them in and out on the log at receptionist desk and should also be document the activity in the resident's medical records. V1 stated a formal investigation on how R47 accessed alcohol was not conducted because he was not aware that R47 had alcohol in his possession. V1 stated he is not sure how R47</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2020
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S9999	<p>Continued From page 21</p> <p>accessed alcohol and its possible staff may have provided him with it. V1 stated that he is not even sure if R47 ever drank the alcohol. V1 stated that V2 (Director of Nursing) had the alcohol that was allegedly confiscated from R47 in her possession. V1 stated that V2 did not inform him that on 10/19/20 R47 was found to be intoxicated and in possession of alcohol until 10/21/20 when V2 threw the alcohol contraband in his office. V1 stated he believed the alcohol belonged to V2 and she was likely consuming it and trying to sabotage V1 by alleging that R47 was found to be in possession of the alcohol and intoxicated.</p> <p>10/22/20 03:13 PM R47 stated that because there was no social service worker to discuss his feelings and needs with, set up counseling or alcohol abuse therapy services for him, or assist him with discharging from the facility he became increasingly sad and depressed and began abusing alcohol to feel better. R47 stated he began sneaking in alcohol and drinking to feel better and cope with these issues. R47 stated he had been escorted by V16 (Activities Aid) in the community to pay his phone bill but had also been allowed to go out into the community without staff escorting him and visit his family. R47 stated that he and the other residents are not being monitored in the facility and therefore he was able to sneak out of the facility to get alcohol. R47 stated he never brought alcohol in the facility when he was out on pass but would drink it right outside of the facility when he did go out. R47 would not disclose how he got out of the facility but stated he was able to get out undetected.</p> <p>Physician Progress note dated 07/20/20 documents R47 has Alcoholic Gastritis and Alcohol Dependence Syndrome.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2020
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S9999	<p>Continued From page 22</p> <p>Physician Progress note dated 09/10/20 documents R47 has alcohol dependence, and a discussion was conducted with R47 with recommendation for screening and behavioral counseling interventions in primary care to reduce alcohol misuse in adults.</p> <p>Nursing Progress Note dated 10/05/20 documents R47 was exhibiting behavior of and suspected of being under the influence of a substance; physician notified and order for drug screening was given and carried out. No documentation was found of drug screening results.</p> <p>Physician Progress note dated 10/07/20 documents R47's must avoid alcohol as that is what caused a previous downfall in his well-being.</p> <p>Social Services Progress note dated 10/08/20 documents a quarterly care screening and interview was completed; R47 does not appear to be capable of unsupervised outside pass privileges at this time and does not appear capable of safely navigating in the community independently; R47 was invited to attend a care conference with his clinical team with social services to be present to address social services needs of resident. No documentation of a care conference or follow up from social services was found for R47. No other social service documentation was found for R47 after 08/11/20.</p> <p>Nursing Progress Note dated 10/19/20 documents R47 was observed to appear intoxicated, was found with alcohol in his room, was sent out to the hospital for evaluation and testing and returned from the hospital with a diagnosis of intoxication.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2020
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NAME OF PROVIDER OR SUPPLIER BERKELEY NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6909 WEST NORTH AVENUE OAK PARK, IL 80302
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(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) COMPLETE DATE
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S9999	<p>Continued From page 23</p> <p>R47's current care plan documents he is at risk for alteration in Mood and Psychosocial well-being related to restrictions on visitations to the facility due to COVID-19 with interventions including Observe for changes in mood and/or psychosocial changes such as increased confusion, changes in sleep patterns, changes in behavior, nervousness, weight loss, crying episodes, etc.; Consult with MD if any changes in mood and/or psychosocial status is observed. Provide 1:1 socialization/activities and/or bedside socialization/activities as needed.</p> <p>R47's current care plan documents R47 has a diagnosis & history of severe mental illness including major depressive disorder and schizophrenia. The resident's problems & symptoms are manifested by at times poor contact with reality, hearing voices that are not present communicating with them, and depression with interventions including discuss the benefits of group or individual psychotherapy w/ the attending physician or psychiatrist.</p> <p>R47's care plan does not include alcohol abuse counseling or related social services.</p> <p>A social services and contraband policy was requested from V1 (Administrator) 10/22/20 and was not provided.</p> <p>(B)</p>	S9999		
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