Illinois Department of Public Health

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| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2308 OLD HICKS ROAD LONG GROVE REHAB &HC CTR C(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S 000 Initial Comments Annual Licensure and Certification Survey S 9999 Final Observations S 100 Statement of Licensure Violations 300.610a) 300.1010h) | |
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| ALDEN LONG GROVE REHAB &HC CTR 2308 OLD HICKS ROAD LONG GROVE, IL 60047 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S 000 Initial Comments Annual Licensure and Certification Survey S 9999 Final Observations Statement of Licensure Violations 300.610a) | 1/2023 |
| LONG GROVE, IL 60047 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S 000 Initial Comments Annual Licensure and Certification Survey S 9999 Final Observations Statement of Licensure Violations 300.610a) | |
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| Annual Licensure and Certification Survey S9999 Final Observations Statement of Licensure Violations 300.610a) | (X5) COMPLETE DATE |
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| Statement of Licensure Violations 300.610a) | |
| 300.610a) | |
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| 300.1210b) 300.1210c) | Ç: |
| Section 300.610 Resident Care Policies | 53 |
| 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. | |
| Section 300.1010 Medical Care Policies | Þ |
| h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's Attachment A Statement of Licensure Violations | |

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

TITLE

(X6) DATE

| STATEME | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIF A. BUILDING | PLE CONSTRUCTION 3: | (X3) DATE COMF | SURVEY | |
|---|---|--|---|---------------------|-------------------|--|--|
| 8.7 | | IL6005714 | B. WING | | 04/4 | 1/2023 | |
| 84 N | PROVIDER OR SUPPLIER | STREET AL 2308 OL | DDRESS, CITY, D HICKS RO ROVE, IL 60 | | | 11/2023 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETE DATE | |
| S9999 | Continued From pa | age 1 | S9999 | - 12 oc | | | |
| 5 | | care or treatment of such change in condition at the time | | | e | | |
| | | ** ** | | \$ \$ | EI | | |
| | Section 300.1210 Nursing and Perso | General Requirements for nal Care | | 160 | 8. 61 | 16 9 | |
| 1 | | e. The | ė | 4 4 | 22 | 100 | |
| = , , , , , , , , , , , , , , , , , , , | care and services t practicable physica well-being of the re each resident's con | shall provide the necessary o attain or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing | | 8 E | # = 1 | 80 No. 15 St. 15 | |
| y. | care and personal | care shall be provided to each e total nursing and personal | | 6. | | 4 ₂ 8 | |
| W 30 | 77.77 | 8 6 | 1.0 | | 9): | 6 | |
| 49 | c) Each direct and be knowledgea respective resident | care-giving staff shall review ble about his or her residents' care plan. | 3 | 9 | | ă. | |
| 1 | | | 85 ×C. | 7 | | | |
| | These requirements by, | s were not met as evidenced | (0) | 4 | = | | |
| | review the facility faresident's weights (inotify the physician weight loss in a time to supervise and as significant weight lofailures apply to 1 or reviewed for weight | on, interview and record iled to obtain and monitor a R141). The facility failed to (V11) of R141's significant ely manner. The facility failed sist a resident (R141) with ss during meals. These f 11 residents (R141) loss in the sample of 30. ributed to R141's significant % in 19 days. | | | | | |

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| | Department of Public | | ns m s = | 9 (0.00) | FURIV | APPROVE |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| 15. 14. | * * * * | | A. BUILDING | 3: | 331 | LLICO |
| IL6005714 | | B. WING | | | 11/2023 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY. | STATE, ZIP CODE | | |
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| ALDE! | LONG GROVE RENA | LONG GI | ROVE, IL 60 | 047 | | |
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| \$9999 | Continued From pa | age 2 | S9999 | 100 | | 25 |
| | The findings include | le: | | 18 | | İ |
| 15 | There is the | | × × | G _p | | |
| | | e plan showed R141 was ility on December 1, 2022 with | | | | III |
| | diagnoses of deme | entia and cognitive impairment. | | | | |
| 2 | The care plan show | wed R141 was at risk for | | | 544 | 1/- |
| | plan showed R141 | her diagnosis of dementia. The had a poor appetite upon | 100 | | | |
| | admission to the fa | | | 9_ | | |
| | R141's resident as | sessment dated December 7, | | 23 | | Ė |
| | 2022 showed R141 | I needed one person to | | | | |
| ž. | physically assist he | er with eating. | 115 | 12 | | |
| 18 | R141's physician o | rder dated December 1, 2022 | (A) 411 | | | |
| | showed, "Check we for 4 weeks." | eight weeklyevery Thursday | 25 | | | |
| | R141's Weight Sun | nmary Report printed January | | | | |
| | 10, 2023 showed R | 1141 weighed 114.1 pounds | = | - 3 | | |
| | facility), 116.1 lbs o | 1, 2022 (admission to the n December 15, 2022, and | | | | 59 |
| | 100.5 lbs on Janua | ry 3, 2023. The report showed | | Ý. | | |
| | R141 sustained a s | Ignificant weight loss of 13.44 ays (12/15/22-1/3/23). The | | ** | = 89 | 0 2 |
| | report showed no d | ocumented weights for R141 | 23 | | w- | |
| | during the weeks of | December 8, 2022 and | | | 12 | |
| 20.0 | December 29, 2022 | | ! | * 2 | | |
| 37. | R141's Comprehen | sive Nutritional Assessment | | | | |
| 3.0 | dated January 5, 20 experienced a signi | 23 showed, "Resident ficant weight loss over 30 | | (E. Ti | | 19 |
| e .i | days Weight loss | | | | <u>.</u> | |
| 8 | On January 0, 2022 | | | .e | **** | - 6 |
| | frail and thin as she | at 9:35 AM, R141 appeared was lying in bed. | | 85 | × | . 3 |
| | | at 1:09 PM, V9 (Husband of | | | | |
| | | w she (R141) has lost some | - 10 | | 27.4 4.25 | 92 |

Illinois Department of Public Health

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6005714 01/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2308 OLD HICKS ROAD **ALDEN LONG GROVE REHAB &HC CTR** LONG GROVE, IL 60047 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 3 S9999 On January 10, 2023 at 8:12 AM, V6 Certified Nursing Assistant (CNA) entered R141's room and placed a breakfast tray on R141's bedside table. R141 was lying in bed, looking at her cell phone. V6 immediately exited R141's room without repositioning R141 in bed to eat or opening up R141's food tray or drink containers. On January 10, 2023 at 8:17 AM, V6 CNA walked back into R141's room, said hello to R141, and then proceeded to start feeding R141's roommate. R141's food remained covered. R141 looked around her room as she laid in bed. V6 CNA provided no verbal encouragement, verbal cueing, or physical assistance to eat to R141. On January 10, 2023 at 8:22 AM, R141's food remained covered. No food had been consumed by R141. V6 CNA continued to feed R141's roommate. On January 10, 2023 at 8:25 AM, R141's food remained covered. R141 was awake in bed. V5 Licensed Practical Nurse (LPN) walked into R141's room to speak with V6 CNA. V5 LPN provided no verbal encouragement, verbal cueing, or physical assistance to eat to R141. On January 10, 2023 at 8:33 AM, R141 lifted the cover off her food, looked at it, and placed the cover back down. R141 opened a small container of low-fat yogurt and began feeding herself. V6 CNA remained in R141's room. feeding R141's roommate. V6 CNA provided no verbal encouragement, verbal cueing, or physical assistance to eat to R141. R141 consumed 50% of the low fat yogurt.

On January 10, 2022 at 8:40 AM, V6 CNA walked

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6005714 01/11/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2308 OLD HICKS ROAD ALDEN LONG GROVE REHAB &HC CTR LONG GROVE, IL 60047 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIY (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY)** S9999 Continued From page 4 S9999 into R141's room and lifted the cover off of R141's tray. One scoop of uneaten scrambled eggs and one muffin were noted on the tray. A small carton of milk remained unopened. A small container of half-eaten yogurt was noted. V6 CNA looked at R141 and stated, "You don't want anything to eat?" R141 stated, "I don't like my breakfast." V6 CNA immediately picked up R141's tray and exited the room with the tray. On January 10, 2023 at 10:30 AM, V10 Registered Dietician stated, "Newly admitted residents are to be weighed once a week for the first four weeks and then once a month. We rely on resident's food intake reports and weights to monitor residents for weight loss. The goal, of course, is to prevent weight loss before it becomes significant. If a resident experiences significant weight loss, it should be reported to the physician, dietician, and the resident's family as soon as possible. I see there are no recorded weights for (R141) on December 8th or 29th. 2022. The no weight for December 29, 2022 is really a concern because it was during that time that (R141) lost all of that weight. Her weight loss is very concerning. It looks like (R141) was at risk for weight loss upon admission because she was not eating well. It looks like she needs anywhere from supervision to the assistance of one person to eat. If she is not eating, she would need more assistance. She definitely needs encouragement and cueing when eating." On January 10, 2023 at 1:55 PM, V11 Physician stated, "I was informed of (R141's) weight loss today (1/10/23) during rounds. Maybe the reason no one called to let me know about her weight loss last week was because they knew I would be rounding today?"

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| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 | PLE CONSTRUCTION 3: | (X3) DATE COMP | SURVEY |
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| | <u> </u> | IL6005714 | B. WING | | 01/1 | 1/2023 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
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| 2 | | ts policy dated September | | 50 | | |
| | | idents will be weighed to veights and identify trends of | | | | |
| | weight loss or weigl | nt gain1. A baseline weight upon admission. The resident | 18 | 34 | | 25 |
| 2 | will be weighed wee | ekly for 4 weeks after | | | | |
| | | thly thereafter 3. Report to physician/NP, dietary | | 3/2 | | 28 |
| | | istered dietician) consultant ble party of any weight loss or | | | 1,3 | 20 |
| İ | gain greater that 5% | within one (1) month, 7.5% | | E C _m | 94 | |
| | within three (3) mor months" | ths or 10% within six (6) | 0. | | | |
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| | (6) | | | | | |
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