DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. REGENCY REAHBILATION CENTER, LLC D/B/A REGENCY REHABILITATION CENTER, Respondent.	)))))))))	Docket No. NH 15-S0231

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLACEMENT
ON QUARTERLY LIST OF VIOLATORS;
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Licensure Investigation conducted by the Department on April 15, 2015, at Regency Rehabilitation Center, 6631 Milwaukee Avenue, Niles, Illinois 60714. On June 1, 2015, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

A Plan of Correction is required to be submitted by the facility within two weeks from the date the violation notice was sent. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice. Please email the Plan of Correction to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then you can mail it to the attention of: Leona Juhl, IDPH, Long Term Care/QA, 525 West Jefferson, Springfield, IL 67261.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices. **Please email**

the hearing request to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then you can mail it to the attention of: Leona Juhl, IDPH, Long Term Care/QA, 525 West Jefferson, Springfield, IL 67261.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

Debra D. Bryars 19

Debra D. Bryars
Designee of the Director
Illinois Department of Public Health

Dated this 2nd day of June, 2015.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. REGENCY REAHBILATION CENTER, LLC D/B/A REGENCY REHABILITATION CENTER, Respondent.	)))))))))	Docket No. NH 15-S0231

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Thomas Winter
Licensee Info:	Regency Rehabilitation Center, LLC
Address:	6840 N. Lincoln Avenue Lincolnwood, IL 60712

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 2nd day of June 2015.

Leona Juhl
Long Term Care/QA
Illinois Department of Public Health

B300/15-S0231/Regency Rehabilitation Center/4-15-15/llj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S 000	Initial Comments Annual Licensure Survey Validation Survey for Subpart U	S 000		
S9999	Final Observations Statement of Licensure Violations Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. This requirement is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to check for Gastrostomy tube placement before administering medication to one resident (R14) in the supplemental sample. The findings include; On 4/14/2015 at 1:10 PM, E9 (Nurse) was observed to administer medication to R14. E9 did not check for Gastric tube placement before administering R14 ' s medications. R14's current physician's order showed R14 is scheduled for Furosemide solution 20 mg/2.5 ml	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 1	S9999		

per Gastric tube at 1:00 PM, Carbamazepine Suspension 100 mg/5 ml per gastric tube at 1:00 PM, and Potassium Chloride 20 meq 1 tablet crushed in water per gastric tube at 1:00 PM.
On 4/14/2015 at 1:20 PM, E9 stated she is required to check for placement of the gastrostomy tube by pulling back on the syringe but she did not check for placement for R14 because R14's feeding comes back up in the tubing.
The facility's policy on Enteral Tube Medication Administration revised on 12/2013, procedure # 8-a, showed to check placement of the naso-gastric or gastrostomy tube: "Insert a small amount of air into the tube with a syringe and listen with stethoscope over the stomach for placement."

Section 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

This requirement is NOT MET as evidenced by:

Based on observation, interview and record review the facility failed to assure that residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 2	S9999		

received the correct dosage of medications as ordered by the physician. This affected two residents (R13, R14) in the supplemental sample.

The findings include;

R13's current physician's order showed R13 is scheduled to receive Baclofen 20 mg tablet with Baclofen 10 mg tablet, total dose 30 mg by mouth twice a day.
On 4/14/2015 at 10:00 AM, during observation of medication administration, E10 (Nurse) administered Baclofen 10 mg 1 tablet to R13.

On 4/14/2015 at 11:00 AM, E14 ADON (Assistant Director of Nursing) stated R13 is to receive 30 mg of Baclofen three times a day.

R14's current physician's order showed R14 is scheduled for Furosemide solution 40 mg/5 ml, to give 20 mg/2.5 ml per Gastric tube at 1:00 PM, Carbamazepine Suspension 100 mg/5 ml per gastric tube at 1:00 PM, Potassium Chloride 20 meq 1 tablet crushed in water per gastric tube at 1:00 PM, and Albuterol Sulfate for nebulization 2.5 mg/3ml , 3ml inhalation at 1:00 PM.
On 4/14/2015 at 1:10 PM, during observation of medication administration to R14, E9 (Nurse) prepared Furosemide 10 mg/ml, 4 ml, Albuterol Sulfate 0.63mg/3ml, 1 ampule via nebulizer, Carbamazepine Suspension 100 mg/5 ml per gastric tube at 1:00 PM,
Potassium Chloride 20 meq 1 tablet crushed in water.

This resulted in a 9.67 percentage medication error rate.

The facility's policy on Medication Administration revised on 12/2013, procedure # 6 showed all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 3 medications must be administered to the resident in the manner and method prescribed by the physician. Section 300.1630 Administration of Medication C. Medications prescribed for one resident shall not be administered to another resident. This requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that medication ordered for one resident is not administered to other residents. This affected one resident (R6) in the sample and one resident (R14) in the supplemental sample. The findings include: On 4/14/2015 at 1:10 PM, during observation of medication administration, E9 (Nurse) administered Albuterol Sulfate 0.63 mg/3 ml 1 ampule to R14 that was labeled for R6. R6 current physician's orders showed R6 has orders for Albuterol Sulfate 0.63 mg/3 ml for nebulizer. R14's current physician orders showed that R14 has orders for Albuterol Sulfate 2.5 mg/3 ml 1 ampule inhalation three times a day. On 4/14/2015 at 1:20 PM, E9 was prompted by the sruveyor to reconcile Albuterol Sulfate medication before administering. E9 stated she does not have the Albuterol ordered for R14. E9 stated she will administer R6's Albuterol Sulfate 0.63mg/3ml because it is the same Albuterol. The facility's policy on Administration of Medication revised on 12/2013, procedure # 7 showed Medications ordered for one resident may not be administered to another resident. Section 300.1640 Labeling and Storage of	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 4 Medications a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage. (See subsections (f) and (g) of this Section.) 1) These cabinets, rooms, and carts shall be well lighted and of sufficient size to permit storage without crowding. 2) All mobile medication carts shall be under the visual control of the responsible nurse at all times when not stored safely and securely. This requirement is NOT MET as evidenced by: Based on observation and record review the facility failed to ensure that medications were secured and in visual control. This involved one resident (R8) in the sample and two residents (R15, R16) in the supplemental sample. The findings include; R15's current physician's orders showed R15 is scheduled for the following medications at 9:00 AM: Ascorbic Acid 500 mg 1 tablet by mouth, Aspirin 81 mg 1 tablet by mouth, Ferrous Sulfate 325 mg 1 tablet by mouth, Lisinopril 20 mg 1 tablet by mouth, Zoloft 50 mg 1 tablet by mouth, Vitamin B Complex 1 tablet by mouth, Calcium 600+D (3) 600 mg 1 tablet by mouth, Multivitamin 1 tablet by mouth, Fish Oil 500 mg 2 capsule by mouth, and Furosemide 20 mg 1 tablet by mouth. On 4/14/2015 at 9:15 AM during medication administration observation, E8 (Nurse) prepared all medications scheduled for R15 for administration at 9:00 AM. E8 left the poured medication in a clear medication cup on top of the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 5	S9999		

medication cart and went down the hall to the nurse's station to wash her hands, and then returned to administer the prepared medication to R15.
R16's current physician's orders showed R16 is scheduled for the following medications at 9:00 AM: Docusate Sodium 100 mg 1 tablet by mouth, Ferrous Sulfate 325 mg 1 tablet by mouth, Namenda ER 28 mg 1 tablet by mouth, Citalopram 20 mg 1 tablet by mouth, and Metoprolol Tartrate 25 mg 1 tablet by mouth.
On 4/14/2015 at 9:35 AM during medication administration observation, E8 (Nurse) prepared all medications scheduled for R16 for administration at 9:00 AM. E8 left poured medication in a clear medication cup on top of the medication cart, went down the hall to the nurse's station to wash her hands, and then returned to administer the prepared medication to R16.
The nurses' station is located 3 rooms down the hall from R16 and 4 rooms down the hall from R15. The location of the sink in the nurses' station required E8 to have her back to the medication cart while washing her hands.

R8 was admitted to the facility on 6/12/2014 with diagnoses that included Multiple Sclerosis, Muscle weakness and Chronic Pain according to R8's current physician's order sheet.
R8's quarterly MDS (Minimum Data Set) dated 3/11/2015 showed R8 is cognitively intact and scored 13/15 on the BIMs (Basic Interview for Memory).
On 4/13/2015 at 11:55 AM, R8 observed to have 1 bottle of Debrox ear drops, 1 bottle of Ibuprofen 200 mg expired 9/2014, 1 bottle of Vitamin B12, and 1 bottle of Vitamin B Complex expired 2/2013 at her bedside within her reach.
On 4/15/2015 at 10:55 AM, E2 (Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 6	S9999		

Nursing) stated residents must be assessed for the ability to self-administer medications. E2 also stated that an order is then obtained from the physician to allow self-administration of medications kept at bedside. E2 states R8 did not have these requirements in place.

300.2040 Diet Orders
b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered.
e) A therapeutic diet means a diet ordered by the physician as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet).
f) All therapeutic diets shall be medically prescribed and shall be planned or approved by a dietitian.

This requirement is NOT MET as evidenced by:

Based on observation, interview, and record review, the facility failed to offer therapeutic diets planned and approved by a dietitian as well as failed to serve the renal diet according to the planned menu.

This applies to all 195 of 203 residents receiving oral diets as well as 3 of 3 residents observed at trayline receiving non-mechanically altered renal diets.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 7	S9999		

On 4/13/15 at 10:45 AM the trayline prepared early lunch trays for R10-12 who attend dialysis. R10-12 physician diet orders call for renal diet. The renal diet spreadsheet for lunch 4/13/15 shows rice is to be served for renal diets. R10-12 received mashed potatoes instead of the rice for lunch. Z1 (Consulting Director of Food Service Management) suggested that those receiving the mashed potatoes may have also been receiving mechanically altered diets in addition to renal diets for which mashed potatoes were planned. R10-12 do not have physician orders for mechanically altered diets.

As of 4/13/15 at 5:00PM, general and therapeutic menu alterations were planned and served by E3 (Assistant Food Service Director) and at no time was the dietitian consulted regarding the changes to the menus. Menu changes were made to the 4/10/15 supper,4/13/15 lunch, and 4/14/15 lunch meals. E3 stated she made the changes to the menus due to errors in food ordering the previous week. E3 stated she did not consult Z1 nor her consultant dietitian for approval. Per facility Menu Changes policy/procedure (2010) " Permanent changes in the menu must be approved by the licensed consultant dietitian. " Z1 stated she verified with the consultant dietitian that E3 did not ask to have the consultant dietitian review the changes.

300.2070 Scheduling Meals
b) Bedtime snacks of nourishing quality shall be offered. Snacks of nourishing quality shall be offered between meals when there is a time span of four or more hours between the ending of one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 8	S9999		

meal and the serving of the next, or as otherwise indicated in the resident's plan of care.

This requirement is NOT MET as evidenced by:

Based on interview and record review, the facility failed to deliver bedtime snacks to the resident units as stated in their policy and procedure.

This applies to all 204 residents in the facility.

The findings include:

On 4/13/15, R7 (10:30 AM) and R10 (11:40 AM) stated bedtime snacks were often not offered and not available when the nursing staff looked for the snacks on the unit. R7 stated he complained several times to E3 and facility however the problem still exists. R7 stated on 4/11/15 he requested a bedtime snack and nursing staff were unable to locate any snacks delivered from the kitchen. R7 was told the kitchen was closed and other units had not received their bedtime snacks from the kitchen. R7 stated he complained during resident council and others had voiced their concerns. Resident Council Meeting Minutes dated March 27, 2015 show " Dietary: The evening snack trays are not coming up when they are supposed to. " E3 stated she was aware residents complained they did not receive evening snacks on 4/11/15, and was investigating the incident however she had not yet talked to the individual responsible. A facility staff also confirmed the kitchen did not deliver evening snacks on 4/11/14. Facility policy/procedure Nourishments (Night-Time Snacks) states: " Nourishments will be provided to the residents at approximately bedtime .... Dietary department will deliver the bedtime nourishment (snack) as planned on the cycle menu to the nursing units

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 9 after the evening meal .... Residents will receive an appropriate bedtime snack according to their diet order .... Nursing will distribute the bedtime nourishments. " 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750). (Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989) 750.120 General - Food Protection a) At all times, including while being stored, prepared, displayed, served or transported, food other than whole, unprocessed raw fruits and unprocessed raw vegetables shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage, and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous foods shall be 41°F or below, or 135°F or above, at all times, except as otherwise provided in this Part. 750.151 Ready-to-Eat Potentially Hazardous Food, Date Marking a) On-Premises Preparation (prepare and hold cold) Except when packaging food using a reduced oxygen packaging method, and except as specified in subsections (d) and (e) of this Section, refrigerated, ready-to-eat potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 10	S9999		

clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and maintained at 41°F or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.

750.540 Management Sanitation Training and Certification

a) All food service establishments as defined in Section 750.10, except Category III facilities, shall be under the operational supervision of a certified food service sanitation manager. Category III facilities do not require the operational supervision of a certified food service sanitation manager.

1) Category I facilities. Category I facilities as defined in Section 750.10 shall have a certified food service sanitation manager on the premises at all times that potentially hazardous food is being handled, except as specified in subsections (a)(1)(A) and (B) of this Section. A certified food service sanitation manager is not required on the premises during hours of operation when all food products sold have been prepared and packaged commercially or prepared under the supervision of a certified food service sanitation manager.

750.820 e) 2) Manual Cleaning and Sanitizing
e) The food-contact surfaces of all equipment and utensils shall be sanitized by:
2) Immersion for at least one minute in a clean solution containing at least 50 parts per million of available chlorine as a hypochlorite and having a temperature of at least 75 degrees F.; or

730.830 h) 3) Mechanical Cleaning and Sanitizing
h) Machines using hot water for sanitizing may be used provided that wash water and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 11	S9999		

pumped rinse water be kept clean and water shall be maintained at not less than the temperature stated in Section 750.830(h)(1) through (5).
3) Single-tank, conveyor machine:

wash temperature 160 degrees F.
final rinse temperature 180 degrees F.

This requirement is NOT MET as evidenced by:

Based on observation, interview and record review, the facility failed to ensure individuals certified in sanitation were present on premises at all times during the preparation and service of perishable foods; failed to wash, rinse, and sanitize dishes/equipment in a safe and sanitary manner; failed to store perishable food at acceptable temperatures; and failed to properly label and date stored food to protect residents from foodborne illness.

This affects all 195 residents receiving oral diets in the facility.

The findings include:

On 4/14/2015 at 11:50 AM, E4 (Food Service Worker) was washing pots and pans in the three compartment sink. When asked to measure the sanitizer concentration of the third compartment, E4 was unable to locate test strips. E3 provided test strips and measured the sanitizer concentration at 10 ppm. E3 stated the concentration of the bleach sanitizing solution should be at least 50 ppm. E3 added more bleach to the sink, re-measured the concentration, and the concentration measured 50 ppm. Facility policy/procedure Manual Sanitizing (2010) states the chlorine sanitation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 12 concentration is to measure " 50-100 parts per million minimum 10 second contact time. " On 4/8/2015, 4/9/2015, 4/10/2015, 4/11/2015 test strips used to verify sanitizing water reached the correct temperature, showed the water did not reach sanitizing temperatures. The test strips recorded did not turn the color indicator dark brown verifying the water reached 170 degrees Fahrenheit. No dish machine thermometer temperatures were recorded for these dates nor were any other methods utilized to verify the proper sanitizer temperature was reached. The Daily Temperature Monitoring of Dish Machine records for the month of April PM shift show temperatures recorded at 170 degrees Fahrenheit however also showed test strips which definitively turned dark brown. Except for PM shift logs dated 3/13/15-3/26/15 and 3/28,3/29,3/30/15, Daily Temperature Monitoring of Dish Machine for March AM and PM shifts show test strips which did not turn dark brown however temperatures recorded indicate the 170 degree Fahrenheit. In addition, all temperatures were recorded 170 degrees Fahrenheit. Facility policy/procedure Mechanical Cleaning and Sanitizing (2010) states " Dishmachines using hot water for sanitizing may be used if the temperature of the wash water is no less than that specified by the manufacturer, which may vary from 150 degrees Fahrenheit to 165 degrees Fahrenheit, depending on the type of machine, and if the final rinse temperature is no less than 180 degrees Fahrenheit. " On 3/14/15 Z2 (dishmachine repair service representative) wrote " The NSF food code states that the dishes must reach a minimum of 160 degrees so 160 tapes are the correct strip for measuring the minimum temperature of the dishes. " The product utilized and recorded on the Daily Temperature	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 13 Monitoring of Dish Machine until 3/14/15 were not the 160 degree tapes mentioned in the representative ' s report. On 4/13/2015 potentially hazardous foods requiring refrigerated storage were located unrefrigerated and at room temperature in resident rooms. At 10:15 AM R11 had stored four 100% apple juices, two cranberry juices, creamers and whipped spreads located on her bedside table and shelves. R11 stated she collected the items over the past several days and stated she didn't feel they needed refrigeration. At 11:00 AM, R7 had stored two 100% apple juices on her bedside table and stated she saved them from the day before. The product labels for all the juices, creamers, and whipped spreads instructed the products be ' kept refrigerated ' . As of 4/14/15, no care plan existed to address residents ' behaviors of storing perishable foods unrefrigerated in their rooms. Facility Food Storage Policy (undated) states: 3. Cold foods shall be maintained at temperatures of 40 degrees Fahrenheit or below. On 4/13/15 at 9:45 AM, multiple items were located in the walk in cooler not labeled or dated with an open date or use by date including partially covered beef gravy served the day before, a small pan of yellow food substance E3 was unable to identify, diced green pepper cooked and served the day before, and cooked bacon. Facility Labeling and Date Marking Foods Policy/Procedure (2012) states: Food prepared on premises to be held cold will be marked with the date of preparation and time as required for proper cooling. This food will also be marked with the date to discard or to be use by. " No date of preparation or date to discard were located on the products listed.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 14 Several items in dry storage were labeled with a month and day, however no year was listed as a part of the date marking including rice dated 3/2, salad dressing dated 4/9, food thickener dated 4/9, and oatmeal dated 4/2. E3 stated she was unable to determine which year some of the products in dry storage were received since there were no dates included on most of the food items stored, but believed they were from the past year. Facility Labeling and Date Marking Foods Policy/Procedure dated 2012 states: Canned food and other shelf stable items such as cake mixes will be marked with the date received. If the product does not have an expiration date, it will be marked with a discard or use by date. " On 4/14/15 during the Environmental Tour, five bottles of thickened liquid were noted in the fourth floor pantry. The bottles were opened and undated. The label on the bottle instructs: "Storage and Handling: Store in a cool, dry place. When ready to serve, chill, break seal, retighten cap and shake well. Refrigerate unused portion. Discard if not used within 10 days of opening." On 4/14/15, as the Environmental tour continued, two bottles of open, undated thickened liquids and one bottle of thickened liquid open and dated 3/3/15 were found in the third floor pantry. Two open and undated bottles of thickened liquid were also found on the nursing medication cart. E15 (Nurse) stated she gets the bottles of thickened liquid from the pantry refrigerator. E15 stated she opened one of the bottles at the start of her shift but did not date it. E15 stated she received the other undated bottle of thickened liquid from the night shift nurse.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 15 On 4/14/15, during the tour on the second floor, one container of chicken noodle soup from a grocery deli marked "use by 1/20/15" was found in the panty refrigerator. On 4/15/15 at 11:50 AM, E1 (Administrator) stated that nurses are responsible for dating thickened liquids when bottles are opened and that nursing staff are responsible for assuring the pantry refrigerator is checked for proper temperature and contents. As of 4/15/15 at 2:00 PM, the food service department sanitation licenses provided by the facility show only two individuals E6 (Cook) and E7 (Cook) are licensed by the Department of Public Health as being certified in food service sanitation. The dietary schedule shows 22 of 42 days the kitchen operated during times an individual certified in food service sanitation was not present. Z1 confirmed each cook works an 8 hour shift. On 4/14/15 after handling and loading dirty dishes into the dish machine, E5 (Food Service Worker) removed the first layer of yellow rubber gloves from her hands which exposed another pair of rubber gloves. E5 shook liquid from the second pair of rubber gloves she was still wearing, walked to the clean dishes on the other side of the dishmachine, and began stacking and storing the clean dishes without first removing the second pair of rubber gloves and washing her hands. E5 continued to move from clean to dirty and dirty to clean dishes without washing her hands. Section 300.7060 Environment	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 16 a) The environment (cultural, social, and physical) shall support the functioning of cognitively impaired residents. It shall accommodate behaviors, maximize functional abilities, promote safety, and encourage residents' independence by compensating for losses resulting from the disease process in accordance with each resident's care plan. This requirement is NOT MET as evidenced by: Based on observation and interview, the facility failed to assure that the oxygen storage room containing hazardous materials was secured to prevent access by residents with wandering and rummaging behaviors. This failure had the potential to affect one resident (R4) in the sample and nine residents (R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25) in the supplemental sample among the 48 residents on the Certified Dementia Unit. Findings include: On 4/13/15 at 10:15 AM during the initial tour of the Certified Dementia Unit, the oxygen supply room was noted to have the exterior handle angled downward. The door to the storage unit opened when the handle was pulled. Reactivation of the locking system was achieved by flipping the door handle from the inside. The room contained 10 small, unopened oxygen cylinders in stationary holders; one small oxygen cylinder with a flow valve attached in a rolling holding; and various oxygen tubing. E11 (Nurse Manager) stated "This door should always be locked" and called maintenance for service. On 4/13/15 at 10:20 AM, E12 (Maintenance Director) checked the Oxygen room door handle,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007793	A. BUILDING: _____ B. WING _____	04/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY REHABILITATION CENTER	6631 MILWAUKEE AVENUE NILES, IL 60714

(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
S9999	Continued From page 17	S9999		

which has an exterior key lock pad. The lock held on the first use and then the handle again stuck in the downward position, leaving the door unlocked. E12 stated "The lock must be broken and will have to be replaced."

On 4/13/15 at 10:35 AM as the surveyor was preparing to leave the unit, the oxygen storage room handle was again noted to be angled downward, and freely opened when pulled. E11 was again made aware of the unlocked room.

During observations on the Certified Dementia Unit the morning of 4/13/15, R24 and R18 were observed wandering on the unit. On 4/14/15 at mid-day, R4 and R19 were observed wandering on the unit.

On 4/15/15, E13 (Dementia Unit Director) provided a list of wandering and rummaging residents that included R4, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25. At 3:15 PM, E13 stated the unit does not have a specific policy about securing doors locked to the soiled and clean utility rooms or to the oxygen rooms, but staff are inserviced that all doors should remain locked and staff are expected to round daily to check.

(B)