		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		<u>NO. 0938-039</u> .te survey		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILD		G		COMPLETED		
		14L016	B. WING		1	12/16/2019		
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E			
	N ILLINOIS ACADEMY			998 CORPORATE BLVD				
NORTHER				AURORA, IL 60502				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
E 000	Initial Comments		E OC	00				
E 039	were evaluated, in co recertification survey, was not in complianc Establishment of the Program, 42 CFR 44 EP Testing Requirem CFR(s): 441.184(d)(2 *[For RNCHI at §403 HHAs at §484.102, C "Organizations" unde §485.920, RHC/FQH Facilities at §494.62]: (2) Testing. The [facil to test the emergency must do all of the follo (i) Participate in community-based ev (A) When a not accessible, conduce exercise every 2 (B) If the [fa natural or man-made activation of the emergency community-based or	, on 12/16/19. The Facility e with Standards for Emergency Preparedness 1.184, as evidenced by: ents 2) .748, ASCs at §416.54, CORFs at §485.68, OPO, rr §485.727, CMHC at C at §491.12, ESRD : ity] must conduct exercises y plan annually. The [facility] owing: a full-scale exercise that is ery 2 years; or community-based exercise is uct a facility-based functional years; or cility] experiences an actual emergency that requires	E 03	39				
	every 2 years, oppos functional exercise un this section is conduct not limited to the follo (A) A second	cted, that may include, but is						

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CENTER STATEMENT OF AND PLAN OF NAME OF PP	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14L016	. ,	NG	E CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE 198 CORPORATE BLVD AURORA, IL 60502 PROVIDER'S PLAN OF CORRECTION	FORM OMB NO (X3) DATE COMP	0: 01/09/2020 A APPROVED 0. 0938-0391 SURVEY LETED 16/2019
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
E 039	functional exercise; or (B) A mock or (C) A tableto is led by a facilitator a discussion using a na clinically-relevant set of problem statem prepared questions emergency plan. (iii) Analyze f maintain documentati exercises, and emerg revise the [facility's] ef *[For Hospices at 418 (2) Testing for hospice patient's home. The f exercises to test the e annually. The hospice (i) Participate in community based ever (A) When a or not accessible, condur based functional exercise or man-made emerger of the emergency plant exempt from engaging scale community-based facility-based fut the onset of the emergency functional exercise unithis section is conduc not limited to the follor (A) A second	r disaster drill; or op exercise or workshop that and includes a group irrated, t emergency scenario, and a bents, directed messages, or designed to challenge an the [facility's] response to and on of all drills, tabletop lency events, and mergency plan, as needed. 8.113(d):] tes that provide care in the hospice must conduct emergency plan at least e must do the following: a full-scale exercise that is ery 2 years; or community based exercise is act an individual facility cise every 2 years; or spice experiences a natural ency that requires activation n, the hospital is g in its next required full ed exercise or individual unctional exercise every 2 ear the full-scale or nder paragraph (d) (2)(i) of ted, that may include, but is	E	139			

Facility ID: ILPRTF016

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/09/2020 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION		(X3) DATE	
		14L016	B. WING				12/ ⁻	16/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, 2	ZIP CODE		
NORTHER	RN ILLINOIS ACADEMY			99	98 CORPORATE BLVD			
NORTHER				A	URORA, IL 60502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
E 039	exercise; or (B) A mock (C) A tableto is led by a facilitator a discussion using a na clinically-relevant set of problem statem prepared questions emergency plan. (3) Testing for hospice care directly. The hose exercises to test the e year. The hospice mu (i) Participate in that is community-base (A) When a of not accessible, condu facility-based function (B) If the hose or man-made emerged of the emergency plan exempt from engaging full-scale community b functional of the emergency eve (ii) Conduct an a that may include, but following: (A) A second community-based or a exercise; or (B) A mock (C) A tableto by a facilitator that incousing a narrated, emergency scenario,	disaster drill; or op exercise or workshop that and includes a group irrated, t emergency scenario, and a nents, directed messages, or designed to challenge an es that provide inpatient spice must conduct emergency plan twice per ust do the following: an annual full-scale exercise sed; or community-based exercise is act an annual individual nal exercise; or spice experiences a natural ency that requires activation n, the hospice is g in its next required based or facility-based exercise following the onset ent. additional annual exercise is not limited to the d full-scale exercise that is a facility based functional disaster drill; or op exercise or workshop led cludes a group discussion clinically-relevant	E	039				

Facility ID: ILPRTF016

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	D: 01/09/2020 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		14L016	B. WING			_	12/	16/2019
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
NODTUER	N ILLINOIS ACADEMY			9	998 CORPORATE BLVD			
NORTHER				/	AURORA, IL 60502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	questions des emergency plan. (iii) Analyze the I maintain documentati exercises, and emerge the hospice's emerge *[For PRFTs at §441.7 §482.15(d), CAHs at § (2) Testing. The [PRT conduct exercises to a twice per year. The [I do the following: (i) Participate in that is community-base (A) When a c not accessible, condu facility-based function (B) If the [PF experiences an actua emergency that require emergency plan, the [engaging in its next re based or functional exercise fol emergency event. (ii) Conduct an [a and that may include, following: (A) A second (C) A tableto is led by a facilitator a discussion, using a na clinically-relevant	signed to challenge an hospice's response to and on of all drills, tabletop ency events and revise ncy plan, as needed. 184(d), Hospitals at §485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must an annual full-scale exercise sed; or community-based exercise is ict an annual individual, nal exercise; or RTF, Hospital, CAH] I natural or man-made res activation of th facility] is exempt from equired full-scale community individual, facility-based llowing the onset of the additional] annual exercise or but is not limited to the d full-scale exercise that is individual, a facility-based r disaster drill; or p exercise or workshop that ind includes a group		039				

Event ID: YW3911

Facility ID: ILPRTF016

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/09/2020 APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		14L016	B. WING				12/	16/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	TATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES					8 CORPORATE BLVD URORA, IL 60502			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	prepared questions emergency plan. (iii) Analyze the [f maintain documentati exercises, and emerg the [facility's] emergen *[For LTC Facilities at (2) The [LTC facility] r test the emergency pl including unannounce emergency procedure ICF/IID] must do the f (i) Participate in that is community-base (A) When a c not accessible, condu facility-based function (B) If the [LT an actual natural or m requires activation of the LTC facility is exer required a full-scale c individual, facility following the onset of (ii) Conduct an a that may include, but following: (A) A secon community-based or a functional exercise; or (B) A mock (C) A tableto is led by a facilitator ir using a narrated, emergency scenario, statements, directed r	designed to challenge an facility's] response to and on of all drills, tabletop lency events and revise ncy plan, as needed. \$\frac{\\$483.73(d):]} must conduct exercises to lan at least twice per year, ed staff drills using the es. The [LTC facility, following: an annual full-scale exercise sed; or community-based exercise is int an annual individual, hal exercise. C facility] facility experiences han-made emergency that the emergency plan, mpt from engaging its next community-based or -based functional exercise the emergency event. additional annual exercise is not limited to the d full-scale exercise that is an individual, facility based r disaster drill; or op exercise or workshop that holudes a group discussion, clinically-relevant	E 03	39				

L

Facility ID: ILPRTF016

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 14L016 B. WING 12/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 998 CORPORATE BLVD AURORA, IL 60502 998 CORPORATE BLVD AURORA, IL 60502 12/16/2019	1/09/2020 PROVED 38-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NORTHERN ILLINOIS ACADEMY STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	VEY
NORTHERN ILLINOIS ACADEMY 998 CORPORATE BLVD AURORA, IL 60502 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLE DATE	019
NORTHERN ILLINOIS ACADEMY AURORA, IL 60502 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
AURORA, IL 60502 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (x5) COMPLE DATE	
COMPLE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATI	
	(X5) MPLETION DATE
E 039 Continued From page 5 emergency plan. (ii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills; tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. ''[For ICF/IIDs at \$483.475(d)]; (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (1) Participate in an annual full-scale exercise is not accessible, conduct an annual individual, facility-based functional natural or man-made emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based exercise that natural or man-made emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or following: (3) Conduct an additional annual exercise that may include, but is not limited to the following: (4) A bacond full-scale exercise that may include, but is not limited to the following: (4) A bacond full-scale exercise that may include, but is not limited to the following: (b) A made emergency plan, the ICF/IID is exempt from engaging in its next required functional exercise; or (c) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the ICF/ID's response to and maintain documentation of all divisition	

Facility ID: ILPRTF016

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		14L016	B. WING			12/	16/2019
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
NORTHER	RN ILLINOIS ACADEMY				998 CORPORATE BLVD AURORA, IL 60502		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	exercises, and emerged the ICF/IID's emerger *[For OPOs at §486.3 (d)(2) Testing. The Of to test the emergency following: (i) Conduct a pap or workshop at least a is led by a facilitator a discussion, using a na emergency scenario, statements, dire questions designed to plan. If the OPO expe or man-made emerged of the emergency plat engaging in its next following the onset of (ii) Analyze the C maintain documentati and emergency event and OPO's] emergency This STANDARD is r Based on document determined that the F participation in a full-s community based or v exercise is not availab based exercise to tes annually. Findings include: 1. The Facility's "Eme (2019) was reviewed "Exercises/Drills:s drills are conducted. B	ency events, and revise ncy plan, as needed. 460] PO must conduct exercises plan. The OPO must do the ber-based, tabletop exercise annually. A tabletop exercise and includes a group arrated, clinically relevant and a set of problem ected messages, or prepared to challenge an emergency eriences an actual natural ency that requires activation n, the OPO is exempt from required testing exercise the emergency event. PO's response to and on of all tabletop exercises, is, and revise the [RNHCI's cy plan, as needed. not met as evidenced by: review and interview, it was acility failed to ensure scale exercise that is when community based ole, an individual Facility t the Emergency Plan ergency Management Plan" on 12/9/19 and required, semi-annual exercises and	E	039			

Facility ID: ILPRTF016

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PRINTED: 01/09/2020

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/09/2020 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	
		14L016	B. WING			_	12/	16/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
NORTHER	RN ILLINOIS ACADEMY				998 CORPORATE BLVD AURORA, IL 60502			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	"Emergency Manager required participation community-based or test the Emergency P 2. On 12/9/19 at appr interview was conduc Operations Manager fires, tornados, and b highest hazardous ris frequently to test the emergencies. E #2 st requested to participa scale exercise and ha	ment Plan" lacked the in a full-scale Facility-based exercise to Plan. oximately 10:30 AM, an	E	039				

Facility ID: ILPRTF016

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