STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008213	A. BUILDING: _____ B. WING _____	12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDWICH REHAB & HCC	902 EAST ARNOLD STREET SANDWICH, IL 60548

(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	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies 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 300.1210 General Requirements for Nursing and Personal Care 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008213	A. BUILDING: _____ B. WING _____	12/05/2014

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S9999	Continued From page 1	S9999		

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 applicable. (Section 3-202.2a of the Act)

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.

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:

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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008213	A. BUILDING: _____ B. WING _____	12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 2 resident. (A, B) (Section 2-107 of the Act)	S9999		

These Requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to prevent an unstageable pressure ulcer, failed to assess and document resident ' s wounds, failed to develop a specific care plan to address skin breakdown and failed to ensure wound treatments were implemented. These failures contributed to R11 developing an unstagable pressure ulcer to the left buttock.
This applies to 3 of 7 residents (R11, R3, R10) reviewed for pressure ulcer in the sample of 12.
The findings include:
1. R11 ' s Physician Order Sheet (POS) of 12/14 shows the diagnoses to include Senile Dementia, Muscle Weakness, Abnormality of Gait, Aftercare Following Joint Replacement, Posterior Dislocation, Hip Prosthesis.
The Minimum Data Assessment Set (MDS) of 09/29/14 shows R11 as incontinent of bowel and bladder, and requires extensive assistance with bathing, hygiene and transfers.
R11 ' s Braden Scale of 06/30/14 shows a score of 17 (moderate risk for developing pressure ulcer). R11 ' s care plan of 06/30/14 does not document specific risk factors for possible skin breakdown.
The Nursing note dated 11/05/14 at 5:00 PM shows a new order to off load wound to left buttock and monitor daily; and wound care nurse if needed.
The Treatment Flow Sheet/Treatment Administration Record of 11/14 shows the weekly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008213	A. BUILDING: _____ B. WING _____	12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDWICH REHAB & HCC	902 EAST ARNOLD STREET SANDWICH, IL 60548

(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 skin checks were done on 11/03/14, 11/10/14, 11/17/14 and 11/24/14. The skin assessment note on 11/03/14 documents clear skin. The skin assessment notes on 11/10/14 and 11/17/14 shows open areas on right shin and calf. The skin assessment note on 11/24/14 shows clear skin. No documentation regarding R11's wound on the left buttock was shown. No wound assessments of the left buttocks (description, measurements) were found for R11. The Nursing note for R11 on 11/13/14 states "Hydrocolloid dressing to left buttock. Wound measurement of 2.5 cm". (No other wound description is documented.) The Physician Progress Note dated 11/17/14 shows "Left buttock is an Acute Necrotic Tissue (unstageable) Pressure Ulcer ...initial wound encounter measurements are 1.9 cm in length x 1.7 cm width, with an area of 3.23 sq cm ...wound bed is 51-75% adherent, yellow slough. The facility wound tracking sheet for R11 was not initiated until 11/24/14. The left buttock wound measured 1.8x 1.0 cm with the wound status documented as deteriorating. There is no care plan identifying the presence and treatment interventions of R11's left buttock pressure ulcer. On 12/04/14 at 11:05 AM, E3 and E4 (Certified Nursing Assistants-CNAs) provided incontinent care to R11 and a foam dressing was observed on R11's left buttock area. On 12/04/14 at 10:55 AM, E2 (Director of Nursing-DON) said that when the Certified Nursing Assistants (CNAs) find anything unusual on the resident's skin, they are to report it to the nurse right away. " The nurse should document the findings right away-the wound length, width, and depth, if any, the condition of the wound bed and the drainage. The nurse should inform the doctor right away and document all orders. "	S9999		

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	IL6008213	A. BUILDING: _____ B. WING _____	12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 4 On 12/04/14 at 11:05 AM, E3 and E4 (CNAs) stated "We perform skin checks with the resident's shower schedules and record them. If we find anything-redness, skin tear, wound, drainage, anything abnormal, we let the nurse know and show it to her." The pressure reducing cushion/mattress was not initiated until 11/20/14. The Nursing note dated 11/20/14 at 3:45 PM states " May have pressure reducing cushion/mattress per MD order." The facility's pressure sore prevention policy dated 05/07 says..."documentation of the pressure area must occur upon identification and at least once each week...the assessment must include characteristic,treatment and response to treatment...initiate problem on care plan." 2. The undated Resident Fact Sheet shows R3 has the following diagnoses: Benign Prostatic Hypertrophy with Urinary Obstruction, Dementia, Diabetes Mellitus, history of Acute Renal Failure, and recurrent Urinary Tract Infections. The Minimum Data Set (MDS) of 10/31/14 shows R3 was at risk for developing pressure ulcers and had one or more unhealed pressure ulcers at stage 1 or higher. The Minimum Data Set (MDS) of 6/12/12 shows R3 has a history of a healed left hip pressure ulcer, and has an indwelling urinary catheter. R3 has moderate cognitive impairement. R3 requires extensive assistance from 2 staff members for bed mobility. On 12/2/14 at 1:25 PM E3 and E9 (Certified Nursing Assistants-CNAs) were performing perineal care for R3. A dry, scabbed wound was noted on R3's left hip that was approximately 0.3 x 0.4 cm. The nurses notes dated 10/15/14 labeled 'late entry from 10/13/14' show that a CNA reported to the nurse that R3 had a "fragile area to his left hip". The nurse note states, "R3's left hip has an	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008213	A. BUILDING: _____ B. WING _____	12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDWICH REHAB & HCC	902 EAST ARNOLD STREET SANDWICH, IL 60548

(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 abrasion and redness noted at raised area about the size of an egg. The doctor was called." The Physician Wound Care notes dated 10/17/14 show R3 had a stage 3 pressure ulcer measuring 0.9 cm x 0.6 cm with no drainage noted. The notes state the wound bed was 26-50% adherent, yellow slough. On 12/4/14 at 10:00 AM, E5 (Licensed Practical Nurse-LPN) stated "The Doctor ordered the x-ray on 10/13/14 because we thought the area appeared jutted out ... the area had some breakdown, it was blanchable but the area was darkened. E5 stated the interventions in place were to turn R3 every 2 hours " but he would keep turning himself back to face the wall ...We were propping pillows under him to try to get him to stay off of the left side, but he would keep ending up on the left side." On 12/4/14 at 9:00 AM, E7 (Registered Nurse-RN) stated "When we put R3 into bed he is mobile and he can turn himself. E7 stated, "R3 always wanted to face the wall (when in bed). " E7 stated skin checks are done weekly by the CNA giving the resident a shower ...and if they see anything of concern, they let the nurse know." E7 stated after R3 developed the new pressure ulcer on his left hip, they turned R3's bed around to where R3 would not be on his left hip when he was facing the wall. On 12/4/14 at 11:00 AM, E5 (LPN) stated, "Skin checks are done weekly by the nurse and it is usually on the resident's shower day. The information is documented in the treatment book ...the treatment records from October should say what interventions were in place before he (R3) developed a pressure ulcer ...the interventions after he (R3) developed a pressure ulcer were more frequent checks to keep him off of his left side, his bed was turned around, and he is out of bed more often."	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDWICH REHAB & HCC	902 EAST ARNOLD STREET SANDWICH, IL 60548

(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		

The Pressure Ulcer Care plan dated 6/30/14 for R3 states, "Assist resident to turn and reposition every 2 hours and as needed or per reposition schedule." The care plan has not been updated to address the history of a left hip wound or specific intervention to prevent reoccurrence.
On 12/3/14 at 8:15 AM E2 (Director of Nursing-DON) stated that R3 had a pressure ulcer on his left hip when he was admitted to the facility on 6/5/14. E1 stated the left hip pressure ulcer that R3 had on admission has healed and the current pressure ulcer located on R3's left hip was facility acquired.
On 12/3/14 and 12/4/14, requests were made to E2 (DON) for R3s October and November treatment records, all applicable (prior to R3's wound development). E2 was asked to provide prevention and treatment interventions implemented for R3's pressure ulcer. No requested documentation was provided prior to survey exit.
R3's risk factors for developing pressure were not identified and documented. No documentation was found indicating the R3 was non compliant with turning or positoning, or that he favored his left side. The facility did not document a complete wound assessment of R3's pressure ulcer prior to R3 being seen by the wound doctor on 10/17/14.

3. The Physician Order Sheet dated 12/1/14 shows R10's diagnoses to include Subarachnoid Hemorrhage of Left Parietal Occipital Region and Dementia.
The facility nursing re-admission assessment (return from hospital) dated 10/28/14 shows R10 had "redness on buttocks ". No additional assessment or information regarding the redness on the buttocks was documented. The pressure ulcer risk score on 10/28/14 was assessed as 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008213	A. BUILDING: _____ B. WING _____	12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
S9999	Continued From page 7	S9999		

(high risk).
The Care plan dated 6/9/14 (most recent) for R10 shows she is at risk to develop pressure related to incontinence, confusion, impaired balance and impaired bed mobility. The interventions include applying house stock incontinent barrier cream to peri area with every incontinent episode and as needed, to complete a daily skin check with documentation, providing a pressure relieving device in the wheelchair. The care plan was not updated to address the wound on R10's red buttocks.
The treatment record dated 11/1/14 shows R10 received weekly skin checks (not daily). On 11/3/14 it is noted R10 has "Coccyx reddened". The weekly skin checks on 11/10/14 and 11/17/14 also state R10 ' s coccyx is reddened. There is no additional skin assessment regarding the reddened coccyx between 10/28/14 - 11/17/14. There is no skin treatment order documented.
The nurses ' notes dated 11/22/14 at 2230 hrs (10:30 PM), states R10 has a " Purple area to coccyx 2.0 cm x 1.0 cm with pinpoint open area. Cleansed with normal saline and covered with dry dressing. "
The treatment record on 11/24/14 shows, " Coccyx 4.0 x 2.0, Stage II " . No additional wound assessment is documented.
The physician order sheet on 11/23/14 shows the order, " Refer to wound doctor for open area to coccyx " . The physician order sheet on 11/24/14 shows the order to " Cleanse with wound cleanser, apply (saline gel) and cover with foam dressing daily. " Review of the November 2014 treatment record shows the first treatment to the coccyx area was not completed until 11/25/14.
On 12/3/14 at 2:15 PM, R10 was observed in bed lying on her back. On 12/3/14 at 4:00 PM, E11 and E12 (CNA) assisted R10 to get up into the reclining geriatric wheelchair. R10 was turned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008213	A. BUILDING: _____ B. WING _____	12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDWICH REHAB & HCC	902 EAST ARNOLD STREET SANDWICH, IL 60548

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S9999	Continued From page 8 provide incontinence care and no dressing was noted over the coccyx wound. R10 had been incontinent of stool. E11 confirmed the treatment dressing was not in the soiled brief. When incontinence care was completed, barrier cream was not applied. R10 was transferred to the wheelchair. There was no pressure reducing cushion placed under R10. On 12/3/14 at 3:30 PM, E5 (LPN) stated, " I usually do R10 ' s wound treatment each day between 10:30 - 11:00 AM. " The facility policy Decubitus Care/Pressure Areas of 5/2007 states, " The pressure area will be assessed and documented on the treatment administration record. Complete all areas, document size, stage, site, depth, drainage, color, odor and treatment (upon obtaining from physician). " The policy states to " Initiate the (wound) problem on the (resident) care plan. " The Pressure Sore Prevention Guidelines dated 11/2012 states, " Care plan entry; Skin risk and appropriate interventions are to be placed on the care plan. If despite interventions, a pressure ulcer develops, the care plan must reflect updated interventions or healing of ulcers and additional interventions for further prevention of pressure ulcers. " (B) 300.615e) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information. e) In addition to the screening required by Section 2-201.5a) of the Act and this Section, a facility shall, within 24 hours after admission of a	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SANDWICH REHAB & HCC	902 EAST ARNOLD STREET SANDWICH, IL 60548

(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	S9999		

resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)

These Regulations were not met as evidenced by:

Based on interview and record review the facility failed to request criminal history background checks within 24 hours, on resident seeking admission to the facility.
This applies to 1 of 12 residents (R9) reviewed for Identified Offender in the sample of 12 and 7 residents (R20, R23, R34, R35, R51, R53, R54) in the supplemental sample.
The findings include:
On 12/4/14 the review of the last 10 resident admissions shows no Illinois State Police (ISP) Criminal History Background Check for 8 of the 10 residents.
On 12/4/14 at 9:00 AM, E13 Business Office Manager (BOM) said the Identified Offender information on the last 10 admissions are missing and can ' t be found. All the information would have to be reprinted.
On 12/4/14 11:30 AM, E1 (Administrator) said the business office does the background checks within 24 hours of admission. E1 said I don ' t where that information is, or where it went.
On 12/3/14 at 1:00 PM, the ISP information was requested for the last 10 admissions, but only 2 were received.
The facility's 2/16/12 Identified Offender Policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008213	A. BUILDING: _____ B. WING _____	12/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 10 and Procedure states: It is the policy of this facility to establish a resident sensitive and resident secure environment. In accordance with the provision of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. #3. Conduct a Criminal History Background Check: Within 24 hrs of admission, request a name based Uniform Conviction Information Act (UCIA) criminal history background check based on name, date of birth, and other identifiers required by the Department of State Police for any resident seeking admission to the facility. (AW) 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background check Act [225 ILCS 46] and Health Care Worker Background Check code (77 ill. Adm. Code 955). These Regulations were not met as evidenced by: Based on interview and record review the facility failed to check the Healthcare Worker Registry prior to hiring new certified nursing assistants. This applies to all 48 residents residing in the facility. The findings include: The facility ' s Census and Conditions of Residents Federal form #672 (12/2/14) documents there are 48 residents residing in the facility. The 11/30/14 Nurse Aide Roster documents the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008213	A. BUILDING: _____ B. WING _____	12/05/2014

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S9999	Continued From page 11 last 10 CNA ' s (Certified Nursing Assistant) hired to be E8,E9, E11, E12, E20-25. The personnel files for each CNA did not have a copy of the Illinois Registry background check. E9 was hired 7/31/14 and had no fingerprint on file and had no registry check. E8, E11, E12 and E20-25 each had a fingerprint date but had no check against the registry. On 12/4/14 at 1:15 PM, E13 stated she performs all of the website background checks for all new employees. E13 stated she sets up the new employees to get their fingerprints done but does not know how to get the results from the State Police for the Criminal Background Checks. E13 stated she did not know the results had to be in the employee file. E13 stated for the CNA ' s, she runs their name thru the Registry and does all of the background checks, but she does not enter the names into the registry portal. The facility ' s 2/28/12 policy for Health Care Worker Background Check states it is the policy that all persons employed are required to be free of conviction of committing, or attempting to commit any crime listed in the health Care Worker Background Check Act. The facility will request a background check on all employees. 5. The facility shall conduct Internet searches on certain web sites including the Illinois Sex Offender Registry; the Department of Corrections ' Sex Offender Search Engine. (AW)	S9999		