PRINTED: 10/19/2021

Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** (X3) DATE SURVEY A. BUILDING: _ COMPLETED IL6009336 B. WING 08/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **751 NORTH OAK STREET CARLINVILLE REHAB & HCC** CARLINVILLE, IL 62626 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (X5)(EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 **Initial Comments** S 000 Annual Licensure Survey S9999 Final Observations S9999 Statement of Licensure Violations: (1 of 2) 300.610a) 300.1210b) 300.1210d)6) 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 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 Attachment A Statement of Licensure Violations each resident's comprehensive resident care

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

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6009336 B. WING 08/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **751 NORTH OAK STREET** CARLINVILLE REHAB & HCC CARLINVILLE, IL 62626 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met evidenceed by: Based on observation, record review, and interview, the facility failed to provide supervision to prevent falls and wandering for 2 of 8 residents (R14, R34) reviewed for accidents and supervision in the sample of 46. This failure resulted in R34 having multiple falls resulting in a nasal fracture, head contusion and hip fracture. Findings include: R34's Face Sheet, printed on 8/4/21, documents R34 has diagnoses of unsteadiness on feet, muscle weakness, other abnormalities of gait and mobility, anterior dislocation of left humerus, displaced intertrochanteric fracture of the right femur, lack of coordination and history of falling. The Face Sheet documented these diagnoses had onset dates prior to 8/16/21. R34's Care Plan, not dated, documents "(R34) is at risk for falls related to a hx (history) of falls and impaired mobility." R34's Care Plan interventions

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hematoma on forehead."

On 8/9/2021 at 9:12 AM V16, Licensed Practical Nurse (LPN), stated R34 has poor safety

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accident document) for witnessed fall with no

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED IL6009336 B. WING 08/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 751 NORTH OAK STREET CARLINVILLE REHAB & HCC CARLINVILLE, IL 62626 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 4 S9999 injuries. R34 continues to attempt to self-transfer. resident involved with activities throughout the day." R34's Health Status Note, dated 6/16/2021 23:40. documents Note Text: "Writer received call from (Local Hospital) ER (emergency room). R34 is reported to have Left Hip Fracture. R34 is being transferred from (Local Hospital) to (Regional) hospital in (nearby city)." On 8/6/2021 at 7:40 AM V26, LPN, stated "R34 has poor safety awareness". V26 stated "when R34 gets his mind set on something he is going to do it". V26 stated on 6/16/2021 R34 was making attempts to stand, and she placed R34 across from the nurse's station so she could watch him. R34 stated that she had V25, Unit Aide, sitting there to perform one on ones with R34 as she went down hall to pass her medication. V26 stated that V25 can't touch him so she couldn't prevent his fall. V26 stated she assessed R34 while on floor and he had no internal or external rotations. V26 stated that R34 was lifted off the floor with 2 CNA's and placed in bed. V26 stated this is when R34 complained of hip pain. On 8/9/2021 at 9:15 AM V25 stated she works throughout the building. V25 stated her job consists of passing ice, passing trays, taking the smokers out, making beds and wheelchair cleaning. V25 stated she cannot perform any hands-on care for the residents. V25 stated on 6/16/2021 R34 was sitting across from the nurse station against the wall. V25 stated R34 kept trying to stand up, pushing up from the wheelchair. V25 stated R34 told her he was going to stand up. V25 stated she left R34, across from the nurse station, went to the top of the hall and

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2. R14's Admission Record, print date of 8/4/21. documents R14 was admitted on 6/26/20 with diagnoses of Epilepsy, Encephalopathy, Cognitive Communication Deficit, Dementia and Profound

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY					
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S9999	Continued From page 6		S9999		15					
	Intellectual disabilities.		×.							
	R14's Minimum Date R14 is severely cog	a Set (MDS), dated 6/11/21, nitively impaired.				:				
2.0	elopement risk/wand documents R14 war	dated, documents, R14 is an derer. The Care Plan anders the halls and goes into								
Y	other people's room:	s as well as touch doors with		A 4 8						
	Plan interventions de	If turned around. The Care ocument that staff should				0.0				
W 100	redirect R14, get R1	4 out of the room if by				976				
22	around, and refer to	e is gets stuck, and can't turn		=1	£4	V-3				
	, ė	,,,	10							
	inher wheelchair on	M, R14 was propelling herself the hall with no supervision. ame out of room B12.								
9 (1000)	On 8/3/2021 at 8:40 herself in her wheeld	AM, R14 was propelling hair through the hall.				S2				
ar A fi	At 8:44 AM R14 ente to yell "get out, get ou	red R20's room. R20 began ut".		=	U. Said	99 (5)				
- 2	removed R14 from R	I staff intervened and (20's room and placed R14 in ed to self-propel through the				1 P G 1				
	in her room all the tin her (R14) to get out. I through her roommat stated sometimes sha happens waking her	PM, R20 stated R14 comes ne. R20 stated she yells for R20 stated (R14) goes re's stuff. "It scares me." R14 e is asleep, and this up and startling her. R20 e resident council meeting	a							
98	yesterday and told the something about residual	em they needed to do dents coming in and out of she guesses they are		12		10				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		1			
A LA A AP AP PROGRAMMENT ARE ALLEGED.		DRESS, CITY, STATE, ZIP CODE		08/	08/09/2021		
CARLIN	VILLE REHAB & HCC	751 NOR1	TH OAK ST	REET			
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S9999	Continued From page 7		S9999				
	harmless but how does she know they are harmless. R20 stated "It's scary."						
	On 8/2/21 at 11:43 AM, R35 stated R14 steals her things like pens and hairbrushes because she wanders around.		-	=			
	Aide (CNA), stated, '	6 AM, V9 Certified Nurse's "(R14) just wanders around people's rooms. We have to				6	
	"(R14) does wander all over the facility ar	II, V2, MDS/LPN, stated, in her wheelchair. She goes and she is quick. Staff should d giving her something to			m		
	does wander around wheelchair, and she	f, V25 Unit Aide, stated R14 the building in her requires supervision to get out of other residents'	î ,		-	2	
	"I&A (incident and ac	lated 3/4/2021 at 2:37 AM, cident) R14 as being struck in her head. There is no	5. 4		200		
	diagnosis of PTSD (p disease), CHF (conge heard yelling "Get out tapping noise. ADON Nurses) went to see v (R109) hitting (R14), a	30-year-old white male with					

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED IL6009336 B. WING 08/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **751 NORTH OAK STREET CARLINVILLE REHAB & HCC** CARLINVILLE, IL 62626 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) S9999 Continued From page 9 S9999 and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status. sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3)Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care

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of Nurse's (ADON) stated before accessing a

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: __ COMPLETED IL6009336 B. WING 08/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 751 NORTH OAK STREET **CARLINVILLE REHAB & HCC** CARLINVILLE, IL 62626 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 11 S9999 gastric tube for feeding or medication administration, placement and residual should be assessed. On 8/4/2021 at 10:30 AM, V16 stated when using a gastric tube, she would check for residual and placement before passing medications through the gastric tube. On 8/4/21 at 10:30 AM, V16 stated she called the doctor for R52 to be sent out to hospital for his tube. On 8/4/2021 at 2:35 PM V4. Minimum Data Set Coordinator/LPN stated that she would expect for nurses to check for placement and residual on a gastric tube before using it. On 8/4/2021 at 2:45 PM, V4, stated "We do not have a policy on Administration of medications via enteral tube we expect staff to use their scope of practice." V4 was further questioned on what that means and V4 stated that the facility expects the staff to do the correct actions according to the staff's education. no violation

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