Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING IL6009559 01/27/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1610 NORTH LAKEWOOD DRIVE EFFINGHAM REHAB & HEALTH C CTR** EFFINGHAM, IL 62401 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **TAG** DEFICIENCY) S 000 Initial Comments S 000 Complaint Investigation 2150427/IL130342 S9999 Final Observations S9999 Statement of Licensure Violations 300.610a) 300.1210b)5) 300.1210c) 300.3240a) Section 300.610 Resident Care Policies 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 Attachment A Nursing and Personal Care Statement of Licensure Violations The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological

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

TITLE

(X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PUN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
EFFINGH	IAM REHAB & HEALT	HCCTR	RTH LAKEW AM, IL 6240				
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S 99 99	Continued From pa	ge 1	\$9999				
	well-being of the re-	sident, in accordance with					
		nprehensive resident care					
		I properly supervised nursing care shall be provided to each					
	resident to meet the	e total nursing and personal		¥:			
		esident. Restorative ude, at a minimum, the					
5	following procedure						
	-> 411						
		ing personnel shall assist and is with ambulation and safe					
	transfer activities as						
		retain or maintain their highest					
	practicable level of	tunctioning.			İ		
vi.		care-giving staff shall review					
	and be knowledgea respective resident	able about his or her residents'					
	respective resident	care plan.					
	0	Abuse and Newlast					
	Section 300.3240	Abuse and Neglect					
		icensee, administrator,					
		of a facility shall not abuse or					
	neglect a resident.	(Section 2-107 of the Act)					
	These regulations	are not met as evidenced by:					
	mese regulations a	are not met as evidenced by.					
		and record review the facility	4				
		sfer 1 of 3 (R6) residents ers in the sample of 7. This					
	failure resulted in a	displaced proximal humerus		8			
		uiring Emergency Room (ER) tment on 1/20/21 along with					
	pain management	_					
	,	• •	}				
	Findings Include:						

A Minimum Data Set (MDS) Dated 2/29/20

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	400		A. SOLONO.		С	
	**:	IL6009559	B. WING			7/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
EFFINGH	HAM REHAB & HEALT	M C CTR	TH LAKEW AM, IL 6240	OOD DRIVE 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL D BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	documents R6's ad 9/20/16. R6's Brief Score is documente not cognitively intac well as "Bed Mobilit" "Total Dependence assist." The "Functi Room" and/or "Wal as "Activity did not on the R6's Plan of Care with documents, "R6 us wheelchair, and assume "Nurse's Notes" man Nurse, LPN) dated R6 was noted to ha existing blue/purple tear. New onset bruextending to top R6 forearm with swellir notified and awaitin "Nurse's Notes" man 11:30 AM document of the action of the swelling to the R6's left shoulder with the left elboth R6's left shoulder with the proximation beneath the humen involve the articular displacement of the noted. The glenohum	mission date to the facility as Interview for Mental Status ed as "99," indicating she is et. R6's "Transfer Status" as ey" is documented as requiring of "Two + persons physical ional Status" of "Walk in k in Corridor" is documented occur." with a "Start Date" of 5/3/19 es a hoyer (mechanical) lift, sist of 2 for transfers." ade by V16 (Licensed Practical 1/20/21 at 7:15 AM document, evered/purple bruising near bruising from previous skin uising is documented as its left shoulder to lowering noted. V21 (Physician) greturn call. ade by V16 dated 1/20/21 at at a new order for a venous its left upper extremity and ow and shoulder. -ray report dated 1/20/21 ings of, "A complete fracture all humerus is identified just all head. The fracture does not surface. Superior medical edistal fracture fragment is imeral and acromioclavicular intact. Diffuse osteopenia is	\$9999			
		Room (ER) "After Visit 20/21 documents R6	!			

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		OOMI LEIGD		
					l c	:	
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			0 1/21/2021				
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		l	
		1610 NOR	TH LAKEWO	OOD DRIVE		1	
EFFINGHAM REHAB & HEALTH C CTR EFFINGHAM, IL 62401							
· -	OUB MARDY CTA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
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	presented to ER wi	th the reason for visit being an					
		s diagnosed with "Fracture of					
		f the left humerus, shoulder		5			
		skeletal assessment					
		is marked tenderness over				000	
		merus and severe pain with					
		of the left shoulder. There is					
		ess diffusely over the distal half					
		oow, forearm, and wrist."					
	Treatment docume	nted as being completed is a					
	left arm sling applie	ed, along with morphine and					
	ordansetron medic	ations administered.	ļ				
			i				
		dated 1/22/21 by V22					
		ents R6 was seen for					
	evaluation of a left	arm injury. V22 documents	j l	@			
	imaging studies sh	ow a "fracture of the proximal	ļ				
		% displacement of the head in					
	relation to the shaf	t." V22 documents a treatment					
	plan as, "Nonopera	ative treatment. For comfort we					
		immobilizer for her to use.	Į				
	Follow-up will be in	4-weeks."	{				
		startian December de composite en					
		stration Records documents on					
		1 R6 was administered Tylenol					
		ng) by mouth for the reason					
		." Another entry made on					
		M documents R6 was					
	administered "Nord	co"	15				
	(Hydrocodone/Ace	taminophen) 5/325 mg by	ļ				
	mouth with the rea	son listed as "arm pain."					
	On 4/27/24 at 42:4	1 PM, V21 (Physician) states					
	be would expect th	ne facility to follow R6's plan of				7/5	
	ne would expect the	s of care including transfer					
	status.	5 of care including transfer					
15	sidius.						
	On 1/22/21 at 11:0	5 AM, V12, Certified Nurse					
	Accident (CMA) et	tates that R6 was in bed when				-	
	che arrived to worl	k on 1/20/21. V12 states that					
	1 211G OLLIACO IO MOLI	COLLIEDIEL VIE GIGIOG HIGE	J	<u> </u>			

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		IL6009559	B. WING			27/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EFFINGH	IAM REHAB & HEALT	HCCIR	TH LAKEW AM, IL 6240	OOD DRIVE			
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S9999	Continued From pa	ge 4	S9999		-		
	anything abnormal, gown and had some tear area on her left month. V12 states to out of bed and into by lifting her under the morning herself transferred R6 from chair by lifting her under the shower room R6. V12 states she since May 2020 and transferred with a hireported to V1 she V1 instructed her or brittle bones. V12 states a lift to transfer R6 remployment during positioned awkward notified by V1 on 1/2 pending investigation has been trained in injury of unknown or	Ily to lift. V12 states she was 20/21 that she was suspended on outcome. V12 states she abuse and if she observes an rigin or abuse of any sort she e nurse and Director of	7				
		PM V13, CNA states that she		20		X	
	was working 1st shi went to R6 room to R6 was in a gown a with no abnormal or V13 states herself a bed in put her into hunder her arms. V1: used. V13 states sh with R6 the rest of the notified by V1 via pheas suspending per variation.	fft on 1/20/21. V13 states she get her out of bed. V13 states and was acting her normal self, r new onset bruising noted. and V12 transferred R6 out of her wheelchair by lifting her 3 states a gait belt was not he had no further interaction he day. V13 states she was none that evening that she anding investigation related to eture. V13 states she has		R			

Illinois Department of Public Health

GWCT11

Illinois Department of Public Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING IL6009559 01/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1610 NORTH LAKEWOOD DRIVE **EFFINGHAM REHAB & HEALTH C CTR** EFFINGHAM, IL 62401 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 5 S9999 since learned that R6 was to be transferred via hover lift by education that has been provided by V1. V13 states she just wasn't aware. R6 states the resident transfer status can be found in their chart. On 1/26/20 at 2:23 PM, V14, CNA states she was working on 1/20/21 when R6's fractured arm was discovered. V14 states herself and V12 transferred R6 from her wheelchair to the showerchair in R6's room by lifting her under her arms, not using a gait belt. V14 States R6 was wheeled to the shower room and once undressed purple bruising was observed to R6's left shoulder, arm and part of her chest. V14 states V16 Licensed Practical Nurse was notified and examined R6. V14 states R6 seemed to be her normal self pretty much, and guarded the extremity slightly more than usual, maybe, but has very low cognitive function. V14 states V16 stated she would notify the physician and to be careful with the extremity during her shower. V14 states the shower was completed without incident and herself and V17 transferred R6 back into her wheelchair by picking her up under her arms again. V14 states she was contacted by V1 later that evening and notified she was suspended pending investigation. V14 states a 2 person physical transfer is her normal method of transferring R6, although she states she knows some staff use the hoyer for her though. V14 states you can find out a resident transfer status by checking their chart. V14 states she since has had to complete transfer training prior to returning to work. On 1/22/21 at 2:14 PM, V16 Licensed Practical Nurse states she was working the morning R6 fracture was discovered. V16 states around 7:15

Illinois Department of Public Health

AM she was notified that V14 needed her in the

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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shower room ar chair. V ruddy re purple be states R reported that she bruised V16 state Thrombother skin V16 state with R6's was goir called V ordered came to V16 state the studitechnicial dislocate knowled looked to notified a	Id witnessed with her lead with her lead with her lead with her lead was guared in o incident was awared when she uses R6 has a cosis (DVT) at the facility at	states she entered the shower d R6 sitting in the shower 6 left elbow was swollen and eft shoulder and there was eading onto her chest. V16 ding her arm and V14 to cause injury had occurred of and that the arm was indressed her to be bathed. In a history of Deep Vein and her thought was that with ad possibly developed a DVT. Tructed V14 to be very careful getting her dressed and she will be controlled the x-ray was a coutpatient x-ray services and performed the studies. Sted the x-ray technician with a x-raying the shoulder the R6 had a history of a in shoulder. V16 said not to her is shown the x-ray which acture. V16 states V21 was v1 and R6's family with orders	S9999				
(DON) s around 9 bruising R6's roo R6's arm any disco staff repo happene they und V1 states	tates upon load she wanto her left a m where shown. V1 states comfort or dispreted they down, they just ressed her an investign.	AM, V1, Director of Nursing her arrival to work on 1/20/21 is notified by staff that R6 had rm. V1 states she went to be observed purple bruising to R6 did not appear to be in stress at that time. V1 states lid not know what had noticed the bruising when to shower her this morning. It is gation of unknown injury was that R6 is confused and	ts.			: EI	

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

PRINTED: 02/18/2021 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING: _ **B. WING** IL6009559 01/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1610 NORTH LAKEWOOD DRIVE EFFINGHAM REHAB & HEALTH C CTR** EFFINGHAM, IL 62401 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG **DEFICIENCY**) S9999 S9999 Continued From page 7 utilizes a hoyer lift for all transfers. V1 states that night shift staff interviews note R6 was her normal self with no bruising or abnormalities noted. V1 states that V13 is the staff member who reported dressing R6 on 1/20 in the am with no concerns noted, V13 and V12 reported transferring R6 from her bed to her wheelchair on 1/20 with no incident or concerns noted. V12 and V14 reported transferring R6 from her wheelchair to her shower chair on 1/20 with no incident. V14 reported bruising to V16 while undressing R6 for her shower. V1 states V12, V13, and V14 were all suspended pending the investigation. V1 states that R6 does have a roommate, but the roommate is confused and unable to give detail on any occurrence that happened. In a letter dated 1/25/21 directed to the Illinois Department of Public Health, states that the letter is to serve as a follow up to an incident that occurred on 1/20/21 involving R6. Following facility investigation their conclusion documents R6 sustained injury as a result of being improperly transferred approximately three times via two person axillary lift. The report documents all parties were suspended during the investigation, and completed the "Limited Resident Lift Program" prior to return of duty. A summary of care provided post incident

documents R6 was transferred to the local Emergency Room for evaluation and treatment where she later returned to the facility that day and was seen by V22 (Physician-Orthopedic) on 1/22/21 where it was determined surgical repair of the fracture would be contraindicated and a supportive sling was prescribed. The letter documents the facility has taken measures to prevent further incidents as such by providing staff education and also updated R6's plan of

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING IL6009559 01/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1610 NORTH LAKEWOOD DRIVE EFFINGHAM REHAB & HEALTH C CTR** EFFINGHAM, IL 62401 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOUL DIBE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) S9999 S9999 Continued From page 8 Review of the not dated "Limited Resident Lift Program" documents the purpose for the program as, "This policy describes ways to ensure that employees use safe resident handling and movement techniques at (Company) facilities for tasks that are designated as high-risk for safe resident handling and movement injuries." The same policy goes on to list one of the goals of the program as, "Reduce the injury potential for both the resident and caregiver." (B)

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