Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008106	A. BUILDING: ______ B. WING ______	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

(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 Complaint Investigation 2112641 / IL132947	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 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 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	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
	IL6008106	A. BUILDING: ______ B. WING ______	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

(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		

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:
3)Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect

a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Requirements were not Met evidencded by:

Based on observation, interview, and record review, the facility failed to keep a resident free of restraints for one of three residents (R1) reviewed for restraints in the sample of 6.

This failure resulted in psychosocial harm to R1 as demonstrated by R1 crying, swinging her arms, and actively attempting to free herself from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008106	A. BUILDING: ______ B. WING ______	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

(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		

three separate restraints.

The findings include:

On 4/22/21 at 8:00 AM, R1 was in bed on her left side facing the wall. R1's eyes were closed and R1 was resting quietly.

At 10:15 AM, R1 was sitting in a recliner in her room. V9, R1's family member was seated beside her. R1 showed no agitation or aggression as she said to V9 "get me out of here" and "I don't want to be here".

On 4/21/21 at 1:46 PM, V9 said R1 was transferred to the facility on 4/6/21 from a facility in Kentucky to be closer to family. V9 confirmed the identity of R1 in a photograph and identified that she purchased the clothing R1 was wearing (in the photograph). It's disturbing to see (the photograph).

At 4:45 PM, V10, R1's family member said R1 didn't have a bad bone in her body and it would make her sick if she saw that picture of herself being strapped in the wheel chair, and gait belt tied to a hand rail. It's disgusting and makes me sick too. It's inhumane. I was absolutely horrified when I saw that photo. There would be no circumstance that would make it okay. (R1) would feel like an animal tied up and caged. She can't get away. I returned a call to the facility on 4/20/21 around 10:00 AM. They said they wanted verbal consent for a restraint, but they hadn't decided what type. They did not tell me (R1) had already been restrained. They said (R1) wouldn't stay in her room, was unstable on her feet, and they were afraid she'd fall. (V9 and V10) confronted V1 Administrator about it on 4/20/21 about 4:00 PM and showed her the picture. I'm a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008106	A. BUILDING: ______ B. WING ______	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

(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	S9999		

Certified Nursing Assistant (CNA) and I know this type of restraint is not allowed.

When I gave consent for a restraint, I was thinking side rails, or a seat belt, nothing to the extent of what is shown in that photo. R1 is scared and doesn't know what's going on. I spent the night with her on 4/20/2, I was scared to go to work in the morning and leave her there. It's heartbreaking. Nobody deserves this. It's abusive. V10 began crying and the interview had to be stopped.

On 4/22/21 at 8:26 AM, V5 Certified Nursing Assistant (CNA) said when she got to work on 4/20/21 around 5:00 AM, she saw R1 restrained with two gait belts, and wheelchair was connected to the handrail. R1 also had a seat belt on. R1 was in the dining room by the two bathrooms alone. Nobody else was around. "That's abuse. R1 was trying to move and get out. You don't restrain someone like that. There are other options like get more staff. They try to cover everything up". I heard V2 Director of Nursing (DON) and V8 Licensed Practical Nurse (LPN) talking about it and I told them I saw it (R1 restrained). "Those people are being neglected". "They were more worried that I had a picture of it than they were about what happened to the resident".

On 4/22/21 at 8:30 AM, V2 DON said if restraints are used a physician order is needed immediately and the physician should see the resident within eight hours. Fall prevention is not an acceptable rationale for restraints. We use gait belts to transfer people. Using a gait belt for a restraint is not acceptable. At 8:48 AM, V2 said she called V4 Registered Nurse (RN) at 8:40 AM on 4/20/21 and asked him if he restrained R1 and he said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008106	A. BUILDING: ______ B. WING ______	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

(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	S9999		

yes. "I told him it was illegal to restrain a resident like that".

At 8:52 AM, V1 said V4 told her R1 was in a wheelchair with a seat belt on. A gait belt was placed around her "sounded like the same place as the seat belt". "He (V4) looped another gait belt through the first one and put it around a handrail. Another resident was going to fall, and the CNA was not available. I have it narrowed down to less than an hour as to how long R1 was restrained". "I would feel frustrated, confused, and angry if that happened to me. It's "absolutely a violation of her rights".

On 4/22/21 at 9:25 AM, V4 Registered Nurse (RN) said on 4/20/21 at 2:00 AM, R1 was confused, restless, and kept leaving her room. "I needed to attend to other residents". I put (R1) in a wheelchair with a quick release seat belt "to give me peace of mind". The wheelchair was broke. The brakes didn't work and R1 could still move so I got a gait belt and secured it around R1 and put the buckle behind the wheel chair so if R1 was able to release the seat belt she was still kept in place. V4 said around 4:00 AM, another resident was agitated, and he had to go in her room. So, I got another gait belt and looped it through the first gait belt and secured it to the handrail. "I'd look out in the hall every 5-10 minutes to check on her (R1) though". "It was a very hard night for me". "To be honest, I got exhausted going to her (R1's) room every 5-15 minutes". V4 said R1 was restrained from 2:00 AM until around 3:00 AM and then again from 3:15 AM until 5:30 AM. Between 3:00 AM and 3:15 AM, I tried to put her to bed but she got right back up. So, I put her back in the wheelchair and applied the seat belt and gait belt again. "I worked with V7 Certified Nursing Assistant (CNA)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008106	A. BUILDING: ______ B. WING ______	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

(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		

that night. V7 was laying on the couch for a while and then went into a bed and I let her sleep". V4 said he did not fill out any restraint assessment or other paperwork, did not notify R1's family or the doctor, and did not document the use of the restraint in R1's record. V4 said he did not report the restraint usage to the next shift. V4 said he returned to the facility at 11:00 AM as requested by V1 Administrator. At that time, V4 said he was directed by V1 to complete the restraint assessment and other restraint forms, call the doctor, and enter the addendum progress note in R1's medical record.

On 4/22/21 at 10:23 AM, V8 Licensed Practical Nurse (LPN) said restraints are not used for fall prevention. "You don't just tie a resident to a radiator. That's abuse".

On 4/23/21 at 10:22 AM, V7 CNA said she worked the night shift with V4 on 4/19/21. "I never worked the night shift before. I fell asleep. I woke up about 3:47 AM and saw R1 tied next to the heater to the handrail with two gait belts. I asked the nurse (V4) why R1 was restrained like that and that it wasn't right. R1 was crying, asking for her parents, swinging her arms, actively trying to move and get out. Any normal person would be in distress. You shouldn't use a gait belt as a restraint. You could hurt yourself trying to get out of it. You use gait belts to transfer a resident. I personally felt uncomfortable. I saw R1 last around 6:00 AM. She was in her room alone in the wheelchair and the seat belt was on her.

On 04/23/21 at 11:45 AM, V6 facility Medical Director/R1's physician said he couldn't say restraining a reasonable person (in the manner R1 was restrained) wouldn't cause distress and psychosocial harm. "There would have been a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008106	A. BUILDING: ___ B. WING ___	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

(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 better way to do it. I would say there was an error in judgement on the best way to restrain someone". V6 said he "would not approve using gait belts to restrain his residents". "It's unsafe and not it's intended use". V6 said he thinks the reason for the restraints was that without 1:1 supervision they had trouble preventing falls. On 4/23/21 at 8:20 AM, V11 CNA said on 4/20/21 at 6:00 AM, R1 was in a wheelchair with a seat belt on by the nurses' station and had the seat belt on the whole shift. At 10:50 AM, V3 said a resident with dementia may communicate distress by being aggressive, agitated, and restless. At 10:54 AM, V2 said crying out, combativeness, and being easily agitated are ways a resident with dementia may communicate distress. R1's face sheet showed a 77-year-old female admitted to the facility on April 6, 2021 from Kentucky. R1's social service progress note dated 4/6/21 at 3:00 PM showed R1 was tearful, timid and V3 Social Services Director attempted to comfort her without success. This note showed R1 was not interview able and R1's behaviors got much worse with "sun downing". R1 refused her medications prior to transporting from Kentucky to the facility. R1's 4/6/21 4:00 PM Nursing Admission Assessment showed a diagnosis of dementia with behaviors. R1's 4/6/21 5:00 PM nurses note showed she is very anxious, fearful, and does not demonstrate proper use of the call light. R1's 4/7/21 8:00 AM nurses note showed R1 was disoriented, times 4, and combative with staff. R1 was sent to the local emergency room for evaluation. The emergency room documentation	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008106	A. BUILDING: ______ B. WING ______	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

(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		

dated 4/7/21 showed R1 was seen for dementia and an acute situational reaction to stress. R1's nurse's notes dated 4/16/21 showed R1 wanted to walk because she is getting bored. R1's nurse note dated 4/19/21 on the 6PM-6AM shift and authored by V4 showed: 9PM no signs of wandering/confusion, 11- asleep, 12 asleep, 1AM, woke up agitated, 3AM confused, 6AM confused. There is no documentation in R1's medical record regarding behaviors requiring restraint, attempts at interventions prior to restraints being applied, monitoring of R1 while restrained, releasing of the restraint, or notification of family, physician, or Administration of the restraint application.

R1's nurse note addendum authored by V4 (on 4/20/21 at 11:00 AM) showed a seat belt and "additional safety measures" was applied at 2:00 AM due to increased confusion, agitation, and combativeness. This note showed V4 "tried to put her back in bed because she remained calm and quiet". Fifteen minutes later after "hearing resident rise", V4 put R1 back into the wheelchair with the seat belt and "additional safety measures". R1's physician telephone orders showed restraint orders were not received until 4/20/21 at 11:30 AM (9 ½ hours after initiated).

R1's restraint order showed to use a restraint for increased restlessness. R1's screening assessment for harmful behaviors showed R1 was minimal to low risk. On 4/22/21 at 1:30 PM, V3 clarified the form was completed on 4/15/21. R1's preadmission paperwork faxed to the facility on 4/2/21 showed R1 had severe difficulty following even simple commands, had numerous falls, had intermittent crying, asking for her mom and dad, experienced major functional and cognitive decline, had increased emotional behaviors, moderate adverse behaviors, outbursts and perseverations and a note dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008106	A. BUILDING: ______ B. WING ______	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

(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		

3/25/21 showed she was on one to one supervision.

Photographic evidence provided by the complainant to the central registry showed R1 (identity confirmed by V9 R1's family member and V10 R1's family member) seated in a wheelchair leaning forward. The front entrance doors are directly in front of R1. There is a gait belt around R1's waist and secured behind the back of the wheelchair. Another gait belt is looped around the first and secured to a handrail adjacent to the restroom door nearest the front entrance.

R1's 4/6/21 elopement assessment showed the facility would provide 1:1 supervision when R1 had signs and symptoms of restlessness.

The facility's 7/24/18 Physical Restraint Policy showed physical restraints shall not be used for discipline or convenience. A physical restraint is any physical or mechanical device, equipment, or material attached or adjacent to the resident's body, which the individual cannot remove easily, and which restricts freedom of movement or normal access to his or her body. Also, physical restraint may include a device which prevents the resident from rising. The procedure showed to complete the Physical Enabler/Restraint Use/ Reduction Evaluation. Obtain verbal and/or written consent from the resident/legally responsible party. Document in the nurses' note the date, time, and which type of consent obtained prior to physical restraint being applied. Obtain a physician order for restraint. The order must include specific medical/physical reason, type of restraint, "release and reposition at least every two hours" and when to be used. Apply the restraint according to the manufacturer directions. Document in the nurses notes the type of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008106	A. BUILDING: ______ B. WING ______	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER: ROCHELLE REHAB & HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 900 NORTH 3RD STREET, ROCHELLE, IL 61068

(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		

restraint being used and the resident's response to the physical restraint.

The facility's 1/3/18 Emergency Use of Physical Restraints Policy showed emergency restraints shall only be used based on an emergency, and only after the completion of an emergency restraint assessment. Consideration of the restraint must be in the areas of reason, mental status, physical limitation, type of restraint to be used, and family notification and agreement. If a physician is not immediately available, a nurse with supervisory responsibility may approve in writing, the use of the physical restraint. A confirming physician order must be obtained as soon as possible, but no later than eight hours after the restraint has been applied. The procedure showed to complete an emergency restraint assessment and notification of the physician. Notify the family of the physician's order and the reason the restraint was obtained. The resident utilizing an emergency use restraint must always be in full view of a staff person. Documentation in the resident's clinical record must include: the behavior that prompted the use. Date and times the restraint was applied and released. The name and title of the person responsible for the application and supervision of the physical restraint.

The manufacturer's instructions for use of the facility's gait belt was requested. The product description was received instead. The manufacturer's instructions for use showed the gait belt's intended use was to assist patients during transferring and walking activities. The belt provides a place for the caregiver to securely hold the patient. Warnings: A gait belt is not for use as a restraint on wheelchairs. Gait belts are only to be used for assisting residents during

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008106	A. BUILDING: ______ B. WING ______	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE REHAB & HEALTH CARE CENTER	900 NORTH 3RD STREET ROCHELLE, IL 61068

(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 transferring, lifting, and walking. The facility's Abuse Prevention Program Policy dated 11/28/16 showed this facility affirms the right of our residents to be free from abuse. This includes any physical restraint not required to treat the resident's medical symptoms. The facility is committed to protecting our residents from abuse by anyone including but not limited to facility staff and staff from other agencies. Abuse is the willful injection of unreasonable confinement with resulting mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents they observe, hear about, or suspect to a supervisor and to the administrator. " B "	S9999		