Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ 11/03/2022 IL6003198 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 901 ILLINI DRIVE **FONDULAC REHABILITATION & HCC** EAST PEORIA, IL 61611 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 DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) **Initial Comments** S 000 #1 Facility Reported Incident of 10/27/22/IL152873 #2 Complaint 2228505/IL152588 S9999 S9999 Final Observations #1 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3 300.1210d)6) 300.1220b)1)2)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Attachment A Nursing and Personal Care Statement of Licensure Violations The facility shall provide the necessary **b**)

Illinois Department of Public Health
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 (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C IL6003198 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 ILLINI DRIVE FONDULAC REHABILITATION & HCC EAST PEORIA, IL 61611 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 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. Restorative measures shall include, at a minimum, the following procedures: Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. Pursuant to subsection (a), general d) nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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. Section 300.1220 Supervision of Nursing Services The DON shall supervise and oversee the

_ Illinois C	epartment of Public	Health			FORM APPROVED
STATEME	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION S:	(X3) DATE SURVEY COMPLETED
		IL6003198	B. WING	<u> </u>	C 11/03/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE	11/03/2022
FONDUL	AC REHABILITATION	& HCC 901 ILLIN			
(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 SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	DIBE COMPLETE
\$9999	Continued From pa	ge 2	S9999		
	nursing services of	the facility, including:	!		
		nd directing the activities of		LB	84
n ³⁸	assessment of the rinclude medically defunctional status, se impairments, nutrition psychosocial status condition, activities	the comprehensive residents' needs, which efined conditions and medical ensory and physical onal status and requirements, discharge potential, dental potential, rehabilitation status, and drug therapy.			= 2
ii	plan for each reside comprehensive assuand goals to be accurant personal care a Personnel, represer nursing, activities, dimodalities as are on be involved in the proplan. The plan shall reviewed and modifineeded as indicated	ating other services such as ietary, and such other dered by the physician, shall eparation of the resident care be in writing and shall be ed in keeping with the care by the resident's condition.			
12	a) An owner, license agent of a facility sha resident. (Section 2-	e, administrator, employee or		40 Ar	
	Based on observation	n, interview and record		9	

U\$7V11

Illinois D	epartment of Public		FORM A	APPROVED		
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	IL6003198			V	C 11/03/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FONDUL	AC REHABILITATION	& HCC 901 ILLIN				
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETE DATE
89999	Continued From pa	ge 3	S9999	=		
	supervise a cognitive dependent resident smoking time for the smoking in a sample in R5 suffering burn hospitalization that intubated (placed of the burn unit. Thes	ailed to assess, monitor, and yely impaired, oxygen (R5) during a designated ree residents reviewed for e of five. This failure resulted is to the face and requiring necessitated R5 to become in a ventilator) and admitted to e failures have the potential to oking residents residing in the	÷			
	Facility.	*		=======================================	8) (4	·
i e	Findings include:		(9)		2 2	W
	documents: the pati dining room has bee resident smoking ar resident whom choo smoking assessment residents choosing to responsible staff me the designated smo 10:30 am to 10:45 a	noking Policy, undated, io area to the side of the en designated as the only rea for the facility; each oses to smoke will have a nt completed prior; and all to smoke will have a ember outside on the patio at ke times (9:00 am to 9:15 am, am, 1:30 pm to 1:45 pm, 4:00 7:00 pm to 7:15 pm).	8	#8 ×	~	-
	R5, R6, R7, R8, R9, R14 as smokers. T	ker's, undated, documents R4, R10, R11, R12, R13 and he list also documents R5 two Resident's on oxygen	e.			
	residents must alwa	licy, undated, documents that ys be accompanied by a staff and may not keep his/her own	15	# 3	1.	di N
	Report, dated 10/31	Department Five Day Final /22, documents that R5's ental Status/BIMS score			ei er	

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: IL6003198 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 ILLINI DRIVE FONDULAC REHABILITATION & HCC EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 4 S9999 shows that (R5) has moderate cognitive deficit (score of 9/15). (R5) was on the Facility smoking patio and a staff member witnessed R5 with an oxygen tank turned on "flames coming from the side of his (R5's) face" and that the "employee hollered for help and went outside" to ensure the safety of the resident and other resident that was smoking. The Report concludes that R5 was admitted to a local Hospital for burns to the face. R5's Physician Order Sheet, dated 10/1/22 through 10/31/22, documents diagnoses including Traumatic Brain Injury, Cognitive Deficit, Cataracts, Neurocognitive Disorder with Behaviors, Emphysema, Asthma and Epilepsy. R5's Facility Smoking Assessment, undated, documents that the "Resident must be evaluated with the following physical abilities to be permitted to smoke per Facility Policies and Procedures" and that a Physician's Order is in place to permit the Resident to smoke. R5's Smoking Assessment dated 10/25/21 documents a handwritten note, "no changes" on 12/31/21 and 4/6/22. The Smoking Assessment documents that R5 was able to flick the lighter on and off, demonstrate safety measures for handling cigarette, exhibit clear understanding of the smoking policy and require moderate assistance with smoking. The Facility could not produce a Smoking Disclosure Form or any additional Smoking Assessments for R5. R5's Hospital History and Physical/H&P, dated 10/27/22, documents: that R5 presented to the Hospital, and admitted to the Burn Unit, after suffering burns to the face while smoking a cigarette on oxygen, there was soot noted to the patient's nares (nose) and visualized in the nasopharynx/oropharynx, hair burnt off on right

Illinois Department of Public Health

Illinois D	epartment of Public	<u>Health</u>			FORM APPROVE	ΞD
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		Į.	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING		C 11/03/2022		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE	100,2022	\dashv
FONDUL	AC REHABILITATION	& HCC 901 ILLIN				i
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	Ē
\$9999	Continued From pa	ge 5	S9999			\dashv
38	and eye; R5 was intermedication for post burns required Intra (antibiotic), Levophe and Propofol (sedat	d left eyebrow, burns to lips tubated and started on a intubation hypotension; facial evenous medication (Rocephin ed (elevates blood pressure) tion) and topical (apply to skin)	#			
Σv.	medication treatment oil-hydrophilic and Ethat creates a prote consultation; R5 was Hypoxic and Hypero Respiratory Failure	nt (Bacitracin, mineral Balsam Peru-Castor (topical ctive layer) and a wound s diagnosed with Acute capnia (rapid breathing) and was Intubated and on ettings. The H&P documents	2. X ***			96
90 90 90	that R5 had a high r life-threatening dete imminent threat to li more vital organ sys complexity medical Respiratory Failure documents that R5	probability of imminent or prioration, high probability of fe, acute impairment of one or stems and/or required high decision making due to and Shock. The H&P also had superficial partial and so burns to significant areas			xs	
	On 11/2/22, at 10:32 patio and stated, "Ti with us."	am, R7 was on the smoking nere is never anyone out here		⇒ _@		
10 E	smoking patio with (tubing caught his facto use his lighter, he lighter, you know, so cigarette. All of the shoot up in flames, shim and pulled his o	am, R4 stated, "I was on the R5) when (R5's) oxygen be on fire. (R5) was not able was not able to use the label I helped him light his sudden, I saw (R5's) face so I immediately went over to oxygen hose off and	×		8 BES 100 2 D ₂ ES	## ##
	it was still burning, a while it was still on tl Director) then came	rew it on the ground, because nd it burned for a little while, ne ground. (V15/Activity running out. (R5) had his and his beard was shinged	8 Si		-2	

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING: IL6003198 **B. WING** 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 ILLINI DRIVE **FONDULAC REHABILITATION & HCC** EAST PEORIA. IL 61611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY S9999 Continued From page 6 S9999 off. See that large black burn spot right there on the ground, right outside of the exit door, that is where I threw (R5's) oxygen tubing. There was no staff out there, just me and him (R5). We never usually have any staff out here with us, we even know the code to get out of the door." On 11/1/22, at 10:28 am, an approximate one foot by one foot black circular area was within five feet of the Facility's smoking patio exit door. R7, entered the exit code and the smokers proceeded out the exit door to the patio. (V17/Certified Nursing Assistant) was present in the smoking area, handing out smoking supplies. On 11/1/22, at 11:09 am, (V15/Activity Director) stated, "Around 4:00 pm, I was walking through the small dining area, with my arms full of board games, and I saw (R5) through the window to the smoking patio, and I started screaming, because (R5) had flames coming from his face. I dropped the games and ran outside, and (R4) was pulling his oxygen tubing off of his face. R1's Nurse (V16) came running out and told me to shut off (R5's) oxygen tank, and (V16) started to pat the flames out on (R5's) face and neck. No staff was present and there was only one other person out on the smoking patio and that was (R4)." On 10/31/22, at 1:10 pm, V2 (Director of Nursing) stated, "On 10/27/22, at 4:00 pm, during the designated smoking time, R5 stopped at the nursing station with an empty tank of oxygen. (R5) got two cigarettes and (V10/Licensed Practical Nurse) identified that (R5's) oxygen tank was empty, so (V10) put on a new full oxygen tank and (R5) proceeded to the Facility smoking patio. No staff were on the smoking patio when this happened, but (V15/Activity Director) saw flames coming from R5's face, through a window.

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: _ C B. WING IL6003198 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 ILLINI DRIVE **FONDULAC REHABILITATION & HCC EAST PEORIA. IL 61611** 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 7 S9999 and screamed for help and ran outside onto the smoking patio. (V15) saw (R4) pulling (R5's) oxygen tubing away from (R5's) face and (R5's) nurse (V16) started emergent care. (R5's) face was covered in soot and (R5's) beard was singed. (R5) was sent out to the Emergency Room, admitted to the Hospital and eventually became intubated. (R5) is still in the Hospital." On 11/2/22, at 11:47 pm, V1 (Administrator) stated, "The Smoking Assessments should be completed every quarter. We should have had a Smoking Disclosure Form for (R5) but we did not get one from him, but we will when he gets back to the Facility." V1 verified that the handwritten entry on to the Smoking Assessment Form should have been re-evaluated due to (R5's) cognition and the Facility should have completed a new form." (A) #2 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)1) 300.1220b)2) 300.1630d) 300.3210t) 300.3220f) These Regulations were not met as evidenced by: Section 300.610 Resident Care Policies

Illinois D	epartment of Public	Health			FURM	APPROVED
AND PLAN OF CORRECTION INFORMATION NUMBER		1 ' '	E CONSTRUCTION	(X3) DATE	SURVEY PLETED	
IL6003198			B. WING			C 03/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FONDUL	AC REHABILITATION	& HCC 901 ILLIN	I DRIVE ORIA, IL 616	611		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 8	S9999			
	procedures, govern the facility which sh Resident Care Polic	Il have written policies and ing all services provided by all be formulated by a cy Committee consisting of at itor, the advisory physician or				ħ.
	the medical advisor representatives of r the facility. These p with the Act and all	y committee and nursing and other services in policies shall be in compliance rules promulgated thereunder. es shall be followed in		· · · · · · · · · · · · · · · · · · ·		W.
	operating the facility least annually by th	y and shall be reviewed at is committee, as evidenced by dated minutes of such a	6	e 91 20 70		N N A
	Section 300.1210 C Nursing and Person	General Requirements for nal Care		<u>-</u>		
	care and services to practicable physical well-being of the releach resident's complan. Adequate and care and personal cresident to meet the care needs of the releach process.	shall provide the necessary of attain or maintain the highest of attain or maintain the highest of the highest	= 53	्रम च	34 30%	J.Pr
		care-giving staff shall review ble about his or her residents' care plan.		×	27	á.
3. A	Medication hypodermic, intrave be properly adminis	s, including oral, rectal, enous and intramuscular, shall stered.		, fi		×
	20	897	1			

_Illinois C	epartment of Public	Health				FORM.	APPROVED
	AND PLAN OF CORRECTION I INFINITIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
4.2	IL6003198		B. WING			C 11/03/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	STATE, ZIP CODE			
FONDUL	AC REHABILITATION	& HCC 901 ILLIN	II DRIVE ORIA, IL 616	611			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		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 pa	ge 9	S9999		V		
5 83	Services	Supervision of Nursing		n n			>
	b) The DON si nursing services of	hall supervise and oversee the the facility, including:				Ţ.	.=.
\$	assessment of the include medically defunctional status, se	the comprehensive residents' needs, which efined conditions and medical ensory and physical		¥5			E
9	psychosocial status condition, activities	onal status and requirements, , discharge potential, dental potential, rehabilitation status, and drug therapy.	20.	÷ 3			¥3
	Section 300.1630 A	dministration of Medication		s)		i	
	medication order ca prescriber shall be a reasonable, depend	, a licensed prescriber's innot be followed, the licensed notified as soon as is ling upon the situation and a		5 S		70	4 81
13	notation made in the	e resident's record.				3- 3	¥)
	Section 300.3210 G	eneral					
W	not subjected to phy	shall ensure that residents are vical, verbal, sexual or e, neglect, exploitation, or property.)3	45
	Section 300.3220 M	ledical Care					8
	administered as ord physician orders sha	ent and procedures shall be lered by a physician. All new all be reviewed by the facility's or charge nurse designee					
	within 24 hours after	r such orders have been			31		

US7V11

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: _ IL6003198 B. WING 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 ILLINI DRIVE FONDULAC REHABILITATION & HCC EAST PEORIA, IL 61611 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Continued From page 10 \$9999 S9999 issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) These Regulations were not met as evidenced by: Based on record review and interview the facility failed to obtain and administer physician ordered medications for a new admission for one (R1) resident reviewed for medication administration. This failure resulted in R1 being hospitalized for treatment of an altered mental status due to an elevated Ammonia blood level. Findings include: Facility Medication Administration Policy, revised 11/18/2017, documents: the complete act of administration entails verifying the physician's orders, giving the individual dose to the proper resident and promptly recording the time and dose given; medications much be prepared and administered within one hour of the designated time or as ordered; medications must be identified by using the seven rights of administration including right time and right documentation; after a drug is given, record the date, time and name of drug, dose and route on resident's Administration Record/MAR, document any medications not administered for any reason by circling initials and documenting on back of the MAR the reason for omission: if the medication is not available for a resident, call the pharmacy and notify the physician when the drug is to be expected to be available; notify the physician as soon as practical when a scheduled dose of medication has not been administered for any reason; and report errors in medication administration immediately per policy.

Illinois Department of Public Health

Illinois D	epartment of Public	Health			i Orani	AFFROVED	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
3)	R()	II 6000400	B. WING		5 C		
		IL6003198				3/2022	
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
FONDUL	AC REHABILITATION	& HCC 901 ILLII EAST PE	ORIA, IL 616	11		74	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO THI DEFICIENCY)		SHOULD BE APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 11	S9999	0	W ₁₂ 90		
÷		dated 10/11/22, at 5:20 pm, arrived and admitted to the		# # # # # # # # # # # # # # # # # # #		, E	
	documents that R1 diagnoses including Asthma, Diabetes,	er Sheet, dated 10/11/22, admitted to the Facility with g Cirrhosis of the Liver, Chronic Obstructive		27 (F)	m	3 # #	
	Disease and Ascite R1's Medication Ad	ministration Record/MAR,	ė sve	# U. W.	***	95	
520	document administ (Lactulose): for He secondary to Cirrho the liver) on 10/12/2 Cirrhosis medication	ough 10/18/22, does not ration of medication of medication oatic Encephalopathy osis (degenerative disease of 22 at 8:00 am and 12:00 pm; on (Xifaxan, treats diarrhea) on and 10/18/22, at 8:00 am.				2	
SIE	also does not docu stock and other me Multivitamin, Vitam 10/12/22 and 10/14 (Lasix) on 10/12/22 liver medication for on 10/12/22 at 8:00 (Flovent) and on 10	0/11/22 through 10//18/22, ment administration of Facility dication: Vitamins (Vitamin C, in D, Iron and Folic Acid) on 1/22, at 8:00 am; diuretic and 10/18/22, at 8:00 am; fluid build-up (Spironolactone o am; Steroid Nasal Spray for 1/12/22 and 10/18/22 at 8:00	× .			N ***	
e W	Disorders (Pantopr R1's Nursing Notes 10/18/22, does not	Pump Inhibitor for Esophagus azole) on 10/12/22 at 8:00 am , dated 10/11/22 through document that R1's Physician missed doses of medication.				#3 W 12 #3 12	
		dated 10/18/22, at 10:00 pm, was sent to the local hospital tered Mental Status		12. 14.		50	

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: IL6003198 **B. WING** 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 ILLINI DRIVE **FONDULAC REHABILITATION & HCC EAST PEORIA. IL 61611** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) S9999 Continued From page 12 S9999 R1's Hospital Admission History and Physical Record, dated 10/19/22, documents that R1 admitted to the hospital with the clinical impression diagnoses including a Subdural Hemorrhage, Altered Mental Status, Liver Cirrhosis secondary to Non-Alcoholic and Hepatic Encephalopathy. The Hospital Record also documents "factors that made the patient critically ill were the subdural hematoma" and "Patient's sister is in the room with her and provides history. States that she is been altered since going to rehab facility last week. Last known normal was earlier last week, over a week ago." The Record also documents, on 10/19/22, "Labs remarkable for elevated ammonia. Neurosurgery evaluated the patient and advised based on Commuted Tomography (CT) and their exam they believe subdural hemorrhage is not the cause of her presentation. With ammonia being elevated most likely hepatic encephalopathy and sister says this is consistent with previous episodes of hepatic encephalopathy. Discussed with general medicine team who agreed to admit the patient" and noted on CT, regarding the subdural Hemorrhage, while in the Emergency Department "unlikely to be cause of her AMS (Altered Mental Status) as level of consciousness out of proportion size of hemorrhage." The Hospital Records also document Patient was discharged on 10/11/22, with strict instructions take her Lactulose and Rifaximin/Xifaxan. Patient unfortunately had worsening encephalopathy from ammonia retention and was readmitted in the hospital 10/19/2022. Patient subsequently got better with Lactulose anemia, oral Lactulose and was back to her baseline. On 10/28/22, at 8:05 am, V13 (R1's Sister) stated, "I had to talk (V2/Director of Nursing) on

Illinois Department of Public Health

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 IL6003198 11/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 ILLINI DRIVE FONDULAC REHABILITATION & HCC EAST PEORIA, IL 61611 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 13 S9999 10/12/22, because my Sister (R1) had not gotten any of her (R1) medication since she admitted the night before. (V2) told me that when a new admission comes to the Facility after 4:00 pm, it is too late for the Facility to get the medications in, and that the Facility will not get them in until the next night. My Sister (R1) went without important medication for her Cirrhosis and if she does not get that Lactulose or Xifaxan it can cause her ammonia level to rise and makes her have extremely confused." On 10/28/22, at 12:12 pm, V10 (Licensed Practical Nurse) stated, "I was the nurse that admitted (R1) and she was alert and oriented. I sent her medications off to the pharmacy to be filled. Some of her medications could have been given through the stock supply, but the Lactulose and Xifaxan needed to be delivered. From what I know, the medications did not come in until around noon the next day." On 10/28/22, V2 (DON) stated, "(R1) admitted to the Facility late on the night of October 11, 2022. If our Pharmacy does not have the new orders by 4:00 pm the day prior, the Resident's medication does get delivered until the next night. We have a backup pharmacy that can be called, and also have stock box of medications that we can use, even Lactulose is not a stock medication. The nurses should document all of this, especially if the back up pharmacy was called and they should also document that the Physician was called if the medication is not available. I actually saw (R1's) medications get delivered at lunch time on October 12, 2022, the next day, I think it came from the backup pharmacy. (V12/R1's sister) called me and was upset about (R1) not getting (R1's) Lactulose and Xifaxan medication for (R1's) Cirrhosis. (V12) had concerns about (R1)

Illinois Department of Public Health

US7V11

Illinois Department of Public Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SUR\ COMPLETE	/EY D
			B. WING		С	
NAME OF I	PROVIDER OR SUPPLIER	IL6003198 STREET AD		STATE, ZIP CODE	11/03/20	22
	AC REHABILITATION	I & HCC 901 ILLIN	DRIVE			
(X4) ID		TEMENT OF DEFICIENCIES	DRIA, IL 61	PROVIDER'S PLAN OF CORRECT	CTION	(X5) OMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE
59999	Continued From page 14		S9999			
-1	doses were missed not give (R1) any n	nd having problems, if any I. I told her (V12) that I could nedications that were already gh we had just received them, ainst the law."			96	<u></u>
	stated, "We have a not sure why the no stock medications them for her morni	25 am, V2 (Director of Nursing) a back up stock box and I am urses did not even pull out the like the Vitamins and give ng dose on 10/12/22, until her delivered. (R1) has been in the			55566K	
		9/22 and has still not been	A	35 32	¥. **	50
ў . з	stated, "I was not r received her presc buildup is due to he problems and can	24 pm, V13 (R1's Physician) notified that (R1) had not ribed medication. Ammonia er (R1) hospitalization definitely cause confusion.			3	
105	body is by 'pooping Lactulose and Xifa	of the ammonia out of (R1's) y' and that is the purpose of the xan. There really is no			**	ā
4	doses of these me	y also kill bacteria. Missed dications could definitely cause vels to rise, which caused her us."		# # # # # # # # # # # # # # # # # # #	*0	
390	(A)					3 5
8				#6		
5	V					
				1a'		
	粉				2	

US7V11