Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	COMPLE	
	A		A BUILDING:			
		IL6008213	B. WING		10/0	; 6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SANDWI	CH REHAB & HCC		ARNOLD S'			
044.50	QUILBIADV CTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	n.	ave.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investiga 2318292/ IL165143					
S99 9 9	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.610a) 300.1210a) 300.1210b) 300.1210d)3)					
	Section 300.610 R	esident Care Policies				
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory of nursing and othe policies shall comp. The written policies the facility and shall by this committee, and dated minutes.	advisory physician or the committee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating the reviewed at least annually documented by written, signed of the meeting.				
	facility, with the par the resident's guard applicable, must de comprehensive car includes measurab	nsive Resident Care Plan. A ticipation of the resident and dian or representative, as evelop and implement a re plan for each resident that ale objectives and timetables to		Attachment A Statement of Licensure Violater	iions	
LABORATOR	BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE					

STATE FORM

PRINTED: 11/22/2023

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING IL6008213 10/06/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 902 EAST ARNOLD STREET SANDWICH REHAB & HCC SANDWICH, IL 60548 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 1 59999 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 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 quardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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: 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. These requirements are not met as evidenced by:

A. Based on observation, interview, and record review the facility failed to provide a deaf resident with a mode of meaningful communication for 1

Illinois Department of Public Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
ANU PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						•
		IL6008213	B. WING			6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
O411014			ARNOLD S			
SANDW	CH REHAB & HCC		H, IL 60548			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	QI	PROVIDER'S PLAN OF CORRECT	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLETE	
S99 99	Continued From pa	ge 2	S9999			
	of 6 residents (R1) of the sample of 6. The unable to community, as Coordinator. R1 was ervices for several depression and isole. B. Based on observative the facility far necessary social sea history of schizoar residents (R1) revies social services in the	reviewed for quality of life in is failure resulted in R1 being cate with his friends in the well as his Care Services sunable to receive counseling months and showed signs of				
	The findings include	:				
	his head covered. Rethe room was dark. until the noon meal. V8 (R1's POA), and R1's room. R1 was was resting against connected to a smathe ceiling. The wire across the room, interest device, under the To "It looks like the vide but he can't answer Coordinator) calling if he knew how to an loudly and signed be to answer it, but the been working since doesn't work. They stated, "He has no visited in the since working since doesn't work. They stated, "He has no visited in the since working since doesn't work. They stated, "He has no visited in the since working since doesn't work. They stated, "He has no visited in the room was a since working since doesn't work. They stated, "He has no visited in the room was a since working since doesn't work. They stated, "He has no visited in the room was a since working since doesn't work. They stated, "He has no visited in the room was a since working since doesn't work."	AM, R1 was lying in bed, with k1's blinds were closed and R1 remained in his dark room At 12:30 PM, the surveyor, V9 (Ombudsman) entered pulling at a thick mattress that his bed. R1's TV was II box, with wires extending to be extended to the ceiling and to the wall. R1's electronic V, would flash lights. V8 said, to calling system is ringing, it. It's V19 (R1's Care Service." V8 signed to R1 and asked asked to V8, "YES. I know how video is not working. It hasn't 6/25/23. I keep telling them it don't do anything about it." V8 way to communicate with the building without this video				

Illinois Department of Public Health

STATEMEN	NT OF DEFICIENCIES		WAS BUILTING		T	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		100	A. BUILDING:		COMI	LETED
	i	11 6000049	B MINO		С	
		IL6008213	B. WING		10/0	06/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SANDWI	ICH REHAB & HCC	902 EAST	ARNOLD ST	TREET		
JANUTH	CH REMAB & HOU	SANDWIC	H, IL 60548	l .		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(XS)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
IAG	REGUCTIONTON	SCIDENTIFTING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
22222		_				
S9999	Continued From pa	ige 3	S9999			
		called and asked numerous				
	times. I ask every ti	ime I'm here and I get "I don't	!			
	know?, You need a	hotspot, or it needs to be hard	!			
	wired." The problen	n is no one communicates with				
	us. He (R1) is supp	posed to have video calls with				
		es Coordinator/Counselor]				
		the video communication				
	device to sign with	[V19] or anyone else. It				
	provides a meaning	Iful way for him to				
	communicate. KT IS	s culturally deaf. He has been				
		he was ingrained in the deaf				
		coming to this facility. He is				
	mental functioning	I can see a decline in his ability to sign, and his mood.				
	He seems dentess	ed to me and I understand				
		he gets to use his primary				
		n Sign Language (ASL), is				
	when I visit. I try to	make it weekly, but he doesn't				
	have any way to co	mmunicate in ASL otherwise.				
		would provide that, much				
	needed interaction,	for him. It's just sad to see.				
	He had a great con	nection with [V19], but he				
	hasn't been able to	communicate with her in				
		of and a Social Worker, so she				
		a ways that others can't. I've				
		es why the facility doesn't have				
		ons for him and they don't				
		that either. The lack of				
		e is beyond frustrating!"V3				
		- DON) entered R1's room.				
	R1 pointed at the w	rires and signed, "Why is this				
	Still not working: v	/3 replied, "I don't know. I				
		ed in this issue. The higher				
	ups nave been name	dling it. V8 (R1's POA) stated, tal health. It should be				
i						
		ed that it had not been				
	Mosting was held w	/23. At 1:01 PM, a Care Plan vith R1, V8 (R1's POA), V9				
		(Administrator in training), V3				ĺ
	, (Onibudsilian), vz i	(Administrator in training), v.s.)	: I		ı	í l

(DON), and V18 (Social Services Director). V19

Illinois Department of Public Health

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				С		
		IL6008213	B. WING		10/0	6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SANDWI	CH REHAB & HCC	902 EAST	ARNOLD S	TREET		
SAILDIII	ON KENAD & NOC	SANDWIC	H, IL 60548	;		
(X4) ID		TEMENT OF DEFICIENCIES	(II)	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
S9999	Continued From pa	ge 4	S9999	OLI IOLIOITY		
	•			15		
	interpreter V10 intr	conference call with an oduced herself and said that				
	she had been in cor	ntact with R1 for over 25				
		enjoyed her interactions with				
		bility to use his video				
		ice is imperative to his mental				
		care needs. V19 said she had				
	not been able to cor	mmunicate with R1 for months				
	and had made mult	iple attempts to reach him.				
		ed services to R1 on a weekly				
		communication device				
	stopped working. V	19 said she had notified the				
	raciity that she coul	d not get in contact with R1				
		ortance of being able to R1, V19 said the video				
	communication device was imperative for R1's mental health and social networking. V8 sat					
		m R1 to interpret R1's sign				
		de interpretation to R1. R1				
		o have a care plan and				
	discuss his concern	s. R1 said he'd only had one				
		said R1 had been in the				
	facility over a year a	nd this meeting was only his				
		the communication at the				
		1 said some of the CNAs do				
		to communicate simple a few are trying to learn sign				
		e had not been able to use				
		ation device since 6/25/23.				
		talk with V19 (Care Services				
	Coordinator/Counse	elor) weekly, but had not been				
	able to communicat	e with her in months. R1				
	looked down at the	floor and his eyes teared up.				
	R1 said he keeps te	lling the staff that the video				
		ot working, but nothing ever				
		he communication sucks at				
		she had spoken with V1				
		r), V3 (DON), V17 (Previous				
		Ind V20 (Maintenance				
linnie Donne	Director) and still it (doesn't work and R1 can't				

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: _ IL6008213 **B. WING** 10/06/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 902 EAST ARNOLD STREET **SANDWICH REHAB & HCC** SANDWICH, IL 60548 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR USC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) S9999 Continued From page 5 59999 communicate with the outside world. V8 (R1's POA) explained that the video communication device provided R1 with weekly counseling, care service coordination, and access to his friends in the deaf community, V3 (DON) stated, "I wish I knew how much this did for R1 sooner." V8 replied, "I've been telling everyone." V8 continued to discuss R1's care and the recent falls. V3 (DON) and V8 (R1's POA) discussed R1's increased weakness. V8 said R1 is basically wheelchair dependent now and the facility is using a mechanical lift to transfer him. V19 replied, "Oh my, that's a HUGE change for him, I didn't know that. This is why the communication with me is so important. The physical changes also effect his mental wellbeing." V3 stated, "[V2 (Administrator in training)] and myself were not kept in the loop on this. IV1 - Acting Administrator] and [V20 - Maintenance Director] were involved. Clearly the communication is not working." V3 (DON) said IT (Information Technology) would be notified and someone would need to make the trip from Peoria to figure out what the problem is. At 3:45 PM, R1 was sleeping in his dark room. R1's Face Sheet dated 10/5/23 showed diagnoses to include, but no limited to: diabetes. epilepsy, heart failure, schizoaffective disorder. chronic respiratory failure, dysphagia, anemia, hypothyroidism, unspecified hearing loss, hypertension, and morbid obesity. R1's facility assessment dated 7/7/23 showed he had moderate cognitive impairment and was deaf, non-speaking.

Illinois Department of Public Health

R1's Progress Notes were reviewed. There was no documentation of the facility's attempts to get

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
	IL6008213		B. WING		10/0	; 6/2023
NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
SANDWIG	CH REHAB & HCC					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	CTION SHOULD BE COMPLE O THE APPROPRIATE DATE	
S9999	PROVIDER OR SUPPLIER 902 EAST A 902 EAST A SANDWICH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		S9999			

Illinois Department of Public Health

PRINTED: 11/22/2023

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COMPLETED B. WING IL6008213 10/06/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 902 EAST ARNOLD STREET **SANDWICH REHAB & HCC** SANDWICH, IL 60548 **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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 7 S9999 R1's EMR did not contain any visits with Behavioral Health Services while he was at the facility. On 10/5/23 at 2:25 PM, V8 stated, "He can't contact anyone. He's getting depressed, He's lonely. He gets mad at me because nothing happens after the meetings. There is poor follow-through and communication here. There are a few CNAs that are trying to learn ASL and make the effort to use the white board. But he isn't having any meaningful, deep conversations. He should be allowed to discuss concerns that he doesn't want his sister (me) to know. He doesn't have that luxury because they rely on me for his communication needs. He went from a deaf community that he was very involved with to this facility and he has no meaningful way to communicate. I'd like him to have an interpreter for care plans and important conversations, so I can just be his sister. The facility has never provided an interpreter for R1. When he goes to the hospital there is an interpreter. They tell me they can't do it." On 10/5/23 at 2:55 PM, V3 (DON) said she wished V8 would have explained the importance of R1's video communication device. V3 said it's important for R1 to have counseling and communicate with the deaf community. On 10/6/23 at 10:40 AM, V3 (DON) said R1 had not been provided Behavioral Health Services by the facility. V3 said R1 should have been followed by Behavioral Health Services due to his

Illinois Department of Public Health

diagnoses of Bipolar Disorder and Schizophrenia. V3 said it is important to properly manage his medications and to ensure that his mental health is not declining. V3 said the facility did not have a

Illinois Department of Public Health

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		11 6000242	B. WING		С	
		IL6008213	D. 11110		10/0	6/2023
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
SANDWI	CH REHAB & HCC		H, IL 60548			
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 8	S9999			
	policy regarding Bel	havioral Health Services.				
	said her interactions V16 said they would board. V16 said 2-3 complaining about t she referred him to asked about his TV like: "Report it to Ma his own hotspot;" or "I really don't unders for a while. I reporte Administrator]. I tok Director]. We spoke meetings." V16 said impaired resident sl V16 said, "I question	I [V20 - Maintenance e about it in morning I R1 was the first hearing he had seen at the facility. I hear the appropriateness of his iting on the white board does				
	familiar with R1. V1 white board to deter V15 said she is tryir language. V15 said conversations with a stays in his room m said he will come or he will read the pap R1 came out of his came to the facility, phone that hooked using it all the time, several months.	AM, V15 (CNA) said she was 5 said she mostly used the mine R1's immediate needs. In the said state of the said to learn some sign it is difficult to have any deep a white board. V15 said R1 ost of the day and sleeps. V15 at for meals and sometimes er in the morning. V15 said room more, when he first V15 said R1 had a video up to his TV and she saw him but it hadn't been working for				
	Director) said R1's \ "out of my scope an	PM, V20 (Maintenance video communication device is d ability. I forwarded the issue ven't heard anything back."				

STATE FORM

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		100 100.1	A. BUILDING			
		IL6008213	B. WING		10/0	; 6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
SANDWI	CH REHAB & HCC		ARNOLD ST	TREET		
			H, IL 60548			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
59999	Continued From pa	ae 9	59999			
S9999	V20 said R1's video not been working for device stopped wor for the EMR (Electrinstallation. V20 sai looked at it and all it connected correctly Director] was trying On 10/6/23 at 12:30 Director) said he st when R1 was admi "more lively," when said he was able to wheelchair and his for meals or social therapy ended, he movies, but started room. V17 said R1 device frequently to network before it st one in the building had provided a boo V17 stated, "I'm sui being able to social R1's video issues s re-wired, toward the V8 (R1's POA) sporeported that the deno one was common was very frustrated contact anyone. V1 Administrator) abou "They (R1 and V8) resolution. He speronly came out for mattention to the time	o communication device had be months. V20 said R1's rking when the facility rewired onic Medical Record) id, "It shouldn't be that way. I the wires appear to be to figure it out as well." B PM, V17 (Previous Activity arted working at the facility ted in 2022. V17 said R1 was he came to the facility. V17 oget in the car from the sister was able to take him out events. V17 said after R1's would come out for some spending more time in his used his video communication ocommunicate with his social copped working. V17 said no knew ASL, but V8 (R1's POA) ok and he was trying to learn. The [R1] felt very isolated, not lize with anyone." V17 said we with him regularly and evice still wasn't working and unicating with her. V17 said V8 because R1 had no way to 7 said he notified V1 (Acting and the was trying to real not with the would pay and come out for the meals, oming out. The CNAs would				
		" V17 said he used the white cate with R1, but it was hard to				

Illinois Department of Public Health

PRINTED: 11/22/2023

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6008213 10/06/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 902 EAST ARNOLD STREET SANDWICH REHAB & HCC SANDWICH, IL 60548 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 10 S9999 complete a Mood Assessment, And I understand that not having social interactions would be very isolating. I'd spend more time in my room too. [V8] said her being utilized as [R1's] interpreter all the time was a dis-service to him and it was supposed to be the responsibility of the facility to ensure he could communicate effectively." On 10/6/23 at 12:59 PM, V1 (Acting Administrator) said she was notified of issues with R1's video communication device on 9/5/23, V1 said V8 (R1's POA) was upset because it wasn't working. V1 stated, "I told her that nothing stated we needed to supply wifi and that she would need to pay for wifi service. She [V8] became very upset with me, so I sent [V20 - Maintenance Director] in to check on it. He sent me pictures of the setup. He said he checked the wires to see if they were cut or not attached properly and could not find an issue. I called IT." The surveyor informed V1 that R1 reported the service had been down since 6/25/23. V1 said she was not aware and she took action as soon as she was aware. V1 said V8 (R1's POA) told her it was how R1 "communicated with a counselor or something." V1 stated, "Its a video that allows him to sign and someone to sign back to him. The DON said she had other means of communication, but did not tell me what she was using." V1 said she had made no effort to obtain an ASL interpreter for R1. The 9/18/23 Resident Council Meeting Minutes showed, ".. Staff communication needs to improve. Staff constantly using, "I don't know, Should at least attempt to find out for residents."

Illinois Department of Public Health

The facility did not have a Communication Policy. The facility provided "Restorative Nursing Communication Program." This program included

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 **!L6008213** 10/06/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 902 EAST ARNOLD STREET **SANDWICH REHAB & HCC** SANDWICH, IL 60548 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) S9999 Continued From page 11 59999 "Interventions/Approaches... Encourage socialization with other residents who are able to interpret this resident communication attempts..." R1 was not on the Restorative Communication Program. (B)

Illinois Department of Public Health