

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H 0001050	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/11/2023
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NAME OF PROVIDER OR SUPPLIER CHARLESTON REHAB & HEALTH CC	STREET ADDRESS, CITY, STATE, ZIP CODE 716 EIGHTEENTH STREET CHARLESTON, IL 61920
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(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: 2361277/IL156445	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)1)3) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001358	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/21/2023
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NAME OF PROVIDER OR SUPPLIER CHARLESTON REHAB & HEALTH CC	STREET ADDRESS, CITY, STATE, ZIP CODE 716 EIGHTEENTH STREET CHARLESTON, IL 61920
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S9999	<p>Continued From page 1</p> <p>accident, injury or change in condition at the time of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>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:</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>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.</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide post-operative pain medication as ordered to a newly admitted resident (R1). This failure resulted in R1 sustaining prolonged severe pain with nausea, vomiting and verbalizing</p>	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: #0001600	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/17/2023
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NAME OF PROVIDER OR SUPPLIER CHARLESTON REHAB & HEALTH CC	STREET ADDRESS, CITY, STATE, ZIP CODE 716 EIGHTEENTH STREET CHARLESTON, IL 61920
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S9999	<p>Continued From page 2</p> <p>a desire to die.</p> <p>Findings include:</p> <p>R1's Diagnosis Sheet (current) includes the following diagnoses: Post Left Shoulder Replacement, Left Shoulder Pain, Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure and Congestive Heart Failure.</p> <p>R1's Hospital Discharge Orders dated 2/12/23 at 11:27 am documents the following order for pain medication: Percocet 10 milligrams (mg) with 325 mg of acetaminophen (Percocet 10/325 mg) every 4 (four) hours as needed for pain.</p> <p>R1's Medication Administration Record (MAR) dated 2/12 and 2/13/23 does not document R1 receiving any Percocet 10/325 mg pain medication.</p> <p>On 2/17/23 at 10:50 am, V2 Director of Nursing confirmed that R1 was admitted to the facility a little before noon on 2/12/23 and R1 was alert and oriented to person, place, and time. V2 stated that R1 came with orders for Percocet (oxycodone 10 mg with 325 mg of acetaminophen). V2 stated none of R1's medications came from the facility's pharmacy, and the facility did not have the correct dosage of Percocet in the facility. V2 confirmed that V2 did not call V3 Medical Director to get a new prescription for pain medication.</p> <p>On 2/21/23 at 10:50 am, V3 confirmed that V3 did not receive a call from the facility to let V3 know that R1's medications had not been delivered. V3 stated "absolutely (R1) would have severe pain that would require a Schedule II pain narcotic. The facility needed to have (R1's) pain</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>medication on hand when (R1) arrived at the facility so that (R1's) pain did not get out of control. V3 confirmed had the facility notified V3, the pain medication could have been ordered and delivered from a local pharmacy.</p> <p>On 2/21/23 at 11:10 am V7 Licensed Practical Nurse (admitting nurse) confirmed that R1 did not receive any pain medication from the pharmacy and the facility did not have the Percocet dosage ordered for R1 in house. V7 stated R1 was assessed during the day on 2/12/23 for pain and R1 rated R1's pain at an "8" (eight) (on a pain scale of 1 to 10, 10 being the worst pain experienced). V7 confirmed R1 was in a lot of pain and V7 should have called V3 about R1's pain and the lack of R1's medications. V2 also present at this time, confirmed that R1's pain level was high. V2 documented an assessment at 3:00 am on 2/13/23 with R1 rating R1's pain at a "7" (seven).</p> <p>On 2/21/23 at 12:10 pm, R1 (residing in a different facility) was sitting upright in a recliner with oxygen at 2 liters per nasal cannula. R1 confirmed R1 was in so much pain by the late afternoon of 2/12/23 and the facility never gave R1 any pain medication. R1 stated the pain was so severe and debilitating that R1 became nauseated and was vomiting and became short of breath and did not have any inhaler medication. R1 stated this went on through the evening and the night and R1 did not sleep. R1 stated "I called my daughter and told her to come and get me and take me somewhere else because I could not stand the pain in my shoulder any longer. The pain radiated across my neck and back, and down my arm. It was so bad it just made me want to die." R1 stated R1's pain was between an 8 and 10 on the pain scale and R1</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>had told both nurses (V7 and V2) at the facility of R1's severe pain level.</p> <p>The facility policy titled "Pain Prevention & Management" dated 12/7/17 documents the following:</p> <p>"It is the facility policy to assess for, reduce the incidence of and the severity of pain in an effort to minimize further health problems, maximize ADL (Activities of Daily Living) functioning and enhance quality of life.</p> <p>Pain - an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in such terms of such damage. Pain is subjective and should be documented as perceived by the resident.</p> <p>Pain Management - the assessment of pain and if appropriate, treatment in order to assure the needs of residents who experience problem with pain are met."</p> <p>(B)</p>	S9999		