STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005441	A. BUILDING _____ B. WING _____	C 10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINCKNEYVILLE NURSING & REHAB	708 VIRGINIA COURT PINCKNEYVILLE, IL 62274

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S 000	Initial Comments Complaint Investigation: #2358804/IL165789	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.3240b) 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 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to keep a resident free of physical restraints for 1 (R1) of 5 residents reviewed for physical restraints in the sample of 9. This failure resulted in R1 being tied down in a wheelchair with a bath blanket for an undisclosed amount of time. An independent reasonable person would respond to being restrained to a wheelchair with feelings of fear, anxiety, frustration, agitation, and humiliation. The Findings include: R1's Face Sheet dated 10/23/2023 documents R1 being admitted to the facility on 10/5/2023 with a diagnosis of Major Depressive Disorder, recurrent, unspecified, Frontotemporal dementia, Barrett's esophagus with dysplasia, unspecified, Type 2 diabetes mellitus without complications, Obstructive sleep apnea (adult) (pediatric), Need for assistance with personal care, Unspecified osteoarthritis, unspecified site, Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, Dementia in other diseases classified elsewhere, moderate, with psychotic disturbance. R1's	S9999		

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S9999	Continued From page 2 Minimum Data Set (MDS) dated 10/23/2023, documents Section C, Brief Interview for Mental Status (BIMS) score is 2, severely, impaired, cognition, Section GG, Independent with bed mobility, transfers, toileting, ambulating, eating, supervision with touching assistance with dressing. R1's Physician's Order dated for the month of October 2023 does not list any restraint ordered for R1. On 10/24/2023, at 6:30 AM, V5, (Certified Nurse Aide /CNA) stated that she worked the night of 10/12/2023. V5 stated that when she came on her shift, she noticed R1 sitting up at the nurse's station. V5 stated that he was sitting there calmly, not trying to get up. V5 stated she went about her shift and noticed R1 appeared to be looking tired. V5 stated that she asked him to come with her and she would help him get ready for bed. V5 stated R1 usually walks independently but was not getting up from his wheelchair. V5 stated that she went over to R1 and took the blanket off him and noticed there was another blanket underneath. V5 stated that she tried to take that blanket off R1, but noticed it was tied down to the wheelchair. V5 stated that it took her about 2 minutes or so to get the bath blanket untied from the wheelchair.V5 stated that V10 (CNA) came up to her and asked, "Why are you putting R1 to bed?", "I was coming to do it". V5 stated that she asked V10, "Who tied this blanket down on R1's wheelchair?" V5 stated that she told V10, "We can't tie any resident down". V5 stated that V10 stated to her, "I can't chase him around all night", "What are we supposed to do?". V5 stated that she went up to V8, (Licensed Practical Nurse /LPN) and reported to her that she found R1 tied down with a bath blanket to his wheelchair. V5	S9999		

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S9999	Continued From page 3 stated that V8 just looked at her and stated, "Ok." V5 stated that after she put R1 to bed, he stayed in bed and slept all night. V5 stated that when V6 (LPN) came on her shift the next morning, she reported to her that she found R1 tied down with a bath blanket to his wheelchair. V5 stated that V6 stated she would notify V1 (Administrator) and V2 (Director of Nursing/DON). On 10/23/2023, at 11:05 AM, V6 (LPN) stated that she worked 10/13/2023 on day shift. V6 stated that V5 (CNA) reported to her that when she was putting R1 to bed last night, she noticed that R1 was tied down with bath blanket in his wheelchair. V6 stated that she reported this to V1 (Administrator) right away. On 10/23/2023, at 12:00 PM, V1 (Administrator) stated that it was reported to her on 10/13/2023 that R1 was found to be tied down with a bath blanket in his wheelchair, the night before. V1 stated that an investigation was initiated, all proper notifications were made (Power of Attorney, Police Department, Primary Physician, & Ombudsman). V1 stated that R1's skin was assessed and there were no injuries noted. V1 stated that it was founded that V10 (CNA) had tied R1 down with a bath blanket in his wheelchair. V1 stated that V10 was immediately suspended and later terminated for not following policies and procedures for LTC facilities. V1 stated that all staff were in-serviced on Use of Restraint/Reporting of Reasonable Suspicion of a Crime. On 10/23/2023, at 9:45 AM, attempted to contact V10 (CNA) by phone but was unable to get in contact with him. The facility's final investigation report dated	S9999		

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S9999	Continued From page 4 10/17/2023 documents in parts ... It was reported on 10/13/2023 that V10 (CNA) had tied R1 in a wheelchair using a bath blanket around 6:30 PM the night before. Nurse assessment completed on R1, and no injuries were noted. V10 was suspended until further investigation. V12 (Family), Local Police Department, V13 (Primary Physician) and Ombudsman were notified. On 10/13/2023, V1 (Administrator) interviewed V5 (CNA), and she stated when she came on shift at 10:00 PM, 10/12/2023, she walked down the hall to the nurse's station, as she approached the nurse's station, she saw R1 and another resident sitting along the wall. V5 stated that R1 was not trying to get up, he was just minding his own business with a blanket draped across him. V5 started to get him out of the wheelchair and noticed he was not moving. V5 asked R1 what was wrong, and he just looked at her, that is when V5 noticed another blanket was still across his waist. V5 tried to pull it off and realized someone tied R1 to the wheelchair with a bath blanket prior to her coming on shift. V10 (CNA) walked by and stood in the doorway to R1's room and asked, "What are you doing?" V10 stated multiple times he was going to lay R1 down. V5 walked back down the hallway and told V10 that she doesn't know who did that to R1, but it was not ok. V5 went to the nurse's station and told the charge nurse, V8 (LPN). V5 stated that V8 just looked at her and said, "Ok". V5 waited until day shift nurses got to the facility and told V6 (LPN) what had happened and V6 stated she would let the Director of Nursing know. V1 was notified of this incident on 10/13/2023, at 8:45 AM. V1 notified V12 (Family), V13 (Primary Physician), Local Police, and Ombudsman. A facility wide In-Service was conducted on Use of Restraints and Reporting of Reasonable Suspicion of a Crime in a Long-Term care facility ...After further	S9999		

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S9999	Continued From page 5 investigation, we find that V10 (CNA) needs to be terminated for not following policies and procedures for Long-Term care facilities. There was no restraint assessment included in R1's Clinical Records to indicate the use of bath blankets as a restraint. The facility's policy, Use of Restraints, dated April 2017, documents under Policy Statement: Restraints should only be used to treat the resident's medical symptoms and never for discipline or for staff convenience, or for the prevention of falls. 4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: b. Tucking sheets so tightly that a bed-bound resident cannot move; c. Placing a resident in a chair that prevents the resident from rising; 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptoms and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that might improve the symptoms; 9. Restraints shall only be used upon a written order from the physician and after obtaining a consent from the resident and or/representative (sponsor). The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint and the period of time for the use of the restraint. (B)	S9999		