Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
71101211	or correction.	BENTH TO A TOTAL TOMBER.	A. BUILDING:				
	IL6007504		B. WING		C 01/03/2024		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
PLEASA	NT VIEW REHAB & H	CC	H JACKSON N, IL 61270				
(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)	_D BE	(X5) COMPLETE DATE	
S 000	Initial Comments		S 000				
	Facility Reported In 12/27/23/ IL168333	cident Investigation of					
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a) 300.1210b)5)						
	Section 300.610 R	esident 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 Persor	nal Care					
	care and services to practicable physical well-being of the re- each resident's con plan. Adequate and care and personal of resident to meet the	shall provide the necessary of attain or maintain the highest l, mental, and psychological sident, in accordance with aprehensive resident care l properly supervised nursing care shall be provided to each e total nursing and personal esident. Restorative					

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE (X6) DATE 01/18/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			A. BOILDING.			:	
	IL6007504		B. WING		01/03/2024		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
PLEASA	NT VIEW REHAB & H	CC:	H JACKSON				
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	N, IL 61270	PROVIDER'S PLAN OF CORRECTION	N N	(Y5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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	
S9999	Continued From pa	ge 1	S9999				
	measures shall include, at a minimum, the following procedures:						
	5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.						
	These requirements are not met as evidenced by:						
	review the facility far resident for 1 of 3 resafety in the sample	on, interview, and record ailed to safely transfer a esidents (R1) reviewed for e of 3. This failure resulted in leg laceration requiring 29					
	The findings include	e:					
	12/29/23 shows "or skin tear to left low interviews on file, it assisted by 2 Certif from wheelchair to	ted Incident Final dated in 12/27/23, R1 sustained a er extremity. Per staff was noted resident was being ied Nursing Assistants (CNA) bed using a mechanical lift. resident was noted to bump					
	reclining wheelchai protection sleeves of V4 CNA rolled the pleft lower leg. R1 her left lower leg. Fhurts still. I can tell said she and V5 CN her bed to the wheeleg on the wheelcha	M, R1 was sitting up in a r in her room. R1 had padded on both arms and lower legs. badded sleeve down on R1's ad a gauze bandage covering R1 stated "I had 29 stitches. It there is something there." V4 NA were transferring R1 from elchair and they bumped R1's ear. V4 said R1 had the sat the time. V4 said they					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
						;	
		IL6007504	B. WING		01/0	3/2024	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
PLEASA	NT VIEW REHAB & H	CC	TH JACKSON N, IL 61270				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG			COMPLETE DATE	
S9999	Continued From page 2		S9999				
		s of lowering R1 into the					
		1 said "ouch!" V5 entered the					
		nversation, and said when R1 nished lowering her to the					
	wheelchair and the	n rolled down the protective					
		ere was a large piece of skin bright red blood dripping. V5					
	said the skin tear w	as very large and was more					
	long than wide. V4 and V5 said they got the nurse right away. R1 said she remember saying ouch when being transferred but didn't remember						
	what her leg bumpe	ed.					
	lowered R1's protect removed the gauze contained a large usutures. R1's wour the edges where R in place. R1's would areas that appeares soreness during the change. V3 said F sutures herself and sutures removed at laceration happenemechanical lift.	M, V3 Registered Nurse ctive sleeve on her left leg. V3 dressing. R1's left lower shin neven laceration with visible and had sutures visible along 1's skin flap was secured back and was red with some open d moist. R1 complained of edressing removal and R1 had picked out some of the was scheduled to have the fter 10 days. V3 said R1's d during a transfer with the					
	Note dated 12/27/2 laceration to her lef bound, injured while Laceration is 6 cenirregular, flap. Skir technique, interrupt	gency Department Physician 3 shows "Patient has a it distal shin. Patient is bed e on mechanical lift at facility. timeters in length. Shape: a closure: 29 sutures, simple ed technique." The same R1 was prescribed tramadol 50 ain.					
		s statement from V4 dated nortly after 3 PM, this CNA and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	1 00		TE SURVEY MPLETED	
		IL6007504	B. WING		01/0) 3/2024	
	NAME OF PROVIDER OR SUPPLIER PLEASANT VIEW REHAB & HCC STREET ADDRESS, CITY, STATE, ZIP CODE MORRISON, IL 61270						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
S9999	another CNA (V5) utransfer R1 into her the transfer residen said ouch my leg. V5 pulled down leg Nurse was then not The facility's witnes 12/27/23 shows "shand change resider into the reclining whide of the wheelch We proceeded to loresident was safely leg sleeve and notionurse." On 1/3/24 at 10:24 investigation reveal during the transfer wheelchair. The facility's Limiter and Procedures sheemployees use safe movement technique.	ised the mechanical lift to reclining wheelchair. During its left leg hit side of chair. R1 After we lowered her into chair, sleeve then noticed skin. ified." Is statement from V5 dated fortly after 3 PM went to check int, when done transferred her neelchair and her leg hit the air. The resident said ouch, ower her into the chair. When in her chair, I pulled down the ced a skin tear and notified the AM, V1 Administrator said the ed that R1's injury happened when her leg hit the side of the december of the ed Lift Resident Handling Policy ows "purpose: to ensure that the resident handling and the erisk for safe resident handling ries."	\$9999				

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