Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009559	A. BUILDING: ______ B. WING ______	C 01/17/2024

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EFFINGHAM REHAB & HEALTH C CTR	1610 NORTH LAKEWOOD DRIVE EFFINGHAM, IL 62401

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S 000	Initial Comments Complaint Investigation #23510362/IL167717	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3300a)b)e)j)k) 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	S9999		

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care needs of the resident.

Section 300.3300 Transfer or Discharge

a) A resident may be discharged from a facility after he or she gives the administrator, a physician, or a nurse of the facility written notice of his or her desire to be discharged. If a guardian has been appointed for a resident or if the resident is a minor, the resident shall be discharged upon written consent of his or her guardian or if the resident is a minor, his or her parent unless there is a court order to the contrary. In such cases, upon the resident's discharge, the facility is relieved from any responsibility for the resident's care, safety or well-being. (Section 2-111 of the Act)

b) Each resident's rights regarding involuntary transfer or discharge from a facility shall be as described in subsections (c) through (y) of this Section.

e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge.

j) The planned involuntary transfer or discharge shall be discussed with the resident, the resident's representative and person or agency responsible for the resident's placement, maintenance, and care in the facility. The explanation and discussion of the reasons for involuntary transfer or discharge shall include the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the

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discussions and made a part of the resident's clinical record. (Section 3-408 of the Act)

k) The facility shall offer the resident counseling services before the transfer or discharge of the resident. (Section 3-409 of the Act)

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to provide an acceptable reason for discharge and failed to allow a resident to return to the facility for 1 (R1) of 3 residents reviewed for transfer/discharge in the sample of 19. This failure resulted in R1 remaining in the emergency room without placement from 12/12/23 to 12/18/23 and being admitted to a hospice room at the hospital due to not having a facility to be discharged to. This failure resulted in R1 having feelings of embarrassment, devastation, abandonment and fear of not knowing what was going to happen to him.

Findings Include:

R1's Admission Record with a print date of 1/4/24 documents R1 was admitted to the facility on 10/20/23 with diagnoses that include quadriplegia, adjustment disorder with anxiety, adjustment disorder with mixed disturbance of emotions and conduct, spastic hemiplegia, neurogenic bowel, and pressure ulcers.

R1's BIMS (Brief Interview for Mental Status) dated 11/03/23 documents a score of 15, which indicates R1 is cognitively intact.

R1's MDS (Minimum Data Set) dated 12/12/23 documents under Section G, R1 is dependent on

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staff for all Activities of Daily Living (ADL's). Under Section I, this same MDS documents a diagnosis of quadriplegia.

R1's undated Care Plan documents a Focus area with an initiation date of 11/04/23, "Dependent for ADLs- Unable to assist/Assists only minimally. Not a candidate for Restorative Programming. Further decline in ability/participation likely due to Quadriplegia. Resident is dependent on 2 assist via Hoyer lift for transfers/ADLs." The interventions documented for this Focus area include, "Place in wheelchair for positioning while up and all transport .... Provide bathing, hygiene, dressing and grooming per Resident's preference as able .... Provide oral care with am and pm cares .... Scheduled repositioning program ...Transfer Resident using mechanical device of Hoyer and 2 staff members ..." This same Care Plan documents a Focus area with an initiation date of 11/06/23 of, "Resident (R1) is known to display/has history of paranoid thoughts/behaviors and/or open conflict/criticism with others including false accusations. Resident refuses care, then accuses staff of denying him care. Adjustment disorder w (with)/mixed disturbances of emotions and conduct." The interventions documented for this care area include, "Administer psychotropic medications as ordered by physician ... Allow resident time and opportunity to express feelings, anger, or frustration. Provide empathy and validation of feelings while orienting to reality. Ensure 2 staff members are present for care and services to minimize risk of false accusations .... Investigate any reality basis and share facts w/resident. Provide reality orientation as possible ...Psychotherapy services as needed/desired/tolerated by resident ..."

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S9999	Continued From page 4 R1's Progress Notes dated 12/12/23 documents, "Res (resident/R1) showing s/s (signs/symptoms) of AMS (altered mental status) with hallucinations and delusions. Res making statements that he "fell out of bed." Res is paraplegic and unable to get himself in/out of bed. Res transported to (name of local hospital) via (name of local ambulance service)." On 1/2/2024 at 2:16 PM, V3 (Hospital Case Manager) stated R1 was sent to the local hospital for evaluation on 12/12/23. V3 stated R1 was discharged from the hospital and cleared to return to the facility on that same day. V3 stated the facility refused to re-admit R1 to the facility. V3 stated the facility hand-delivered discharge papers to R1 while in the hospital emergency room. V3 stated R1 remained in the hospital emergency room from 12/12/23 to 12/18/23. V3 stated on 12/18/23 they were able to get R1 admitted to their in-house hospice and R1 remained in the hospital in a hospice room. V3 stated they have attempted to find placement for R1 and have been unable to find a facility that will accept him. The facility Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents dated 12/12/23 documents under Federal Proceeding. " ...This facility seeks to transfer or discharge you pursuant to the regulations of the Health Care Financing Administration for states and long-term care facility ...the reason for this proposed transfer or discharge is: your welfare and needs cannot be met in this facility, as documented in your clinical record by your physician ...the safety of individuals in this facility is endangered ...the health of individuals in the facility would otherwise be endangered, as documented by a physician in	S9999		

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S9999	Continued From page 5 your clinical record ..." The notice documents R1 will be relocated to the local hospital and the effective date of the transfer is documented as 12/12/23. The untitled letter signed by V11 (Physician) and attached to the facility discharge dated 12/12/2023 documents, "It is in my profession (sic) opinion with collaboration of my colleagues: (R1) is not suitable for residency in (name of facility). He has been non-compliant with his wounds treatment, medication, IV (intravenous) therapy, and physician orders. (R1) has exhibited psychosocial distress to other residents that reside within (name of facility). This included but is not limited to the following: verbal aggression, having to relocate his once roommate to a different room to ensure he was not subjected to this. It is of this facility's duties to protect the safety of all the residents while creating a calm living environment. Due to the sensitivity of the population of those we serve including those who have schizophrenia, developmental delays, trauma/PTSD (post-traumatic stress disorder), dementia/Alzheimer, and other mental health diagnosis where the presentation of his behaviors created adverse effects on these residents. Many interventions were utilized in attempts to resolve (R1) bio-psycho-social needs. An attempt to be assessed by (name of clinical social worker and psychiatric consultants) to aide in assisting him in his mental and emotional needs; however, this was met with refusal, thus unable to provide treatment. (Name of facility) also attempted to send many referrals for this resident to outside agencies, Long-Term Care Facilities, Behavioral Homes, and more; however, being met with denials. His refusal of care impacts his overall well-being, coupled with his underlying mental and behavioral changes impede the ability to	S9999		

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provide continuity of care to address his medical needs."

R1's regional hospital discharge papers dated 9/16/23, prior to R1's admission to the facility, document, "R1 is a ...male with a past medical history of quadriplegia due to recent spinal cord injury and glaucoma .... Had stage 4 decubitus ulcers ...Pt (patient/R1) left the hospital AMA (against medical advice) ...throughout hospitalization Pt (R1) refused IV, labs, and IVF (intravenous fluids) ..." This indicates the facility was aware of R1's behaviors of refusal of care prior to admission to the facility.

R1's local hospital record with an admission date of 12/12/23 documents the following progress notes.

12/12/23 9:02 AM, "Patient (R1) is a ...quadriplegic who was sent in from nursing home for shoulder pain. Patient was discharged from the nursing home while patient was in the ER (Emergency Room) due to staff at the nursing home being unable to deal with him. Currently we are looking for placement for the patient ..."

12/12/23 1:41 PM, "This RN (Registered Nurse) spoke with V2 (Director of Nurses) at (name of facility). Again, let V2 know that patient was up for discharge and clarified with her that they will not be allowing patient to return. Requested documentation of refusal to allow the patient to return be faxed to the ER (Emergency Room), V2 stated they would be happy to fax written documentation of this refusal."

12/12/23 3:59 PM, "This patient (R1) has requested to go elsewhere than his current NH (nursing home) facility ..."

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12/12/23 5:13 PM, "V1 (Administrator) and V2 (Director of Nurses) from (name of facility) dropped of PT (patient/R1) D/C (discharge) papers and took documenters name as recipient."

12/12/23 6:59 PM, "Patient (R1) ...male history of quadriplegia presenting from the nursing home for musculoskeletal pain. Patient was sent to the ER by the nursing home and then discharged from the nursing home ...."

12/13/23 1:54 PM, "Multiple referrals sent to various nursing homes today ...."

12/13/23 7:32 PM, "Briefly, (R1) ...is being evaluated for placement. Patient (R1) is a quadriplegic and apparently difficult to manage at NH where he was discharged and will not be accepted back. Case management is working on placement."

12/14/23 3:36 AM, "I assumed care of this patient (R1) ...Patient has been in this emergency department for nearly 2 full days, awaiting placement. Case management has been seeing the patient. He was discharged from his nursing home. The patient is adamant that he would like to be DNR (do not resuscitate), on hospice, with comfort measures only. He clearly has an infected sacral wound, which I see he was admitted for earlier this month although he declines treatment for this. He continues to decline treatment for this here ...The patient understands that refusal of treatment for his infections could lead to worsening condition and possible death ..."

12/16/2023, "I again assumed care of this patient

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...at 7 PM on 12/14. Patient (R1) is refusing any medical treatment, is desiring to be on hospice, is no longer welcome at his living facility, so case management is working on placement at an alternative facility."

12/18/23 9:45 AM, "Reviewed Hospice philosophy and desire for hospice care. Patient (R1) understands his choices and able to decipher benefit vs (versus) burden. He is requesting comfort care. Patient informed all long-term care referrals have been declined. Agreeable to plan for possible transfer to accepting hospice house.

On 1/4/24 at 11:29 AM, R1 stated he was not aware he was being discharged from the facility when he went to the emergency room on 12/12/23. R1 stated he didn't want to return to the facility because he felt like he would just get "revenge" care. When asked why he was discharged from the facility R1 stated he thought it was because he called the state agency on the facility. R1 stated when the director (no name given) delivered the discharge papers to the hospital she told him he should never have called the police. R1 stated the hospital is currently looking for other options for him. When asked if there was any harm related to his discharge R1 stated, "Absolutely." R1 stated he knew it was revenge. R1 stated he told them (the facility) it was illegal to evict someone for no reason. At 3:03 PM on this same date, when asked how he felt about the involuntary discharge, R1 stated it was "devastating and embarrassing." R1 stated he felt abandoned, afraid, and "didn't know what was going to happen to him."

On 1/4/24 at 1:58 PM, V8 (CNA) stated R1 was never really rude to her. V8 stated she had witnessed him being rude to other staff. V8 stated

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she never heard R1 yelling or cursing at other residents and didn't have any residents complain to her about R1's behaviors.

On 1/4/24 at 2:03 PM, V9 (LPN) stated R1 was just an unhappy person. V9 stated he wouldn't let her, or several other staff provide care for him. V9 stated R1 called staff names and talked about their personal appearances. V9 stated R1 refused care such as dressing changes and turning and repositioning. When asked if any of R1's behaviors were ever directed at other residents? V9 stated, "No. It was mostly towards staff." When asked if she had any other residents complain about R1's behaviors, V9 stated, "Not really."

On 1/4/24 at 1:33 PM, V5 (CNA) stated R1 preferred V5 to be his caregiver. V5 stated R1 was verbally aggressive with other staff but not with him. When asked if R1 was ever verbally aggressive with other residents V5 stated he didn't think so. When asked if any other residents reported being afraid of R1 or appeared afraid of R1, V5 stated, "I wouldn't say so." V5 stated R1 usually got out of bed and came out of his room at least daily. When asked if R1 was verbally aggressive in front of other residents V5 stated, "The majority of the time he wasn't. I would say he was just happy to be up and out of his room."

On 1/4/24 at 1:40 PM, V6 (CNA) stated she and R1 got along pretty well. V6 stated R1 could be difficult and challenging but she didn't have any issues with R1. V6 stated she never witnessed R1 yelling, cursing, or harming other residents. V6 stated she did have residents complain about R1's screaming and cursing. V6 stated they appeared disgusted but not afraid. When asked what she did to mitigate R1's behaviors, V6

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stated she would have conversation with R1 and meet R1's needs as much as possible and report to V1 (Administrator) if she needed assistance. V6 stated R1 never physically harmed anyone.

On 1/4/24 at 1:50 PM, V7 (Restorative Aid/CNA) stated she got along with R1. V7 stated R1 didn't have a problem with her. V7 stated she remembered R1 having two roommates at different times. V7 stated one of them was masturbating and R1 yelled at him so they moved the roommate to a different room. V7 stated no other residents have voiced fears or concerns related to R1's behaviors.

On 1/4/24 at 2:01 PM, R10 stated he doesn't remember being roommates with R1. R10 stated he was not scared of anyone at the facility and doesn't remember being afraid of or feeling threatened by any other resident.

On 1/4/24 at 2:08 PM, R11 stated he had a roommate with R1's name. R11 stated he didn't have any problems with R1. R11 stated he is not afraid of any resident at the facility. R11 stated he has never been scared of another resident since he has lived at the facility and was not aware of any resident having a problem with a peer.

On 1/4/24 at 12:20 PM, V4 (LPN) stated R1 was very angry, resisted care, and made false accusations against staff. V4 stated R1 didn't really come out of his room but when he did, he was more social. V4 stated R1 would get upset at night and start screaming at staff and the other residents on his hall would get upset. V4 stated R1's language offended a lot of people. When asked what the facility did to mitigate R1's behaviors, V4 stated she didn't really know. V4 stated she knew the social worker, nurse

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practitioner, and therapist spent a lot of time in R1's room. V4 stated R1 enjoyed having certain people to vent to. When asked what she did when R1 was having verbally aggressive behaviors, V4 stated she would let V2 (Director of Nurses) know and write a detailed progress note. V4 stated R1 didn't have many good days. V4 stated she would also utilize social services and the therapist. When asked about distraction, redirection, or activities as interventions, V4 stated R1 wasn't really up for staff redirection. V4 stated she knew R1 enjoyed getting up. V4 stated R1 would refuse to get up a lot but when he did get up you could tell R1 really enjoyed it. When asked if other residents reported or appeared being afraid of R1, V4 stated there was one night that he was screaming and yelling and R4 was upset and tearful. V4 stated R4 didn't say she was afraid, but she appeared afraid.

R4's progress note dated 12/12/23 10:31 PM documents, "This nurse went to administer res's (R4) 1000 medication. Res stated that she was tired due to being kept up all night by "the man across the hall who yells awful things all day and night long." This nurse asked res what the man (R1) says. Res became tearful. Res stated "He is always yelling the F word which really upsets me. The way he talks to staff is awful. I feel bad for you guys for having to listen to him talk like that. But it's scary for me too. Especially at night. I just lay here and have to listen to the awful things he screams." Res also stated, "You guys (staff) are in there all the time, and that takes you guys away from helping other residents." Admin (V1/Administrator) and DON (V2/Director of Nurses) made aware of res's concerns and statements. R4 was discharged from the facility prior to this survey so was not available for interview.

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On 1/4/23 at 2:57 PM, V10 (Social Services Director) stated R1 was loud and could be very angry and other residents would hear him and be scared. When asked if other residents reported being scared to her, V10 stated she knew the information was in the resident records. This information was requested from the facility. The facility provided this surveyor with R4's progress note dated 12/12/23. They were unable to provide other reproducible evidence related to peers being afraid of R1.

On 1/4/24 at 3:18 PM, V2 (Director of Nursing) stated R1 was sent to the local hospital because he was demanding to be sent. V2 stated they heard he was trying to press criminal charges against staff and staff were upset about how R1 had treated them the night before. V2 stated after talking with their corporate office and medical director they determined it was in everyone's best interest to discharge R1. V2 stated there were no charges that were brought against any staff and the allegations were investigated by the facility and the local police. V2 stated she was not aware of R1 targeting any other residents. V2 stated it was unsettling for residents to lay in bed at night and listen to R1 be so insulting. V2 stated she was only aware of R5 complaining regarding R1's behavior and that was because her room was close to R1's and she was alert and oriented.

On 1/04/24 at 11:25 AM, R5 stated she is not scared of any other resident at the facility. R5 denied knowing any other resident that was scared of any resident. R5 stated she has a lot of friends that are residents here. R5 denied any concerns.

On 1/4/23 at 3:37 PM, V1 (Administrator) stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009559	A. BUILDING: ______ B. WING ______	C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EFFINGHAM REHAB & HEALTH C CTR	**1610 NORTH LAKEWOOD DRIVE EFFINGHAM, IL 62401**

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S9999	Continued From page 13 on the morning of 12/12/23, R1 requested to be transferred to the local emergency room and to call the police. V1 stated she advised the staff to send R1 out per his request. V1 stated R1 reported to the local hospital he wanted to press charges on facility staff for battery. V1 stated the allegation of abuse was investigated by the facility and local law enforcement and there were no findings, and no charges were filed against any staff. V1 stated they had been reviewing a possible discharge for R1 since they couldn't meet R1's needs. V1 stated hospice had been in and R1 refused hospice services with four different providers. V1 stated they reviewed R1's refusal of care. V1 stated on night shift prior to R1 being transferred to the local hospital on 12/12/23, R1 had been shouting and it was bothering R4. V1 stated after reviewing the information with the interdisciplinary team they came to the conclusion it was better for the psychosocial care of our other residents to discharge R1 from the facility. V1 stated there were only three staff members R1 liked, so medical care was met with resistance from R1. V1 stated R1 told hospice and the local law enforcement on 12/12/23 at the hospital that he didn't want to return to the facility, so that helped make the decision in moving forward with the involuntary discharge. V1 stated R1 was not allowed to return to the facility from the hospital. V1 stated R1 was transferred to the hospital on 12/12/23 and was given the immediate involuntary discharge papers while at the hospital on 12/12/23. V1 stated she knew there were residents who complained about how R1 talked to the staff and him cursing. V1 stated R1 did not yell at other residents. R1 was just vocal and vulgar. When asked if R1 was capable of physically harming someone, V1 stated, "No, R1 only had control of his left arm."	S9999		

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S9999	Continued From page 14 The undated facility Transfer and Discharge Policy and Procedure documents, "It is the policy of (name of corporation) not to transfer or discharge a resident unless: 1. The transfer or discharge is necessary to meet the resident's welfare, and the resident's welfare cannot be met in the facility ...3. The safety of individuals in the facility is endangered .... In all cases except the last, documentation in the resident's clinical record shall be required. The residents attending physician must document in the resident's clinical record that the facility cannot provide for the resident's welfare, or that the resident no longer requires the facilities services. Documentation in the resident's clinical record by any physician that the health of other individuals would be endangered is cause for transfer or discharge. Type of Transfer and Discharge: Less than 30-day notice. Transfers and discharges with less than 30 days' notice may occur in limited circumstances. 1. The health or safety of others in the facility is endangered; 2. The health of the resident has improved to allow more immediate transfer or discharge; 3. The residents urgent medical needs require more immediate transfer; 4. The resident has not resided in the facility for 30 days." Under Involuntary transfers or discharge the policy documents, Except for the case of late payment or nonpayment, the facility shall notify the resident and the residents family member, surrogate or representative of the transfer and the reasons for the transfer as stated in the clinical record ...In all other instances of involuntary transfer or discharge the mandated federal and state 30 day 'Notice Transfer or Discharge" will be issued, and the following steps taken. 1. The planned involuntary transfer or discharge shall be discussed with the resident, guardian, residents' representative and/or the	S9999		

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S9999	Continued From page 15 person or agency responsible for the resident's placement, maintenance, and care in the facility. 2. The discussion shall be carried out by the administrator or his/her designee. The content of the discussion and explanation shall be summarized in writing including the names of those in attendance. The summary shall be made a part of the resident's clinical record. 3. A physician's discharge order shall be obtained in the residents record prior to discharge. 4. Prior to transfer or discharge the Social Services Director shall counsel the resident and summarize the counseling session in the resident record." (B)	S9999		