PRINTED: 11/16/2023 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: COMPLETED A. BUILDING: _ B. WING IL6006555 10/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **505 STEVENS STREET** NOKOMIS REHAB & HEALTH CARE CENTER NOKOMIS, IL 62075 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY S 000 Initial Comments S 000 Annual Health Survey S9999 Final Observations S9999 Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)2) Section 300.610 Resident Care Policies 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 The facility shall provide the necessary care and services to attain or maintain the highest

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

care needs of the resident.

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

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
IL6006555		IL.6006555	B. WING		10/26/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
NOKOMIS REHAB & HEALTH CARE CENTER 505 STEVENS STREET NOKOMIS, IL 62075						
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	OULD BE COMPLETE	
S9999	Continued From page 1		S9999			
	seven-day-a-week ba 2) All treatm be administered as or	practiced on a 24-hour, sis: ents and procedures shall dered by the physician. are not met as evidenced by:				
	failed to collect a Urinicausing a delay in treat Extended-Spectrum B which is an infection refor 1 of 16 residents (I Care in the sample of	eta Lactamases, (ESBL), equiring contact isolation, R16) reviewed for Quality of				
:	Findings include: R16's Face Sheet, dat R16 has Chronic Kidn	ted 10/24/2023, documents ey Disease.				
	R16's Physician's Ord documents, "Get UA, (Culture and Sensitivit	(Urinalysis), with CNS,				
	R16's Progress Notes for the order, or attempt	do not indicate a reason pts to obtain the UA.				:
	R16's Lab Report door on 9/12/2023, and the contained blood, bacte which are abnormal re	eria and mucous, all of				
	documents R16's cultu- >100,000 CFU, (Color milliliter of Extended-S					

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PRINTED: 11/16/2023 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:** COMPLETED A. BUILDING: _ IL6006555 B. WING 10/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **505 STEVENS STREET NOKOMIS REHAB & HEALTH CARE CENTER** NOKOMIS, IL 62075 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 2 S9999 The Infection Surveillance Monthly Report, dated 10/23/2023, documents R16's infection onset was 9/16/2023, and an order was received to begin an injectable antibiotic. R16's Medication Administration Record, (MAR), documents, "Ertapenem Sodium Injection Solution Reconstituted, 1 GM, (Gram), -Inject, 1 gram intramuscularly, one time a day for UTI, (Urinary Tract Infection) for 6 Days, Use Lidocaine, (numbing agent), 1% Injectable solution 3.2 ml to reconstitute." It further documents, "9" on 9/18/2023. R16's Physician's Orders, dated 9/16/2023, documents, "Contact isolation for ESBL in urine." On 10/24/2023 at 1:10 PM while being provided peri-care, R16 became upset and was crying. At this time, V9, Certified Nursing Assistant, (CNA), stated, "She probably thinks were are going to mess with her heel, (change her pressure ulcer dressing), or give her a shot (the Intra-muscular antibiotic injection)." On 10/25/23 at 3:29 PM, V2, Regional Director of Nursing, stated, "A lab specimen should be collected as soon as they can, within a couple days-definitely within 72 hours. She was probably symptomatic and that is why they collected it." On 10/26/2023 at 10:47 AM, V11, Licensed Practical Nurse, (LPN), stated she took the order for the UA and culture to be completed because,

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Tuesday.

"(R16's) urine smelled really bad. She was also, more aggressive and agitated. I don't know if they tried to straight Cath, (cathaterize), her." V11 also stated the Facility's labs are picked up every

STATE FORM

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PRINTED: 11/16/2023 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: COMPLETED A. BUILDING: B. WING IL6006555 10/26/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **505 STEVENS STREET NOKOMIS REHAB & HEALTH CARE CENTER** NOKOMIS, IL 62075 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) S9999 Continued From page 3 S9999 On 10/26/2023 at 11:47 AM, V2 stated she started R16's antibiotic from the "C-box", (convenience box), and it contains only one dose. V2 stated, the "9" on the MAR means 'See Progress Notes'. V2 stated, the "2" on the MAR indicates resident refusal. R16's Progress Notes, dated 8/18/2023, documents the Pharmacy did not bring the antibiotic, Pharmacy was called, and the Doctor was notified, for new orders. R16's Progress Notes does not document, any new orders were received. R16's Progress Notes do not document if the Doctor was notified, or of R16's refusal of the medication. On 10/26/23 at 1:30 PM, V2 stated, "(V11) text the Doctor on her personal phone and the Doctor just replied, "Thank-you." The Facility's Laboratory Tests policy, dated 9/27/2023, documents, "Appropriate laboratory monitoring of disease processes and medication requires consideration of many factors including concomitant disease(s) and medication(s), wishes of the residents and family and current standards of practice." It further documents, "Laboratory testing will be completed in collaboration with Medicare guidelines, Pharmacy recommendations and Physician Orders. Obtain laboratory orders upon admission, readmission and PRN, (as needed), medication and condition monitoring per the Physician's Order."

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(B)