DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u> 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		STRUCTION		E SURVEY PLETED
		145478	B. WING				C /03/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		/03/2010
					EVENS STREET		
NOKOMIS	REHAB & HEALTH CAR			ΝΟΚΟ	MIS, IL 62075		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		DATE
					DEFICIENCY)		
F 000	INITIAL COMMENTS		F 0	00			
	Complaint #1646098	/IL89406					
	A Partial Extended Su	urvey was conducted.					
F 157	483.10(b)(11) NOTIF	Y OF CHANGES	F 1	57			
SS=D	(INJURY/DECLINE/R	COOM, ETC)					
	consult with the resid known, notify the resi or an interested family accident involving the injury and has the pol intervention; a signific physical, mental, or p deterioration in health status in either life thr clinical complications significantly (i.e., a ne existing form of treath consequences, or to b	nent due to adverse commence a new form of ion to transfer or discharge					
	and, if known, the res or interested family m change in room or roo specified in §483.15(resident rights under regulations as specific this section. The facility must reco the address and phor	promptly notify the resident ident's legal representative member when there is a commate assignment as (e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of rd and periodically update he number of the resident's or interested family member.					
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	1	TITLE		(X6) DATE

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

(X6) DATE

PRINTED: 11/09/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	LETED
		145478	B. WING				C 03/2016
	ROVIDER OR SUPPLIER	E CENTER		5	BTREET ADDRESS, CITY, STATE, ZIP CODE	<u>, .,</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		NOKOMIS, IL 62075 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 157	This REQUIREMENT by: Based on interview a failed to notify the phy out a tracheostomy tu reviewed for physician of 12. Findings include: R2's Physician Order documents, in part, "E Hemorrhage, Respira Gastrostomy Tube. 9/ (Oxygen) at 5 liters pe 35% humidity." R2's dated 9/7/16 document hand." R2's Care Plan undat newly admitted with the Routine tracheostomy (as needed). Suction hand due to pulling at tube and (indwelling) R2's Nursing Admissi 9/2/16, documents "A Intracranial Hemorrha requiring Tracheostor Rectal tube. ADL (Act Functional Abilities: R	T is not met as evidenced and record review, the facility visician of incident of pulling ube for 1 of 4 residents (R2) in notification in the sample Sheet (POS) for 9/2016 Diagnoses: Intracranial tory Failure, Tracheostomy, 2/16 Order Clarification: O2 er tracheostomy mask at Physician's Order (PO) ints, "May place mitt on left red documents, "Resident racheostomy size #6 shiley. / care every shift and prn prn. 9/7/16 Wear mitt on left tracheostomy tube, feeding catheter." on Assessment, dated dmitting Diagnosis: age, Respiratory Failure ny, Gastrostomy tube,	F	157			
	R2's Nurse's Note, da documents, "Residen (tracheostomy) mask.	t noted pulling at trach					

Facility ID: IL6006555

If continuation sheet Page 2 of 18

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		145478	B. WING				C 103/2016
NAME OF PF	ROVIDER OR SUPPLIER	L	I	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
NOKOMIS	REHAB & HEALTH CAR				505 STEVENS STREET NOKOMIS, IL 62075		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	2	F	157	7		
		ated 9/6/16, at 0100 nt restless in bed pulling at moving it, replace each					
		t has pulled on - has removed inner rts hospital had left hand Ill on trach. Phoned MD					
	R2's Nurse's Note, da documents, "Residen and tracheostomy this	t continue to pull at G-tube					
	R2's Nurse's Note da documents, "Residen Respirations even, ur	t resting quietly.					
	trach out and residen CPR (Cardiopulmona EMTs (Emergency Me took over CPR." The						
		ute Check Monitoring cument R2 was monitored 0/25/16 for being at risk due					
	(DON), stated the fac	AM, E2, Director of Nursing ility had only one resident and that was R2 and the					

Facility ID: IL6006555

If continuation sheet Page 3 of 18

DEPART CENTER		FORM	M APPROVED D. 0938-0391				
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		145478	B. WING				C /03/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NOKOMIS	REHAB & HEALTH CAR	RE CENTER			505 STEVENS STREET NOKOMIS, IL 62075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	facility did not have all tracheostomy after R2 worked on the floor at 9/18/16 and caught R times and pulling at h tube. E2 stated she h taking her mitt off. On 10/26/16 at 11:20 Nurse (LPN), stated s mitt on but she had no off. On 10/26/16 at 12:15 Aide (CNA), stated th caught R2 with the int and reported it. E6 sta her hand on her trach her take it out becaus pulling it out. On 10/26/16 at 1:40 F never seen R2 remov her without it and imm On 10/26/16 at 4:10 F not seen R2 take her seen R2 without it and left hand. On 10/26/16 at 4:12 F had not witnessed R2 her tracheostomy but her mitt and reported On 10/27/16 at 10:32 had seen R2 rubbing	ny resident with 2 expired. E2 stated she nd took care of R2 on 2 with her mitt off several er trach and gastrostomy as not actually observed R2 AM, E3, Licensed Practical she had seen R2 without her ever seen R2 take her mitt PM, E6, Certified Nursing at in the past she had ner cannula of her trach out ated she had seen R2 with b but had not actually seen se she would stop R2 from PM, E4, LPN, stated she had re her mitt but she had seen hediately put it back on. PM, E5, LPN, stated she has mitt off. E5 stated she had d put the mitt back on R2's PM, E7, CNA, stated she took off her mitt or pull out she has seen R2 without it to the nurse on duty. AM, E8, LPN, stated she her mittened left hand ke the mitt off. E8 stated she	F	157	7		

Facility ID: IL6006555

If continuation sheet Page 4 of 18

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICI AND PLAN OF CORREC	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		145478	B. WING				03/2016
NAME OF PROVIDER	OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
NOKOMIS REHAB	& HEALTH CAR	RECENTER			505 STEVENS STREET NOKOMIS, IL 62075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
On 10, had set 15 min back of seen F On 10, had set under of it. E R2's le she ha soon a On 10, aware as the On 10, stated that (R at her it happ R2's c facility her ha The Fa Reside docum superv attend there f	on R2 right away (27/16 at 10:40) een R2 without inute checks and on R2 right away R2 with her trac (27/16 at 10:42) een R2 try to tal her right arm and 9 stated she wo off hand and rep ad noticed R2 tr as R2 was made (27/16 at 3:10 F prior to 9/18/16 floor nurse that (27/16 at 3:10 F prior to 9/18/16 floor nurse that (31/16 at 8:48 A , "There is no re (2) was able to trach. I expected bened." (31/16 at 8:48 A , "There is no re (2) was able to trach. I expected bened." (31/16 at 8:48 A , "There is no re (2) was able to trach. I expected bened."	AM, E10, CNA, stated she the mitt on while doing the d E10 would put the mitt y. E10 stated she had not h tube out. AM, E9, CNA, stated she ke off her mitt by putting it nd wiggle her left hand out ould always put it back on bort it to the nurse. E9 stated ying to take off her mitt as e to wear it. PM, E2 stated she was not 6 when she took care of R2 t R2 was pulling at her trach. AM, Z3, R2's Physician, ecord the facility notified me take her mitt off and pulling ed them to contact me when as no documentation the b that R2 was able to remove d pulled at her trach. Notification for Change in r Status, dated 7/1/12, re: 1. The nurse rse will notify the resident's r on-call physician when a accident or incident	F	157			

Facility ID: IL6006555

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/09/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
		145478	B. WING		C 11/03/2016
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CO	•
NOKOMIS	REHAB & HEALTH CAP	RECENTER		STEVENS STREET KOMIS, IL 62075	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
F 280	Continued From page	e 5	F 280		
F 280 SS=D		(k)(2) RIGHT TO NING CARE-REVISE CP	F 280		
	incompetent or othern incapacitated under t participate in planning changes in care and A comprehensive car within 7 days after the comprehensive asses interdisciplinary team physician, a registere for the resident, and disciplines as determ and, to the extent pra the resident, the resid legal representative;	he laws of the State, to g care and treatment or treatment. e plan must be developed			
	by: Based on interview a failed to review and r effectiveness to addre	is not met as evidenced and record review, the facility evise the care plan for ess current care needs for 1 viewed for care plans in the			
	Findings include:				
	documents, in part, "I Hemorrhage, Respira	Sheet (POS) for 9/2016 Diagnoses: Intracranial atory Failure, Tracheostomy, /2/16 Order Clarification: O2			

Facility ID: IL6006555

If continuation sheet Page 6 of 18

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/09/20 FORM APPROVI OMB NO. 0938-03
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		145478	B. WING		C 11/03/2016
NAME OF P	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP COD	
NOKOMIS	REHAB & HEALTH CAR	RECENTER		5 STEVENS STREET DKOMIS, IL 62075	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIO
F 280	at 5 liters per tracheo humidity." R2's Physic 9/7/16 documents, "M R2's Nursing Admissi documents, "Admittin Hemorrhage, Respira Tracheostomy, Gastrr ADL (Activities of Dail Right arm and right lei Intracranial Hemorrha R2's Nurse's Note dai documents, "Residen (tracheostomy) mask R2's Nurse's Note dai documents, "Residen Oxygen mask and ren R2's Nurse's Note dai documents, "Residen tracheostomy times 2 cannula. Family repor restricted as to not pu mitt for left hand." R2's Nurse's Note dai documents, "Residen tracheostomy times 2 cannula. Family repor restricted as to not pu mitt for left hand." R2's Nurse's Note dai documents, "Residen and tracheostomy this R2's Nurse's Note, dai documents, "Residen and tracheostomy this R2's Nurse's Note, dai documents, "Residen Respirations even, ur R2's Nurse's Note dai documents, "Went to medication. Went to g	stomy mask at 35% cian Order (PO) dated May place mitt on left hand." on Assessment dated 9/2/16 g Diagnosis: Intracranial atory Failure requiring ostomy tube, Rectal tube. ly Living) Functional Abilities: eg with no movement since age on 8/21/16." ted 9/5/16 at 2000 it noted pulling at trach ." ted 9/6/16 at 0100 it restless in bed pulling at moving it." ted 9/7/16 at 1315 it has pulled on e - has removed inner rts hospital had left hand ull on trach. Phoned MD for ted 9/18/16 at 0020 it continue to pull at G-tube s shift." ted 9/25/16, at 2300 it resting quietly. habored."	F 280		

Facility ID: IL6006555

If continuation sheet Page 7 of 18

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		145478	B. WING				C /03/2016
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE		
NOKOMIS	REHAB & HEALTH CAR				505 STEVENS STREET NOKOMIS, IL 62075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	CPR (Cardiopulmona EMS (Emergency Me over CPR." The Nurs 2335 "(Z3, Coroner) h of life." R2's Resident 15 Min Sheets for 9/2016 doo from 9/3/16 through 9 to tracheostomy. The Monitoring Sheet date check documents R2 On 10/26/16 at 10:40 (DON), stated she wo care of R2 on 9/18/16 off several times and stated she did not act mitt off. On 10/26/16 at 11:20 Nurse (LPN), stated s mitt on but she never stated that on the nigl without her mitt on bu her trach when she di stated when she retur medication at 11:30 P her trach was out. E3 breathing and she cal E3 stated EMS arrive attempted to reinsert without success, E3 s at 11:35 PM. On 10/26/16 at 12:15 Aide (CNA), stated th caught R2 with the int	AM, E2, Director of Nursing orked on the floor and took orked on the floor and took or	F	28	0		

Facility ID: IL6006555

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		145478	B. WING				C 103/2016
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
NOKOMIS	REHAB & HEALTH CAR	E CENTER			505 STEVENS STREET NOKOMIS, IL 62075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	her hand on her trach her take it out becaus pulling it out. On 10/26/16 at 1:40 F never seen R2 remov her without it and imm On 10/26/16 at 4:10 F not seen R2 take her seen R2 without it and left hand. On 10/26/16 at 4:12 F had not witnessed R2 out her tracheostomy her mitt and reported On 10/27/16 at 10:32 had seen R2 rubbing against her side to tal noticed R2 doing this ordered the mitt. E8 s back on R2 right away Seen R2 without to 15 minute checks and back on R2 right away seen R2 with her trac On 10/27/16 at 10:42 had seen R2 try to tal under her right arm an of it. E9 stated she wo R2's left hand and rep	 PM, E4, LPN, stated she had re her mitt but she had seen nediately put it back on. PM, E5, LPN, stated she had mitt off. E5 stated she had d put the mitt back on R2's PM, E7, CNA, stated she PM, E7, CNA, stated she PM, E7, CNA, stated she PM, E8, LPN, stated she PM, E8, LPN, stated she had di see R2 without it to the nurse on duty. AM, E8, LPN, stated she har mitt off. E8 stated she shortly after R2 was stated she would put the mitt y. AM, E10, CNA, stated she the mitt on while doing the d E10 would put the mitt y. E10 stated she had not h tube out. AM, E9, CNA, stated she ke off her mitt by putting it not wiggle her left hand out put it back on port it to the nurse. E9 stated ying to take off her mitt as 	F	280			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/09/2016 APPROVED D: 0938-0391
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		145478	B. WING				C 03/2016
NAME OF PR	OVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
NOKOMIS	REHAB & HEALTH CAR	E CENTER			505 STEVENS STREET NOKOMIS, IL 62075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 328 SS=J	has reviewed or reass interventions in place at her tracheostomy to awhile to take off the I there to check on (R2 R2's Care Plan undate newly admitted with tr Routine tracheostomy (as needed). Suction (hand due to pulling at tube and (indwelling of Plan did not documen approach/es that was and did not identify nei intervention/s to addre tubes and/or preventin prevent dislodging the The Facility Policy on Assessment/Care Pla "7.c Care Plan - Plan need/problem, and ind approaches/interventi the resident in mainta in relation to the probl 483.25(k) TREATMEN NEEDS The facility must ensu proper treatment and special services: Injections; Parenteral and entera	2M, when asked if the facility sessed the current to prevent R2 from pulling ube, E2 stated, "It took (R2) hand mitt and staff were) every 15 minutes." ed documents, "Resident acheostomy size #6 shiley. care every shift and prn prn. 9/7/16 Wear mitt on left tracheostomy tube, feeding urinary) catheter. " The Care t any revision of the s in place that did not work ew or alternative ess pulling at R2's trach and ng pulling out the trach or e trach. Comprehensive nning, undated, documents, of care describing a dicating ons to be instituted to assist ining/receiving proper care em." NT/CARE FOR SPECIAL		280			

Event ID: G6UW11

Facility ID: IL6006555

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	-	ID HUMAN SERVICES				FORM	APPROVED
STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			PLETED
		145478	B. WING				C 103/2016
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NOKOMIS	REHAB & HEALTH CAR	E CENTER			505 STEVENS STREET NOKOMIS, IL 62075		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 328	Continued From page	e 10	F	328	8		
	Respiratory care; Foot care; and Prostheses.						
	This REQUIREMENT by: Based on interview a failed to implement ef prevent pulling out a t resident (R2) reviewe the sample of 12. This and death of R2 on 9. This failure resulted in While the Immediate 11/3/16, the facility re Severity Level 2, whil educate staff and eva	n an Immediate Jeopardy. Jeopardy was removed on mains out of compliance at e the facility continues to luate the effectiveness of nd procedures for safe					
	documents, in part, "I Hemorrhage, Hemiple Tracheostomy, Gastri Clarification: O2 (Oxy tracheostomy mask a	gen) at 5 liters per t 35% humidity." R2's dated 9/7/16 documents,					
	documents R2 has se skills for daily decision	Set (MDS) dated 9/15/16 everely impaired cognitive n making, and totally r all activities of daily living					

Facility ID: IL6006555

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		ND HUMAN SERVICES MEDICAID SERVICES					INTED: 11/09/20 [.] FORM APPROVE B NO. 0938-039	
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTF) DATE SURVEY COMPLETED	
		145478	B. WING			C 11/03/2016		
NAME OF PR	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CO	DE		
				505 STEV	ENS STREET			
NOKOMIS	REHAB & HEALTH CAP	RECENTER	NOKOM		IS, IL 62075			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 328	Continued From page	e 11	F 3	28				
	10/3/16 documents, ' PM), staff entered (R tracheostomy tube of CPR (Cardiopulmona initiated as per protor Medical Services) wa approximately 2335 (continued with CPR v were made to reinser without success due being pulled out with Coroner was onsite v pronounced (R2). Up noted that (R2) had a tracheostomy tube, (i and gastrostomy tube, hand to keep her fror was also on 15 minut staff show that CNAs were in the room at a PM) to check on the quietly with her trach place. At 2330 (11:3) entered her room and tube was out and CP also dispatched and arrival. Attempts were tracheostomy tube w swelling at the site. (i cuffed tracheostomy record, (R2) had a hi	Health) Notification dated 'On 9/25/16 at 2330 (11:30 2's) room and noted ut. (R2) was a full code so ary resuscitation) was col. EMS (Emergency as dispatched. EMS arrived (11:35 PM) and they without success. Attempts t the tracheostomy tube to swelling from the tube the cuff inflated. The Deputy						
	years ago she had ba episodes of choking a							

Facility ID: IL6006555

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/09/2016 MAPPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED		
		145478	B. WING				C 03/2016	
NAME OF PI	ROVIDER OR SUPPLIER		- 1		STREET ADDRESS, CITY, STATE, ZIP CODE			
					505 STEVENS STREET			
NOKOMIS REHAB & HEALTH CARE CENTER				NOKOMIS, IL 62075				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 328	10/3/16 documents E (LPN), E6, CNA, and during the investigation R2's Care Plan, undar newly admitted with the Routine tracheostomy (as needed). Suction hand due to pulling at tube and (indwelling under R2's Nursing Admissing 9/2/16, documents, "A Living) Functional Abileg with no movement Hemorrhage on 8/21/ R2's Nurse's Note, da PM) documents, "Res (tracheostomy) mask. R2's Nurse's Note, da PM) documents, "Res at Oxygen mask and R2's Nurse's Note, da AM) documents, "Res tracheostomy times 2 cannula. Family repor restricted as to not pur mitt for left hand." R2's Nurse's Note, da documents, "Residen (Gastrostomy tube) at	Acident Investigation dated 3, Licensed Practical Nurse E11, CNA, were interviewed on. ted, documents, "Resident acheostomy size #6 shiley. care every shift and prn prn. 9/7/16 Wear mitt on left tracheostomy tube, feeding urinary) catheter." on Assessment, dated ADL (Activities of Daily lities: Right arm and right t since Intracranial 16." ted 9/5/16 at 2000 (8:00 sident noted pulling at trach " ted 9/6/16, at 0100 (1:00 sident restless in bed pulling removing it." ted 9/7/16 at 1315 (1:15 sident has pulled on - has removed inner ts hospital had left hand II on trach. Phoned MD for ted 9/18/16, at 0020 t continue to pull at G-tube and tracheostomy this shift." ted 9/25/16, at 2300 (11:00	F	328	8			

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CENTERS FOR MEDICARE & ME	HUMAN SERVICES			FOR	M APPROVED 0. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED		
	145478	B. WING		1	/03/2016		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•			
NOKOMIS REHAB & HEALTH CARE (CENTER		505 STEVENS STREET NOKOMIS, IL 62075				
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
 PM) documents, "Went to get trach out and resident not CPR started. EMTs arriv Nurse's Note documente Coroner) here, CPR stop R2's Resident 15 Minute Sheets for 9/2016 documents from 9/3/16 through 9/25 to tracheostomy. The Ref Monitoring Sheet dated at asleep and calm. On 10/26/16 at 10:40 AM (DON), stated the facility with a tracheostomy after R2 e worked on the floor and 9/18/16 and caught R2 without her not actually observed R2 On 10/26/16 at 11:20 AM had seen R2 without her never seen R2 take her the night of 9/25/16 she on but R2 was not trying 	bored." d 9/25/16, at 2330 (11:30 to resident room to give flush kit. Noted resident ot breathing. 911 called. ved took over CPR." The ed "At 2335 "(Z3, pped. No sign of life." e Check Monitoring ment R2 was monitored 5/16 for being at risk due esident 15 Minute Check 9/25/16 documents last to the trach R2 was M, E2, Director of Nursing y had only one resident d that was R2 and the resident with expired. E2 stated she took care of R2 on with her mitt off several trach. E2 stated she did 2 take her mitt off. M, E3, LPN, stated she r mitt on but she had mitt off. E3 stated that on saw R2 without her mitt g to pull her trach when PM. E3 stated when she medication at 11:30 PM, er trach was out. E3 hing and she called 911 tated EMS arrived and	F3					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 145478 STREET ADDRESS, CITY, STATE, ZIP CODE 505 STEVENS STREET STREET ADDRESS, CITY, STATE, ZIP CODE 505 STEVENS STREET		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
145478 B. WING 11/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NOKOMIS REHAB & HEALTH CARE CENTER 505 STEVENS STREET	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA						
NOKOMIS REHAB & HEALTH CARE CENTER 505 STEVENS STREET			145478	B. WING				-	
NOKOMIS REHAB & HEALTH CARE CENTER	NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
NOKOMIS, IL 62075	NOKOMIS	REHAB & HEALTH CAR	RECENTER						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE	
F 328 Continued From page 14 tracheostomy Lube without success, E3 stated R2 was pronounced at 11:35 PM. E0. CNA, stated she did the 15 minute check on 9/25/16 at 11:15 PM and R2 had her mitt on and she was calm, comfortable and her trach was in place. E6 stated that in the past she had caught R2 with the inner cannula of her trach out and reported it. E6 stated she had seen R2 with her hand on her trach, but had not actually seen her take it out because she would stop R2 from pulling it out. On 10/26/16 at 1:40 PM. E4. LPN, stated she had never seen R2 remove her mitt, but she had seen her without it and immediately put it back on. On 10/26/16 at 4:10 PM. E5, LPN, stated she had not seen R2 take her mitt off. E5 stated she had seen R2 without it and put the mitt back on R2's left hand. On 10/26/16 at 4:12 PM, E7, CNA, stated she had not witnessed R2 took off her mitt or pull out her tracheostomy, but she has seen R2 without her mitt and reported it to the nurse on duy. On 10/27/16 at 10:32 AM, E8, LPN, stated she had seen R2 right way. On 10/27/16 at 10:40 AM, E10, CNA, stated she had seen R2 right away. On 10/27/16 at 10:40 AM, E10, CNA, stated she had seen R2 without the mitt moving her its minute checks and E10 would put the mitt back on R2 right away.	F 328	tracheostomy tube wi was pronounced at 12 On 10/26/16 at 12:15 did the 15 minute che and R2 had her mitt of comfortable and her to that in the past she had cannula of her trach of she had seen R2 with had not actually seen would stop R2 from p On 10/26/16 at 1:40 F never seen R2 remov her without it and imm On 10/26/16 at 4:10 F not seen R2 take her seen R2 without it and left hand. On 10/26/16 at 4:12 F had not witnessed R2 her tracheostomy, but her mitt and reported On 10/27/16 at 10:32 had seen R2 rubbing against her side to tal noticed R2 doing this ordered the mitt. E8 s back on R2 right away Data of the mitt and the set of the not seen R2 without the set of the noticed R2 doing this ordered the mitt. E8 s back on R2 right away	thout success, E3 stated R2 1:35 PM. PM, E6, CNA, stated she eck on 9/25/16 at 11:15 PM on and she was calm, rach was in place. E6 stated ad caught R2 with the inner out and reported it. E6 stated a her hand on her trach, but her take it out because she ulling it out. PM, E4, LPN, stated she had re her mitt, but she had seen hediately put it back on. PM, E5, LPN, stated she had mitt off. E5 stated she had d put the mitt back on R2's PM, E7, CNA, stated she 2 took off her mitt or pull out t she has seen R2 without it to the nurse on duty. AM, E8, LPN, stated she her mittened left hand ke the mitt off. E8 stated she shortly after R2 was stated she would put the mitt y. AM, E10, CNA, stated she the mitt on while doing the d E10 would put the mitt y. E10 stated she had not	F	328				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		145478	B. WING				C 103/2016		
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)			IX i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE		
F 328	Continued From page	e 15	F	328	8				
	had seen R2 try to tal under her right arm ar of it. E9 stated she wo R2's left hand and rep she had noticed R2 tr soon as R2 was made On 10/27/16 at 3:10 F reviewed or reassess in place to prevent R2 tracheostomy tube, E to take off the hand m check on (R2) every 7 was not aware before care of R2 as floor nu	PM, when asked if she ed the current interventions							
	you say that the trach led to (R2's) expiratio stated, "Yes. The trac breathing. I was there	AM, when asked, "Would being pulled out at that time n? " Z4, Deputy Coroner ch was her only means of e and I tried to reinsert the success. When we got there							
	you say that the trach when R2 was found r expiration? ", Z3, R2's	AM, when asked, "Would a being pulled out on 9/25/16 not breathing led to her s Physician, stated, "(R2) ne trach being pulled out at a lot to do with her							
		Tracheostomy Care, "Residents who have ve trach care done daily, or							

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` <i>`</i>		CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
		145478	B. WING				C 03/2016	
NAME OF PROVIDER OR SUPPLIER			•	S	TREET 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)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 328	when needed to keep unobstructed. "The Fa tracheostomy care did interventions to keep tracheostomy safe wh attempting to pull out The Immediate Jeopa and determined to ha E2, DON, documente 9/18/16 at 0020, "(R2 (Gastrostomy) tube a shift." On 10/31/16 at and E2 were notified On 11/3/16, through in and review of the faci records, it was detern following actions: 1. Clinical team review tracheostomy care po exhibits any behavior decannulazation, the the IDT (Interdisciplin needs and intervention 2. On 11/02/16, Admin Nursing continued 10 shifts: including admin housekeeping/laundny the updated tracheos instructed to ensure th staying with the resider new interventions imm Interdisciplinary Team	the airway clean and acility Policy related to d not address appropriate a resident with hen they show signs of their tracheostomy tube. And y situation was identified we begun on 9/18/16 when d in the Nurses Note dated) continues to pull at G and trach (tracheostomy) this 3:12 PM.E1, Administrator, of the Immediate Jeopardy. Anterviews with facility staff lity policy and in-service hined the facility took the wed and revised licy to state that if resident s of attempted resident will be referred to ary team) for review of care ns. histrator and Director of 0% staff education on all histration, nursing, dietary, y and maintenance staff on tomy policy. Staff have been	F	328				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/09/2016 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
145478 B. WIN			B. WING			C /03/2016	
NAME OF PI	ROVIDER OR SUPPLIER				RESS, CITY, STATE, ZIP CODE		
NOKOMIS REHAB & HEALTH CARE CENTER				505 STEVEN NOKOMIS,			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	Continued From page inserviced on the abo		F	28			

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