PRINTED: 12/30/2019 FORM APPROVED

Illinois Department of Public Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: _ B. WING 10/15/2019 IL6009559 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1610 NORTH LAKEWOOD DRIVE **EFFINGHAM REHAB & HEALTH CARE CTR** EFFINGHAM, IL 62401 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 S 000 Initial Comments Statement of Licensure Violations Complaint Investigation: 1957111/IL116110 S9999 S9999 Final Observations Statement of Licensure Violations Complaint Investigation: 1957111/IL116110 Statement of Licensure Violations 300.1210b) 300.1210d)1)2)3) 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 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. Attachment A **Statement of Licensure Violations** Section 300.1210 General Requirements for Nursing and Personal Care

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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If continuation sheet 1 of 7

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Illinois Department of Public Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING IL6009559 10/15/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1610 NORTH LAKEWOOD DRIVE **EFFINGHAM REHAB & HEALTH CARE CTR** EFFINGHAM, IL 62401 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)Ю (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 \$9999 Continued From page 1 Pursuant to subsection (a), general d) nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. All treatments and procedures shall be 2) administered as ordered by the physician. Objective observations of changes in a 3) resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These Regulations are not met as evidenced by: Based on observation, interview and record review the facility failed to provide medications timely and as ordered by the physician, for 1 of 5 residents (R19) reviewed for medication administration in the sample of 30. R19 did not receive eight doses each of two medications that facilitate breathing for four days, six doses of one pain medication for two days, four doses of an anti-anxiety medication and four doses of a narcotic pain medication for one and a half days. These failures resulted in R19 experiencing an increase in pain, anxiety, oxygen therapy use and nausea, and unable to leave his room for meals or activities. Findings include: The September, 2019 Physician's Order Sheet (POS) states that R19 was admitted to the facility on 09/19/19 at 1:20pm. R19's diagnoses include:

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	in pain. R19 said h	ne requires continuous oxygen	, 11					
	was admitted on 2	Liters per minute, yet needed						
	to increase the oxy	gen consumption to 4 Liters						
	per minute, because his anxiety and discomfort							
		out his usual medications and						
	due to all the added aggravation. R19 had rapid							
		and said he was upset and						
	anxious.		n)					
	On 00/26/10 at 1:3	Som V61 (Family) said R19	Ħ.					
	On 09/26/19 at 1:35pm, V61 (Family) said R19 has been very upset and nauseated without his pain and anxiety medications. He is calling V61 frequently and is extremely upset and anxious, saying he is in pain. V61 stated he is waiting to							
	see a pain speciali	ist due to his rotator cuff tears	4 Ti					
		to his anxiety and breathing						
	difficulty. The facili	ity is telling them they could no	ot 🚎					
ļ		ions refilled because it was the	=:					
	weekend when he	ran out and v49 Il Director) would not refill thes	e					
	without first evalua							
	WILLIOUS IN SECVENOR	ading since						
	The September, 2	019 Medication Administration	i ii					
	Record (MAR) in p	part, documents the following:						
	•			** 				
	•	eive Budesonide and						
	Aformoterol on 09/19 at 5:30am, 09/20 - 9/22 at			\$ 00 00 00 00 00 00 00 00 00 00 00 00 00				
	5:30am and 8:00p	om and 9/23 at 5:30am.						
	On 00/23/10 at 2:1	30pm, V2 (Director of Nurses)						
	stated R19 refuse	d to take the Budesonide and		*				
		hing treatments at 5:30am						
		ot want to be awakened at that		E 99 (9 mm)				
	time. On 09/24/19	9 at 3:30pm, V7 (Licensed						
	Practical Nurse) s	aid the facility did not have the	9					
	Budesonide or the	Aformoterol in the building to						
	give to R19 from (09/19/19 through 09/23/19.						
		to work on 09/23/19, she noted						
	these breathing to	eatments were not being give	n. 1					
	V22 (Registered N	Nurse) informed her these						

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Illinois Department of Public Health (X1) PROVIDÉR/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: B. WING 10/15/2019 IL6009559 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1610 NORTH LAKEWOOD DRIVE EFFINGHAM REHAB & HEALTH CARE CTR** EFFINGHAM, IL 62401 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) \$9999 Continued From page 4 S9999 medications did not come in. This is when she called the pharmacy and ordered both medications. The treatments were started on 09/23/19 at 8:00pm. 2. R19 did not receive Pregabalin (Lyrica) 50 milligrams three times a day (7:30am/3:30pm/8:00pm) on 09/19 at 8:00pm. 9/20 x 3 doses and 09/21 x 2 doses. On 09/24/19 at 3:30pm, V7 stated the hospital did not send the facility a prescription for the Lyrica when he was discharged on 09/19/19. She sent a fax to V49 requesting this medication on 09/20/19. The Lyrica was not available for R19 until 09/21/19 at 8:00pm. *The September, 2019 Controlled Substance Proof of Use log documents the following: 1. Alprazolam (Xanax) 0.5mg, take one table by mouth three times daily as needed. R19 received the first tablet at 9:15pm on 09/19/19 and the last tablet at 8:00 PM on 09/21/19. A Controlled Substance Prescription dated 09/23/19 documents R49 ordered Alprazolam (Xanax) #30 tablets for R19. 2. Hydrocodone/ Acetaminophen 5/325 mg. take one-two tablets by mouth every six hours as needed for pain. (Amount Received #10) R19 received the first dose at 9:15pm on 09/19/19 and last dose at 2:00pm on 09/22/19. (The MAR documents R19 received Tylenol for Pain on 09/22/19 at 8:00pm and 9:49am on 09/23/19.) A Controlled Medication Prescription dated 09/23/19 documents R49 ordered Hydrocodone/Acetaminophen 5/325 (Norco) #30

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documentation states that R19 is agitated and short of breath frequently. No note details he is requesting his pain medications or that any of R19's medications did not arrive or could not be

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