

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/14/2018
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FARMER CITY REHAB & HEALTHCARE

404 BROOKVIEW DRIVE
FARMER CITY, IL 61842

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint #1862979/IL102458- F580, F600, F607, F609, F610, 300.1230 b)d)1)2)j)5)l)1-3)5)6) Complaint #1862788/IL102249- F583, F684, F686, 300.1230 b)d)1)2)j)5)l)1-3)5)6) A partial extended survey was conducted.	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 1 of 1 300.3240a)d)e) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

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

TITLE

(X6) DATE

06/01/18

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2018
NAME OF PROVIDER OR SUPPLIER FARMER CITY REHAB & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 BROOKVIEW DRIVE FARMER CITY, IL 61842		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 1 THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on interview and record review the facility failed to prevent witness employee verbal, mental, and physical abuse of one of three residents (R9) reviewed for abuse on the sample of 12. This failure resulted in psychosocial harm to R9 as evidenced by R9's response to the employee's abusive actions including crying, screaming out, flailing, becoming agitated, upset, anxious and nervous. Findings include: On 5/8/18 at 9:08 AM, V4 (Housekeeper) stated on 5/5/2018 at 11:00 AM that she heard V3 (Registered Nurse) state V3 was going to give R9 a pain pill. V4 stated V3 sounded frustrated with R9 and that V3 stated to R9, "That's it, you're getting a pain pill." V4 stated V3 grabbed R9's wheelchair and "whipped" it around and put the pill into R9's mouth. R9 spit the pill out and then V3 started yelling at R9 that R9 was going to take the pill. V4 stated V3 then picked the pill up off the wheelchair and put it back into R9's mouth in a very frustrated manner. V4 stated V3 grabbed R9's face and yelled, "Don't spit it out again." V4 stated R9 then spit the pill out again and R9 was screaming out and crying. V4 stated V3 then yelled to R9, "I am going to mash it up and put it in Applesauce and you are going to take it." V4 stated R9 continued to yell, scream, and cry. V4 stated V3 was straddling R9 and was in R9's face yelling, "You are going to take it." V4 stated V3 grabbed R9's face again and was trying to	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2018
NAME OF PROVIDER OR SUPPLIER FARMER CITY REHAB & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 BROOKVIEW DRIVE FARMER CITY, IL 61842		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 2 "shove" the pill in R9's mouth. V4 stated V3 was screaming at the top of V3's lungs and visitors were coming out of resident's rooms in response to the screaming. V4 stated she told V3 that was enough and to leave R9 alone. V4 stated that V3 then stated, "I don't give a f*** (expletive), they can turn me in." V4 stated to V3 again that was enough. V4 stated V3 then pushed R9's head back and threw water into R9's face. V4 stated she told V3 to walk away. V4 stated V3 then shoved R9's wheelchair back and V3 then went outside the building. On 5/8/18 at 1:00 PM, V12 (Family Member) stated on 5/5/18 before lunch, V12 was in R12's room visiting. V12 stated V12 walked out of R12's room. V12 stated V3 was screaming at R9. V12 stated R9 was going "crazy" and throwing a "fit." V12 stated V3 was upset because R9 would not take R9's pills. V12 stated V3 was screaming for R9 to quit throwing R9's pills on the floor. V12 stated V3 was screaming at R9, "You are going to take your pills!" V12 stated when V12 walked out of restroom V3 was screaming, "I'm not doing this anymore." V12 stated R9 was yelling this to V7 (Licensed Practical Nurse). V12 stated V7 was trying to get V3 to calm down. On 5/8/18 at 11:25 AM, V6 (Certified Nurse's Assistant) stated on 5/5/18 around lunch time, V6 walked towards the nurse's station. V6 stated R9 was in R9's wheelchair behind the nurse's station and V3 was standing directly in front of R9. V6 stated V3 was attempting to give R9 their medicine. V6 stated R9 was swinging her arms at V3. V6 stated was saying loudly to R9, "You have to take your medicine." V6 stated V3 then said V3 was going to crush the medication. V6 stated V3 then attempted to give R9 the medicine again and R9 was crying and flailing R9's arms.	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2018
NAME OF PROVIDER OR SUPPLIER FARMER CITY REHAB & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 BROOKVIEW DRIVE FARMER CITY, IL 61842		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 3 On 5/8/18 at 10:16 AM, V5 (Activity Aide) stated V5 was getting ready to start an activity on 5/5/18 before lunch. V5 stated V4 (Housekeeper) came into dining room and was distraught and upset. V5 stated V4 was looking for V7 (Registered Nurse). V5 stated V4 said to V5 that it was "crazy up front." V5 stated V5 went to nurse's station to see what was going on and saw V3 attempting to give R9 medicine. V5 stated V5 seen V3 tilt R9's head back to get R9 to swallow medicine. V5 stated V3 was trying to give R9 medicine but R9 was refusing. V5 stated V3 then crushed the medicine and gave R9 water. V5 stated R9 was spitting the medicine and water out. V5 stated V3 did manage to get the pill down R9 somewhat. V5 stated V3's voice was raised when talking to R9. On 5/9/18 at 2:06 PM, V3 (Registered Nurse) stated on 5/5/18, an unidentified Certified Nurse's Assistant brought R9 up to the nurse's station before lunch to give R9 a pain pill. V3 stated she attempted to give R9 the pill and R9 spit it out. V3 stated R9 grabbed the cup of water and water spilled everywhere. V3 stated V3 then crushed the pill and R9 took the pill. V3 stated at first R9 would open R9's mouth to take the pill but R9 would spit it back out at V3. V3 stated V3 lifted R9's forehead back to get R9 to swallow the pill. V3 stated R9 was agitated and grabbed the water glass and was throwing it around. V3 stated R9 was flailing R9's arms, resisting cares and hitting. V3 stated after the fourth time V3 gave R9 the pill, R9 swallowed it. V3 stated she was a little frustrated but wasn't screaming. V3 stated V3 never pinched R9's face, just held R9's head back. R9's nurse's notes dated 5/5/18 at 4:00 PM by V3 documents, "(R9) verbally, physically aggressive	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2018
NAME OF PROVIDER OR SUPPLIER FARMER CITY REHAB & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 BROOKVIEW DRIVE FARMER CITY, IL 61842		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 4 (with) staff. Spitting out pills. Will not allow this writer (V3) to give eye (drops). (R9) hitting, biting, throwing water and spitting on staff. Administered pain med (medication) and (R9) calmed down (after) twenty min. (minutes). Will cont. (continue) to monitor." On 5/9/18 at 9:36 AM, V7 (Licensed Practical Nurse) stated on 5/5/18 sometime before lunch that V7 was in R12's room talking to the family. V7 stated V12 left the room and was gone for about ten minutes. V7 stated V7 then heard yelling in the hallway. V7 stated V7 could not tell what the yelling was, so V7 stated V7 stepped out into the hallway and someone said V3 is leaving. V7 stated V3 was at the nursing station crying repeating herself, "I can't do this anymore." V7 stated V3 then went outside. V7 stated V4 told her that V3 held R9's nose and threw water on R9. V7 stated V7 went to check on R9 and R9 was upset. V7 stated R9 was fidgeting a lot in the wheelchair and rocking back and forth. V7 stated R9 appeared anxious and nervous. On 5/14/18 at 1:20 PM, V18 (R9's family member) stated that V18 would expect staff to stop care and reapproach later if R9 was having a bad reaction to cares. V18 stated a bad reaction means yelling out at staff. V18 stated V18 would not want the staff at the facility to force R9 to do anything. V18 stated R9 would not want someone repetitively asking R9 to do something that R9 didn't want them to do. V18 stated before R9 was cognitively impaired, if staff forced R9 to do something then R9 would fight them and call R9's family to report it. V18 stated it would have deeply upset R9 and that R9 would remember it because R9 was the type not to forget things like that.	S9999			

Illinois Department of Public Health
STATE FORM

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2018
NAME OF PROVIDER OR SUPPLIER FARMER CITY REHAB & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 BROOKVIEW DRIVE FARMER CITY, IL 61842		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999	Continued From page 6 following procedures shall be used: 1) The facility shall determine the number of residents needing skilled or intermediate care. 2) The number of residents in each category shall be multiplied by the overall hours of direct care needed each day for each category. 3) Adding the hours of direct care needed for the residents in each category will give the total hours of direct care needed by all residents in the facility. 5) Additional Direct Care Hours Equal to at Least 75% of the Minimum Required The remaining 75% of the minimum required direct care hours may be fulfilled by other staff identified in subsection (f) as long as it can be documented that they provide direct care and as long as nursing care is provided in accordance with the Nurse Practice Act. 6) The amount of time determined in subsections (l)(4) and (5) is expressed in hours. Dividing the total number of hours needed by the number of hours each person works per shift (usually 7.5 or 8 hours) will give the number of persons needed to staff each shift. Calculations shall not include time for scheduled breaks or scheduled in-service training. The number of residents used to calculate staff ratios shall be based on the facility's midnight census. This REQUIREMENT was not met as evidenced by the following: Based on record review and interview, the facility failed to meet staffing requirements for direct care staff hours for 12 of 14 days reviewed. This failure has the potential to affect all 52 residents who reside in the facility. Findings include:	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2018
NAME OF PROVIDER OR SUPPLIER FARMER CITY REHAB & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 BROOKVIEW DRIVE FARMER CITY, IL 61842		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 7 The facility's two-week staffing spreadsheet dated 4/22/18 through 5/5/18 documents staffing for 14 consecutive days. The facility was short the total number of direct care staff hours required for 12 of the 14 days as follows: 4/22/18- Total Hours worked 109 hours, short 28.7 hours 4/23/18- Total Hours worked 117.5 hours, short 20.2 hours 4/24/18- Total Hours worked 128.6 hours, short 5.3 hours 4/25/18- Total Hours worked 120.4 hours, short 17.3 hours 4/27/18- Total Hours worked 122.4 hours, short 15.3 hours 4/28/18- Total Hours worked 110 hours, short 27.7 hours 4/29/18- Total Hours worked 122 hours, short 15.7 hours 5/1/18- Total Hours worked 118.1 hours, short 17.1 hours 5/2/18- Total Hours worked 121.4 hours, short 13.8 hours 5/3/18- Total Hours worked 116.1 hours, short 19.1 hours 5/4/18- Total Hours worked 122.4 hours, short 12.8 hours	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/14/2018
NAME OF PROVIDER OR SUPPLIER FARMER CITY REHAB & HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 BROOKVIEW DRIVE FARMER CITY, IL 61842		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999	Continued From page 8 5/5/18- Total Hours worked 103 hours, short 30.9 hours On 5/14/18 at 2:05pm, V2, Director of Nursing stated the staffing numbers provided were accurate and she realizes the facility was understaffed. The facility's daily nursing staffing log dated 5/7/18 documents 52 residents reside in the facility. (No Violation)	S9999			