

Illinois Department of Public Health

|                                                     |                                                                               |                                                                        |                                                        |
|-----------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6012579</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/19/2018</b> |
|-----------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**IMBODEN CREEK LIVING CENTER**

**180 WEST IMBODEN  
DECATUR, IL 62521**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| S 000                    | Initial Comments<br><br>Annual certification                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | S 000               |                                                                                                                          |                          |
| S9999                    | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1010h)<br>300.1210b)<br>300.1210d)6<br>300.1220b)7<br>300.3240a)b)<br><br>Section 300.1010 Medical Care Policies<br><br>h) The facility shall notify the resident's<br>physician of any accident, injury, or significant<br>change in a resident's condition that threatens the<br>health, safety or welfare of a resident, including,<br>but not limited to, the presence of incipient or<br>manifest decubitus ulcers or a weight loss or gain<br>of five percent or more within a period of 30 days.<br>The facility shall obtain and record the physician's<br>plan of care for the care or treatment of such<br>accident, injury or change in condition at the time<br>of notification<br><br>Section 300.1210 General Requirements for<br>Nursing and Personal Care<br><br>b) The facility shall provide the necessary<br>care and services to attain or maintain the highest<br>practicable physical, mental, and psychological<br>well-being of the resident, in accordance with<br>each resident's comprehensive resident care<br>plan. Adequate and properly supervised nursing | S9999               |                                                                                                                          |                          |

**Attachment A**  
**Statement of Licensure Violations**

Illinois Department of Public Health

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

TITLE

(X6) DATE

**08/06/18**

Illinois Department of Public Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                               |                                                                                                                          |                          |                                                        |
|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6012579</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/19/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>IMBODEN CREEK LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>180 WEST IMBODEN<br/>DECATUR, IL 62521</b>                                   |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| S9999                                                                  | <p>Continued From page 1</p> <p>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including</p> <p>7) Coordinating the care and services provided to residents in the nursing facility.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to track, trend and report weight increases to the dialysis center for a resident with End Stage Renal Disease. The facility also failed to</p> | S9999                                                                         |                                                                                                                          |                          |                                                        |

Illinois Department of Public Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                               |                                                                                                                          |                          |                                                        |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6012579</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/19/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>IMBODEN CREEK LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>180 WEST IMBODEN<br/>DECATUR, IL 62521</b>                                   |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| S9999                                                                  | <p>Continued From page 2</p> <p>consult with the physician to request orders for compression hose. These failures affect one of three residents (R67) in the sample of 18. These failures resulted in the resident being re-admitted to the hospital intensive care unit with a diagnosis of Acute Respiratory Distress and the resident being placed on a ventilator for breathing support. In addition based on interview and record review the facility failed to prevent a fall by failing to accommodate personal needs for one of three residents (R48) reviewed for fall on the sample of 18. This failure resulted in R48 sustaining lacerations to the head and a left Humerus fracture.</p> <p>Findings include:</p> <p>R67's Resident Face Sheet dated 7/18/18 documents R67's diagnoses including Acute Respiratory Failure with Hypoxia, Hemothorax, Pleural Effusion, Acute Respiratory Distress and Stage IV Chronic Kidney Disease (Severe).</p> <p>R67's Care Plans dated 6/22/18 document R67 has a diagnosis of Congestive Heart Failure (CHF). These care plans also document to assess, record and report weight gain. These care plans also document to monitor, record and report dialysis complications to the physician including fluid overload.</p> <p>R67's Weight list dated 7/18/18 documents R67's continued weight increases as follows:</p> <p>6/14/18- 164.4 pounds (lbs)</p> <p>6/15/18- 168.8 lbs (4.4 lbs weight gain since 6/14/18)</p> <p>6/16/18- 172.8 lbs (4 lbs weight gain since</p> | S9999                                                                         |                                                                                                                          |                          |                                                        |

Illinois Department of Public Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>1L6012579</b>          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/19/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>IMBODEN CREEK LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>180 WEST IMBODEN<br/>DECATUR, IL 62521</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| S9999                                                                  | <p>Continued From page 3</p> <p>6/15/18)</p> <p>6/17/18- 175.4 lbs (2.6 lbs weight gain since 6/16/18)</p> <p>There is no documentation in R67's medical record that the Dialysis facility was notified of R67's continued weight gain from 6/14/18 through 6/17/18.</p> <p>R67's Progress Notes dated 6/19/18 at 2:30am document R67 was having increased weakness on 6/19/18 and R67 had Dialysis on 6/18/18. This note documents R67's "weight was trended and shows increase in weight. MD (medical doctor) faxed in regards." There is no documentation the "MD" responded to the concerns of the weight increases for R67.</p> <p>R67's Progress Notes dated 6/19/18 at 4:47am document R67 was "looking worse than before" according to staff and was short of breath at rest with respirations of 52 breaths per minute. R67's lung sounds were with wheezes on expiration and "legs now noted to have four plus pitting edema" and the "MD" was called.</p> <p>R67's Progress Notes dated 6/19/18 at 2:12pm document R67 was admitted to the Intensive Care Unit (ICU) with diagnoses including Respiratory Failure, Hypoxia, CHF Exacerbation and Pleural Effusion.</p> <p>On 07/18/18 at 11:40 AM, V17, R67's Physician stated it is a possibility the compression stockings could cause fluid to be pushed back up to the heart and cause an exacerbation of Congestive Heart Failure (CHF) or fluid overload. V17 stated V17 did not recall giving an order for compression stockings for R67. V17 stated the facility should</p> | S9999                                                                                  |                                                                                                                          |  |                                                        |

Illinois Department of Public Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                               |                                                                                                                          |                          |                                                        |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6012579</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/19/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>IMBODEN CREEK LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>180 WEST IMBODEN<br/>DECATUR, IL 62521</b>                                   |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| S9999                                                                  | <p>Continued From page 4</p> <p>obtain an order for compression stockings before placing them on a residents. V17 stated due to R67 requiring Dialysis that Dialysis is the one monitoring R67's weights and fluid balance. V17 stated the facility should be notifying dialysis related to fluid balance and weight increases.</p> <p>On 07/18/18 at 02:20 PM - V18, Nursing Director of Dialysis unit stated R67 came to the facility after hospitalization on 6/13/18. V18 stated R67 re-admitted to the hospital from the facility on 6/19/18 with Acute Respiratory Distress and had to be placed on a ventilator for breathing support. V18 stated R67 had gained 3kg (Kilograms) from 6/16/18 to 6/18/18 per dialysis weight records and dialysis could not get all R67's extra fluid weight off when they dialyzed R67 on 6/18/18. V17 stated if the facility would have communicated the facility's assessment of weight increase values prior to the dialysis treatment on 6/18/18, the dialysis unit could have evaluated and changed treatment to take additional fluid off and potentially avoided R67's fluid overload that sent R67 to the hospital on 6/19/18. V17 stated that due to R67's hospitalization and fluid balance concerns, post hospitalization on 6/19/18, the dialysis unit had to decrease R67's target weight and increase time R67 was on dialysis machine due to extra fluid so they could pull more fluid from R67. V17 stated some facilities send a communication form, but that the facility R67 resides in does not send communications with the dialysis unit. V17 stated communication sheets would help with updates related to the residents condition as well as changes in vitals, weights, orders or cares. V17 stated it is really important for specialized care and communication between the facility and dialysis. V17 also stated the dialysis facility does not give orders related to compression stockings and that they would defer</p> | S9999                                                                         |                                                                                                                          |                          |                                                        |

Illinois Department of Public Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                                                                                          |  |                                                        |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6012579</b>          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/19/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>IMBODEN CREEK LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>180 WEST IMBODEN<br/>DECATUR, IL 62521</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| S9999                                                                  | <p>Continued From page 5</p> <p>those requests to the primary care physician. V17 stated R67 gaining 11 pounds from 6/14/18 to 6/17/18 is excessive and the dialysis facility should have been notified so they could evaluate the need for any changes in dialysis treatment to address additional fluid. V17 also stated when R67 was admitted to the hospital and intubated on 6/19/18, they removed "a lot" of fluid and R67 had lost 15 pounds of fluid.</p> <p>R48's Event Summary Report dated 5/2/18 at 8:42 AM documents, "At approximately 8:15 AM, staff was alerted to room by sounding bed alarm. (R48) was noted to be lying facedown on bedroom floor with head facing door. Nursing assessment revealed two lacerations to the head with a knot and bruising along with a bleeding (skin tear) to the right hand. Left arm rotated outward and flaccid. (R48) reported extreme pain in left upper extremity." This report also documents that R48 was sent to the emergency room and was diagnosed with a left humerus fracture.</p> <p>R48's Event Summary Report dated 5/2/18 at 8:42 AM documents an investigation which states, "Based on fall investigation, resident pushed call light and sat up at edge of bed wanting to get up and ready for the day. Staff promptly responded to light and informed (R48) that she was assisting another resident but would be in shortly. (R48) laid back down. Approximately ten minutes later staff responded to sounding bed alarm and (R49) calling for help. It appears resident stood up from bed with the intentions to get ready for the day when she lost balance causing (R48) to fall." This report also documents, "Staff reeducated on wake-up times and the importance of prioritizing to meet needs."</p> | S9999                                                                                  |                                                                                                                          |  |                                                        |

Illinois Department of Public Health

|                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                               |                                                                                                                          |                          |                                                        |
|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>IL6012579</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/19/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>IMBODEN CREEK LIVING CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>180 WEST IMBODEN<br/>DECATUR, IL 62521</b>                                   |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| S9999                                                                  | Continued From page 6<br><br>On 7/17/18 at 3:28 PM, V4 Director of Nursing stated stated V4 investigated R48's 5/2/18 fall. V4 stated the staff (V5 Certified Nurse's Assistant and V6 Licensed Practical Nurse) were educated because R48 had sat up on the side of the bed and wanted to get up. R48 has confusion. They should have gotten R48 up at that time. R48's get up time is 7:00 AM to 7:30 AM. The resident's get up times are determined through interview of preference. All resident's have specific get up times. If they (V5 and V6) would have gotten her up she wouldn't have been in the bed and fallen out of bed. R48 got a humerus fracture and lacerations.<br><br>( B) | S9999                                                                         |                                                                                                                          |                          |                                                        |