

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009328	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/13/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SUNSET REHABILITATION & HLTH C	STREET ADDRESS, CITY, STATE, ZIP CODE 129 SOUTH 1ST AVENUE CANTON, IL 61520
---	---

(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	S 000		
S9999	<p>Investigation of Facility Reported Incident of 6-26-2021/IL135463</p> <p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610a) 300.1210b) 300.1210c) 300.1220b)3) 300.2040b) 300.2040g) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) 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</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health

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

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009328	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SUNSET REHABILITATION & HLTH C	STREET ADDRESS, CITY, STATE, ZIP CODE 129 SOUTH 1ST AVENUE CANTON, IL 61520
--	---

(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	<p>Continued From page 1</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</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>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>Section 300.2040 Diet Orders</p> <p>b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered.</p> <p>g) The kinds and variations of prescribed therapeutic diets shall be available in the kitchen.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009328	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/13/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SUNSET REHABILITATION & HLTH C	STREET ADDRESS, CITY, STATE, ZIP CODE 129 SOUTH 1ST AVENUE CANTON, IL 61520
---	---

(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	<p>Continued From page 2</p> <p>If separate menus are not planned for each specific diet, diet information for each specific type, in a form easily understood by staff, shall be available in a convenient location in the kitchen.</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>These requirements were not met as evidenced by:</p> <p>Based in interview and record review, the facility failed to provide R1 with care planned nutritional safety interventions; failed to provide adequate supervision and one staff physical assistance while eating as documented per R1's care plan and MDS (Minimum Data Set) assessment; and failed to make sure the care plan interventions were reflected on R1's physician order sheets (POS's) for one of three residents (R1) reviewed for supervision during meals in the sample of three. These failures resulted in R1 feeding himself, unsupervised, resulting in R1 choking which caused R1's death.</p> <p>Findings include:</p> <p>R1's "Profile Face Sheet," not dated, documents, "Diagnosis: Diffuse tbi (traumatic brain injury) with loss of consciousness of unsp(specified) duration, Aphasia."</p> <p>R1's Care Plan, dated 4-23-21, documents, "Feed Resident Meal: Resident can at times eat very quickly, overfill mouth with food, will stand and pace while eating, res(ident) unable to follow basic commands including recognizing and</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009328	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/13/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUNSET REHABILITATION & HLTH C	STREET ADDRESS, CITY, STATE, ZIP CODE 129 SOUTH 1ST AVENUE CANTON, IL 61520
--	---

(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	<p>Continued From page 3</p> <p>adhering to safety;" and "Provide foods in forms easily picked up-sandwiches, finger foods etc(etera), as able and res(ident) tolerates."</p> <p>R1's "Physician Orders Sheet," dated 6-11-21, does not include finger-foods as part of R1's dietary order.</p> <p>"Dietary Admission Assessment," dated 4-9-21, documents, R1's "Dental Status-few teeth poor condition."</p> <p>R1's Minimum Data Set (MDS), dated 4-22-2021, documents, R1's "Functional Status: H. Eating as Self Performance-2 (limited assist) and Support-2 (one-person physical assist)."</p> <p>Court document entitled "In the Circuit Court for the Twenty-Third Judicial Circuit Dekalb, Illinois," dated 4-25-21 (fax), documents, "Physicians Report (V14), as a physician licensed to practice medicine in all its branches in the State of Illinois, submits the following report on the above named (R1) alleged to be a disabled person, based on an examination of the respondent on 4-24-21. 1. Describe the nature and type of the respondent's disability: Total cares 24/7 pt (patient) with severe traumatic brain injury, non-traumatic psychosis, nonverbal, severe behavior issues, cannot do any activities of daily living. 3. State whether in your opinion, the respondent is totally or only partially incapable of making personal and financial decisions, and if the latter, the kinds of decisions which the respondent can and cannot make. Include the reasons for this opinion: Pt is totally incompetent & unable to do any personal cares or make any decisions."</p> <p>Facility document, entitled "IDPH Notification Form," dated 6-26-21, documents, "Resident (R1)</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009328	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/13/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SUNSET REHABILITATION & HLTH C	STREET ADDRESS, CITY, STATE, ZIP CODE 129 SOUTH 1ST AVENUE CANTON, IL 61520
--	---

(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	<p>Continued From page 4</p> <p>diagnoses included: Bipolar Disorder, aggressive behavior, flat affect; psychosis; traumatic brain injury with impulsiveness; aphasia; and left frontal hematoma. During supervised lunch meal, staff noticed resident was eating quickly. Staff attempted to instruct resident to eat slower and resident did not follow direction. Resident noted to begin to choke. Heimlich maneuver was initiated immediately by staff. 911 was called. EMT's arrived and were unable to remove food. Resident was a DNR (Do Not Resuscitate) and time of death was 12:21 p.m. and announced by paramedics."</p> <p>"Fulton County Coroner Preliminary Investigation Report," dated 6-26-21 regarding R1's death, documents, "Due to evidence from the body and the medical history my ruling is of an accidental death due to: Brain Hypoxia, due to choking, due to previous Intracranial brain injury."</p> <p>On 7-1-21 at 12:50 p.m., V4 (Certified Nursing Assistant/CNA) confirmed on the day of R1's expiration 6-26-21, during the noon meal, R1 was not receiving staff assistance with eating and R1 was eating very fast and when asked to slow down, R1 stood up for the table and walked out of the dining room and started choking. V4 (CNA) initiated the Heimlich maneuver on R1.</p> <p>On 7-6-21 at 10:30 AM V6 (CNA) stated, "Someone summoned staff to the B hall for help over the intercom. I went to B hall to help and found (R1) right outside of the dining room on the floor. (V4/CNA) was performing the Heimlich maneuver on (R1) and told me that (R1) had choked and collapsed in her arms. (V4/CNA) could not get her arms around (R1) to do the Heimlich right. I immediately took over the Heimlich. (R1) had a lot of sweet potatoes and</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009328	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/13/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SUNSET REHABILITATION & HLTH C	STREET ADDRESS, CITY, STATE, ZIP CODE 129 SOUTH 1ST AVENUE CANTON, IL 61520
---	---

(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	<p>Continued From page 5</p> <p>pieces of ham coming up out of his mouth. (R1) did a lot better with finger foods. If (R1) would not get finger food, he would eat too fast and shove large amounts of food in his mouth. (R1's) meat needed to be cut up."</p> <p>On 7-6-21 at 10:55 AM V8 (Licensed Practical Nurse/LPN) stated, "I was working on C-wing and heard a page for all nurses to report to B-wing. When I got to B-wing, (R1) was on the floor and (V5/LPN) was finger sweeping (R1). (R1) needed finger food or he would try to eat too fast. We never cut (R1's) meat up. No one assisted (R1) with eating that day."</p> <p>On 7-6-21 at 11:55 AM V17 (Cook) stated, "I made (R1's) tray the day that he choked. I had put a slice of ham, soft sweet potato chunks, and a vegetable (unsure which one) on his tray. I did not cut the meat up. I was never aware of (R1's) care plan interventions indicating (R1) needed finger foods. I never look at the resident's care plans."</p> <p>(A)</p>	S9999		