Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
IL6000947		IL6000947	B. WING		C 06/11/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRES				STATE, ZIP CODE		
BEVERL	Y FARM FOUNDATION		IBERT ROA Y, IL 62035			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE	
Z 000	COMMENTS		Z 000			
	Complaint Investiga	ition	!		**	
	2143524/IL134133					
Z9999	FINDINGS		Z9999			
	Statement of Licens	sure Violation				
	350.620a) 350.1210 350.1220j) 350.1230d)1) 350.1230d)2) 350.1230d)3) 350.3240a)					
	Section 350.620 Re	sident Care Policies				
	procedures governing facility which shall be involvement of the a shall be available to public. These written	nave written policies and ng all services provided by the e formulated with the dministrator. The policies the staff, residents and the n policies shall be followed in and shall be reviewed at				
	Section 350.1210 He	ealth Services		8		
		vide all services necessary to ent in good physical health.				
	Section 350.1220 Ph	nysician Services	S.			
	of any accident, inju- condition that threate	otify the resident's physician ry, or change in a resident's ens the health, safety or r, including, but not limited to,	Ø1	Attachment A Statement of Licensure Violations		
inois Depart	ment of Public Health DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	(X6) DATE	

STATE FORM

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** A. BUILDING: _ COMPLETED C B. WING IL6000947 06/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6301 HUMBERT ROAD BEVERLY FARM FOUNDATION GODFREY, IL 62035 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Z9999 Continued From page 1 Z9999 the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical. nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. Section 350.3240 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) These regulations were not met as evidence by: Based on record review and interview, the facility failed to implement policies and procedures to prevent neglect for 1 of 1 individual (R1) when they failed to:

condition.

1. Ensure staff implemented their policy on Abuse and Neglect, affecting 1 of 1 (R1) individual in the sample who resides in Hillier, when they failed to

monitor and complete a thorough nursing assessment for R1 who had a change in

2. Ensure nursing staff followed their policy regarding a change in condition, when staff failed

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R1's Individual Service Plan (ISP) dated 10/20/20 documents, "R1 uses a wheelchair for mobility. At times R1 will get out of wheelchair independently or off the furniture to get objects from the ground to place in his fanny pack. R1 is capable of using phrases and short sentences, expresses himself

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emotional condition."

or regression from each individual's established goals, and changes in individual's physical or

The Facility's job descriptions titled. Licensed Practical Nurse, dated September 24, 2019. documents in part, "Recommend changes to

responsibility to ensure that all lab work, physical

physician when needed. Assume the

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approx 7:30 AM."

weird. Upon assessment resident had respirations 32; would not respond to verbal stimuli. Sternal rub x 2. resident did not verbally respond or open eyes but was moving around. Oxygen 85%. Put on 2L per Nasal Cannula. O2 up to 95%. Tachycardic 120-125. BP and temperature within normal limits. Called EMS

Facility Nursing Note by E17 (RN), dated 5/16/21

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Nurses have a two day orientation." E4 further stated, "I would like to have seen E33 (Charge Nurse) go over and assess R1; she didn't." When E4 was asked if a full head to toe assessment should have been done, E4 stated, "A head to toe assessment should be done by the Nurse when

something is wrong with an individual."

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CBC was last drawn on 10/20/20.

Review of Pharmacy recommendation dated 5/7/21 documents, "This resident does not have a

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Hydronephrosis."

Proteus Mirabilis, Kidney Stone with

During interview with E39 (Supervisor) on 5/26/21 at 2:10 PM, E39 stated, "I last worked May 13th on the midnight shift. R1's urine has always been smelly. He grunts when he pees. He has been doing that for years and nursing was aware."

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