Illine	ois C	Department of Public	Health			FOR	MAPPROVE	ΞD
		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:		TE SURVEY MPLETED	
,		,	IL6006548	B. WING			C	
NAMI	E OF I	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE	1 04	/27/2022	_
HEL	.IA H	EALTHCARE OF NEW	TON 300 S SC	OTT STREE				
	_		NEWTON	l, IL 62448				
(X4) PRE TA	FIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	ID RE	(X5) COMPLETE DATE	Ξ.
S	000	Initial Comments		\$ 000				_
		Complaint Investiga	tion: 2253162/IL146100	i			1	
SS	9999	Final Observations		S9999	i i			
		Statement of Licens	ure Violations:		*			
		300.1210b) 300.1210d)6			F6			
		Section 300.1210 G Nursing and Person	eneral Requirements for all Care					
		and services to attain practicable physical, well-being of the resi each resident's comp plan. Adequate and p care and personal ca	provide the necessary care nor maintain the highest mental, and psychological dent, in accordance with prehensive resident care properly supervised nursing are shall be provided to each total nursing and personal sident.					
		d) Pursuant to subscare shall include, at and shall be practice seven-day-a-week ba	section (a), general nursing a minimum, the following d on a 24-hour, asis:					
		assure that the reside as free of accident ha nursing personnel sha	cautions shall be taken to ents' environment remains izards as possible. All all evaluate residents to see seives adequate supervision event accidents.					
		These Requirements evidenced by:	were NOT MET as		, v			
	E	Based on interview ar	nd record review, the facility		Attachment A Statement of Licensure Violations			

inols Department of Public Health
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 05/17/2022 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 С IL6006548 B. WING 04/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **300 S SCOTT STREET** HELIAHEALTHCARE OF NEWTON NEWTON, IL 62448 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 1 S9999 failed to timely notify the physician of signs and symptoms indicative of an injury/hip fracture, and to immediately obtain orders for an x-ray for one (R2) of three residents reviewed for quality of care in the sample of three. This failure resulted in R2 experiencing a delay in medical treatment including surgical intervention for a right hip fracture for at least three days or more from the time symptoms were noted. Findings include: On 4/22/22 at 10:20 am, V2 (Hospital Social Worker) stated the facility sent R2 to the emergency room (ER) on the evening of 04/19/22. V2 stated the facility staff stated that R2 fell on 03/31/22 and was experiencing hip pain and swelling of the right leg. V2 stated the facility staff said they did not send R2 to the ER sooner because R2 had not previously complained of pain. V2 stated an x-ray done in the ER showed that R2 had sustained a broken right hip. V2 expressed concern regarding the length of time between the fall and the facility sending R2 to the ER for evaluation and treatment. R2's Diagnosis List documented diagnoses including Vascular Dementia without Behavior Disturbance, Chronic Obstructive Pulmonary Disease, Cognitive Communication Deficit, Atrial Fibrillation, and Muscle Weakness. R2's Care Plan with a review date of 01/26/22 documented, "(R2) has a history of falls, with the last one being 03/31/22." R2's 02/07/22 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 7, indicating R2 has severe deficits in cognitive functioning. This BIMS

	Department of Public				ION	MARKOVEL
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006548			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		C		
NAMEOF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	1 04/	27/2022
HELIAH	TEALTHCARE OF NEW	TON 300 S SC	OTT STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DRE	(X5) COMPLETE DATE
S9999	Continued From page	ge 2	S9999			
	prompting after five current month, The	ert, could repeat three words uld repeat one of them without minutes, and could state the same MDS indicated R2	(3) (4)			
	others, and was usu The MDS also indica assistance of one sta	ach, usually understood ally understood by others. ated R2 ambulated with the aff member and had no of motion to the upper or				*
	a score of 20, indicat to being disoriented to	isk Assessment documented ting R2 is at risk of falls due to person, place, and time at ry of three or more falls in s.				
	"Resident was in bed to her chair. Resident comp and head pain. Resid was sent out to ER for treatment. Doctor and	ated 03/28/22 documented, and tried to transfer herself t fell and hit right side of clains of right sided leg, rib, lent is on blood thinners and or further evaluation and d family aware." A 03/28/22 cal stated," (Hip) X-ray sture."				
	(Registered Nurse/RN on floor in hallway. Re injury. Resident taken assessed, small skin t	restigation, completed by V8 I) documented, "Resident esident denies any pain or to hospital-no. Resident tear to right elbow noted. factors: Ambulating without using wheelchair."				
	K2) stated she is a nu	am, V3 (Family Member of rse. V3 said R2 has a due to self-transfer and safety issues due to				14

Illinois Department of Public Health FORM APPROVE							MAPPROVED
		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:		E SURVEY APLETED
			IL6006548	B. WING _		04	C /27/2022
	NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS CITY	, STATE, ZIP CODE		12112022
	WEL IAU	EAITHCARE OF NEW	200.0.00	OTT STREE			
	ПЕСІАП	EALTHCARE OF NEW		, IL 62448	- •		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULID BE	(X5) COMPLETE DATE
	S9999	Continued From pa	ge 3	S9999			
		advanced Dementia fall was on 03/31/22 back pain due to sp gave R2 prn (as ner she complained of p stated beginning 04 Member) began obsright hip and yell our V6 asked various st (R2's Physician/Fac an order to x-ray R2 always said R2 did r were monitoring R2 her condition. V3 staff they asked aboracility has several a now. V3 stated where R2 was soiled, so V3 swollen from the this bruised, and R2's right right right right results and R2's right	a. V3 stated R2's most recent 2. V3 stated R2 had chronic inal curvature. V3 stated staff eded) pain medication when pain and it was effective. V3 /02/22, she and V6 (Family serving that R2 would grab her tin pain. V3 stated she and aff numerous times to call V5 ility Medical Director) and get is right hip. V3 stated staff not need an x-ray, and they and keeping V5 informed of ated she cannot recall which but the x-ray, because the agency staff working there in she visited R2 on 4/16/22, 3 removed R2's clothing to saw that R2's right leg was gh down, R2's right hip was ght foot was externally ne informed V9 (Licensed	39999			
		Practical Nurse/LPN stated V9 said she was getting an x-ray but it x-rayed that day as it V9 didn't think the coprovider was available further until 4/19/22, that R2 had been selfon 4/22/22 at 11:40a Assistant/CNA), state 3/31/22, V4 did not regist hip, nor range of swelling, or external recall that R2 would attime but R2 also wo pain all over and course.) and V9 examined R2. V3 vould contact V5 about t probably wouldn't be t was a holiday weekend and ontracted portable x-ray le. V3 said she heard nothing when she was notified by V6				

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 IL6006548 04/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 S SCOTT STREET HELIA HEALTHCARE OF NEWTON **NEWTON. IL 62448** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S9999 Continued From page 4 S9999 believed nursing staff were giving R2 prn pain medications. On 4/22/22 at 11:45am, V6 (Family Member) stated when she visited R2 on 4/2/22. R2 seemed to be in pain, grabbing her right hip and saying her leg hurt. V6 stated on that date (4/2/22) she saw R2's right leg out of her clothing and noticed a bruise on the right hip, but V6 did not notice if there was any swelling or external rotation at that time. V6 stated R2 seemed to be less able to move the right leg like usual. V6 stated on 4/2/22 she started asking the nurses to get the right leg x-rayed, and staff would always say they would "Check with (V5) and let us know." V6 stated "They just kept saying that anytime we asked." V6 stated she didn't know which staff she talked to as the facility has a lot of agency staff working at present. V6 stated when R2 was in pain, nursing staff would give her a pain pill, and R2 was also getting a scheduled pain pill. V6 stated everything came to a head when V3 (Family Member) visited on 4/16/22, and V3 told V6 that R2's right leg was swollen. V6 stated V3 said she had the nurse come in and look at it, and the nurse said they would get it x-rayed. V6 stated she never heard any more about it until the evening of 4/19/22, when the facility called and said they were sending R2 to the ER because the right hip was fractured. On 4/22/22 at 1:00pm, V7 (RN) stated her first day at the facility was on 04/07/22. V7 stated she had very little interaction with R2. V7 stated she did not recall doing any physical assessments on R2. V7 stated she didn't recall hearing anything from the CNA's or in report about R2's right hip. V7 stated she didn't think R2 ever complained of pain or needed PRN (as needed) pain

medication. V7 stated when she worked on

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY
,		IL6006548	B. WING		04	C 27/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, 9	STATE, ZIP CODE		LITEULL
HELIAH	EALTHCARE OF NEW	TON 300 S SC	OTT STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULED BE HE APPROPRIATE	(X5) COMPLE DATE
	04/19/22, she recall which documented right femur. V7 state (Family) and V5 (Ph to be sent to ER. V7 ambulance immedia ER. On 04/22/22 at 1:10 on duty when R2 fel immediately assess head-to-toe physical neurological check, physical injuries, excelbow. V8 stated V5 rounding at that time and gave no new treathed ays that followe with the right leg or had her usual complication of hip/leg approached her one remember the date, hip needed an x-ray. R2's right hip, and the swelling, external rot the leg, so she didn't does not recall if she assessment. V8 state assessment she did remembered helping morning, and R2 didn't does not recall if she assessment she did remembered helping morning, and R2 didn't stated R2's range of always was, and at tis stand up unassisted wheelchair and would stated she came in to	Is seeing a faxed x-ray result that R2 had a fracture of the ed she immediately notified V6 sysician), and V5 ordered R2 stated she called the ately and R2 was sent to the ately and R2 was sent to the ately and R2 was sent to the ed R2's vital signs and did a levaluation and a and there were no findings of cept a small skin tear to right (Physician) was in the facility e, so he also assessed R2, eatment orders. V8 stated in ed, R2 exhibited no issues hip. V8 stated she recalled R2 aints of back pain, but no pain. V8 stated R2's family time, of which she does not and asked V8 if she felt R2's V8 stated she assessed ere were no bruises, ation, pain, or shortening of contact V5. V8 stated she documented this ed this was the only formal for R2 in April 2022, but she the CNA's dress R2 one not have any bruises, ation, or shortening. V8 motion was the same as it mes R2, as usual would while seated in her direquire redirection. V8 work at 6:00am on 4/19/22 //22 order on the desk for R2		DEPICIENCY		

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING IL6006548 04/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 S SCOTT STREET HELIA HEALTHCARE OF NEWTON NEWTON, IL 62448 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY**) S9999 Continued From page 6 S9999 called the facility's contracted portable x-ray. provider. V8 stated their staff came out within a couple of hours, and she recalls it was before lunch. V8 stated the results had not come in when she left at 2:00pm that day. Afax communication from V5's office, dated 04/18/22, documented an order for R2 to receive a right hip/pelvis and right femur x-ray. An illegible signature and "Done, 04/19/22" were handwritten in the lower right corner. A04/19/22 Right Radiological Examination, Femur, for R2 documented, "Question Femoral Neck Fracture." On 4/22/22 at 1:45pm, V5 (Physician) stated R2 fell on 03/31/22 while he was rounding at the facility. V5 stated he assessed R2, and noted R2's face was bruised, but there were no injuries to the right hip or leg. V5 stated nobody from the facility contacted him about R2 until V9 (LPN) called his office on 4/18/22 at 11:44am saving the right leg was swollen, and V5 stated he then ordered an x-ray of the right hip. V5 stated his next contact with the facility was on 4/19/22 when V7 called and stated the x-ray showed a right hip fracture, and V5 ordered R2 to be sent to ER. V5 stated R2 subsequently required surgery to repair the hip. V5 stated he was unaware the leg had been swollen and R2 had been complaining of pain on 04/16/22. V5 stated he would have ordered an x-ray immediately. V5 further stated when he ordered the x-ray on 04/18/22, it should have been done stat (immediately), and if the portable x-ray provider was unavailable, staff should have called him for an order for R2 to be sent to the ER. V5 additionally stated that if staff had notified him on 04/02/22 of the family's

request for an x-ray because of R2's complaints

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2)-MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY DENTIFICATION NUMBER: A. BUILDING: COMPLETED C IL6006548 B. WING 04/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **300 S SCOTT STREET** HELIA HEALTHCARE OF NEWTON NEWTON, IL 62448 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 7 S9999 of hip pain, he would have ordered the x-ray immediately. V5 stated he is available by phone 24 hours a day for his patients and the facility knows how to contact him. V5 stated the facility's lack of action meant that R2 went without intervention for the hip fracture for three extra days. V5 stated complications from the untreated fracture could have included bleeding into the fracture with resulting anemia, since R2 is taking Carrel stated other complications could include a blood clot from the fracture, and the development of a pressure ulcer from the lack of normal mobility. V5 stated he doubted it took from 03/31/22 until 04/16/22 for R2 to develop leg swelling and external rotation of the leg. V5 stated he expected staff to do a physical assessment of R2 at least daily for several days after the fall in case new symptoms developed or something was missed during the initial assessment. V5 stated he doubted nursing staff were adequately assessing R2 in the days after the fall. A04/19/22 ED (Emergency Department) Hospital Admission Evaluation documented, "History of Present Illness: (R2) is an 88-year-old female presenting via EMS (Emergency Medical Services) from the nursing home for evaluation after a fall. (R2) was complaining of more right hip pain today so they did (an) x-ray which showed right hip fracture so (they) sent patient to ED... Assessment and Plan: Closed right hip fracture. Patient is admitted to (hospital)...Orthopedic surgery will be consulted regarding her care...She will be given morphine for pain every 4 hours as needed." On 4/22/22 at 2:15pm, V9 (LPN) stated that on 4/16/22, V3 (Family) asked her to assess R2's right leg, which was swollen and painful. V9

Ilinois Department of Public Health

stated she does not recall if it was bruised. V9

Illinois [Department of Public	Health			FORM	APPROVED
,	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	E SURVEY
AND PUI	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3:		PLETED
						C
		IL6006548	B. WING			27/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDECC OITY	STATE 7/2 CODE	1 04/	LIIZUZZ
				STATE, ZIP CODE		
HELIAH	EALTHCARE OF NEW	NON	OTT STREE , IL 62448	:1		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	CORRECTION -	(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	DATE
1225	187/			DEFICIENC	τ)	
S9999	Continued From pa	ge 8	S9999			
	stated that V3 said	she, V6 (Family), and V11				
	(R2's Power of Atto	rney), did not want R2 sent to				:
	the emergency roor	n. V9 stated she told V3 she				
	did not think the por	rtable x-ray provider would				
	come out on a holid	lay weekend. V9 stated she				
	did not try to contac	t the x-ray provider. V9 stated				1 .
	she did fax V5's office about R2's status, but then					-
	realized as it was the	e weekend, his office would				
	be closed. V9 stated she did not call V5. V9 stated she told the oncoming nurse, V10 (RN) about the hip, and that R2 would need to be monitored. When asked, if in her professional opinion, R2 should have been sent to the ER on					
7.44						
	04/16/22, or if she s	hould have contacted V5, V9				
	stated she is agency	y staff and is not very familiar				
	with R2, so she coul	ldn't say for sure. V9 stated		1		
	she did not recall ev	er performing a physical		*		1
	ehe did not recall die	except for 04/16/22. V9 stated scussing R2 with any of R2's				
- 72	family prior to 4/16/2					
	runny prior to 4/ 10/2					
- 6	On 4/22/22 at 1:35p	m, V3 (Family) stated she				
	told V9 (LPN) that it	is always difficult for R2 to go				
	to the ER because s	the gets upset and confused				
	due to her Dementia	a, and V3 felt it was preferable				
	if R2 didn't have to g	o but did not state that the				1 1
(0.1)	family didn't want R2	to go out. V3 stated she had				
	assumed v9 called v	V5 (Physician). V3 stated V9		ſ	ĵ	
	did not say one way or other if she thought R2 should be sent out.			194		
1	Should be sent out.	1,000				
4	On 4/22/22 at 2:45pr	m, V10 (RN) stated when she				
	came on duty on 4/1	6/22, V9 stated V3 did not		-		
	want R2 sent to the I	ER. V10 stated that V9 stated		r 		1
	she called V5, and the	nat R2 was to be monitored,	12		1	l l
	and there was no ord	der for an x-ray. V10 stated				
. 0	she did not talk to an	y of R2's family. V10 stated				
	already had MAD etc	/5 as she believed V9				7 .
	the family ever sekin	ted she did not recall any of g for R2 to get an x-ray. V10				
	the fairing ever dakill	g for the to get all x-ray. V10				[

PRINTED: 05/17/2022 FORM APPROVED

	Departition of Public				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED	
		IL6006548	B. WING		С
NIANE OF					04/27/2022
NAME OF	PROVIDER OR SUPPLIER	_		STATE, ZIP CODE	
HELIAH	EALTHCARE OF NEW	NEWTON	OTT STREE , L 62448	:T 	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
S9999	Continued From page	ge 9	S9999		
	stated she recalled and 04/17/22, and F herself with a good a complaints of pain the she thought she had on R2 on both days documented it. V10 about R2. V10 state staff roll R2 from sid her, and she did not stated she did not rethe right leg did not 1 On 04/26/22 at 2:35 times on occasion won a ten scale nor st V12 stated when this scale for cognitively	working with R2 on 04/16/22 k2 was her usual self, she fed appetite, and had no nat V10 recalled. V10 stated I done a physical assessment but was not sure if she had stated she did not contact V5 d she recalled observing CNA e to side when they changed appear to be in pain. V10 call seeing any bruises, and ook swollen. om,V12, RN, stated there are hen R2 cannot rate her pain ate the location of the pain. I happens, staff utilize a pain impaired residents. V12			
	ensuring R2's pain is On 4/22/22 at 3:15pr	n, V1 (Administrator) was			
	asked for any Nursin for April 2022. V1 pro slips of paper titled, "handwritten notes sh "Skin Issues-0 (zero, illegible signatures in signature lines; 4/9/2 were no CNA or Nurs	g Assessments done for R2 duced three printed half Shower Sheets," all with owing the following: 4/6/22: none)." The sheet had the CNA and Nurse 2: Skin Issues: 0." There se signatures on this sheet:	~		
1	and 4/16/22: Skin is: helped with bed bath. was signed by V4, bu signature on this form				
5	03/31/22 fall status, F complaining of pain, F	ng Progress Notes entation about R2's post t2's family reports of R2 R2's family requesting an			

SYNTHEMPT OF DEPICIENCIES AND PLAN OF CORRECTION COMPLETED COMPLETED	Illinois D	Department of Public	Health			I OK	MAPPROVED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 S SCOTT STREET NEWTON, IL 62448 (X4) ID PREFIX (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 10 physical assessment or range of motion, until a 04/16/22 note at 3:40pm. This Nursing Progress Note was authored by V9 and documented the following: "(R2) (is) noted to have swelling to the right hip and RLE (Right Lower Extremity) with complaints pain at times to RLE. Family here and requesting x-ray orders from MD (Medical Doctor). Family notified by this nurse that x-ray may not be possible today here at the facility due to it being a holiday weekend. (Easter). This nurse informed the family states understanding. Oncoming nurse (V10/RN) notified." A Change in a Resident's Condition or Status Policy dated November 2016 documented, "A facility must immediately inform the resident; consult with the resident's consistent with his or her authority, the resident representative(s) when there (are) changes in level of care, resident rights, etcetera."	AND PLAN OF CORRECTION IDENTIFICATION NI IMPER-							
AMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 S SCOTT STREET NEWTON, IL. 62448 SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG COMPLETE DATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 10 physical assessment or range of motion, until a 04/16/22 note at 3:40pm. This Nursing Progress Note was authored by V9 and documented the following: "(R2) (is) noted to have swellling to the right hip and RLE (Right Lower Extremity) with complaints pain at times to RLE. Family here and requesting x-ray orders from MD (Medical Doctor). Family notified by this nurse that x-ray may not be possible today here at the facility due to it being a holiday weekend. (Easter). This nurse informed the family that we would monitor for changes and pass the information on to (V5/Physician). The family states understanding. Oncoming nurse (V10/RN) notified." A Change in a Resident's Condition or Status Policy dated November 2016 documented, "A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there (are) changes in level of care, resident rights, etcetera."		IL6006548		B. WING		04	_	
Summary Statement of Deficiencies Summary Statement of Deficiencies Summary Statement of Deficiencies Summary Statement of Deficiencies Summary Statement of Deficiency Must be preceded by Full. Regulatory Must be preceded by Full. Regulatory or Isso Identify India	NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		LIIZUZZ	
REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 10 physical assessment or range of motion, until a 04/16/22 note at 3:40pm. This Nursing Progress Note was authored by V9 and documented the following: "(R2) (is) noted to have swelling to the right hip and RLE (Right Lower Extremity) with complaints pain at times to RLE. Family here and requesting x-ray orders from MD (Medical Doctor). Family notified by this nurse that x-ray may not be possible today here at the facility due to it being a holiday weekend. (Easter). This nurse informed the family that we would monitor for changes and pass the information on to (V5/Physician). The family states understanding. Oncoming nurse (V10/RN) notified." A Change in a Resident's Condition or Status Policy dated November 2016 documented, "A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there (are) changes in level of care, resident rights, etcetera."	HELIAH	EALTHCARE OF NEW	OTON 300 S SC	OTT STREE				
physical assessment or range of motion, until a 04/16/22 note at 3:40pm. This Nursing Progress Note was authored by V9 and documented the following: "(R2) (is) noted to have swelling to the right hip and RLE (Right Lower Extremity) with complaints pain at times to RLE. Family here and requesting x-ray orders from MD (Medical Doctor). Family notified by this nurse that x-ray may not be possible today here at the facility due to it being a holiday weekend. (Easter). This nurse informed the family that we would monitor for changes and pass the information on to (V5/Physician). The family states understanding. Oncoming nurse (V10/RN) notified." A Change in a Resident's Condition or Status Policy dated November 2016 documented, "A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there (are) changes in level of care, resident rights, etcetera."	PREFIX	D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL)			(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	COMPLETE		
		physical assessment out 16/22 note at 3:4 Note was authored following: "(R2) (is) right hip and RLE (Is complaints pain at the requesting x-ray or Doctor). Family notion may not be possible to it being a holiday nurse informed the for changes and past (V5/Physician). The Oncoming nurse (V5/Physician) and Reside Policy dated Novem facility must immediate consult with the residence of care, resider	nt or range of motion, until a 10pm. This Nursing Progress by V9 and documented the noted to have swelling to the Right Lower Extremity) with imes to RLE. Family here and ders from MD (Medical fied by this nurse that x-ray to today here at the facility due weekend. (Easter). This family that we would monitor as the information on to family states understanding. 10/RN) notified." Ident's Condition or Status ber 2016 documented, "A ately inform the resident; dent's physician; and notify, or her authority, the resident ten there (are) changes in	S9999				