Illinois Department of Public Health STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED
			A BUILDING.		С
IL6004188		B. WING		10/18/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
TWIN LAKES REHAB & HEALTH CARE PARIS, IL 61944					
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
\$ 000	S 000 Initial Comments		S 000		
:: :2	Investigation of Fac 9/21/22 - IL151729	ility Reported Incident of			
89999	Final Observations	ø.	S9999		
	Statement of Licens	sure Violations:		ŧ	=
£#	300.610a) 300.1210 b) 300.1210 c) 300.1210d)6)	W.S.			
	Section 300.610 Re	esident Care Policies			
2:	procedures governi facility. The written be formulated by a Committee consisti	shall have written policies and ng all services provided by the policies and procedures shall Resident Care Policy ng of at least the dvisory physician or the		Ŋ	=
₩ #2	medical advisory co of nursing and othe policies shall compl The written policies the facility and shall	ommittee, and representatives or services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually documented by written, signed		¥	.83
	Section 300.1210 ( Nursing and Persor	General Requirements for nat Care		R	
	care and services to practicable physical well-being of the res each resident's com- plan. Adequate and	shall provide the necessary of attain or maintain the highest of attain or maintain the highest of the highest		Attachment A Statement of Licensure Violations	AS
Illinois Department of Public Health					

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

TITLE

(X6) DATE

Illinois Department of Public Health (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ C IL6004188 B. WING 10/18/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 EADS AVENUE TWIN LAKES REHAB & HEALTH CARE **PARIS, IL 61944** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 Continued From page 1 S9999 resident to meet the total nursing and personal care needs of the resident. Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour. seven-day-a-week basis: 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 These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to provide supervision and proper transfer technique during toileting to prevent a fall for one (R1) of three residents reviewed for falls on the sample list of three. This failure resulted in R1 sustaining a fractured right humerus resulting in decreased mobility and pain. Findings include: R1's undated care plan documents; admission to the facility on 8/13/22 for rehabilitation of a pelvic fracture and prior to admission R1 lived at home independently. R1's admission weight is documented as 103.5 pounds and R1's admission care plan documents R1 is to have the assistance of 2 staff with a gait belt used at all times for transfers.

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ANDPLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ FL6004188 B. WING 10/18/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **310 EADS AVENUE** TWN LAKES REHAB & HEALTH CARE **PARIS, IL 61944** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 2 S9999 S9999 R1's admission fall assessment documents R1 as a high fall risk, requiring assistance with activities of daily living and with a history of previous falls. R1's Minimum Data Set dated 8/20/22 documents R1 as cognitively intact and requiring a two person physical assistance for toileting. R1's fall investigation dated 9/21/22 documents that R1 fell while toileting resulting in a broken right humerus. Physician orders dated 9/21/22 document that this fall with fracture required an X-ray, an emergency room visit and the subsequent use of a right arm sling for four weeks. On 10/18/22 at 8:35AM, R1 was sitting in a recliner with the right arm in a sling and propped upon a pillow. R1 stated, "I came (to the facility) because I fell at home. When I fell here, I just got dizzy in the bathroom and fell. I didn't have a belt on. Before I fell, I was in a room with a bathroom but when I got back from the hospital, they put me in here with a commode. Upon wincing when moving R1's right arm, R1 stated, "The nurse should be coming in to bring me my pain medicine and to help me move this," pointing to her right arm. On 10/18/22 at 9:00AM, V2 Director of Nursing stated, "We moved (R1) from her old room to a new one because she really isn't wanting to move much and prefers to just have the girls get her up to a commode. I have gone down and talked to her about the importance of getting up and out of the chair, but since the fall I think that she has been afraid to get up." R1's care plan dated 10/7/22 documents R1 has

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLANOF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C **B. WING** IL6004188 10/18/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 EADS AVENUE TWIN LAKES REHAB & HEALTH CARE **PARIS, IL 61944** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 3 S9999 been incontinent more frequently since the right shoulder fracture. On 10/18/22 at 1:30PM, R1 was sitting in her recliner. R1 stated, "I prefer to just sit here. My knee hurts, my arm hurts. It is just better if I don't move." On 10/18/22 at 11:00AM, V3 Physical Therapy Assistant stated, "The standard of care is to use a gait belt for transfers. It is too bad that R1 fell because prior to that she was doing really well." On 10/18/22 at 9:41AM, V4 Certified Nursing Assistant stated, "I wasn't using a gait belt and I couldn't get to (R1) before she fell." V4 Certified Nursing Assistant's (CNA) disciplinary documentation dated 9/21/22 documents that V4 CNA failed to transfer R1 properly and left R1 unattended resulting in resident safety being jeopardized. On 10/18/22 at 9:55AM, V6 Nurse Practitioner stated, "It is possible that if the staff had been using a gait belt, ((R1's) fall) could have been prevented." The facility gait belt and transfer policy revised date 4/10/06 documents, "All certified nursing assistants and licensed nursing personnel engaged in the lifting and transferring of residents will use gait belts. Mechanical lifts will be used when the use of gait belts does not provide an adequate margin of safety. The use of gait belts and mechanical lifts is essential to reduce the risk of accident and injury to both residents and employees. After orientation to facility policy and training in the use of gait belts, employees who fail to use them or to use them appropriately should be consider subject to disciplinary

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: C **B. WING** IL6004188 10/18/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 EADS AVENUE TWIN LAKES REHAB & HEALTH CARE **PARIS, IL 61944** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE DATE PREFIX TAG TAG DEFICIENCY) S9999 Continued From page 4 S9999 measures. Gait belts are mandatory." (B)

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