STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	10/21/2022

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COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations 1/3 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2)5) Section 300.610 Resident Care Policies 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. Section 300.1210 General Requirements for Nursing and Personal Care 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 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. Section 300.1210 General Requirements for	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Nursing and Personal Care d) 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: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to timely identify, assess, monitor and provide treatments for pressure ulcer treatment and prevention for 1 of 3 residents (R59) reviewed for pressure ulcers in the sample of 42. This failure resulted in R59 developing 3 facility acquired pressure ulcers requiring a right above the knee amputation. Findings Include: R59's Facesheet documents admission to facility on 2/3/2021 with diagnosis of Coronary Artery Disease, Chronic Kidney Disease, Type 2 Diabetes, Hypertension with heart failure, dysphagia following cerebral infarction (stroke). R59's Minimum Data Set (MDS) dated 6/3/2022 documents R59 is at risk for pressure ulcers but	S9999		

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S9999	Continued From page 2 had no pressure ulcers present. R59's MDS also documents he is totally dependent on staff for bed mobility and all ADLs (activities of daily living), and has impairment on lower extremity one side. R59's Nursing Assessment sheet dated 5/29/2022 has no documentation of pressure ulcers. R59's Physician Order Sheets (POS) dated 5/29/2022 documents skin checks weekly Sunday 2-10 (on evening shift). R59's Nurse's notes dated 5/2/22-6/4/22 have no documentation of the presence of any issues with R59's heels. R59's Nurse's notes dated 6/5/2022 documents "(R59) has 2 pressure ulcers to bilateral heels. Left heel 7X5 (w), 3X3 (L), Right 3X10 (w), 7X3 (L) with eschar." R59's Nurse's notes dated 6/5/2022 documents, "Clean right and left heel ulcers with normal saline and apply Neosporin ointment and non adhesive dressing daily for 5 days." R59's Physician Order (PO) also documents this same order. R59's PO dated 6/6/2022 documents, "Povidine iodine 10% solution apply to left and right heel daily." R59's 6/2022 Treatment Administration Records (TAR) Weekly Summary documents 6/5/2022 Right heel- pressure ulcer 3x10 (w), 7x3 (L) Eschar, Left heel- pressure ulcer 7x5 (w) 3x3 (L) red and inflamed. No other documentation of weekly summary of pressure ulcers on 6/2022	S9999		

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S9999	Continued From page 3 TAR. R59's Nurse's notes dated 6/6/2022 documents "(R59) has black mark on left heel and red mark on right heel. (Wound doctor) viewed marks and ordered betadine to both heels daily." R59's Nurse's Notes, dated from 6/7/22-10/9/22, have nothing documented about R59's bilateral heel pressure ulcers. R59's 7/2022 TAR has no documentation of weekly summary of pressure ulcers. R59's TARs regarding weekly skin checks shows no skin checks completed on 6/12/2022, 6/19/2022, 6/26/2022, 7/3/22, 8/7/22, 8/14/2022, 9/10/2022, 9/17/2022, 9/24/2022. R59's TAR regarding betadine to bilateral heels shows no treatments on 6/17/2022, 6/20/2022, 6/26/2022, 6/30/2022, 9/10/2022, 9/11/2022, 9/12/2022, 9/13/2022, 9/14/2022, 9/15/2022, 9/16/2022, 9/17/2022, 9/18/2022, 9/19/2022, 9/21/2022, 9/22/2022, 9/23/2022, 9/24/2022, 9/25/2022, 9/26/2022. R59's Wound physician notes dated 8/2/2022 document Site 1 Unstageable DTI (Deep Tissue Injury) of the left heel partial thickness with intact skin of greater than 73 days duration. Wound size 2 x 3 x Not measurable cm (centimeters). Continue betadine twice daily. Site 2 Unstageable DTI of the Right heel partial thickness with intact skin of greater than 62 days duration. Wound size 4 x 5 x Not measurable cm. Continue betadine twice daily. Etiology of both: pressure. Factors complicating wound healing: Diabetes Mellitus. This was the first visit by wound physician.	S9999		

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S9999	Continued From page 4 https://npiap.com/page/PressureInjuryStages documents the definitions, "Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4)." R59's Wound physician notes dated 8/9/2022 document Site 1 Unstageable DTI of the left heel partial thickness with intact skin. Continue betadine twice daily. No change in wound size or wound progress. Site 2 Unstageable due to necrosis of the right heel full thickness. Wound has thick adherent black necrotic tissue 100%. No change in wound size or wound progress. Continue betadine twice daily. Surgical excisional debridement procedure performed on right heel	S9999		

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S9999	Continued From page 5 wound. R59's Wound physician notes dated 8/16/2022 document Site 1 Unstageable DTI of the left heel partial thickness with intact skin. Wound size 2 x 1 x not measurable cm. Continue betadine twice daily. Wound progress: improved. Site 2 Unstageable (due to necrosis) of the right heel full thickness. Wound size 4 X 5 X not measurable cm. Wound has thick adherent black necrotic tissue 100%. No change in wound size or wound progress. Continue betadine twice daily. R59's Wound physician notes dated 8/23/2022 documents Site 1 Unstageable DTI of the left heel partial thickness with intact skin. No change in wound size or wound progress. Continue betadine twice daily. Site 2 Unstageable (due to necrosis) of the right heel full thickness. Wound has thick adherent black necrotic tissue 100%. No change in wound size or wound progress. Continue betadine twice daily. R59's Wound physician notes dated 8/30/2022 documents Site 1 Unstageable DTI of the left heel partial thickness with intact skin. No change in wound size or wound progress. Continue betadine twice daily. Site 2 Unstageable (due to necrosis) of the right heel full thickness. Wound size 4 X 4 X not measurable cm. Wound has thick adherent black necrotic tissue 100%. Wound progress: improved. Continue betadine twice daily. R59's Wound physician notes dated 9/6/2022 documents Site 1 Unstageable DTI of the left heel partial thickness with intact skin. No change in wound size or wound progress. Site 2 Unstageable (due to necrosis) of the right heel full thickness. Wound has thick adherent black	S9999		

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S9999	Continued From page 6 necrotic tissue 100%. No change in wound size or wound progress. Continue betadine twice daily. R59's Nurse Practitioner progress notes dated 9/8/2022 documents "Skin normal temp and color." R59's Nurse Practitioner progress notes dated 9/12/2022 documents "Skin normal temp and color." R59's Wound physician notes dated 9/14/2022 documents Site 1 Unstageable DTI of the left heel partial thickness with intact skin. No change in wound size or wound progress. Continue betadine twice daily. Site 2 Unstageable (due to necrosis) of the right heel full thickness. Wound has thick adherent black necrotic tissue 100%. No change in wound size or wound progress. Continue betadine twice daily. R59's Wound physician notes dated 9/20/2022 documents Site 1 Unstageable DTI of the left lateral heel partial thickness with intact skin. No change in wound size or wound progress. Continue betadine twice daily. Site 2 Unstageable (due to necrosis) of the right heel full thickness. Wound has thick adherent black necrotic tissue 100%. No change in wound size or wound progress. Continue betadine twice daily. Surgical excisional debridement procedure performed on right heel wound. Site 3 new Unstageable DTI of the left medial heel partial thickness with intact skin of greater than 2 days duration. Wound size 3 x 3 x not measurable cm. Etiology: pressure. Betadine twice daily. R59's Care Plan, start date 9/20/2022 and reviewed 9/22/22, documents Pressure Ulcer Present. Braden score 21 (Total score of 12 or	S9999		

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S9999	Continued From page 7 less represents HIGH RISK for pressure ulcer). Risk factors include incontinent of bowel and bladder and needing assistance for transfers. Interventions include, assess for cause of pressure of pressure ulcer. Observe for pressure cause friction and contributing factors. Complete avoidable/Unavoidable pressure ulcer assessments as needed to investigate contributing factors and preventions interventions used. Nurse to measure and monitor wound status progression or deterioration every week. Notify Medical Doctor (MD) and family of changes, Document physician response. Treatments as ordered. Pressure relieving device in wheelchair and pressure reducing mattress. Pressure reduction boot when in wheelchair. Float heels when in bed. Skin risk assessment. Braden scale weekly for 4 weeks upon admission or readmission and then quarterly and as needed. R59's medical record has no documentation of a Pressure Ulcer Care Plan prior to the one initiated on 9/20/22 although R59 was identified with pressure ulcers on 6/5/22. R59's Minimum Data Set (MDS) dated 9/22/2022 documents R59 is at risk for pressure ulcers, has 3 unstageable pressure injuries presenting as deep tissue injuries, none of which were present on admission. R59's MDS also documents he is totally dependent on staff for bed mobility and all ADLs (activities of daily living), and has impairment on lower extremity one side. R59's Treatment Administration Records (TAR) regarding weekly skin checks shows no skin checks completed on 6/12/2022, 6/19/2022, 6/26/2022, 7/3/22, 8/7/22, 8/14/2022, 9/10/2022, 9/17/2022, 9/24/2022. R59's TAR regarding betadine to bilateral heels	S9999		

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S9999	Continued From page 8 shows no treatments on 6/17/2022, 6/20/2022, 6/26/2022, 6/30/2022, 9/10/2022, 9/11/2022, 9/12/2022, 9/13/2022, 9/14/2022, 9/15/2022, 9/16/2022, 9/17/2022, 9/18/2022, 9/19/2022, 9/21/2022, 9/22/2022, 9/23/2022, 9/24/2022, 9/25/2022, 9/26/2022. R59's Wound physician notes dated 9/27/2022 document Site 1 Unstageable DTI of the left lateral heel partial thickness with intact skin. No change in wound size or wound progress. Site 2 Unstageable (due to necrosis) of the right heel full thickness. Wound has thick adherent black necrotic tissue 100%. Wound size 3.8 X 4.1 X not measurable cm. Wound progress: improved. Add Alginate Calcium with Kerlix (gauze wrap) once daily, Change betadine to once daily. Surgical excisional debridement procedure performed on right heel wound. Site 3 Unstageable DTI of the left medial heel partial thickness with intact skin. Wound size 3 x 2.8 x not measurable cm. Wound progress: improved. Continue betadine twice daily. R59's Physician Order Sheets dated 9/27/2022 documents "Right heel betadine and alginate and gauze wrap daily." R59's Wound physician notes dated 10/4/2022 document Site 1 Unstageable DTI of the left lateral heel partial thickness with intact skin. Wound size 1.6 x 1 x not measureable. Wound progress no change. Continue betadine twice daily. Site 2 Unstageable (due to necrosis) of the right heel full thickness. Wound has thick adherent black necrotic tissue 100%. Wound size 4 X 4 X not measurable cm. Wound progress: no change. Continue Alginate Calcium with Kerlix once daily and betadine once daily.	S9999		

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S9999	Continued From page 9 Surgical excisional debridement procedure performed on right heel wound. Site 3 Unstageable DTI of the left medial heel partial thickness with intact skin. No change in wound size or wound progress. Continue betadine twice daily. R59's Nurse Practitioner progress notes dated 10/10/2022 documents presents "for nursing report that Right heel wound has increased drainage and odor. Nursing reports he has been followed by (Wound Consultant) for wound care." "Skin: right heel with large unstageable wound moderate amount of serosanguinous drainage, right foot is red and warm to touch, + odor. Left heel with blister and blister to left great toe." "Assessment and plan: right and left heel wound: concern for sepsis vs osteomyelitis. Transfer to ER (emergency room) for further care of wounds to bilateral heels." R59's Nurse's notes dated 10/10/2022 "(R59) sent to ER due to wound on right heel having a foul order." R59's Hospital H&P (history and physical): HPI History of Present Illness report dated 10/10/2022 at 4:15PM documents "Chief Complaint right foot wound." It continues, R59 presents for "evaluation of a malodorous, nonhealing right foot wound. Plan x rays of the foot showed multiple pockets of gas and recommends were to proceed with right above the knee amputation urgently." It further documents a right above the knee amputation was performed without complications. "Assessment and plan 1. Severe sepsis" "2. Necrotizing soft tissue infection" "3. Diabetic infection of right foot:" "Status post above-the-knee amputation. He has large unstageable pressure ulcer on the left heel."	S9999		

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S9999	Continued From page 10 R59's hospital discharge Patient Signature Page, given to patient on 10/13/22, documents R59 was seen for: Severe sepsis, cellulitis of right foot, acute hypernatremia. R59's Nurse's notes dated 10/13/2022 documents "(R59) readmitted with right above the knee amputation (AKA). Waffle boot to left foot with heel protector. Stump sock to right AKA." On 10/19/2022 at 1:15PM, R59's right above the knee amputation Wound site was clean and dry with sutures intact. No drainage observed. Left heel appeared soft, intact and red with minimal drainage. On 10/20/2022 at 3:50PM, V20, Nurse Practitioner, stated, "Our practice wasn't following (R59)'s wounds because he was being followed by a wound company. I am the one who sent (R59) out to the hospital. I asked the nurse taking care of (R59) the day he went out, how long his wound had smelled and she said just that day. It is hard to say if missing a treatment would have contributed to the gangrene. I would expect treatments to be completed as ordered. I would also expect the care plan to be updated so everyone is aware of changes." On 10/21/2022 @ 9:15AM, V4, Infection Preventionist, stated "I was the nurse the day (R59) went out. Staff noticed the smell and thought (R59) just needed a shower. I had the Nurse Practitioner look at it and she sent him out." On 10/20/2022 at 2:30PM, V17, Certified Nursing Assistant (CNA), stated "I knew his foot looked bad because it was black. It smelled terrible the	S9999		

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S9999	Continued From page 11 day he went out. I didn't smell it before that." The Facility's Decubitus Care/ Pressure Areas policy and procedure, revised 1/2002, documents, "Policy: To ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer, once identified." It continues, "Procedure: 1. Upon notification of skin breakdown, an Newly Acquired Skin Condition report will be completed and forwarded to the Director of Nurses. 2. The pressure area will be assessed and documented on the Pressure Sore Record form." And, "3. Notify the physician for treatment orders." "4. Documentation of the pressure area must occur upon identification and at least once each week on the Pressure Sore Record." "5. Reevaluate the treatment for response at least every two (2) to four (4) weeks. Most pressure areas will respond to treatment in this amount of time. If no improvement is seen in this time frame, contact the physician for a new treatment order." "7. Initiate problem on care plan." (A) 2/3 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies 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	S9999		

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S9999	Continued From page 12 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. Section 300.1210 General Requirements for Nursing and Personal Care 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 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. Section 300.1210 General Requirements for Nursing and Personal Care d) 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: 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. Regulations were not met as evidenced by: A. Based on interview and record review, the facility failed to provide supervision for 1 of 4 residents (R111) reviewed for elopement in the sample of 42.This failure resulted in R111 leaving the facility on 12/11/2021 without any of the staff attempting to stop him or alerting any staff he was leaving. R111 left the facility unnoticed without	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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S9999	Continued From page 13 staff intervention. B. Based on interview and record review, the facility failed to perform a safe transfer for a dependent resident for 1 of 6 residents (R9) reviewed for falls in the sample of 42.This failue resulted in R9 falling out of a full mechanical body lift. Findings include: R111's Progress Notes dated 11/9/2022 at 6:36 PM, documents, "Resident is a new admit from (Hospital). He was admitted on 10/17/2021 for a fall. He was found in his garage. No injuries substantiated. Increased confusion noted from family. Diagnosis of: kidney disease, HIV positive, HTN (hypertension), nephrectomy. He is orientated to himself. He is ambulatory but has issues with balance." R111's Elopement Evaluation dated 11/9/2022 documents: Resident is able to exit the building; requires assistance once outside the building; poor decision making; inability to identify safety needs; severe mental illness. R11's Score 6, High Risk= 5-10. R111's Care Plan documents a diagnosis of dementia. R111's Cognitive Assessment for November 2022 documents R111 was moderately impaired for cognition. 111's Nutritional Assessment documents a diagnosis of altered mental status, dementia, malnutrition, nephrectomy and AIDS. R111's Psychosocial Social Service Progress	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	10/21/2022

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COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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	Continued From page 14 Notes dated 12/3/2021, "Resident entered Social Service Office to inquire about his car. Social Service Director (SSD) reminded resident that his car was at his house in the garage and SSD also reminded resident that resident was very thankful." R111's Care Plan with a start dated of 11/22/2021 documents (R111) "discharge not feasible due to care needs." R111's care plan with a goal date of 3/12/2022 for Behavior documents, "(R111) may seek to leave home. Related diagnosis include: Altered mental status due to metabolic encephalopathy. Desires discharge from facility. Brief Interview Mental Status of 9 (9 out of 15= moderately impaired cognition) on admission assessment. (R111) has a cell phone and is able to make and receive calls independently. Validate (R111's) desires to leave the facility. Allow him to verbalize feelings. Seek to resolve any concerns. Educate (R111) on the need to sign out of the facility if going out on leave." R111's Psychosocial Social Service Progress Notes dated 12/2/2021, "Friend in facility visiting resident and he asked to speak with myself (V14) (SSD) friend came to SS (social service) office and introduced himself (V14) and he began providing information about resident's family and informed friend that family relationships was beyond my practice and that my jobs was to ensure that resident was taken care of while in our facility friend then stated that upon discharge that resident could move with him and his mother. SSD informed friend that she (SSD) would inform resident of his friend's offer and he was very thankful. Very thankful." R111's Nurse's Notes dated 12/11/2021 at 11:17 AM, "I was informed that resident did not return	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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S9999	Continued From page 15	S9999		

from out on pass. I immediately drove to the facility at this time, already notified corporate, and called all department heads, resident's brother, and police while staff did an outdoor facility grounds and neighborhood search. Staff had thought resident went out on pass but not sure of the visitor he left with."

On 10/21/2022 at 9:10 AM, V4, Registered Nurse (RN) stated, "I remember I got a phone call in the middle of the night telling me (R111) was missing. Those are my notes in his chart documenting the elopement. We think (R111) left with a visitor. We have a locked door that needs a code in order to open the doors. We are not allowed to give the code out to anyone including visitors. We are supposed to assist them. We discussed it at the meeting and we do not know how (R111) got out of the facility."

On 10/21/2022 at 12:34 PM, V28, Housekeeping/ Activities, stated, "I remember working that night and I saw (R111) with his bags packed. He told me his boyfriend was coming to pick him up and take him home. I did not see him leave or help him with the code to get out. We are not to ever give out the door codes to visitors. I never questioned him about leaving or checking to see if he was okay to go home. I was pushing my laundry cart and just making conversation."

R11's Incident Report dated 12/15/2021 document, "On 12/11/2021 at 10:30 PM, staff reported that (R111) was out on a visit and had not returned to the facility. Investigations began immediately including notifications to police, physician and family. During this investigation, staff and alert residents were interviewed. Two housekeepers stated they saw (R111) leave out the door by Nurse's station rolling a Suit Case

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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S9999	Continued From page 16 and was with another male whom was there visiting with (R111) around 2:30 PM. The oncoming Nurse received report from previous Nurse. The nurse that come on shift asked where the Resident was at because he was not in the room and the Nurse stated that the Resident was out on a visit and had not yet returned. When resident's brother was called to inquire when resident would be returning, he stated that (R111) was not with him and he was not sure who visited him earlier. The oncoming Nurse immediately contacted Administrator and Assistant Director of Nursing (ADON), to notify them that the resident was out of the facility and had not returned, head count completed and (R111) was not counted. Staff immediately looked outside, looked in all rooms, bathrooms, storage areas, closets, laundry area etc. Staff and alert residents were interviewed for possible sightings. Facility conducted a thorough search of the grounds including outdoor shed, staff members worked together to sweep each consecutive room to avoid possibility of resident moving to adjacent room undetected. ADON, Administrator was called immediately. Investigation began immediately including notification to police, physician and family. Staff searched parked cars, ditches, expanding search through the neighborhood by foot and car also. Police were given a description of resident and clothing worn and they immediately began assisting with search. Search was done of facility, grounds and expanding search through community by foot and car. Police notified the facility that they sent ping to the Residents cell phone to track his location. Administrator contacted every possible contact for the Resident. The following morning 12/12/2021 at 9:33 AM. (R111) made contact with facility Social Service (V10) and informed her that he was at his	S9999		

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	IL6007496	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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	Continued From page 17	S9999		

Residence and that he was safe. He informed Social Service that he left the facility with his friend on 12/11/2021 and that his friend will be staying with him and helping him at home. On 12/12/2021 at 9:33 AM, "Social Service Director informed (R111) that she would meet him at his residence and the resident agreed to that. Resident informed SSD that he did not want to come back and that he wanted to stay at his residence with his friend. Resident signed Against Medical Advise (AMA) and gave the resident the rest of his belongings. Family, and Physician notified."

R111's medical records does not document any outing visit he took on 12/11/2021.

R111's Interdisciplinary Summary dated 12/11/2021, "At facility calling resident family and friends. Family and friends did respond and stated that they hadn't heard from resident. Informed both parties to have resident call. Facility to confirm his safety."

On 10/20/2022 at 11:34 AM, V10, Social Service Director, stated, "When (R111) came into the facility, he had a lot of confusion. He was HIV positive, he had hypertension. He was very confused and was always wanting to know where his car was. He liked to play the piano and he would have visitors come and visit him. His son would come and other male friends. One Saturday in December, I got a call from (the former Administrator) because (R111) was missing. I was not working that day so I cannot say how he got out of the facility. All I know is that he got out on the afternoon because some housekeepers saw him leave the building with another person. As soon as I got the call, I came in and started call his cell phone and family. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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S9999	Continued From page 18	S9999		

family did not know where he was at. The next day, (R111) called me and told me he was safe and I went to his house. I never went inside his house. There was another man there and he was yelling out at me and telling me (R111) was not going back to our facility and he was going to take care of (R111). He (the other man) said he was staying with him (R111) and he (R111) was not going back. I tried to talk to (R111) and he nodded to everything the other man was saying. I do not know the name of the man that was yelling at me. I think it was his partner but that is just a guess. I asked (R111) if he wanted to come back and he shook his head 'no' and then (I) asked him to sign the Against Medical Advice (AMA) papers and he did and I left."

R111's elopement and medical records do not document who was at R111's house and who stated they would be assisting with his care. There was no name or person identified by the facility assisting R111 with his care.

On 10/21/2022 at 9:01 AM, V25, Activities, stated, "I was working in the business office the day (R111) eloped. I do not know how he got out of the building. That night, I got a call telling us he was missing, but I was not aware of anything while I was working that Saturday."

On 10/21/2022 at 9:46 AM, V1, Administrator, stated, "I was not here working at the time (R111) eloped from the facility. I would expect statements to be included from staff working that day of what they saw and interviews documenting it. I would expect the administrator to view the cameras to see what happened and how (R111) even got out of the building. Staff are to never give out codes to visitors. Our cameras are only good for seven days so I cannot even tell you

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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S9999	Continued From page 19 what was on the camera. I would expect staff to never give out codes and for staff to never assist a resident with leaving without checking with others to make sure they are cleared to leave." The Facility Missing Resident Policy with a revision dated 8/13/2014, documents, "It is the policy of (Facility) that reasonable precautions are taken to minimize the risks of resident elopement attempts. Reasonable precautions include, but are not limited to door alarms, personal door alarm activities devices, staff intervention, staff education regarding response to door alarms and individual resident intervention. It is the policy of (Facility) to demand immediate response to elopement attempts, door alarm activation and participating in search attempts in the event that a resident is deemed missing." The Door Alarm Policy with a revision date of 10/2006 documents, "It is the policy of the (Facility) to ensure resident safety and security through the use of door alarms. Door alarms require immediate attention and response by facility staff to ensure the safety of all residents. Disengaging the alarms is not allowed until the reason for activation is determined. Steps to be taken: Go directly to the door where the alarm is sounding. Go completely outside the door to view the environment. Initiate a search of the immediate area if no resident or visitor is visualized. Instruct visitor or vendors how to properly disengage the alarm before leaving the facility. Conduct an immediate count of all residents. Initiate the Missing Resident Policy when unable to account for all residents." B. Findings include: R9's Nurses Notes dated 8/4/22 at 2:00 PM	S9999		

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	IL6007496	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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	Continued From page 20	S9999		

document, "Resident had a fall. She fell out of the (full body mechanical lift) sling. Staff stated that one of the straps was not connected while lifting her up. She has bilateral 4 inches of scratches to elbow. No other injury noted. NP (Nurse Practitioner) was notified . She was in the building. Administrator was notified. Resident is on 15 minute checks and neurochecks. Resident is laying in bed at this time. X-rays was ordered to sacrum, coccyx, lumbar spine, x-rays bilateral elbows. "

R9's Minimum Data Set (MDS) dated 7/13/22 documents she is severely cognitively impaired. It also documents she is dependent on staff for transfers.

R9's Care Plan dated 7/13/22 documents, "(P) Problem: Resident has risk factors that require monitoring and intervention to reduce potential for self injury. (Consider medical conditions, sensory alterations, balance, gait, assistive devices, cognition, mood/behavior, safety awareness, compliance, medications, restrictions, restraints)." A new approach added to this care plan dated 8/4/22 documents, "Related to fall, staff to ensure that resident understands transfer process."

On 10/19/22 at 1:35 PM, V7, Licensed Practical Nurse (LPN), stated she was the nurse on 8/4/22 and documented R9's fall. V7 stated (V11) and (V12) Certified Nursing Assistants (CNAs) were transferring R9 when she had a fall from the full body mechanical lift. V7 stated R9 fell to the floor and she thinks R9 was caught and lowered to the floor by the CNAs.

On 10/19/22 at 2:00 PM, V1, Administrator, presented R9's document, "Quality Improvement Review" dated 8/5/22 at 9:30 AM which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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S9999	Continued From page 21 documents, "QA (Quality Assurance) committee meet to review fall on 8/4/22, staff reported resident fell out of (full body mechanical lift) sling b/c (because) one of the straps was not connected. Resident sustained bilateral scratches to elbow, no other injury noted. Resident complained of no pain or discomfort, was placed on 15 minute checks with neuro checks. Staff educated on transfer process and proper sling placement. X-rays were ordered with no findings." R9's Fall Risk Assessment dated 7/13/22 documents a score of 22 indicating she is high risk of falls. R9's x-ray reports dated 8/4/22 of coccyx/ sacrum/lumbar region and right and left elbows document R9 did not have any fractures from her fall. On 10/19/22 at 3:48 PM, V11, CNA, during phone interview, stated she and another CNA (V12) were transferring R9 from her chair to the bed when R9 fell on 8/4/22. V11 stated V12 had attached the straps of the sling to the lift. V11 stated she was observing and controlling the remote to lift R9 out of her chair. V11 stated they had just lifted R9 and removed her chair from under her and one of the straps on the side of the sling just snapped out and R9 fell to the floor onto her butt. V11 stated R9 was not that high, but they were not able to slow her fall and she fell directly to the floor. V11 stated R9 had complained of pain to her elbows or ankles, she could not remember which, but any injury she sustained was minor. V11 stated she did not help transfer R9 from the floor to her bed but three staff lifted R9 from the floor without the mechanical lift and placed her in her bed. V11 stated she had not received any training on using	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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	Continued From page 22 the full body mechanical lift, but was just told briefly how to use it during her orientation. On 10/19/22 at 3:59 PM, V12 stated she and V11 were transferring R9 from her chair to her bed when R9 fell from the (full body mechanical lift). V12 stated R9 was already hooked up to the lift when she walked into R9's room. V12 stated that was her first day working in the facility and she did not know why they had V11 training her because V11 was a brand new CNA herself. V12 stated she thinks V11 had not hooked up the sling straps to the mechanical lift correctly and that is why R9 fell from the sling. V12 stated R9 was not very high in the air when she fell and she did not think R9 was injured. V12 stated she had experience using full body mechanical lifts during her time as a CNA but did not receive any instructions from the facility regarding their policy for using the lift. V12 stated after R9's fall, V7, LPN, did educate her and V11 on using the lift. V12 stated she, V7, LPN and V6, CNA, lifted R9 from the floor and put her into her bed after her fall. The facility's policy, "Mechanical Lift" revised 10/30/08 documents, "Policy: The mechanical lift may be used to lift and move a resident with limited ability during transfer while providing safety and security for residents and nursing personnel." Under "Procedure" it documents, "9. Attach the appropriate colored loops on the bars." (B) 3/3 300.610a) 300.1210b) 300.1210d)1)	S9999		

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	IL6007496	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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S9999	Continued From page 23 Section 300.610 Resident Care Policies 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. Section 300.1210 General Requirements for Nursing and Personal Care 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 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. Section 300.1210 General Requirements for Nursing and Personal Care d) 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: 1)Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Regulations were not met as evidenced by:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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S9999	Continued From page 24 Based on observation, interview and record review, the facility failed to administer medication as ordered for 1 of 25 residents reviewed for medication (R8) in the sample of 42. This failure resulted in R8's significant med errors of missing two doses of insulin with subsequent need for transfer to the emergency room (ER) due to elevated blood sugar. Findings include: R8's Undated Face Sheet documents she was admitted on 3/26/2022. R8's Care Plan, dated 4/15/2022 and reviewed 7/13/2022 R8's care plan did not address R8's diabetes or any goals or approaches. R8's Minimum Data Set (MDS) dated 7/13/2022 documents R8 is cognitively impaired and has a diagnosis of diabetes. R8's Physician Order Sheet (POS) dated 9/26/2022 documents Lispro 5 units subq (subcutaneous) TID (three times a day) with meals breakfast and lunch. Glargine 20 units subq at bedtime (HS.) There was no sliding scale insulin order on the readmission POS dated 9/26/2022. R8's Medication Administration Record (MAR), dated 9/26/2022, documents Lispro 5 units subq TID with meals breakfast and lunch. There was no documentation Lispro insulin was administered at 4:00 PM on 9/26/2022 and no documentation glargine insulin 20 units was administered at 8:00 PM. R8's Nurse's Note, dated 9/26/2022, has no documentation of why R8 didn't receive the two	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHAB & HEALTH CC	614 NORTH SUMMIT COLLINSVILLE, IL 62234

(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	Continued From page 25 doses. R8's Nurse's Notes dated 9/27/2022 at 11:20 AM document notified MD (physician) via internal electronic system of elevated blood glucose reading high. N.O. (new order) given to give 10 units Humalog subq now and to recheck reading in 1 hour. 12:30 PM rechecked resident blood glucose at this time. Blood glucose reading hi. Notified MD via internal electronic system. N.O. send to ER and give 5 units. 1:00 PM called EMS (Emergency Medical Services)/ambulance for transport. Called local hospital with report. Called 911 for transport. 1:32 PM Resident left facility via ambulance with emergency medical technicians (EMTs) x4. R8's ER Visit Note, dated 9/27/2022 documents HPI (history of present illness) patient is an 89-year-old female who presents ER with hyperglycemia (high blood sugar.) Apparently today at the nursing home her blood sugars have been running in the 400s and they cannot get it controlled with her new sliding scale insulin. Nursing home contacted and they did not give the patient (R8) her Lantus (glargine insulin) last night. Blood sugar coming down with 1 dose of insulin 10 units. We will have patient's home Lantus tonight and inform the nursing home that they can readminister tomorrow. Additional instructions: your blood sugar was elevated because you did not receive your Lantus last night. You were given your home Lantus dose while in the ER today. R8's POS, dated 9/26/2022 documents no physician's order for sliding scale insulin. On 10/20/2022 at 12:45 PM, V13, Consultant RN (Registered Nurse), stated she expects staff to	S9999		

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S9999	Continued From page 26	S9999		

administer medications per physician's orders. V13 stated when a resident is readmitted to the facility, she expects staff to document a nurse's note to state the resident was readmitted, so all staff know the resident is back in the facility. V13 stated the facility holds resident's bed and medications for 14 days when they are discharged. V13 stated the 14th day the medications are returned to the pharmacy. V13 stated if R8 was discharged on 9/12/2022 and readmitted on 9/26/2022, that was 15 days so her medications would have to be reordered from the pharmacy and she expected the medications to be available at the facility within a few hours of the resident being back at the facility. V13 stated insulin is considered a significant medication because if the resident misses a dose of insulin the resident's blood sugar can quickly plummet. V13 stated she expected staff to either retrieve insulin from the facility's insulin emergency kit or call the pharmacy and get a STAT (immediately) run from the pharmacy to deliver the insulin so the resident doesn't miss a dose. When staff obtain insulin from the facility's emergency kit or contact pharmacy for a STAT delivery of insulin, she expects staff to document a nurse's note, so staff know what has been done to ensure the resident gets the physician prescribed medication. V13 stated if the box for the corresponding date is blank on the resident's MAR that means the medication wasn't administered.

On 10/20/2022 at 3:45 PM, V20, Nurse Practitioner (NP), stated when a resident is readmitted to the facility if the resident was on the medication in the past, she expected the medication to be immediately available to the resident and if the medication was not available, she expected staff to utilize the facility's insulin

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S9999	Continued From page 27 emergency kit to ensure the physician order medication in a timely manner. V20 stated she expected staff to document physician's orders correctly and to administer insulin as prescribed. V20 stated she wasn't aware R8 missed two doses of insulin on 4/26/2022, she stated the insulin should have been available and administered per physician's orders. V20 stated insulin is considered a significant medication because of what can occur if the resident doesn't receive a scheduled dose which includes diabetic coma. The Facility's Medication Administration Policy revised 11/18/2017, documents each facility shall establish a policy for the routine time of medication administration. Medications must be prepared and administered within one hour of the designated time or as ordered. Medications must be identified by using the 7 rights of administration which includes right resident, right drug, right dose, right consistency, right time right route and right documenation. After a medication is given, record the date, time and name of drug, dose and route on the resident's individual MAR. Document any medications not administered for any reason by circling initials and documenting on the back of the MAR the date, the time, the medication and dosage and the reason for omission and initials. If the medication is not available for the resident, call the pharmacy and notify the physician when the drug is expected to be available. Nofiy the physician as soon as practical when a scheduled dose of a medication has not been administered for any reason. (A)	S9999		