Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING IL6009336 07/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **751 NORTH OAK STREET CARLINVILLE REHAB & HCC** CARLINVILLE, IL 62626 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 S 000 Initial Comments Annual Licensure and Certification Survey S9999 \$9999 Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, Attachment A Statement of Licensure Violations safety, or welfare of a resident, including, but not limited to, 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. The

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(XB) DATE

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: \_ B. WING \_ 07/27/2023 IL6009336 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **751 NORTH OAK STREET CARLINVILLE REHAB & HCC CARLINVILLE, IL 62626** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 \$9999 Continued From page 1 facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements were not met as evidenced by: Deficiency requires two deficient practice statements. A. Based on interviews and record review the facility failed to timely treat a urinary tract infection

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6009336		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
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S9999	(UTI) for 1 of 6 resincontinent/(UTIs) if failure resulted in Fon 6/2/23, delay of treatment, and subthe critical care unidiagnosis of UTI w. Findings include:  R17's July 2023 Place documented R17 for antibiotics, persinfections, sepsis, sepsis with septical lactamase (ESBL).  R17's Minimum Dadocuments that R1 Status score was a	idents (R17) review for urinary in the sample of 42. This R17 having symptoms of UTI physician notification and sequently being admitted to t at the local hospital with lith septic shock.  The septic shock is a septic shock in the septic shock is a septic shock. The septic shock is a septic shock in the septic shock is septic shock.		#			
	extensive assist of and is always inco R17's Care Plan d "R17 will be free of urinary tract infection monitor/document for signs/symptom malaise foul smell nausea and vomition hematuria, cloudy loss of appetite, but R17's Vital Sign refrecord documents had an elevated to Fahrenheit (F). To on 6/2/2023 at 11:	two people for toileting needs					

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 07/27/2023 IL6009336 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **751 NORTH OAK STREET** CARLINVILLE REHAB & HCC CARLINVILLE, IL 62626 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 \$9999 Continued From page 3 R17's Progress Notes that documented R17's physician was notified of R17 having an elevated temperature. R17's infection screening evaluation assessment dated effective 6/2/2023 documents R17 had a fever of >102° F and had new/marked increase in symptoms of urinary frequency, urinary incontinence, urinary urgency, acute dysuria, and abdominal pain with no notification of physician. R17's clinical record contains fax document to V19 (Physician) dated 6/4/2023 at 5:40 PM documented "(R17) has been diaphoretic, clammy, pale, lethargic, has poor appetite on and off all weekend. She seems to be experiencing increased confusion today. She is disorientated and states she does not feel well. Afebrile. States she feels like she has a UTI. Incontinent of urine. States she is having dysuria." R17's Progress Note dated 6/4/2023 at 6:06 PM documents "R17 has been diaphoretic, pale, clammy, and lethargic with poor appetite and fluid intake throughout the weekend. Encouraged oral hydration but she has been sleeping a lot. on 6/2/23 at 11:56 pm her temp was 102.4 but was alleviated with acetaminophen. She seems to be experiencing AMS /Increased confusion today. She is disoriented and she states she does not feel well. C/o dysuria and "vaginal discomfort." She also stated she feels like she has a UTI. Incontinent of urine. Notified (V19's) office." R17's Progress Note dated 6/5/2023 at 3:51 AM documents, "Res remains pale, clammy, and diaphoretic. Res states that "something is not right". Res has been very tearful this shift. Afebrile. C/o (complaints of) vaginal discomfort at times with dysuria. (Res) stated that she did not

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING: B. WING IL6009336 07/27/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **751 NORTH OAK STREET CARLINVILLE REHAB & HCC** CARLINVILLE, IL 62626 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 \$9999 Continued From page 4 want to go to the hospital, she would wait for response from PCP (primary care physician) r/t (related to) lab orders." R17's Progress Note, dated 6/5/2023 at 10:58 AM documents "@ (at) 1000 Call out to V19 (Physician) in regard to resident complaining of not feeling well, resident seems a little confused, complains of dysuria and just not feeling right. New orders received for CBC, CMP and UA with C&S obtained through straight cath." The Progress Note documented \*@ 10:15am Urine obtained per straight cath and call out to (Local hospital lab) lab, writer spoke with lab and lab is going to come out and draw CBC and CMP and pick up urine while here." R17's Progress Note, dated 6/5/2023 at 7:25 PM documents R17 was experiencing increase pain and Shortness of Breath. The Note documented "Writer sent R17 to ER for further evaluation. MD aware. POA called but did not answer phone and unable to leave voicemail. R17 states she will call her husband at the hospital. Writer gave report to ER (Emergency Room) RN (Registered Nurse)." R17's Hospital records dated 6/6/2023 documents R17 was admitted to hospital on 6/5/2023 with diagnosis of Septic Shock due to UTI. R17's hospital records document that R17 was in distress from abdominal pain upon presentation at Local Emergency Department and became hypotensive not responding to Intravenous fluids bolus and was started on blood pressure support drug, R17 was admitted to critical care unit. On 07/26/23 at 3:17 PM, V3 (MDS/LPN) states she documented on the infections criteria assessment on 6/4/2023 about R17's temp on

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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 IL6009336 07/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 751 NORTH OAK STREET **CARLINVILLE REHAB & HCC CARLINVILLE, IL 62626** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 5 6/2/2023 but did not notify the doctor of the fever or the frequency and urgency at that time. V3 states she does not have any documentation of R17 being monitored from 6/2/2023-6/4/2023 or of the doctor being notified on 6/2/2023 of fever of 102.4 ° F. V3 states V19 was notified on 6/4/2023 of R17's fever and urinary symptoms. On 07/26/23 at 3:26 PM, R17 states that she had a UTI on 6/2/2023 and that staff did not take care of it immediately. R17 states "It took a few days for them to treat me and by then I was sick. I went to the hospital and just laid in the bed at the hospital and cried for days. It was very stressful." Facilities policy titled Significant Condition Change of Notification, undated, documents "Purpose is to ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as onset of temperature of 101 degrees or higher with or without symptoms, when any of the situations exists the licensed nurse will contact the resident's representative and their medical practitioner. Prior to calling the medical practitioner the nurses will completer the SBAR assessment, charting will include an assessment of the resident's status as it relates to the change in condition and will be done each shift for 72 hours for residents with change of condition." B. Based on observation, interview, and record review, the facility failed to provide timely, complete incontinent care and urinary catheter care for 4 of 6 residents (R7, R17, R30, R41) reviewed for urinary incontinence and urinary catheter usage in a sample of 42.

PRINTED: 08/22/2023 **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: COMPLETED A. BUILDING: \_ B. WING IL6009336 07/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **751 NORTH OAK STREET CARLINVILLE REHAB & HCC CARLINVILLE, IL 62626** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5)(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 6 Findings include: 1. On 07/26/2023 at 10:15 AM, V18 (Certified Nurse Assistant/CNA) with the assistance of V5 and V13 (Certified Nurse Assistants/CNAs) performed indwelling urinary catheter care on R41. Using a different disposable wipe, she cleansed front to back of R41's left groin, right groin, and the down the center of labial folds. R41's indwelling urinary catheter was tightly secured to her right leg that was being supported by V5 (CNA). The indwelling urinary catheter was pulled tightly against her right thigh and was kinked at the point where the tubing connects to the drainage bag. V18 took a disposable wipe and cleansed from the outside of the labial fold towards the drainage tubing and did not cleanse from the meatus outward. R41's Physician order sheet, dated 07/27/2023, documented diagnoses of Neuromuscular dysfunction of bladder, unspecified and Urinary tract infection. R41's Care plan dated, 03/17/2023, documented, "Catheter care every shift and (as needed)." It continues, "Check tubing for kinks each shift." On 07/27/2023 at 10:20 AM, V1 (Administrator) stated she would expect the staff to perform catheter care and incontinent care per the skills check off list. 2. R30's MDS dated 4/19/2023 documents R30 is cognitively intact and requires extensive

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assistance for toileting needs.

R30's Care Plan dated 6/23/2023 documents. "(R30) has bladder incontinence (due to) impaired mobility." Interventions include, "Check Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  751 NORTH OAK STREET  CARLINVILLE, IL 62626										
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S9999	R30's Care Plan da "(R30) has potential integrity related to u decreased mobility." is on diuretic (medic therapy."  On 7/25/2023 at 9:4 soiled for 6 hours. I' wetter'. Staff will coryou'. I don't want to ulcers)."  3. R17's Face shee R17 has a personal Infections), Vaginitis Confinement Status R17's MDS dated 6 cognitively intact an assistance for toileti R17's Care Plan data is incontinent of bow R17's Care	ted 6/23/2022 documents, for impairment to skin rinary incontinence and It further documents, "(R30) cation that increases urination) and AM, R30 stated, "I've sat m what they call a 'heavy me in and say, 'I just changed get open areas (pressure at dated 7/26/2023 documents history of UTIs (Urinary Tract to, Anxiety and Bed arequires extensive ng needs.	S9999							
Marsia Passar	has actual skin issue	ed 7/26/2023 documents R17 es r/t urine incontinence and e Associated Skin Damage)								

Illinois Department of Public Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING IL6009336 07/27/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **751 NORTH OAK STREET CARLINVILLE REHAB & HCC CARLINVILLE, IL 62626** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 8 to her buttocks r/t urine incontinence. It further documents R17 has bowel incontinence and interventions include, "Provide perl-care after each incontinent episode." R17's Care Plan dated 7/26/2023 documents R17 has a history of renal failure and recurrent abnormal urinalysis with need for monitoring and treatment. On 7/25/2023 at 9:54 AM, R17 stated, "They check on my roommate (R30) but then don't check on me. I feel ignored. One time my sheets were brown. I had urinated and had a bowel movement. I get UTI's very easily. I wasn't changed all afternoon that day. It sometimes takes 4-5 hours to get changed." The Facility's Resident Council Minutes dated 6/7/2023 documents cath (catheter) bags not being drained. It further documents, "Peri (perineal) care not being provided with urine incontinence." 4. On 7/24/2023 at 9:25 AM, during incontinent care for R7, V4 and V5 (CNAs) donned gloves and did not wash or sanitize hands. R7 was on his left side in bed. V4 and V5 removed R7's adult diaper, V5 with right gloved hand cleansed R7's rectal area from front to back with wipes. V5 did not cleanse R7's buttocks. R7 was repositioned to his back. V5 cleansed R7's right groin and left groin. V5 did not cleans R7's penis or retract R7's foreskin. R7's Care plan dated 11/20/2020 documents that R7 has bowel and bladder incontinence. R7's care plan documents to wash, rinse, and dry perineum.

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 IL6009336 07/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **751 NORTH OAK STREET CARLINVILLE REHAB & HCC CARLINVILLE, IL 62626** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) S9999 Continued From page 9 S9999 R7's Minimum data set (MDS) dated 6/14/2023 documents that R7 requires extensive assistance and one-person physical assistance for toileting. The facility Skills Check List for Catheter care, undated, documents to separate labia or retract foreskin and maintain the positron throughout procedure, for female- use washcloth with warm water and soap to cleanse labla change the position of the washcloth for each downward stroke change position of wash cloth and cleanse around meatus with clean washcloth, rinse with warm water using same technique. The facility Skills Check List for Male Peri Care. undated documents pull back foreskin and wash tip of penis using circular motion beginning at urethra. (A)