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 IL6009831 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1405 NORTH SECOND STREET SWANSEA REHAB HEALTH CARE SWANSEA, IL 62226 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) S 000' Initial Comments S 000 Annual Licensure Survey S9999 \$9999 Final Observations Statement of Licensure Violations: 300.610a) 300,1010h) 300.1210b) Section 300.610 Resident Care Policies 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. Section 300,1010 Medical Care Policies The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, 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 facility shall obtain and record the physician's plan of care for the care or treatment of such Attachment A accident, Injury or change in condition at the time Statement of Licensure Violations of notification.

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

TITLE

(X6) DATE

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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 DENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6009831 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1405 NORTH SECOND STREET SWANSEA REHAB HEALTH CARE SWANSEA, IL 62226 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE TEACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 1 S9999 Section 300.1210 General Requirements for Nursing and Personal Care The facility shall provide the necessary b) 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to notify the Physician and/or Nurse Practitioner in a change in condition for 1 of 1 resident (R95) reviewed for change in condition in the sample of 24. Due to this failure R95's condition worsened with increased blood noted in his stools the next day, requiring him to be admitted to the hospital for treatment. Findings include: R95's Face Sheet documents he was admitted to the facility on 9/15/23. R95's Cumulative Diagnosis Log, undated, documents his diagnoses as: Ortho Aftercare, (right hip fracture post-surgery); Gastrointestinal Bleed, (GI Bleed); Reduced Mobility-Activities of Daily Living Deficit, Gout; Wound Surgical Site Care, and Gastroesophageal Reflux Disease. (GERD).

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED 09/28/2023	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULT TAG CROSS-REFERENCED TO THE APPROPRIES.)		DE COMPLE	
S9999	Continued From page 3		S9999				
	up at 6:30 PM*. These handwritten notes were written on the back of a facility census report that was dated 9/20/23.						
	(DON), stated, she Doctor or Nurse Pro- observed blood in a she would consider be an abnormal find check to see if the rehemorrhoid or some blood in the stool, bright away. V2 state comes to the facility on the same day. Si Doctor or Nurse Pro-	PM V2, Director of Nursing, would expect staff to call the actitioner immediately if they resident's stool. V2 stated, blood in a resident's stool to ling and the Nurse should esident had a bleeding ething that may cause the ut it should still be reported d, the Nurse Practitioner every week, but not always he stated, by notifying the actitioner, that would allow for onal tests to determine what in the stool.					
	Nurse, (LPN), stated the Nurse's Note on R95's stool. V6 stated after they tolleted R5 blood. V6 stated, shourse Practitioner, bentered into the facilitherefore she could be actitioner a messa	ge about him. V6 stated, she			-		
	did not feel the amoustool was "blood transhe had checked him not have any. V6 sta Nurse Practitioner, s Wednesday when stated, she was not sentering residents intificat admitted, but R9	unt of blood she saw in his asfusion amount." V6 stated, in for hemorrhoids, but he did ated, she did write that V18.					

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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: IL6009831 **B. WING** 09/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1405 NORTH SECOND STREET **SWANSEA REHAB HEALTH CARE** SWANSEA, IL 62228 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (XIS) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 4 S9999 here to enter him into the system. V6 stated, it was a Sunday when she first noted R95 had blood in his stool. On 9/27/23 at 4:30 PM V1, Administrator, stated. the Nurse would have been able to notify the Nurse Practitioner of the blood in R95's stool even if he had not been entered into the facility's system. V1 stated, the Nurse Practitioner should have been notified when V6 first saw blood in R95's stool. On 9/28/23 at 8:15 AM V18, NP, stated, V6, LPN should have notified the Nurse Practitioner on call as soon as she noted R95 had blood in his stools. because of his Medical History of a GI bleed. V18 stated, any staff can add a resident's name to the Electronic Medical System the facility uses to notify Doctors and Nurse Practitioners when a resident has a change in condition. V18 stated, the actual treatment probably would have been the same, but there should not have been a delay in reporting abnormal signs and symptoms, including R95 having blood in his stools. V18 stated, she does not know why they would have waited until Wednesday to notify her when the blood was observed in R95's stool on Sunday. The facility's policy, Notification for Change in Resident Condition or Status, revised 12/7/17 documents, "Policy: The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, DON, Physician, Guardian, HCPOA (Health Care Power of Attorney), etc.) of changes in the resident's medical/mental condition and/or status. Procedure: 1. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been! a. Any symptom, sign or apparent discomfort that is 1. Sudden in onset 2.

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