

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011613	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/08/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HENRY REHAB AND NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1650 INDIAN TOWN ROAD HENRY, IL 61537
--	---

(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
S 000	Initial Comments Original Complaint Investigation: #2324514/IL160441 Original Complaint Investigation: #2324546/IL160521	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.620a) 300.1210a) 300.1210b) 300.3300b) 300.3300j) 300.3300l) 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 300.620 Admission, Retention and Discharge Policies a) All Involuntary discharges and transfers	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health

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

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011613	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/08/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HENRY REHAB AND NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1650 INDIAN TOWN ROAD HENRY, IL 61537
---	---

(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	<p>Continued From page 1</p> <p>shall be in accordance with Sections 3-401 through 3-423 of the Act.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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.</p> <p>Section 300.3300 Transfer or Discharge</p> <p>b) Each resident's rights regarding involuntary transfer or discharge from a facility</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011613	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/08/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HENRY REHAB AND NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1650 INDIAN TOWN ROAD HENRY, IL 61537
---	---

(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	<p>Continued From page 2</p> <p>shall be as described in subsections (c) through (y) of this Section.</p> <p>j) The planned involuntary transfer or discharge shall be discussed with the resident, the resident's representative and person or agency responsible for the resident's placement, maintenance, and care in the facility. The explanation and discussion of the reasons for involuntary transfer or discharge shall include the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's clinical record. (Section 3-408 of the Act)</p> <p>l) A resident subject to involuntary transfer or discharge from a facility, the resident's guardian or if the resident is a minor, his or her parent shall have the opportunity to file a request for a hearing with the Department within 10 days following receipt of the written notice of the involuntary transfer or discharge by the facility. (Section 3-410 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to serve an appropriate non-emergent involuntary discharge and allow the resident and resident's family time to appeal the notice and failed to provide adequate dementia care to a resident with a diagnosis of Alzheimer's disease for one of three residents (R1) reviewed for discharge in the sample of four. This failure resulted in R1 being removed from his environment after displaying a care planned</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011613	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/08/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HENRY REHAB AND NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1650 INDIAN TOWN ROAD HENRY, IL 61537
--	---

(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	<p>Continued From page 3</p> <p>behavior of dementia and suffering psychosocial harm that any reasonable person would after being placed over four and half hours away from his family and friends without notice.</p> <p>Findings include:</p> <p>The facility's Care of Resident with Dementia Guidelines, dated 11/5/22, documents "Provide care and support in a way that is respectful, preserves the residents identity, and maintains dignity. Understand the resident's behaviors and aggression and try to understand what may be the causative factor. Remain calm and provide a supportive approach that is individualized to the resident. Understand that behaviors have meanings and is a means to communicate a possible unmet need. Approach is everything. Caregivers can cause a behavior if we don't use the right approach. A resident with dementia can misunderstand what us happening and perceive activities of daily living (ADL) care as traumatic and/or frightening, resulting in resistance to care. Work with the resident to complete ADL tasks using creative approaches to help reduce resistance. Aggressive behaviors may be verbal or physical. They can occur suddenly, with no apparent reason, or result from a frustrating situation. While aggression can be hard to cope with, understanding that the person with Alzheimer's or dementia is not acting this way on purpose can help."</p> <p>The facility's Facility Assessment, dated 5/12/23, documents the facility is able to provide care for residents with the following diagnoses, including but not limited to: Impaired cognition, Mental disorder, Anxiety, Behavior that needs Intervention, Alzheimer's Disease and Non-Alzheimer's dementia.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011613	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/08/2023
NAME OF PROVIDER OR SUPPLIER HENRY REHAB AND NURSING		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 INDIAN TOWN ROAD HENRY, IL 61537		
(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	<p>Continued From page 4</p> <p>The facility's Resident Census and Conditions of Residents, dated 6/7/23 and signed by V14 (Minimum Data Set assessment Coordinator) documents 29 residents reside in the facility with a diagnosis of Dementia and 21 residents reside with Behavioral Healthcare needs.</p> <p>The facility's Transfer/ Discharge policy, dated 11/5/19, documents "The interdisciplinary team and or physician, in consult with the resident or his/her power of attorney (POA) for healthcare, may recommend transfers or discharges. All resident transfers and discharges from this facility require notification and/or authorization of the resident or his/her POA for healthcare, and his/her primary physician. In cases of emergencies the nurse on duty may initiate transfer to a hospital or medical center as resident's status and condition warrants it."</p> <p>The National Institute on Aging online article titled "Changes in Intimacy and Sexuality in Alzheimer's Disease", dated 5/17/17 and located at www.nia.nih.gov, documents "Hypersexuality: Sometimes, people with Alzheimer's disease are overly interested in sex. This is called hypersexuality. The person may masturbate a lot and try to seduce others. These behaviors are symptoms of the disease and don't always mean that the person wants to have sex."</p> <p>R1's Admission record documents R1 was admitted to the facility on 11/4/22 with a principal diagnosis of Alzheimer's Disease.</p> <p>R1's recent Minimum Data Set assessment, dated 4/7/23, documents R1 suffers severe cognitive impairment and requires extensive assistance of one person to transfer, walk and</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011613	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/08/2023
NAME OF PROVIDER OR SUPPLIER HENRY REHAB AND NURSING		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 INDIAN TOWN ROAD HENRY, IL 61537		
(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 5 move around the facility in a wheelchair. R1's Care Plan, dated 2/6/23, documents "(R1) does both independent and group activities. Staff will observe and not leave (R1) unattended during activities." R1's Care Plan, dated 12/26/22, documents "(R1) has expressed sexual desires." R1's Plan of Care, dated 4/21/23 documents "(R1) is at risk for wandering/elopement and (R1's) safety will be monitored every shift by all staff. Interventions: One on one monitoring as necessary, initiated 4/21/23. Targeted one on one supervision, initiated 4/28/23." R1's Care Plan, dated 12/26/23, documents "I currently have an alteration in my behavior status related to Alzheimer's, impaired memory/thinking, and increased sexual drive and may exhibit behaviors such as increased confusion, making inappropriate comments or physically attempting to touch staff and residents; will masturbate and is unable to comprehend or remember appropriate behaviors due to his diagnoses. (R1) does get agitated at times with staff and other residents." R1's Progress Note, dated 5/25/23, document at 11:00 AM "IDT (Interdisciplinary Team) met to discuss the physical assault (R1) attempted with a CNA (Certified Nursing Assistant, V11) during transfer and recommends the resident be discharged to accepting facility for the safety of other residents." R1's Progress Note, dated 5/25/23, documents "Administrator (V1) met with resident to discuss the events happening this morning with Activity Director (V15) present. Involuntary discharge was explained and issued to the resident. Resident did not have any questions or concerns."	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011613	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/08/2023
NAME OF PROVIDER OR SUPPLIER HENRY REHAB AND NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1650 INDIAN TOWN ROAD HENRY, IL 61537		
(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 6 R1's Notice of Involuntary Transfer or Discharge and opportunity for Hearing for Nursing Home Residents, dated 5/25/23, documents R1 is to be an "Emergency transfer or Discharge" due to "the safety of individuals in this facility is endangered." On 6/7/23 at 2:09 PM, V11 (Certified Nursing Assistant, CNA) stated "The day of the incident, I went in to get (R1) up and when I went to stand him, his hand was out and (R1) tried to kiss me but did not make contact. I got him to the dining room, and I let activities know his behavior and I told the nurse (V7, Licensed Practical Nurse)." On 6/7/23 at 11:34 AM, V8 (CNA) stated "I was on the hall with (V11) when she came out of (R1's) room and said "(R1) tried to kiss me." That sometimes was a behavior for him. I hadn't seen him try to do that in the last month or so and I did work with (R1) a lot. For his last couple days (in the facility) he was basically one on one monitoring." On 6/7/23 at 11:20 AM, V7 (Licensed Practical Nurse) confirmed being the nurse for R1 on the day he was discharged. V7 stated "(R1) was back in his room after breakfast. The CNA (V11) saw (R1) up in his room and asked if she could help him back to his chair. (R1) held his hand out to (V11) and pulled her in and tried to kiss her, no contact was made. (V11) came out and told me while I was doing medications and I told her make sure to chart it and don't go back in the room without a buddy. I got done with medication pass and was called into (V1's) office and was asked why I didn't report him being sexual inappropriate to them immediately. I said (R1) was not inappropriate to another resident. We as staff are on our own if we get hit or abused. We worry	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011813	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER HENRY REHAB AND NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1650 INDIAN TOWN ROAD HENRY, IL 61537
---	---

(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	<p>Continued From page 7</p> <p>about the residents. I had no idea (R1) was being taken out of here (the facility). I came back the next day and (R1) was gone. I didn't consider the situation an emergency. His wife (R4) is also a resident here."</p> <p>On 6/7/23 at 12:15 PM, V6 (R1's Family Friend) stated "I have called and talked to (R1) since he's been discharged. (R1's) first day he was so confused and didn't know how he got there and why he was there. He said they had a room that (R4, R1's spouse) could come to. (R4) doesn't want to move that far away. We (Friends and Family) don't want that either. It's sinful to take someone who has dementia that far away, over four and a half hours. (R1) is originally from the Peoria area."</p> <p>On 6/7/23 at 1:20 PM, V12 (R1's family member/ Power of Attorney) stated "I am an international airline pilot. I see a statement from (the facility) and of course don't always open the bills right away. Enclosed in one of those was the notice of Involuntary Discharge. I had no idea that was coming. The fact that we didn't talk is the problem. I live in Atlanta. It read that the date he was transferred was the date the letter was signed. I was a part of the admission process. They told me they would provide extra care and as things progressed, they would just up the care with (R1). I was under no direction that they were going to not care for (R1). They have people in the facility in much worse condition than (R1) and so I knew if they are caring for them, they can care for an 86-year-old man with severe Alzheimer's. The receiving facility (he transferred to) was just as shocked as me, they didn't know why he was there. I want him back in the facility with his wife (R4). (R4) and (R1) were inseparable. They had vacation houses together.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011613	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/08/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HENRY REHAB AND NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1650 INDIAN TOWN ROAD HENRY, IL 61537
--	---

(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	<p>Continued From page 8</p> <p>(R4) and (R1) were always together. I just got the sense that they (the facility) were not going to be bothered with (R1's) behaviors. You can't handle this (Hypersexual) old man who's frail and can't get up without help? (R1's) not strong and they are trained to handle him. He is not mean. Inappropriate, maybe, but not uncontrollable. I just want (R1) back there in (the facility). They (R4 and R1) are wondering where each other are."</p> <p>On 6/8/23 at 10:10 AM, V13 (R1's Physician) confirmed that hypersexual behaviors can be a symptom of Alzheimer's and dementia. V13 stated "We started (R1) on an antidepressant and tried to isolate him away from those vulnerable. V13 stated "I was aware of the discharge. I did not hear the details (of the incident) but just that (R1) assaulted a staff member. I did not know (R1) was issued with emergency status discharge. I had no idea they were moving that quickly or trying to get (R1) out that same day. I do not know why it was escalated that quickly, given the situation was not emergent. I was not aware it was an emergency discharge."</p> <p>On 6/8/23 at 12:10 PM, R4 was sitting in her room reading. R4 stated she knows her spouse (R1) has been transferred far away and she knows the situation but of course she'd rather be in the building together. R4 stated "We've have been married a long time and it's a sad situation. (R1) would rather be in the same residence as me too."</p> <p>On 6/7/23 at 10:30 AM, V1 (Administrator) stated "So on the 25th (of May) is when the incident occurred. (R1) had been making verbal comments to staff prior and we were monitoring that. When it escalated to (R1) reaching out</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6011613	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/08/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HENRY REHAB AND NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1650 INDIAN TOWN ROAD HENRY, IL 61537
--	---

(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	<p>Continued From page 9</p> <p>physically (towards staff), not just verbal we issued the involuntary discharge. (R1) was not making any comments or reaching out to other residents. Since April he hasn't had any resident-to-resident incidents."</p> <p>On 6/8/23 at 1:00 PM, V1 (Administrator) stated "Our basis on reasoning for discharging (R1) was because he made the action of a physical altercation. He didn't make contact but made a physical attempt at a CNA (V11). At that point he no longer was just a verbal threat, he took a step-in action to be physical. He is in an all-male hallway in a smaller facility. He was transferred to the facility that would accept him. I think it's like four hours from here. He was taken that day because it was urgent to get him right out of here with those behaviors. He did not require emergency services or hospitalization."</p> <p>(A)</p>	S9999		
-------	--	-------	--	--