Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION		
AND PLAN	JI CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
		IL6004881	B. WING		C 01/05/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE	, ZIP CODE		
WUITE O	NA DELLA DIL ITATIONI 8 I	1700 WHI	ITE STREET			
WHITE OF	AK REHABILITATION & H	MOUNT V	ERNON, IL 62864	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
S 000	Initial Comments		S 000			
	Complaint Investigation	on 23510756/IL168184				
S9999	Final Observations		S9999			
	Statement of Licensu	re Violations:				
	procedures governing facility. The written p be formulated by a Ro Committee consisting administrator, the advanced advisory commof nursing and other spolicies shall comply. The written policies s the facility and shall be	all have written policies and g all services provided by the olicies and procedures shall esident Care Policy g of at least the visory physician or the nmittee, and representatives services in the facility. The with the Act and this Part. hall be followed in operating be reviewed at least annually ocumented by written, signed				
	Nursing and Persona b) The facility sh care and services to a practicable physical, a well-being of the resideach resident's comp plan. Adequate and p care and personal ca resident to meet the t care needs of the resident	nall provide the necessary attain or maintain the highest mental, and psychological dent, in accordance with rehensive resident care properly supervised nursing re shall be provided to each otal nursing and personal				
•	ment of Public Health DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURI		TITLE	(X6) DATE	

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

Electronically Signed 01/16/24

STATE FORM 6899 If continuation sheet 1 of 9 TG1611

Illinois Department of Public Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION		E SURVEY PLETED
		IL6004881	B. WING		0.	C / 05/2024
	ROVIDER OR SUPPLIER AK REHABILITATION & F	1700 WH	DDRESS, CITY, STATE IITE STREET VERNON, IL 62864			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	and be knowledgeable respective resident card). Pursuant to some small incomplete following and shall be seven-day-a-week backed a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following and Shall be seven-day-a-week backed as a Market following as a Market	are-giving staff shall review le about his or her residents' are plan. ubsection (a), general lude, at a minimum, the expracticed on a 24-hour, asis: nents and procedures shall redered by the physician. exposervations of changes in including mental and as a means for analyzing and uired and the need for ation and treatment shall be fand recorded in the	S9999			
	Based on observation review, the facility fail interventions and dieresidents at risk for a of 3 residents (R3 an in a sample of 3. The experiencing a signifi 1 month, and R1 exploss of 11% in 6 month. The findings include: 1. R3's "New Admiss record documents R3 on 5/29/23. R3's Jan Sheet documents dia Syndrome, hemiplegicerebral infarction, ar	tary recommendations for latered nutritional status for 2 d R1) reviewed for nutrition se failure resulted in R3 cant weight loss of 8.09% in eriencing a significant weight ths. sion Record" in the medical 8 was admitted to the facility uary 2024 Physician's Order gnoses including Ogilive a and hemiparesis following				

Illinois Department of Public Health

STATE FORM TG1611 If continuation sheet 2 of 9

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		_	<u> </u>
		IL6004881	B. WING		01/0	, 5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WHITE OA	AK REHABILITATION & F	1700 WHI	TE STREET			
		MOUNT V	ERNON, IL 628	864		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S9999	Continued From page	e 2	S9999			
	Status) of 10, which is cognitive impairment. of 6/8/23) documents risk for altered nutritions." Interventions doweight weekly first 4 monitor weights monitor weights monitor hanges in weight to RD/LDN (Registered Nutritionist)." A facility document tit Monitoring" document R3: 11/30/23: 136 lbs (pc 12/13/23: 141 lbs 12/20/23: 140 lbs 12/27/23 125 lbs This indicates an 8.05	MD (Medical Doctor) and Dietician/Licensed Dietician led "Weekly Weight ts the following weights for bunds) 9% weight loss (11 lbs) in 1 2/27/23), and a 10.71%				
	A facility document tit Monitoring" documen R3:	led "Daily Weight ts the following weights for				
	12/11/23 133.5 lbs 12/12/23 No weight rd 12/13/23 140.5 lbs 12/14/23 No weight rd 12/15/23 139 lbs 12/16/23 to 12/19/23 12/20/23 139.5 lbs 12/21/23 to 12/27/23 12/28/23 124.5 lbs	ecorded No weights recorded No weights recorded				
	days (12/11/23 to 12/	% weight loss (9 lbs) in 17 28/23), and a 10.75% weight s (12/20/23 to 12/28/23).				

Illinois Department of Public Health

STATE FORM TG1611 If continuation sheet 3 of 9

Illinois Department of Public Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co		(X3) DATE SURVEY COMPLETED
		IL6004881	B. WING		C 01/05/2024
	ROVIDER OR SUPPLIER AK REHABILITATION & H	1700 WH	DDRESS, CITY, STATE ITE STREET VERNON, IL 62864		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
S9999	R3's "Dietary Quarter V4 (Dietary Manager) weighed 144.4 lbs, ar 133.5 lbs. This indicated and surprise and said she did not sure single she hit the NR3's weight of 124.5 ldid not ask V13 to sefacility on 12/28/23. Viet of 13/24 at 12:10pm there were no nutrition R3's lunch tray. On 1, asked if he received rhis meals and R3 sat 2. R1's "New Admissidocuments R1 was at 130 pm (R3 sat 130 pm) and said she did not supprise she hit the NR3's weight of 124.5 ldid not ask V13 to sefacility on 12/28/23. Viet of 13/24 at 12:10pm there were no nutritio R3's lunch tray. On 1, asked if he received rhis meals and R3 sat 2. R1's "New Admissidocuments R1 was at 133.5 lbs. This indicates the received rhis meals and R3 sat 13.5 lbs.	Ally Weights and Vitals" R3's weight was 130.5 lbs. Ally Assessment" signed by a documents on 8/30/23, R3 and on 12/28/23 R3 weighed ates a 7.55% weight loss. All Sament" dated 11/28/23 are dation by V13 (RD/LDN) and the at meals. There are assessments" completed by Dietician in R3's medical All Was asked about the are from 12/20/23 to 12/27/23, are that. V4 said she was alworing buttons when entering be on 12/28/23. V4 said she are R3 when V13 came to the V4 said when V13 makes a sion, she gives the are nurse and they contact are. All M14/24 at 12:20pm, and juice drinks observed on 4/24 at 12:20pm, R3 was nutritional juice drinks with	\$9999		

Illinois Department of Public Health

STATE FORM TG1611 If continuation sheet 4 of 9

Illinois Department of Public Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
		IL6004881	B. WING		0.	C 1/ 05/2024
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
WHITE O	AK REHABILITATION & I	HCC	HITE STREET VERNON, IL 62864	ı		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$9999	Sheet documents dia Parkinson's, weakne dysphagia, altered m Percutaneous Endos tube. R1's Care Plan, date under "Nutrition" R1 nutrition related to de may impact resident self." R1's Care Plar including follow recon Dietician Licensed D and notify RD/LDN or recommendation with care goals." An interdocuments tube feed bolus 5x day with 75 after." R1's "Report of Mont sheet for 2023 docur June- 157 lbs, July- September- 149.8 lb November- 137.2 lbs indicating a weight lo months. A facility document ti	agnoses including ss, diabetes mellitus (DM), mental status, and acopic Gastrostomy (PEG) dd 10/10/2022, documents lis at risk for alteration in mementia and Parkinson's and ability to swallow or feed in documents interventions mendations of Registered ietician Nutritionist (RD/LDN) of discrepancy of in resident's preferences or invention, dated 8/3/2023, sings were changed to "240 mL H2O flush before and lithly Weights and Vitals" ment R1's weights for R1: 154.3 lbs, August-151.8 lbs, so, October- 142.4 lbs, so, and December-139.2 lbs, ass of 11% (17.8 lbs) in 6	S9999			

Illinois Department of Public Health

STATE FORM TG1611 If continuation sheet 5 of 9

Illinois Department of Public Health

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		IL6004881	B. WING		C 01/05/2024
	ROVIDER OR SUPPLIER AK REHABILITATION & H	CC 1700 WH	DDRESS, CITY, STATE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
\$9999	Licensed Dietician Nudocuments "current windicating cont. (conti Mass Index) 19.0. He Soft with Magic Cup whole milk @ (at) me 240 mL (milliliters) Je water flush before and day). No signs of into labs. Recommended Jevity 1.5 to 2 cal (ca current volume. Conti RD as needed." R1's November 2023 (POS) documents an time documented) of recommendation: cha Nurten 2.0, 240 mL wand after." An order of previous order on the 11/7/23 (no time documented) to recent weight gain 5x/day with 75 mL ward R1's weights and Vitals" a Monitoring" document any weight gain since made per the Dietary R1's Dietary Notes by documents, "current will loss. BMI 18.1. Diet to added salt), CCD (Camech (mechanical) so	vV13 (Registered Dietician/ atritionist), dated 10/27/23, rt (weight) 142.4# (pounds) muous) wt loss. BMI (Body is currently on Mechanical FID (three times a day), als and continues to receive vity 1.5 w/ (with) 75 mL d after 5x/ day (times per lerance reported. No new changing formula from lorie) or Nutren 2.0. Maintain nue to monitor and refer to Physician's Order Sheet order dated 11/7/23 (no "per signed dietary inge tube feeding to 2 cal or ith 75 mL water flush before larification written below the same POS, also dated imented), documents, "due continue Jevity 1.5 240 mL iter flush before and after." d on the "Report of Monthly ind "Weekly Weight tation does not document iv V13's recommendation was	S9999		

Illinois Department of Public Health

STATE FORM TG1611 If continuation sheet 6 of 9

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SU COMPLE	
			7. BOILDING.	A. Boilesino.		
		IL6004881	B. WING		01/0	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WHITE OA	AK REHABILITATION & H	ICC 1700 WHIT	E STREET			
***************************************		MOUNT VE	RNON, IL 628			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S9999	Continued From page	e 6	S9999			
		cal or Nutren 2.0 per				
	Practitioner) for an or CCD diet, mechanica	d 11/30/23, from V12 (Nurse der clarification for "NAS, I soft, nectar thick liquids, ube 240 mL 5x/day, 75 mL				
	R1's Dietary Notes by V13,dated 12/6/23, documents, "current wt 139.2# indicating significant weight loss x 3 mos (months) and 6 mos. Noted slight gain x 1 month. BMI 18.4. Current diet ordered is NAS, CCD, mechanical soft, nectar liquids, no bread, magic cup TID, whole milk at meals, 240 mL Jevity 1.5 with 75 mL water before and after 5x/day."					
	facility monthly, and N resident's weights and significant weight loss monthly weights and said she was not give loss on R3, and R3 w when she was at the said she was told R1	d a list of residents with s. V13 said she is given the not the weekly weights. V13 en anything regarding weight as not on her list to be seen facility on 12/28/23. V13 was on the upward side and inds, and that is why they did				
	said they usually do for recommendations and reason the physician the recommendations	d does not know of any would not agree with any of				

Illinois Department of Public Health

STATE FORM 6899 TG1611 If continuation sheet 7 of 9

Illinois Department of Public Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		IL6004881	B. WING		C 01/05/2024
	ROVIDER OR SUPPLIER AK REHABILITATION & H	1700 WH	DDRESS, CITY, STATE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
\$9999	and sends them to the V12 (Nurse Practition On 1/3/24 at 10:30am Nurse) said she is no recommendations on contact the physician of. V3 said if they are do it. On 1/4/24 at 11:30 Al Nurse) said she does dietary recommendat (Physician) or V12 (Nare not in the chart, s On 1/4/24 at 3:13pm, notified of any weight said she was not asker recommendations made Dietician. V12 said she with the facility follow by the Registered Dieto On 1/5/24 at 9:43am, would expect that the Dietician's recommendations recommended in the was notified of R1 he thinks he was notified of R1 he thinks he was notifications could be has not acted on yet. Facility policy titled "Figure (revised 10/13, 10/14) procedure step 5 that significant weight charter in the said of the significant weight charter in the value of value of the	m the V4 (Dietary Manager) e V11 (Physician) or has er) look at them. n, V3 (Licensed Practical t aware of any dietary R1, and R3 and did not about this that she is aware e not in the chart she did not W, V10 (Licensed Practical not recall sending any ions on R1 or R3 to V11 urse Practitioner), but if they he probably did not do it. V12 said she was not loss on R1 or R3. V12 also ed about any dietary ade by the Registered he has seen some issues ing recommendations made etician. V11 (Physician) said he facility follow the Registered dations. V11 said he thinks and R3's weight loss, and fied of the Registered dations. V11 said these in a big stack of papers he Resident Weight Monitoring" , 3/19) documents in "If there is an actual inge (i.e. +/- 5% x 1 month, +/- 10% x 6 months), the	S9999		

Illinois Department of Public Health

STATE FORM TG1611 If continuation sheet 8 of 9

Illinois Department of Public Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE)
IL6004881 B. WING 01/05/20:	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	024
WHITE OAK REHABILITATION & HCC 1700 WHITE STREET	
MOUNT VERNON, IL 62864	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	(X5) COMPLETE DATE
S9999 Continued From page 8 S9999	
S9999 Continued From page 8 healthcare)/family/guardian, physician and dietician are notified." Procedure step 9 documents that "The Dietician shall review and document all significant weight changes along with any recommended nutritional interventions in the dietary progress notes in the medical record monthly." (B)	

STATE FORM 6899 TG1611 If continuation sheet 9 of 9