| Illinois Department of Public Health | | | | | | | | | |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------|-------------------|--------------------------|--|--|--|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED | | | |
| | | IL 6000996 | B. WING | | 08/1 |) 4/2024 | | | |
| | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | | | |
| | NOVIDER OR GOI T EIER | | TH MAIN ST | | | | | | |
| BLOOMI | NGTON REHABILITA | FION & HCC | IGTON, IL 6 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETE DATE | | | |
| S 000 | Initial Comments | | S 000 | | | | | | |
| | Complaint Investiga | ation 2466289/IL176531 | | | | | | | |
| S9999 | Final Observations | | S9999 | | | | | | |
| | Statement of Licens | sure Violations: | | | | | | | |
| | Nursing and Person b) The facility care and services to practicable physica well-being of the re- each resident's com- plan. Adequate and care and personal of resident to meet the care needs of the re- d) Pursuant to nursing care shall in following and shall seven-day-a-week 2) All treat be administered as 3) Objective a resident's conditioned emotional changes determining care re- further medical evaluation made by nursing st resident's medical re- 5) A regula | shall provide the necessary o attain or maintain the highest l, mental, and psychological sident, in accordance with nprehensive resident care l properly supervised nursing care shall be provided to each total nursing and personal esident. subsection (a), general nclude, at a minimum, the be practiced on a 24-hour, basis: ments and procedures shall ordered by the physician. ve observations of changes in on, including mental and , as a means for analyzing and equired and the need for luation and treatment shall be aff and recorded in the | | | | | | | |
| Illinoia Danas | tmont of Dublic Locit | | | | | | | | |
| | tment of Public Health / DIRECTOR'S OR PROVID | ER/SUPPLIER REPRESENTATIVE'S SIG | NATURE | TITLE | | (X6) DATE | | | |
| Electron | ically Signed | | | | | 08/30/24 | | | |

If continuation sheet 1 of 6

| | epartment of Public | | | CONSTRUCTION | | |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------|--------------------------------|--------------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | . , | | (X3) DATE SUI COMPLET | |
| | | B. WING | | | C 14/2024 | |
| | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| | | 1925 SO | UTH MAIN ST | REET | | |
| BLOOMI | NGTON REHABILITAT | BLOOMI | NGTON, IL 61 | 701 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| S9999 | Continued From pa | ge 1 | S9999 | | | |
| | breakdown shall be | practiced on a 24-hour, | | | | |
| | | basis so that a resident who | | | | |
| | | ithout pressure sores does not | | | | |
| | | ores unless the individual's | | | | |
| | | monstrates 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. | | | | | |
| | These requirements are not met as evidenced by: | | | | | |
| | | | | | | |
| | Based on observation, interview, and record | | | | | |
| | review, the facility failed to provide wound | | | | | |
| | dressing changes and skin checks according to physician orders. This failure affects two | | | | | |
| | | R3) out of three reviewed for | | | | |
| | | This failure resulted in R1 | | | | |
| | | le occasions of parasitic | | | | |
| | maggot infestations | | | | | |
| | Findings include: | | | | | |
| | 1 P1's Eace Sheet | , dated 8/2/24, documents R1 | | | | |
| | | e facility 5/25/22 with medical | | | | |
| | | g Diabetes Type 2, Sepsis, | | | | |
| | | ailure, Coronary Artery | | | | |
| | Disease, Right Abo | ve the Knee Amputation, and | | | | |
| | Atrial Fibrillation. | | | | | |
| | R1's Physician Ord | er Sheets (POS) dated for July | , | | | |
| | | ocument physician ordered | | | | |
| | | atment adjustments for the | | | | |
| | facility nursing staff | to apply to R1's left foot and | | | | |
| | | nese POS document to soak | | | | |
| | | n peroxide saturated gauze rol | I | | | |
| | | time, then to begin a | | | | |
| | | e R1's left great toe with | | | | |
| | | ily and apply mild bleach on daily and as needed. On | | | | |
| | tment of Public Health | on daily and as needed. Of | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED C | | |
|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|------------------------------------------------------------------------------------|---------------------------------|-------------------------|
| | | | | | | IL6000996 |
| NAME OF I | PROVIDER OR SUPPLIER | | DRESS, CITY, ST JTH MAIN STF | | | |
| BLOOMI | NGTON REHABILITA | TION & HCC | NGTON, IL 61 | | | |
| (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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| \$9999 | new treatment for F a calcium alginate of left posterior and an (padded absorbent gauze 3 times per v Wednesdays, and I R1's Treatment Adu June 2024 docume R1's left foot were of 6/10/24, 6/14/24, an dressing changes a spaces for these da R1's TAR for July 2 changes for R1's lef 7/12/24, 7/15/24, 7/ 7/22/24, 7/24/24, 7/ same TAR docume checks were not co and 7/30/24. These likewise documented the dates mentione R1's Nursing Notes (unidentified) nurse report there were m On this same date, documented (hospi inform the nurse th | d Physician (V8) ordered a R1's left foot to include to apply (absorbent dressing) to R1's interior foot, apply an ABD pad dressing) and wrap with week on Mondays, Fridays. ministration Record (TAR) for ents R1's dressing changes on not completed on 6/3/24, and 6/26/24. These incomplete are documented as blank ates. 2024 documents R1's dressing off foot were not completed on 216/24, 7/18/24, 7/19/24, 28/24, and 7/29/24. This ents R1's ordered weekly skin pompleted on 7/9/24, 7/16/24, a incomplete treatments are ed by way of blank spaces for | | | | |
| | 7/10/24. On 8/13/24 at 11:05 are usually pretty g dressings but it all o would say there ha | 5 AM, R1 stated, "The nurses ood about changing my depends on who is working. I ve been several occasions ange the dressings for 2 days | | | | |

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| Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ILL6000996 | | (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | TE SURVEY MPLETED | |
|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------|-------------------------------------------------------------------------------|----------------------|--|
| | | B. WING | B. WING | | 14/2024 | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| BLOOMI | NGTON REHABILITA | FION & HCC | UTH MAIN STI NGTON, IL 61 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES | | ID PREFIX TAG | (EACH CORRECTIVE ACT | B PLAN OF CORRECTION CTIVE ACTION SHOULD BE CON NCED TO THE APPROPRIATE | | |
| S9999 | Continued From pa | ge 3 | S9999 | | | | |
| | in row." | - | | | | | |
| | Wound Care, stated nurse, but I have ad Physician) when he (R1) had maggots i hospice had started was when they orde changed the treatm (7/10/24). Then the days ago or so (8/1 needed to let (V8) r wounds." V5 contin Wednesday (8/7/24 again." On 8/14/24 at 9:58 Wound Care, stated TAR then that mean unless there are so that it was done." | PM, V5, Registered Nurse, d, "I just started as the wound ccompanied (V8, Wound Care e comes to check on (R1). Yes n his wounds back when d prescribing the orders, that ared the peroxide soak and tent to the (bleach solution) maggots came back about 10 /24) and hospice decided they resume the care for (R1's) ued, "(V8) was out here last d) and changed the treatment AM, V6, Registered Nurse, d, "If there are blanks on the ns that treatment wasn't done me nurses notes to document AM, V7, Licensed Practical isn't documented, it isn't | | | | | |
| | 8/11/24 do not docu | reviewed from 5/3/24 through ument any further completion ments from what was TAR's. | | | | | |
| | Physician, stated, " aware of (R1) havir on 7/10/24, but (R1 hospice and there i evaluate one reside there was a bit of a | pm, V8, Wound Care I do treat (R1). I was made ng maggots in his foot wound) had been accepted to sn't a need for two doctors to ent for the same wound and n adversarial interaction. The ed me to look at (R1) while I | | | | | |

| Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000996 | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | | DENTIFICATION NOWDER. | A. BUILDING: | | | |
| | | B. WING | | | C 14/2024 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AI | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| BLOOMI | NGTON REHABILITA | TION & HCC | UTH MAIN STE NGTON, IL 61 | | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | HE APPROPRIATE | COMPLET DATE |
| S9999 | Continued From pa | age 4 | S9999 | | | |
| | continued, "I gave s on how to eradicate soaks, then to put a (bleach) solution ev- the treatments are orders, then the go from being able to g hours, according to for the fly larvae to by stating, "As far a facility I couldn't sp having maggots in a uncommon thing, b treatments." 2. R3's Face Sheet was admitted to the diagnoses including Hyperglycemia, An Artery Disease, and with Angioplasty. On 8/13/24 at 3:30 Wound Care, state wound on the heel, which was open an tendon visible, but i are just putting lotic R3's POS for Augus orders initiated 6/18 skin check on Wed order initiated 7/16/ skin checks on Tue PM shift. R3's TAR for June 3 | emia, Hypertension, Coronary d Peripheral Vascular Disease PM, V5, Registered Nurse, d, "(R3) did have an open really on the Achilles tendon, d had some muscle and it is all healed up now and we on on it." st 2024 documents physician B/24 R3 to receive a weekly inesdays. There is a second /24 for R3 to receive weekly esdays on the 6:00 AM to 2:00 2024 documents the order for | | | | |
| | R3's weekly skin ch | necks was originally initiated pleted on Tuesdays during the | | | | |

| Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
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| IL6000996 | | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | COMPLETED | |
| | | B. WING | | 08/1 | C 4/2024 | | |
| AME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| | NGTON REHABILITA | TION & HCC 1925 SO | UTH MAIN ST | REET | | | |
| | | BLOOMI | NGTON, IL 61 | 701 | | | |
| (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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLE DATE | |
| S9999 | Continued From pa | ige 5 | S9999 | | | | |
| | 6 AM to 2:00 PM shift. This same TAR documents the skin check was not completed 6/18/24. R3's TAR for July 2024 documents R3's skin checks were not completed on 6/9/24 and 6/16/24. | | | | | | |
| | | | | | | | |
| | treatment initiated of to R3's heel wound completed on 8/5/2 documents R3's or facility nursing staff | st 2024 documents R3's on 7/31/24 to apply skin prep and leave open to air was not 4 and 8/6/24. This same TAR der initiated 8/7/24 to have 5 apply house lotion to R3's n to air was not completed on 8/10/24. | | | | | |
| | (B) | | | | | | |
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