Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		II 6006274	B. WING		08/23/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADD				STATE, ZIP CODE	00/2	3/2024
OAK HIL	L		ACHER STRI			
(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 (X: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
S 000	Initial Comments		S 000			
	Annual Health Surv	rey				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.610a) 300.1210b) 300.1210d)6)					
	Section 300.610 R	esident Care Policies				
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall comp The written policies the facility and shall	divisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating I be reviewed at least annually documented by written, signed				
	Section 300.1210 Nursing and Person	General Requirements for nal Care				
	care and services to practicable physical well-being of the re- each resident's con- plan. Adequate and care and personal of	shall provide the necessary o attain or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care I properly supervised nursing care shall be provided to each e total nursing and personal				

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

(X6) DATE

TITLE

09/19/24

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		IL6006274	B. WING		08/23/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OAK HIL	L		ACHER STRE DO, IL 62298			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	care needs of the re	esident.				
	 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 					
	These requirements were not met as evidenced by:					
	failed to ensure resisupervised and in a was free of hazards reviewed for falls in resulted in R80 who	and record review the Facility ident was being properly clutter-free environment that for 1 of 5 residents (R80) the sample of 56. This failure had a history of falls tripping side table in the sunroom, ches.				
	Findings include:					
	documents a diagno atrial fibrillation, ove generalized anxiety infarction, major de	der Sheet for August 2024 osis of Alzheimer disease, erweight retention of urine, disorder, myocardial pressional disorder, type 2 thout complications."				
		ta Set dated 7/11/2024 s severely impaired for es of daily living.				

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R80's Care Plan documents he has a history of

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		IL6006274	B. WING		08/2	3/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OAK HIL	L		ACHER STRI DO, IL 62298			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	falls and had fallen 2/16/2024 and 3/3/3/3/2024 and 3/3/3/3/3/3/3/3/3/3/3/3/3/3/3/3/3/3/3/	on 12/14/2023, 1/28/2024,	S9999			
		to right side. Resulting in right				

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OAK HIL	L		ACHER STRI OO, IL 62298			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	eyebrow laceration	and skin tear to right elbow.				
	Tool dated 3/26/202 side on floor of sun when ambulating.	ement Post Fall Assessment 24 documents, "Laying on right room. Staff to assist resident Sunroom assessed, nonessential furniture				
	AM, Resident return PM, via ambulance	tes dated 3/26.2924 at 11:26 ned at approximately 11:30 . Bruising noted to right eye . Resident appears to leaving				
	R80's Progress Notes dated 3/29/2024 at 9:54 AM, "Patient continues to be on observation related to follow up fall day #3 and orders related to Zoo {sic}. Bruising continues to right eyebrow, stitches intact."					
	AM, V22, Registere (R80) was out in the used to be ambulat was in a wheelchair feet got hooked on a gauge on eyebrox	tes dated 8/23/2024 at 11:59 ed Nurse (RN) Nurse stated," e sunroom the day he fell. He ory and had a decline and he r. We are thinking one of his the chair or side table and got w and fell out of the s sent out to the hospital where				
		harge Records dated nts," You have 7 stitches that oved in 7-10 days."				
	Practitioner stated, before thanksgiving health. I would expe	:30 PM, V27, Nurse "(R80) had a heart attack g and did have a decline in ect areas like the sunroom to free of hazards. It was				

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		IL6006274	B. WING 08/23/20			23/2024	
OAK HILL 623 HAMA			DDRESS, CITY, STATE, ZIP CODE ACHER STREET OO, IL 62298				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
\$9999	unfortunate that he The Fall Policy date "Each resident will I will receive care and their individualized I of risk to minimize to an event in which a comes to rest on th but not as a result of force (e.g. resident even may be witness	fell." ed 10/27/2023 documents, on assessed for fall risk and diservices in accordance with level or risk to minimize level the likelihood of falls. A 'fall' is in individual unintentionally e ground, floor, or other level, of an overwhelming external pushes another resident). The seed, reported, or presumed found on the floor or ground,	\$9999				

6899

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