TATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	E CONSTRUCTION		
					(X3) DATE SURVEY COMPLETED	
		IL6009559	B. WING		09/2	0/2024
	OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
EFFINGHAM REH	AB & HEAL	TH C CTR	RTH LAKEWO AM, IL 62401			
PREFIX (EAC	H DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S 000 Initial Co	omments		S 000			
Annual	Licensure S	Survey				
S9999 Final Ot	oservations		S9999			
Stateme	ent of Licen	sure Violations:				
1 of 2						
300.121 300.121 300.121 300.121	0b)4) 0c)					
	300.1210 and Persor	General Requirements for nal Care				
care and practica well-bein each res plan. Ad care and resident	d services t ble physica ng of the re sident's con lequate and d personal o	shall provide the necessary o attain or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to each e total nursing and personal esident.				
encoura incontin appropr urinary t normal l personn who ent catheter clinical o	ige resident ent of bowe iate treatme tract infection bladder fun- iel shall ass ers the faci is not cath condition de	personnel shall assist and is so that a resident who is and/or bladder receives the ent and services to prevent ons and to restore as much ction as possible. All nursing list residents so that a resident lity without an indwelling eterized unless the resident's emonstrates that necessary.				
ois Department of P ORATORY DIRECTOF Electronically Sig	R'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 10/14/24

Illinois D	epartment of Public	Health			1 01 01	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6009559	B. WING		09/2	0/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
EFFING	IAM REHAB & HEALT	TH C CTR	RTH LAKEW AM, IL 6240	OOD DRIVE 11		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	encourage resident in activities of daily circumstances of th demonstrate that di This includes the re- dress, and groom; i eat; and use speec functional commun who is unable to ca shall receive the se good nutrition, groo c) Each direct and be knowledgea respective resident d) Pursuant to nursing care shall in following and shall seven-day-a-week 4) Personal ca 24-hour, seven-day include, but not be C) Each reside clothing in order to of odors, and decer otherwise indicated should be street clo These requirement Based on observati review, the facility fi hygiene care for 1 (for dignity in the sat	bersonnel shall assist and s so that a resident's abilities living do not diminish unless he individual's clinical condition iminution was unavoidable. esident's abilities to bathe, transfer and ambulate; toilet; h, language, or other ication systems. A resident rry out activities of daily living rvices necessary to maintain ming, and personal hygiene. care-giving staff shall review able about his or her residents' care plan. subsection (a), general nclude, at a minimum, the be practiced on a 24-hour, basis: are shall be provided on a r-a-week basis. This shall limited to, the following: nt shall have clean, suitable be comfortable, sanitary, free nt in appearance. Unless by his/her physician, this	S9999			
•	with urine dripping to the second sec	under his chair during				
STATE FOR	M		6899 🤅	9QVH11	If continuation	on sheet 2 of 10

STATEMEN	epartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6009559	B. WING		09/	20/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
EFFINGH	IAM REHAB & HEAL	THCCTR	RTH LAKEWO IAM, IL 62401				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION							
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
S9999	Continued From pa	age 2	S9999				
		ould cause a reasonable omfort, humiliation and					
	The Findings Inclue	de:					
		documents an admission of udes the following diagnosis:					
	7/8/24 documents a Status (BIMS) scor cognitive impairme MDS documents R urine. Section GG Goals documents R touching assistance lower body dressin verbal cues and/or contact guard assist	a Brief Interview of Mental e of 3, indicating severe nt. Section H of this same 31 is frequently incontinent for - Functional Abilities and R31 requires supervision or e for toileting hygiene and g, meaning the helper provides touching/steadying and/or stance as resident completes may be provided throughout nittently.					
	Self Care Deficit - r assist to complete motivated to compl Living). Goals for t participate in bathir for the next 90 day problem area inclu- necessary with stat Set up. Have neces	ocuments a problem area of needs supervision and/or quality care and/or poorly ete ADL's (Activities of Daily his focus area are for R31 to ng/dressing during am/pm care s. Interventions for this de: Assist with ADL's as ff assist of supervision/limited. ssary items in place. Offer					
	needed to allow Re efficient time, safe for changes in Res nurse for follow up	rbal cues. Segment tasks as esident to complete tasks in and quality manner. Observe ident ADL ability and notify w/ Restorative, therapy or ovide privacy and dignity.					

		Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6009559	B. WING		09/	20/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
EFFING	HAM REHAB & HEAL	THCCTR	RTH LAKEWO IAM, IL 62401	OD DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	age 3	S9999			
	and keep closed du sufficient time to co Resident but keep Resident will make ADL's preferences. On 9/18/24 at 11:40 the hall from his roo lunch. R31's clothir armpit to the back o At 11:43 AM, R31 s awaiting lunch and his chair leaking fro passed R31 and as protector on him du	D AM, R31 was walking down om to the dining room for ng was wet from under his of his knees. Sat down in the dining room a puddle began forming under om his seat. Several staff ssisted in placing a clothing				
	V5 (Certified Nurse standing up in a pu down. V5 at this tim to clean him up. Th during this time. At 12:20 PM, R31 r	Assistant/CNA) that R31 was ddle and his pants were falling ne took R31 back to his room ne chair and floor remained we re-entered the dining room in				
		nd sat down in the wet seat puddle of urine under the table				
	a paper towel on th	irector of Nursing/DON) placed e floor and used her foot to asking who spilled something				
	generally incontine wears an incontine not call housekeep floor, but she did no chair. V5 stated tha	PM, V5 stated that R31 is nt of urine and bowel and nt brief. V5 stated that she did ing to clean up the chair or the ot see the puddle under the at the weight of R31's saturated what was causing his pants to				

Illinois D	epartment of Public	Health				ATTROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
,			A. BUILDING:			
		IL6009559	B. WING		09/2	0/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
FFFING	AM REHAB & HEAL	THIC CTR 1610 NOR		OOD DRIVE		
		EFFINGH/	AM, IL 6240	1		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	fall down.					
	that she visits her r stated that she was when she arrived, F area and his clothir stated that once sh cleaned up and cha expects that staff w and not left sitting in stated that while R3 R31 would be emba urine-soaked clothi underneath him alo	PM, V10 (Guardian) stated esidents every quarter. V10 a last there in June 2024 and R31 was sitting in the common ng was wet from urine. V10 e arrived, R31 was taken to be anged. V10 stated that she rill keep R31 cleaned up, dry n urine-soaked clothing. V10 B1 is unable to tell us himself, arrassed to be sitting in ng and a puddle of urine ong with the two other xt to him at the dining room				
	Program Residents Term Care Facilities rights to dignity and the right to make you must treat you with care for you in a ma quality of life, and y					
	2 of 2					
	300.650d) 300.661					
	Section 300.650 P	ersonnel Policies				
Illinois Depa	tment of Public Health					

9QVH11

If continuation sheet 5 of 10

Illinois D	epartment of Public	Health			FORM	APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BOILDING.			
		IL6009559	B. WING		09/:	20/2024
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
EFFINGH	IAM REHAB & HEAL	THCCTR	RTH LAKEWC IAM, IL 62401			
(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 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	age 5	S9999			
		shall check the status of all Health Care Worker Registry				
	Section 300.661 He Check	ealth Care Worker Background	1			
	A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.					
	These REQUIREM evidenced by:	ENTs are not met as				
	failed to ensure the and all required bac checked for employ	and record review, the facility Healthcare Worker Registry ckground check websites were yees. This has the potential to hts residing at the facility.				
	Findings Include:					
	hire date document Assistant/CNA) date employment status Worker Registry ch documents V15's v facility was not able evidence of checkin Eligible to Work, Illi the Department of the Department of Wanted Fugitive wo	ded untitled document with ts V15's (Certified Nurse te of hire was 9/20/23 and as active. V15's Healthcare neck dated 9/18/2024 work eligibility as eligible. The te to provide reproducible ing the Fee Applicant Inquiry, inois Sex Offender Registry, Corrections Inmate Search, Corrections Sex Offender and ebsite, and/or the Office of s website for V15 prior to hire				
	hire date documen 9/1/23 and employ	ded untitled document with ts V5's (CNA) date of hire was ment status as active. V5's				
iois Depar ATE FORI	tment_of Public Health M		⁶⁸⁹⁹ 90	QVH11	lf continua	tion sheet 6 o

STATEMEN	epartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		IL6009559	B. WING		09/	20/2024
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	03/20/2024	
FEEINGH	IAM REHAB & HEAL	1610 NO	RTH LAKEWO	OOD DRIVE		
		EFFING	IAM, IL 62401			
(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 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	age 6	S9999			
	7/8/2024 documen eligible. The facility reproducible evider Applicant Inquiry, E Offender Registry, Inmate Search, the Sex Offender and V and/or the Office of for V5 prior to hire 3. The facility provi hire date documen was 5/6/22 and em V17's Healthcare V 7/26/2022 docume eligible. The facility reproducible evider Applicant Inquiry, E Offender Registry, Inmate Search, the Sex Offender and V	ded untitled document with ts V17's (CNA) date of hire ployment status as active. Vorker Registry check dated nts V17's work eligibility as was not able to provide nce of checking the Fee Eligible to Work, Illinois Sex the Department of Corrections Department of Corrections Wanted Fugitive website, f Inspector General's website				
	hire date documen was 5/6/22 and em V18's Healthcare V 7/26/2022 docume eligible. The facility reproducible evider Applicant Inquiry, E Offender Registry, Inmate Search, the Sex Offender and V	ded untitled document with ts V18's (CNA) date of hire ployment status as active. Vorker Registry check dated nts V18's work eligibility as was not able to provide nce of checking the Fee Eligible to Work, Illinois Sex the Department of Corrections Department of Corrections Wanted Fugitive website, f Inspector General's website e date.				
		ded untitled document with				
ois Depar	tment of Public Health		6899	QVH11	lf continua	

P CODE PCODE RIVE PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
PROVIDER'S PLAN OF CORRECTION (X: EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE DAT
PROVIDER'S PLAN OF CORRECTION (XE EACH CORRECTIVE ACTION SHOULD BE COMP OSS-REFERENCED TO THE APPROPRIATE DAT
EACH CORRECTIVE ACTION SHOULD BE COMP OSS-REFERENCED TO THE APPROPRIATE DAT

TATEMEN	epartment of Public T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		IL6009559	B. WING		09/20/2024		
JAME OF F	PROVIDER OR SUPPLIER		_I DDRESS, CITY, ST		03/20/202		
		1610 NO	RTH LAKEWO				
	IAM REHAB & HEALT	EFFING	IAM, IL 62401				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
S9999	Continued From pa	ge 8	S9999				
	Manager) stated sh since July 2023 and new employees. V7 out an application of employees come in given a paper appli- page having a box the facility to start the employment. V7 station in on a different day start work until finge checks are completed results back. V7 sa on employees year still correct and eliginot print off the indi- pages for V15, V5, she needs to get back	53 PM, V7 (Business Office he has been in this position d completes all paperwork for 7 stated potential employees fil online then when potential h for an interview, they are cation to complete with the las for them to mark that allows he background check for ated, new staff members come y for orientation and do not erprinting and background ted and the facility has the id she does rerun information ly to verify the information is iible to work. V7 stated she did vidual background check V19, V20 and V21. V7 stated, etter at printing the paperwork npleting the background	t				
	stated that V17 and the facility through a hired in the facility a stated, they do not requested for the hi- checks on V15, V5, V1 stated, they do h completing backgro employees, but the regulations. V1 stat healthcare worker b	2:05 PM, V1 (Administrator) d V18 were already working in an agency when they were as full time employees. V1 have the additional information ealthcare worker background , V17, V18, V19, V20 and V21 have a hiring policy on bund checks for new hire facility also follows the ted she does expect all background checks to be alations, printed and kept in files.					
ois Donor		npany Name) "Resident Listing /24, documented 34 residents	J				

Ilinois Department of Public	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	IL6009559	B. WING		09/2	20/2024
IAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FFINGHAM REHAB & HEAL	INCCIR	ORTH LAKEWO HAM, IL 62401			
(X4) ID SUMMARY STA			PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	COMPLET
S9999 Continued From pa	age 9	S9999			
reside in the facility	Ι.				
	(C)				
ois Department of Public Health					