Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6008395	B. WING		01/25/2024	
NAME OF P	TE, ZIP CODE					
SCOTT C	DUNTY NURSING CENTE	RURAL RO WINCHES	OUTE 2 TER, <b>I</b> L 62694			
(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 COMPLETE	
S 000	Initial Comments		S 000			
	Annual Licensure and	d Certification				
S9999	Final Observations		S9999			
	Statement of Licensu	re Violations				
	300.610a)					
	300.1210b)					
	300.1210d)3)					
	Section 300.610 Resi	ident Care Policies				
	procedures governing facility. The written p be formulated by a Ro Committee consisting administrator, the advimedical advisory comof nursing and other spolicies shall comply					
	Section 300.1210 Ge Nursing and Persona	neral Requirements for I Care				
	care and services to a practicable physical, I well-being of the resideach resident's comp plan. Adequate and p care and personal car resident to meet the t care needs of the resident					
	d) Pursuant to so	ubsection (a), general				

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

TITLE (X6) DATE **Electronically Signed** 02/28/24

STATE FORM 6899 MNCS11 If continuation sheet 1 of 6

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE Co		(X3) DATE SURVEY COMPLETED		
		  L6008395	B. WING		0-	1/25/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	-	
SCOTT C	OUNTY NURSING CENT	ER	ROUTE 2			
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ESTER, IL 62694	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
S9999	_	e 1 Hude, at a minimum, the e practiced on a 24-hour,	S9999			
	seven-day-a-week ba	- ' <del>-</del> '				
	resident's condition, i emotional changes, a determining care req	as a means for analyzing and uired and the need for ation and treatment shall be fand recorded in the				
	These requirements by:	were not met as evidenced				
	failed to provide asset for 1 of 3 residents (F condition in the samp	nd record review, the facility essment or timely treatment R9) reviewed for change of ole of 34. This failure resulted or 3 days without physician ined a right fractured				
	Findings include:					
		dated, documents that R9 I/2022, and has diagnoses of and heart failure.				
	that R9 is severely collimited assistance of mobility, eating and hassistance of 2 staff in	Set, dated 4/9/23, documents organitively impaired, requires 1 staff member for bed bygiene, extensive members for transfer, and of 1 staff member for				
	documents, "resident	dated 06/25/2023 12:04 PM, has c/o (complaint of ) shoulder past couple of				

Illinois Department of Public Health

STATE FORM 6899 MNCS11 If continuation sheet 2 of 6

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	COMPLET	ΓED	
		IL6008395	B. WING		01/25	/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
00077.0	SUNTY NURSING SENT	-B RURAL RO	OUTE 2			
SCOTT C	DUNTY NURSING CENTE	ER WINCHES	TER, IL 62694			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
S9999	Continued From page	2	S9999			
•	, -					
	•	ted she has decreased ROM				
	` ` `	his shoulder and area is				
		ea is darker than surrounding tly warm to touch. note - this				
		ys on in bed most of the				
		y. she is OOB (out of bed)				
	_	good spirits chatting and				
		nol given as ordered, will				
	monitor and report sig	gnificant changes."				
	R9's Progress Note, dated 06/26/2023 08:56 AM,					
	documents, "Reported to writer by staff res					
	(resident). c/o right shoulder pain when getting up					
	for breakfast. On ass					
	leaning on the right sl	houlder in w/c (wheelchair).				
		res. also sleeps on the right				
		verbalizes not to touch her				
	shoulder because it h					
		the top of shoulder. Slight				
		touch. Limited rage of D (Medical Doctor), spoke				
		new order) for Shoulder x-ray				
		500mg (milligram) TID (three				
		Dx (diagnosis): possible				
	infection in shoulder. HCPOA (Health Care Power					
	of Attorney) notified."					
	R9's Progress Note.	dated 06/26/2023 09:14 AM,				
		ed R shoulder x-ray x3 views				
		Biotech to call with time."				
	R9's Progress Note o	dated 06/26/2023 05:50 PM,				
	_	d x-ray results, faxed MD.				
		uctions. Results filed in res.				
	chart."					
	, R9's Progress Note <i>a</i>	dated 06/27/2023 12:42 AM				
	R9's Progress Note, dated 06/27/2023 12:42 AM, (V2 Director of Nurses, (DON)) and V1, (Administrator), were both made aware of the fx					
	•	of the xray report return in				

Illinois Department of Public Health

STATE FORM 6899 MNCS11 If continuation sheet 3 of 6

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6008395	B. WING		01	1/25/2024
	ROVIDER OR SUPPLIER	RURAL I	DDRESS, CITY, STATE ROUTE 2 STER, IL 62694	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
\$9999	documents, "Called a nurse regarding x-ray her to see ortho (orth R9's Progress Note, documents, "Residen Does not complain of turned and reposition after she lays still. Restaff without any probability of turned and reposition after she lays still. Restaff without any probability of turned and reposition after she lays still. Restaff without any probability of turned and reposition after she lays still. Restaff without any probability of turned and reposition after she lays still. Restaff without any probability of turned and reposition after she lays till. Resident from ortho appt." It contacts appropriate shoulder N.O may relifting arm above should respond to the new form and the new form	dated 06/27/2023 10:08 AM, and spoke with (V19, Doctor) or results, states (V19) wants opedics)."  dated 06/28/2023 03:30 AM, at has slept during the night. Figure 10 pain unless she is being ed and then will subside esident did take liquids for ollems."  dated 06/30/2023 11:00 AM, at returns via mass transit ontinues, "Direct staff dent returns in wheel chair it to right arm. Resident elly. Denies pain in right move for bathing, avoid ulder height. No PT in right upper extremity and nity."  fails to document any pain, ment for R9 on 6/23/23,  Array, dated 6/26/23, acture of the distal clavicle."  Interpretation Report, ments V2, DON's, interviews	S9999			

Illinois Department of Public Health

STATE FORM 6899 MNCS11 If continuation sheet 4 of 6

Illinois De	epartment of Public He	alth				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		B. WING				
		L6008395	B. WING		01/25/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE		
		RURAL RO		,		
SCOTT CO	DUNTY NURSING CENTE	≣R				
		WINCHES	TER, IL 62694			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(,	_
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		-
IAG	RECOLLITORY OF	LOG IDENTIFICATION OF THE PROPERTY	IAG	DEFICIENCY)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
			+			-
S9999	Continued From page	e 4	S9999			
	(V/22 Licensed Practi	ical Nurse, (LPN)) that she				
	,	irm was broke and hurting.				
		d resident say she was				
	,	•				
		er at lunch on Friday, seen				
	` , •	meds (medication) and then				
	·	y another CNA to lie down in				
	,	seen resident leaning in				
	•	and went to help set her back				
	<u>.</u>	her shoulder was broke and				
		2). (V22) (Unknown) CNA				
	•	ring shoulder pain, assessed				
		s, bruising or marks on the				
	·	sh staff away as she did not				
		esident then taken to bed to				
	lay down. (V18 LPN)	•				
	shoulder, hurting but	· · ·				
		ng at shoulder, no bruising				
	seen. 6/24/23: (V19,	CNA) aware of pain in				
		aff members. (V20, CNA)				
	aware resident is pair	nful in shoulder. (V21, CNA)				
	gave resident a show	er and seen light yellow				
	bruising to R (right) sl	houlder, nurse informed, c/o				
	pain while in shower.	(V23, CNA) helped with				
	getting resident up fo	r shower, resident was c/o				
	right should pain, scre	eaming, to <b>l</b> d nurse (V22),				
	site was assessed an	nd wasn't red or swollen, but				
	was tender to touch,	pain medication was given				
	per nurse. (V24, CNA	assisted with resident on				
	Saturday, voiced c/o	right shoulder pain while				
	eating supper and tak	ken to lie down in bed.				
	Resident hurt with tak	king sweater off and putting				
		ying her down it helped ease				
		shoulder with small pillow.				
		k where she normally sleeps				
	•	n transfers she could cry out				
		ain in her shoulder. (V22,				
		ain with transfer, observed in				
		ess or swelling, had no c/o				
		ents, was up for meals. (V18,				
		der with nurse (V22, LPN),				

Illinois Department of Public Health

STATE FORM 6899 MNCS11 If continuation sheet 5 of 6

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	
		IL6008395	B. WING		01	/25/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIP CODE	1	
		RURAL R		,		
SCOTT C	OUNTY NURSING CENTE	R WINCHES	STER, IL 62694			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
S9999	of brown discoloration as though it was an a (V22, LPN) assessed shoulder, c/o pain with extremity independen slightly warm to touch without movements."  On 1/24/24 at 2:45 PN was questioned if the assessments availabl 6/23/23 and 6/25/23,  On 1/24/24 at 2:55 PN that she agreed that Pheen notified of R9's on the assessments available for the assessments available	bulder to have a pink/ tiny bit in but did appear bruised, felt rea of inflammation. 6/25/23 and noted darkness to in transfers, able to move thy with guarding, shoulder in, relief with rest, no c/o pain of the form of the	\$9999			

Illinois Department of Public Health

STATE FORM 6899 MNCS11 If continuation sheet 6 of 6