(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
	IL6003065		B. WING		R 02/01/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	-
ROSICL	ARE REHAB & HCC	55 FERRE ROSICLAI	ELL ROAD RE, IL 6298	2		
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	First Certification R	evisit to Annual Survey				
S9999	Final Observations		S9999			
	a) The facility shall procedures governi facility. The written be formulated by a Committee consisting administrator, the a medical advisory conformer of nursing and othe policies shall complements.	esident Care Policies have written policies and ng all services provided by the policies and procedures shall Resident Care Policy ng of at least the dvisory physician or the permittee, and representatives or services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed				
	Nursing and Persor b) The facility shall and services to atta practicable physical well-being of the res each resident's com plan. Adequate and care and personal of resident to meet the care needs of the re 4) All nursing pencourage resident	provide the necessary care in 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				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/22/24 **Electronically Signed**

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION		E SURVEY PLETED	
IL6003065			B. WING			R 01/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE	-	
ROSICI ARE REHAB & HCC			ELL ROAD RE, IL 62982			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	circumstances of the demonstrate that didemonstrate that didemonstrate that didentification includes the reduces, and groom; the eat; and use speed functional community who is unable to cashall receive the segood nutrition, grood didentification, grood	ne individual's clinical condition iminution was unavoidable. It is ident's abilities to bathe, it is ident's abilities to bathe, it is ident's abilities to bathe, it is ident's ambulate; toilet; is incation systems. A resident rry out activities of daily living rvices necessary to maintain iming, and personal hygiene. It is identified in a minimum, the following is identified on a 24-hour, including oral, rectal, enous and intramuscular, shall	S9999			
	review the facility far were administered residents reviewed of 14. This failure reweight loss of 11.39. Findings Include: R21's undated New documents R21 was 10/15/2020. R21's I (POS) dated 1/1/24 diagnoses as left his behavioral and psycone in the second residual resid	on, interview, and record alled to ensure supplements as ordered for 1 of 3 (R21) for weight loss in the sample esulted in R21 having a severe in one month. Admission Information form a sadmitted to the facility on Physician's Order sheets to 1/31/24 document R21's p nailing, dementia, chological symptoms of nritis, depression, anemia, and				

Illinois Department of Public Health

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AND BLAN OF CORRECTION TO IDENTIFICATION NUMBER:					E SURVEY MPLETED	
	IL6003065		B. WING		F	
					02/0	1/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROSICLARE REHAB & HCC 55 FERRE ROSICLAF			RE, IL 6298:	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	vitamin D deficienc	y.				
	R21's MDS (Minimum 11/30/2023 documen Mental Status) scor severe cognitive de R21's undated curre Problem area of "Ponutritional status and to) leaves at least 2 interventions for this "Provide diet as ord diet order Encour preferences Offer Document refusal of changes in usual hamber and the properties of the commendations of Dietitian/Licensed Ediscrepancy of recommendations of Dietitian/Licensed Ediscrepancy of recommendations of CR2) preferences of time to eat assess diet-observe for vor cramping Assure prepared in strict consultation rules. Export of the properties of the proper	um Data Set) dated ents a BIMS (Brief Interview for re of 02, which indicates a ficit. ent Care Plan documents a ot (potential) for altered d or weight loss R/T (related 5% of most meals." The s problem area include, lered. See POS for current age self-feedinghonor food r HS (hour of sleep) snack, or 0% consumed. Note abits and report to nurse at mealsMeds and labs as				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					 F	₹
	IL6003065		B. WING			1/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROSICL	ARE REHAB & HCC	55 FERRE ROSICI AI	ELL ROAD RE, IL 62982	,		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	shake) 4 ounces th with a start date of 60 cc (cubic centime R21's Dietary Notes "RD (Registered Diwt: 102 pounds with (times) 1 mo (mont (15.02) x 6 mo (12. 17.5 (down) Diet re Foods with thin liquoz (ounce) (nutrition daily), May use lip papproximately 0 - 5 approximately 25-5 25-75% (S/supper) (resident/R21) receaffected appetite/wire-weighed with wt wt decrease and decrease a	0% (L/lunch), approximately per January logRes ntly ill with covid which likely				
	f/u (follow up) PRN The undated facility document R21's we 115 pounds, Janua are no specific date R21's Medication A dated 12/1/23 to 12 (nutritional shake) signed as administed dated 1/1/24 to 1/3 (oral supplement) 6 start date of 1/16/24 ordered. There is no physician order for 1/2024 MAR indication.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
ANDILAN	OF CONTROL OF TOTAL	IDENTIFICATION NOWIDEN.	A. BUILDING:		COMPLETED	
	IL6003065		B. WING		02/0	₹ 01/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DOGIOL	ADE DELLAD & LICO	55 FERRE	LL ROAD			
ROSICI ARE REHAB & HCC		RE, IL 62982	2			
(X4) ID PREFIX TAG	(EACH 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 APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	R21's Dietary Quarterly Assessment dated 11/30/23 documents under, "Feeding Ability/Adaptive Equipment- Self with setup." The noon meal was observed on 1/18/24,					
	1/22/24, 1/23/24, and 1/24/24. R21 was not observed eating on 1/18, 1/22, and 1/23/24.					
	On 1/23/24 at 11:53 AM, R21 was observed in bed sleeping, V12 (Business Office Manager/CNA) stated R21 stays in bed during lunch at times and when she does, they hold something back for her to eat or feed R21 something else when she gets up. On 1/24/24 at 11:52 AM, R21 was observed in the dining room sitting at a table with two peers. R21 was served a meal of ground roast beef on two slices of bread, fruit cocktail in juice, root beer float pie, cubed potatoes, cooked carrot slices, water, and second glass of what appeared to be juice. R21 took a slice of bread off the sandwich, folded it in half and took a bite out of it. At 11:59 AM, R21 took silverware from V2 (Dietary Manager), picked up the fork and took bites of her food independently with the fork. R21 then used the fork and attempted to pick up the slice of bread off the table. R21 did not appear to be able to see where the food was located on her plate. This was indicated by R21 using the fork and stabbing at the plate and the table surrounding the plate. R21 stabbed at her cup with the fork, inserted the fork into the cup and dumped the contents of the cup onto the table. R21 was observed throughout the meal to struggle with eating with no staff assistance offered. R21 used the silverware at times and					
	used her fingers at	times to eat the food. R21 eat the root beer float pie. R21				

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STATE FORM BYIA12 If continuation sheet 5 of 8

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(VO) MULTIPL	E CONSTRUCTION	(Va) DATE	CLIDVEV	
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE COMP	LETED
		-	A. BUILDING:			
			D WING		F	
		IL6003065	B. WING		02/0	1/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		55 FERRI	ELL ROAD			
ROSICI ARE REHAB & HCC		RE, IL 6298	2			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 N	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEI IOIEIVOT)		
S9999	Continued From pa	ge 5	S9999			
	was continuously of	bserved throughout the meal				
		d assistance with eating by				
	staff.	a assistance with eating by				
	Stair.					
	On 1/24/24 at 12:50	PM, V13 (LPN/Licensed				
		ated R21 started (oral				
		6/24 for weight loss. V13				
		the (oral supplement) was				
	supposed to replace the (nutritional shake) that					
		ered for R21. V13 stated the				
	nursing staff admin	`				
		e (nutritional shakes). This				
	surveyor reviewed I					
		ord with V13 and asked if the				
		vas to replace the (nutritional				
		the (nutritional shake) on the				
		ry 2024. V13 stated she would :00 PM, V13 stated R21				
		eceiving both the (nutritional				
		Il supplement). V13 stated				
		the (nutritional shake) on				
		MAR so R21 did not get the				
		rom 1/1/24 to 1/24/24.				
	,					
	On 1/24/24 at 11:26	6 AM, V16 (Registered				
		she had the facility reweigh				
		erify the weight loss was				
		as so significant. V16 stated				
		ounds on the day she was				
		ted she recommended adding				
		nt) at that time. V16 stated she				
		mmended R21 receive the				
		and would assume R21 was				
		the (nutritional shake) as S stated she would expect if a				
		er for anything the facility staff				
		there to the order. V16 stated				
		R21 being administered the				
		when she was at the facility on				
		ed if not receiving the				

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STATE FORM BYIA12 If continuation sheet 6 of 8

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	IL6003065					R 01/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ROSICI ARE REHAB & HCC 55 FERRE			ELL ROAD .RE, IL 62982			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$9999	(nutritional shake) a contributed to R21's think there was pot some role in that." observation of R21 what V16's expecta staff saw a resident would expect the tecome up with intervious and the stated if R21 refuses and wich 30 minute notice residents are they should report if the resident needs. R21 was not getting it was brought to the On 1/29/24 at 11:33 R21's problem is should report if the resident needs. R21 was not getting it was brought to the On 1/29/24 at 11:33 R21's problem is should report if the resident needs. R21 was not getting it was brought to the On 1/29/24 at 11:33 R21's problem is should report if the resident needs. R21 was not getting it was brought to the ordered and not refund administering it as weight loss. R21's MAR dated 1 R21 took 100% of the times when the and/or it was refused the policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the resident policy of (nan additional calories a cannot and/or are refused to the refused to the refused to the refused to the r	as recommended could have a weight loss, V16 stated "I ential. It could have played This surveyor reviewed the eating on 1/24/24 and asked attion would be. V16 stated if a struggling with eating, she arm to assess the resident and rentions to assist the resident. PM, V1 (Administrator) stated do to sit with and assist R21 arefused assistance. V1 and to eat they would offer her are later. V1 stated if staff a having different eating habits, at so they can determine what V1 stated she was not aware as the (nutritional shakes) until eir attention by this surveyor. B AM, V6 (Physician) stated are will eat and take awants to. V6 stated as long a (nutritional shakes) as the could impact R21's 2/1/23 to 12/31/23 documents the (nutritional shakes) all but here is no documentation and by R21.				

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STATE FORM BYIA12 If continuation sheet 7 of 8

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ROSICLARE REHAB & HCC STREET ADDRESS, CITY, STATE, ZIP CODE 80 SICLARE REHAB & HCC ROSICLARE, IL 62982 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 7 is also the policy of (name of company) to provide guidelines for the selection, ordering, use, and monitoring of nutrition supplements and nourishments Intake of nutrition supplements provided by nursing at med pass shall be documented on the Medication Administration Record (MAR).						 F	₹
ROSICLARE REHAB & HCC Continued From page 7 Is also the policy of (name of company) to provide guidelines for the selection, ordering, use, and monitoring of nutrition supplements provided by nursing at med pass shall be documented on the Medication Administration Record (MAR).			IL6003065	B. WING		02/0	1/2024
ROSICLARE, IL 62982 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 7 is also the policy of (name of company) to provide guidelines for the selection, ordering, use, and monitoring of nutrition supplements and nourishments Intake of nutrition supplements provided by nursing at med pass shall be documented on the Medication Administration Record (MAR).	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
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		guidelines for the so monitoring of nutriti nourishments In provided by nursing documented on the Record (MAR).	election, ordering, use, and on supplements and take of nutrition supplements g at med pass shall be				

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Illinois Department of Public Health STATE FORM