(X6) DATE

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6016356	B. WING		03/1	3/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RADFOR	RD GREEN		JBON WAY SHIRE, IL 60	0069		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure S	Gurvey				
S9999	Final Observations		S9999			
	300.610a) 300.1210b) 300.1210d)1) 300.1630d)  Section 300.610 Rea) The facility shall procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory coof nursing and othe policies shall composition of the written policies the facility and shall	dvisory physician or the ommittee, and representatives r 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 Person b) The facility shall and services to atta practicable physica well-being of the re- each resident's con plan. Adequate and care and personal or resident to meet the care needs of the re-	provide the necessary care and or maintain the highest I, mental, and psychological sident, in accordance with apprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal				

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

03/28/24 **Electronically Signed** 

TITLE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6016356	B. WING		03/1	3/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RADFOR	RD GREEN		JBON WAY SHIRE, IL  60	0069		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	care shall include, a and shall be practic seven-day-a-week  1) Medications hypodermic, intrave be properly adminis  Section 300.1630 Add of the properly administ of the properly administer of the	at a minimum, the following sed on a 24-hour, basis: a, including oral, rectal, enous and intramuscular, shall stered.  Administration of Medication in, a licensed prescriber's annot be followed, the licensed notified as soon as is ding upon the situation, and a e resident's record.  NT is not met as evidenced by:  and record review the facility a resident's post-surgical pain red for 1 of 7 residents (R326) in an agement in the sample of sulted in R326 experiencing ght (approximately 7-10 hours)  e:  shows R326 has admitting gruss system, presence of other and grafts, spondylolisthesis in spinal stenosis in the and low back pain.  charge paperwork dated	S9999			
		R326 had an order for ic analgesic) 5 mg every 4				

Illinois Department of Public Health

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6016356	B. WING		03/1	3/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RADFOR	RD GREEN		IBON WAY SHIRE, IL  60	0069		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	hours for pain management. R326 last received 10 milligrams (mg) of Oxycodone at 5:15 PM on 3/8/24, before being discharged from the hospital.					
		shows that R326 was lity at 7:10 PM on 3/8/24.				
	On 3/12/24 at 9:29 AM, R326 said she admitted to the facility on 3/8/24 following lower back surgery and that she was here to receive therapy and pain management. Overnight from 3/8/24 to 3/9/24, R326 said there was a mix up with her pain medication and she was in severe pain, stating pain was a 9 out of 10 and she did not receive pain medication to relieve the pain. R326 said she was only offered acetaminophen (Mild analgesic).					
	Nurse/RN) said that report from the hos that R326 was adm spinal nerve lamine paper script sent with one tablet by mouth for pain. V17 said s	Y AM, V17 (Registered to she was the one who took pital regarding R326. V17 said itting following a L3 and L4 ctomy and that she had a th her for Oxycodone 5mg a every four hours as needed he completed her shift around and R326 had not requested ring V17's shift.				
	written by V18 (RN) c/o (complains of) s needed) Tylenol (ac Encouraged to repo	e dated 3/9/24 at 9:54 AM, states, " Slept on and off, severe back pain. PRN (as cetaminophen) administered osition, refusing due to pain. available from pharmacy				
		S AM, V18 was attempted to one and was unable to be				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	IL6016356	B. WING		03/1	3/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RADFORD GREEN		JBON WAY SHIRE, IL 60	0069		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' 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 3	S9999			
R326's Medication March 2024 shows Oxycodone 5 mg ur (approximately 14 h documented dose f also documents R3  On 3/13/24 at 12:00 Nurse/LPN) said the received the prescribe receive the next do duty would call the protocols to access from the locked menurse's station. V19 out of 10, providing going to be very eff  On 3/13/24 at 11:35 resident's pain is sua resident has pain soon as possible.  On 3/13/24 at 9:31 locked medication or residents require Plantibiotics, and the them from the pharmedications from the dispenser, the nurse pharmacy, provide hospital, and they waccess the medicate V16 said that the fathe hospital and the been able to remove	Administration Report for that R326 did not receive ntil 3/9/24 at 7:40 AM. nours after the last rom the hospital). This form 26's pain as "Bracing".  O PM, V19 (Licensed Practical at if the facility has not iption and the time frame to se has passed, the nurse on pharmacy and go through the and retrieve the medication dication dispenser in the 9 said if the pain level is a 9 PRN acetaminophen is not				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		IL6016356	B. WING		03/13/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
RADFOR	RD GREEN		IBON WAY SHIRE, IL 60	0069		
(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 APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	Facility Active Inventory form (locked medication dispenser) shows Oxycodone HCL 5 mg tablet is available in the locked medication box in the nurse's station on the 3rd floor.  On 3/13/24 at 1:12 PM, V20 (Nurse Practitioner) said that the facility had the medication available in the locked medication box. V20 would have expected the nurse on duty to retrieve the medication from the locked medication box to give to R326.					
	The facility Pain Assessment and Management policy dated 10/22 states, " 2. "Pain Management" is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals Monitoring and Modifying Approaches 5. Contact the prescriber immediately if the resident's pain or medication side effects are not adequately controlled."					
	"B"					
	Statement of Licens 300.1210b)1)	sure Violations II of II:				
	Nursing and Person b) The facility shall and services to atta practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of resident to meet the care needs of the re-	General Requirements for hal Care provide the necessary care hin or maintain the highest l, mental, and psychological sident, in accordance with aprehensive resident care l properly supervised nursing care shall be provided to each total nursing and personal esident. Restorative				

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PRINTED: 04/09/2024 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6016356	B. WING		03/1	3/2024
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/1	0/2024
RADFORD GREEN			IBON WAY SHIRE, IL 60	0069		
(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)	LD BE	(X5) COMPLETE DATE
S9999	following procedure  1) The licenser restorative/rehabilithave successfully of training program the classroom/lab training as evidenced diploma, or other waccredited school of agency such as a Sof nurses or a State training shall addresoutlined in subsecti Section. This person Nursing, Assistant In nurse designated be in charge of the resprogram.  This REQUIREMENT Based on interview failed to ensure a reprogram was provide designated nurse was who successfully coclassroom/lab training. This failures residents currents.	des: d nurse in charge of the ative nursing program shall completed a course or other at includes at least 60 hours of ing in restorative/rehabilitative ed by a transcript, certificate, ritten documentation from an or recognized accrediting state or National organization elicensing authority. Such as each of the measures ons (b)(2) through (5) of this on may be the Director of Director of Nursing or another by the Director of Nursing to be torative/rehabilitative nursing  NT is not met as evidenced by:  and record review, the facility estorative/rehabilitative nursing ded and failed to ensure a was in charge of said program ompleted at least 60 hours of ing in restorative/rehabilitative re has the potential to affect all tly residing in the facility.	\$9999	DEFICIENCY)		
	The findings include The CMS-671 date currently reside in t	d 3/11/24 shows 68 residents				
	Manager) and V10	PM, V9 (Clinical Nurse (Minimum Data Set/MDS no restorative program right				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6016356	B. WING		03/1	3/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
RADFOR	RD GREEN		UBON WAY ISHIRE, IL  60	0069		
(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)	ILD BE	(X5) COMPLETE DATE
\$9999	now. V10 said none be a restorative nur certified when she was program about a year on 3/12/24 at 12:43. Therapist/PT) said restorative program discharged from the them to sign up for activities.  On 3/12/24 at 1:01 purpose of restoratifunction.  On 3/13/24 at 1:31 Nurse/LPN) said their current level of their ROM (range of some contractures, restructuring and loter restorative program. The facility was unatranscript, diploma, documentation from recognized accredit National organization licensing authority staff has received a classroom/lab traininursing.	e of the nurses are certified to see, and she was never was running the restorative ear ago either.  B PM, V7 (Physical the facility used to have a serapy, they recommend for the exercise class with  PM, V8 (PT Aide) said the event the exercise class with  AM, V19 (Licensed Practical expurpose of restorative care ent moving, it helps maintain functioning and can prevent function) from decreasing and V19 said the facility is oking towards providing a in the future.  Belle to provide a certificate, or other written an accredited school or ting agency such as a State or on of nurses or a state showing any of their nursing at least 60 hours of ing in restorative/rehabilitative				
	(Revised July 2017) receive restorative	rative Nursing Services Policy ) shows, "Residents may nursing care as needed to al safety and independence."				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:	·	COMPLETED		
		IL6016356	B. WING		03/1	3/2024	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
RADEOR	RADFORD GREEN 960 AUDUBON WAY						
10.01	- CALLIN	LINCOLN	ISHIRE, IL 6	0069			
(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)	LD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ige 7	S9999				
	_	3-1					
	"B"						

Illinois Department of Public Health

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