(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6004840	B. WING		05/2	22/2024
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY,			
JACKSO	NVILLE SKLD NUR &	RFHAB	VEST WALNUT SONVILLE, IL 6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure S	Survey				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.610a) 300.1210b) 300.1210c) 300.1210d)1)2)					
	Section 300.610 R	esident Care Policies				
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.		he all es e ng lly			
	Section 300.1210 (Nursing and Persor	General Requirements for nal Care				
	care and services to practicable physica 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 high I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to eace total nursing and personal	3			

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

06/12/24 **Electronically Signed**

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	IL6004840		B. WING		05/2	2/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JACKSO	NVILLE SKLD NUR &	REHAB	T WALNUT			
			IVILLE, IL 6		ON	
(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)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 1	S9999			
	care needs of the re	esident.				
	c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.					
	 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 					
	2) All treatments and procedures shall be administered as ordered by the physician.					
	These requirement	s are not met as evidenced by:				
	review, the facility for residents that requi (R26, R56), reviewe sample of 40. This	, observation, and record ailed to provide Oxygen to red oxygen for 2 of 5 residents ed for respiratory care in the failure resulted in R26 with a low oxygen saturation				
	The Findings Include:					
	was originally admir with diagnosis of M Chronic Obstructive Osteoporosis, Athe (ASHD), Sleep Apn Demyelinating Poly Lateral Sclerosis, M Anxiety disorder, H	et, undated, documents R26 tted to the facility on 10/12/16 otor Neuron Disease, Asthma, e Pulmonary Disease (COPD), prosclerotic Heart Disease dea, Chronic Inflammatory recuritis, Arthropathy, Primary Major Depressive disorder, ypertension, Pneumonia, m of bronchus and lung,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6004840	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JACKSO	NVILLE SKLD NUR &	REHAB	ST WALNUT NVILLE, IL 6			
			ID ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	Pulmonary embolism, Venous Thrombosis and Embolism, and Dependence on Supplemental Oxygen.					
	R26's Care Plan, da R26 has shortness with exertion due to document that R26 Ineffective gas exch "Interventions: Oxyc Cannula (NC) as permedications as ord Monitor/document sold to continues, "(R26) apnea, and recent a failure with hypoxian ebulizers, and postaerosol or bronchood Monitor/document are effectiveness, head degrees or resident upright in a chair dubreathing, monitor acute respiratory in restlessness, SOB nebulizer treatment Settings: O2 via 2 liangle on 5/20/24 at 9:38 wheelchair in her round (NC) in her nose with coming out of it. The up to a portable tan wheelchair and was needle on gauge so in red, indicating encould feel anything	side effects and effectiveness." has COPD, Asthma, sleep acute episode of respiratory. She uses oxygen, inhaler, sitioning. Interventions: Give dilators as ordered. In the side effects and the ofference or out of bed uring episodes of difficulty for s/sx (signs/symptoms) of sufficiency: Anxiety, confusion, at rest, cyanosis, somnolence, is per MD orders, Oxygen iters daily via nasal cannula." AM, R26 was sitting in her from with her nasal cannula the no sound of oxygen (O2) ee nasal cannula was hooked is hanging on the back of her is completely empty, with the een all the way to the left side inpty. R26 was asked if she coming out of her nasal				
	upright in a chair dubreathing, monitor facute respiratory in restlessness, SOB nebulizer treatment Settings: O2 via 2 li On 5/20/24 at 9:38 wheelchair in her round (NC) in her nose with coming out of it. The up to a portable tan wheelchair and was needle on gauge sein red, indicating en could feel anything cannula, and she we	aring episodes of difficulty for s/sx (signs/symptoms) of sufficiency: Anxiety, confusion, at rest, cyanosis, somnolence, is per MD orders, Oxygen iters daily via nasal cannula." AM, R26 was sitting in her from with her nasal cannula th no sound of oxygen (O2) e nasal cannula was hooked in k hanging on the back of her is completely empty, with the een all the way to the left side inpty. R26 was asked if she coming out of her nasal was unsure if there was ere was no humidifier				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONTROLLON	IDENTIFICATION NOWIDER.	A. BUILDING:	A. BUILDING:		LLILD
		IL6004840	B. WING	WING 05/22		22/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	STATE, ZIP CODE		
JACKSONVILLE SKLD NUR & REHAB			EST WALNUT ONVILLE, IL 6			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	age 3	S9999			
	(RN)/Hospice Nurs stated "(R26) is us	AM, V11, Registered Nurse se, was seen visiting R26 and ually on between 2 to 5 Liters r oxygen saturation above 89				
	On 5/20/24 at 9:48 AM, V12, Licensed Practical Nurse (LPN), was notified about R26's O2 being off because the portable tank was empty. V12 confirmed that the portable tank was empty and attached R26's NC to the O2 concentrator sitting behind her. V12 obtained an oxygen saturation on R26 which read 88% and V12 increased the O2 to 2.5 L/NC with O2 saturation reading above 90% afterwards.					
	her wheelchair with arouse, shallow bre were bluish in color her nose and attact tank which was totacoming out of the tris behind her and is cannula attached a LPN, was notified a V12 stated "Yes, the tolerate being off her fingers are blue." Vocannula and grabble connected to the Offloor and put it into oxygen at 4 liters/moximeter to R26 where saturation of 51% a approximately five saturation went up went down to 88.	8 AM, R26 was seen sitting in her head down, difficult to eathing, and her fingertips r. R26's nasal cannula was in hed to the portable oxygen ally empty and had no oxygen ank. The oxygen concentrator is currently off with a nasal and lying on the floor. V12, and went in to assess R26. He tank is empty. (R26) doesn' er oxygen that is why her 12 took off R26's nasal ed the nasal cannula that was 12 concentrator lying on the R26's nose and turned on the ninute. V12 attached a pulse nich showed an oxygen and a heart rate at 96. After to ten minutes, R26's oxygen to 88% and her heart rate 12 stated she was going to urse to tell her that R26 was	t			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6004840	B. WING		05/22	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JACKSO	NVILLE SKLD NUR 8	REHAB	T WALNUT			
()(1) ID	STIMMA DV STA	ATEMENT OF DEFICIENCIES	IVILLE, IL 6	PROVIDER'S PLAN OF CORRECTI	ON	(УЕ)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
S9999	Continued From pa	nge 4	S9999			
	without oxygen for saturations had dro	a while and her oxygen opped.				
	On 5/21/24 at 10:45 AM, V2, Director of Nursing (DON), was notified of the incident involving R26 and stated "Please tell me they didn't pick the nasal cannula off the floor and put it in her nose. We will be doing some in-services." On 5/21/24 at 10:50 AM, V1, Administrator, walked into the office where surveyors were sitting and stated, "I already know (about R26 situation), and we are doing an audit right now."					
	On 5/22/24 at 8:35 AM, V4, Assistant Director of Nursing (ADON), stated "We all pitch in to bring residents back from the dining room to their room, but whatever staff brings the resident on oxygen back to their room, should be telling the nurse that the resident is back and needs their oxygen back on."					
	resident on oxygen room, they should be portable tank to the	AM, V25, RN, stated "When a comes back from the dining be switched over from the concentrator. The aids should he resident is back in their				
	supposed to touch resident on oxygen switch it over. I'm n	AM, V26, CNA, stated "I'm not the oxygen, so if I bring a back, I go tell the nurse to ot going to lie, there may be sy and forget to tell the nurse."				
	On 5/22/24 at 10:50 AM, V1, Administrator, stated, "I would expect the staff to ensure that any resident getting transferred while on a portable oxygen tank, returns to their room and is switched over to the concentrator. I would expect					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		IL6004840	B. WING		05/2	2/2024
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00:-	
JACKSONVILLE SKLD NUR & REHAB			ST WALNUT NVILLE, IL 6			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 5	S9999			
	nurse that the resid	oing the transfer to notify the lent is back and then would take care of the residents				
	documents "Chang humidity nebulizer) when not in use (Cl Sunday for Infection	der (PO), dated 3/15/24, e Nebulizer mask/HHN (high & tubing weekly, place in bag hange bag weekly). Every n Control and as needed for sibly soiled or damaged."				
	Rinse and Replace Change oxygen tub	15/24, documents "Oxygen: Intake filter every week. bing and humidifier weekly. very Sunday for Infection				
		15/24, documents "Oxygen: As Needed For Shortness of				
	PRN: if in use, ensu functioning properly	21/24, documents "Oxygen ure portable tank is full and y prior to meals. Transfer to m at HS (hours sleep)."				
		21/24, documents "Continuous via nasal cannula. Every shift eath."				
	documented, "Call aware of low SPO2	e, dated 5/21/24 at 10:54 AM, to hospice (company) to make Resident was placed on PO2 increased to 89-90% on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6004840	B. WING		05/	22/2024
	PROVIDER OR SUPPLIER	REHAR 1517 WES	ST WALNUT			
(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
\$9999	4 L, heart rate 85-9 10 minutes later an Lowered O2 to 3L a message and await DON aware." On 5/22/24 at 10:50 stated that the facili transporting a reside 2. R56's Care Plan, "(R56) has DX (diagonal of the composition of	0. Resident was reevaluated d SP02 was 93% HR 80s. and SP02 is now 94-97%. Left ting return call from (hospice). O AM, V1, Administrator, ity does not have a policy on ent while on oxygen. dated 2/6/2024, documented, gnosis) of COPD (Chronic nary Disease)." It continues, ula as ordered." 4/16/2024, documented that y impaired, required oxygen, ance with ADL's. I/26/2024, documented, via Nasal cannula continuous. air as tolerated every shift." It 21/2024, "Oxygen PRN: if in e tank is full and functioning eals. Transfer to concentrator O PM, R56 was sitting in her hair. R56's oxygen tank was daughter, went and got R56 a PM, V23, R56's daughter, we R56's tank to go empty in d take her (R56) to her room tank. V23 also stated that the ty, and she (V23) has to get	\$9999			

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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 COMF	SURVEY PLETED	
		IL6004840	B. WING		05/2	22/2024
	PROVIDER OR SUPPLIER DNVILLE SKLD NUR &	REHAR 1517 WES	DRESS, CITY, S ST WALNUT NVILLE, IL 6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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
\$9999	Policy, undated, do this procedure is to oxygen administration The following equipmecessary when performed protable oxygen cyllowing the following oxygen the following: 1. Signs of Signs or symptoms "Steps in the Proceconnected to the oxygen of kinks. 6. Turcontinues, "9. Check jar, etc., to be sure and are securely fain the humidifying jakingh enough that the flows through.	cumented, "The purpose of provide guidelines for safe ion. Equipment and Supplies: ment and supplies will be efforming this procedure. 1. linder." It continues, "3. ssessment: Before en, and while the resident is erapy, assess for the or symptoms of Cyanosis. 2. of hypoxia." It continues, dure: 5. Check the tubing cygen cylinder to assure that is n on the oxygen." It is the mask, tank, humidifying they are in good working order stened. Be sure there is water ar and that the water level is e water bubbles as oxygen ure the tubing and humidifying ited. 10. Periodically re-check	S9999			

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