STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2459288/IL180840	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3300j) 300.3300k) Section 300.610 Resident 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. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1 Section 300.3300 Transfer or Discharge j) The planned involuntary transfer or discharge shall be discussed with the resident, the resident's representative and person or agency responsible for the resident's placement, maintenance, and care in the facility. The explanation and discussion of the reasons for involuntary transfer or discharge shall include the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's clinical record. (Section 3-408 of the Act) k) The facility shall offer the resident counseling services before the transfer or discharge of the resident. (Section 3-409 of the Act) These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide/document sufficient preparation and orientation for resident discharges to ensure residents' belongings were not left behind and to minimize feelings of anxiety/depression for 7 (R1, R2, R3, R6, R7, R9 and R10) of 17 residents reviewed for safe and orderly discharge. This failure resulted in R6 and R10 experiencing feelings of fear, anxiety, and sadness and would cause a reasonable person to experience these same feelings. This has the potential to affect all 30 residents that were residing in the facility.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

1. R6's "Admission Record" documented an admission date of 1/27/2024 with diagnoses including Atrial Fibrillation, Hypothyroidism, Sciatica, Hypertension, Depression, and Pain. R6's Minimum Data Set (MDS) dated 11/7/24 documents a Brief Interview for Mental Status (BIMS) score of 13, indicating that R6 is cognitively intact.

An untitled facility provided document that contained a list of residents that resided in the facility with their date of discharge and location of transfer documented R6's discharge date was 11/7/24.

On 11/14/2024 at 3:26PM, R6 was observed and interviewed in her new residence/facility. R6 was sitting up in her wheelchair watching television. R6 was observed to be cognitively intact and was alert and oriented throughout the interview. R6 was asked how the move to the new facility was working out. R6 stated, this facility is nice but the way it all was done at the other facility was not right and "we as residents were not treated right at all." R6 stated "Do you want to know how I initially found out the facility was closing?" R6 stated "I was sitting in the dining room and one of the nurses slid a piece of paper to me and it said, 'the facility is closing.'" R6 stated later that day (V1 - Administrator) and (V9 - Business Office Manager/BOM and Social Service Director/SSD) came to her room and told her the facility was closing and she had one week to choose another facility to go to. R6 stated "I had to be out in one week." R6 stated she was shocked and devastated. R6 stated "I called my son who is my POA (power of attorney) and he was also shocked and said he had not been called. R6 stated it was scary as she was given one week to be out. R6 stated that was her home and she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

been there for 2 years and had made friends that had become like family to her. R6 stated there are some that she knows she will never see again, and "it breaks my heart." R6 stated residents were not even given time to soak it all in and then "we were out the door." R6 stated "I am thankful for this facility and my roommate moved here too and they let us be together." R6 stated she (roommate) doesn't talk or anything but "I kind of watch out for her." R6 stated "I feel like this was all done wrong and I think it is all crooked." R6 was tearful and stated, "I am trying not to cry but it is hard as I can't believe this all happened so quickly, and I miss my friends and I am worried about them. I wonder where they are and if they are happy and are they being treated good. It is just heartbreaking and just wrong. This could have been handled better and they could have given us time to digest all of this and plan, as well as said our goodbyes or find a way to stay in contact with those friends that are like family." R6 stated, "it is like grieving for the loss of a family member." R6 stated, "I am upset, and it will take a while to get over this. I am 87 years old and shouldn't have to feel this way, it is like we really didn't matter to them." R6 stated "everyone is nice here and I am sure they will take good care of us, and the facility is very clean and nice." R6 stated, "I will adjust but I will forever miss my friends."

On 11/15/2024 at 11:21AM, V11 (R6's Power of Attorney/POA), stated he received a call on 11/4/2024 and was informed the facility was closing. V11 stated they told him that they had one week to find placement for R6 and for R6 to be moved. V11 stated he received a letter on Wednesday the 6th, R6 was moved out on the 7th. V11 stated the letter said a closure date of 1/1/25, but that is not what happened. The letter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

said one thing and the inside information was different. V11 stated (R6) is still upset over it all and she talks about it with every phone conversation, but she will adjust. V11 stated during the first phone call, the facility explained they would move all R6's belongings for her, but then on Thursday when they were moving R6, they called and "asked me to bring my truck to move her belongings." V11 stated he told them that they had said they would move all her belongings and that is what they need to do. V11 stated I would have moved her stuff if I needed to, but they need to do what they say they will do. V11 stated they did get R6's belongings moved.

2. R10's "Admission Record" documented an admission date of 11/22/2023 including diagnoses of Cerebral Infarction, Anxiety, and Major Depressive Disorder. R10's MDS dated 8/21/24 documented a BIMS score of 11, indicating R10 has moderate cognitive impairment.

An untitled facility provided document that contained a list of residents that resided in the facility with their date of discharge and location of transfer documented R10's discharge date was 11/5/24.

On 11/14/2024 at 1:50PM V10 (Registered Nurse/RN - Interim Director of Nursing/DON) stated R10 was probably the worse, she was screaming when she was being discharged and saying, "I don't want to leave."

R10 was unable to be observed or interviewed during the survey due to already being discharged to another facility.

3. R7's "Admission Record" documented an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

admission date of 1/22/2020 and included diagnoses of Congestive Heart Failure, Dementia, and Major Depressive Disorder. R7's MDS dated 10/20/2024 included a BIMS score of 7, indicating severe impaired cognition.

An untitled facility provided document that contained a list of residents that resided in the facility with their date of discharge and location of transfer documented R7's discharge date was 11/8/24.

On 11/15/2024 at 1:34PM, V16 (Family Member) stated she was told over the phone by V1 (Administrator) the facility was closing. V16 wasn't sure of the date of the call but V1 told her they needed to get the residents transferred to other facilities as soon as possible because the staff would be leaving and there would not be any one to take care of the residents. V16 stated she went and found a place for R7 to go to. V16 stated she felt she had to find a facility fast because she visits R7 daily and V16 was afraid if she waited too long there may not be any vacant beds anywhere close. V16 stated she was in a panic as she cannot provide R7 with the care he needs because V16 is elderly as well. V16 stated she was notified on 11/8/2024 when R7 left the facility, and she met R7 at the new facility he was being transferred to. V16 stated this all happened quickly, and the residents did not have time to adjust. V16 stated R7 is now more confused, and she is having to spending more time with R7 due to the confusion. V16 stated at first, the facility said they would move all R7's belongings to the receiving facility but then they called and said V16 would have to move R7's belongings, so V16 had to get some help to get R7's stuff to the new facility. V16 stated she has even had to go out during the night to the new facility to help with R7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

because he is so confused and not adjusting quickly to the new surroundings. V16 stated R7's confusion has worsened due to this happening in the manner it happened. V16 stated she feels this was all done wrong and there was not time for the families to adjust, not to mention how residents with memory problems are expected to adjust. V16 stated R7's clothes were mixed in with other residents, but she has it all straightened out finally. V16 stated she has not received a written letter yet about the facility closing. V16 stated she had heard the doors were not closing until 1/1/2025, but they sure were not given that option, and now there is nobody left there. V16 stated this just all happened too quickly for this to be good on any resident.

4. R2's "Admission Record" documented an admission date of 8/4/2024 and included diagnoses of Chronic Obstructive Pulmonary Disease, Emphysema, Anemia, Anxiety, and Major Depressive Disorder. R2's MDS dated 8/14/2024 includes a BIMS score of 15, indicating R2 was cognitively intact.

R2's "Nurses Notes" dated 11/3/2024 at 1:45PM, documents R2 was transferred to the hospital at 2:15PM.

On 11/4/2024 at 2:00PM, reviewed document titled "Social Service Progress Notes" with no noted documentation in relation to discharge/facility closure.

An untitled facility provided document that contained a list of residents that resided in the facility with their date of discharge and location of transfer documented R2's discharge date was 11/3/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

On 11/14/2024 at 10:36AM, V3 (Family Member) was in the facility packing up R2's belongings. V3 was asked if he was notified of the closure of the facility, and V3 stated yes, he was told that the facility was closing but was not sure exactly when he was told. V3 stated staff asked what facility he preferred for R2 to be transferred to, and V3 said he stated that somewhere close was fine. V3 stated his understanding was that the facility was going to stay open until December 31st, so he was not rushed about anything. V3 stated that R2 was moved to another facility from the hospital and the way he found out was that the other facility called to inform him that R2 was there and V3 needed to come do paperwork. Regarding the facility closure, V3 stated he still has not received any letters in writing so far, and he was only informed verbally of the closure by V1 (Administrator).

On 11/15/2024 at 9:45AM, R2 was observed and interviewed in her new residence/facility. R2 stated she was in the hospital and did not know until her husband told her they had to find another place for her to go. R2 said she had been in the hospital for about 4 days when she found this out. R2 stated a hospital staff came in and told her she could go to either of 2 facilities nearby. R2 then said the hospital staff came back in and told her she would be going to (name of her current facility). R2 stated she was a little scared since she had not been around these new people, but she now feels a little better about it. R2 said she came to her new facility on 11/11/2024 from the hospital.

On 11/15/2024 at 12:10PM, V1 (Administrator) stated V9 (BOM/SSD) talked with the hospital during R2's hospital stay. V1 stated V9 informed the hospital that the facility would be closing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

soon. V1 stated she called the hospital to talk with R2 and R2 was in ICU (Intensive Care Unit) and the nurse explained there was not a phone in the room so V1 told the nurse she needs to know what facilities R2 would want a referral sent to. V1 stated the nurse reported R2 would be in the hospital the next few days. V1 stated a few days later the facility received a call from the receiving facility requesting necessary paperwork on R2 and paperwork was sent.

On 11/15/2024 at 9:45AM, V9 (BOM/SSD) stated that R2 was in the hospital and when the hospital called to plan discharge, the hospital was informed the facility would be closing so the hospital sent a referral to a Long-Term Care (LTC) facility and R2 went from the hospital to the other LTC facility.

5. R9's "Admission Record" documented an admission date of 5/23/2024 with diagnoses including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and chronic kidney disease. R9's MDS dated 11/6/2024, documents a BIMS score of 14, indicating R9 is cognitively intact.

An untitled facility provided document that contained a list of residents that resided in the facility with their date of discharge and location of transfer documented R9's discharge date was 11/6/24.

On 11/15/2024 at 2:10PM, V18 (Family Member/POA) stated he received a call from V1 on 11/4/2024 and stated the facility was closing and the residents need to be moved in 7 days. V18 said R9 stated she was told this information as well. V18 stated he has never seen a letter, but he did his homework and called the state and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

was told they were supposed to give a 60-day notice. V18 stated he went out and found a facility for R9 and made all the arrangements. V18 stated he was thoroughly disgusted in the way things were handled and it wasn't right for the families or the residents to have to find a new facility and get things done in only 7 days. V18 stated R9 is the one that told him when her transfer was taking place. V18 stated R9's family moved all her belongings to the new facility as well.

6. R1's "Admission Record" documented an admission date of 7/2/2024, including diagnoses of Alzheimer's Disease, Major Depressive Disorder, and Hypothyroidism. R1's MDS dated 10/15/24 documents a BIMS score of 6, indicating that R1 has severe cognitive impairment.

An untitled facility provided document that contained a list of residents that resided in the facility with their date of discharge and location of transfer documented R1's discharge date was 11/8/24.

On 11/14/2024 at 10:12 AM, V2 (Family Member) stated she was notified on 11/4/2024 that the facility was closing and that they had until December 31st to stay open. V2 stated V9 (BOM/SSD) was the one that called and asked her what facilities she would be interested in so they could send out a referral. V2 stated R1 needed to stay close, so nearby facilities were chosen. V2 stated that V9 explained referrals would be sent out to those facilities and V9 would let them know which one would accept R1. V2 stated that was the last time she heard from the facility. V2 stated that on Friday, 11/8/2024, sometime in the evening she received a call from the receiving facility and was informed R1 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10	S9999		

arrived. V2 said the receiving facility informed her of the arrival of R1 and she needed to come and fill out admission documents. V2 stated she was shocked to find out R1 had been moved already without V2 even knowing who accepted R1 and that R1 had been moved. V2 stated she talked with V1 and V1 stated that they had to get people moved as all of the staff were leaving. V2 stated they were not told this would happen this quickly. V2 stated they thought they had time to get ready before the move. V2 stated, "I didn't figure they would stay open until December 31st, but I sure was not expecting the move to be 4 days later and without proper notification." V2 stated that if she would have known R1 would be transferred on 11/8/2024 then she would have taken off work to be there for R1 during the transfer. V2 stated R1 is not interviewable and probably doesn't realize any details about the transfer.

On 11/14/2024 at 1:50PM, V10 (RN/DON) stated she did know that R1 specifically was transferred, and the family did not know because they came by and were very upset.

On 11/14/2024 at 2:00PM, V1 (Administrator) stated there was miscommunication regarding R1 and her family. V1 said they missed letting R1's family know which facility accepted her and that she was being transferred.

7. R3's "Admission Record" documented an admission date of 7/24/2023 and included diagnoses of Chronic Obstructive Pulmonary Disease, Delirium, and Hypertension. R3's MDS dated 11/14/2024 documented a BIMS score of 7, indicating R3 has moderate cognitive impairment.

On 11/14/2024 at 10:36 AM, R3 was observed sitting in the dining room in wheelchair. R3 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11	S9999		

alert and stated she was not informed until yesterday that she would be moving to another facility. R3 stated that V8 (Family Member) may know because she is her Power of Attorney. R3 stated, "I really don't want to go there (new facility) but I guess that is where I am going." R3 stated she has been wanting to move for some time now as the staff are not very nice here. R3 stated, "Can you let (V8) know I am leaving today?"

On 11/14/2024 at 3:40PM, V8 (Family Member) stated R3 transferred to the receiving facility "today" (11/14/24) and the receiving facility called and informed V8 that R3 was out of one of her medications and it was her seizure medication Keppra. V8 stated the discharging facility told the receiving facility R3 was out of that medication, and they could not order more because R3 was discharging. V8 also stated the receiving facility did not get the information that R3 required a low bed due to falls. V8 stated the receiving facility was going to work on getting the proper bed for R3 and would make sure R3's medication was ordered and that she receives the Keppra as scheduled. V8 stated the receiving facility told her they did not receive much information on R3.

On 11/15/2024 at 10:00AM, R3 was interviewed at the facility she transferred to and said they did not ask her where she wanted to go when she transferred. R3 said they just came in and told her she was coming here. V3 said, "they did not tell me shit."

On 11/14/2024 at 1:40PM, V9 (BOM/SSD) stated on 11/4/2024, there was a meeting with a corporate person (she did not know their name) and staff were informed the doors would close on 1/1/2025. The staff was given the option to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

transfer to other facilities and keep their same benefits and seniority. V9 stated she helped make calls to the families, and that started on 11/4/2024. They informed the families the doors were closing 1/1/2025 and asked where the family wanted referrals sent. V9 stated they started sending referrals on 11/4/2024 and 11/5/2024. V9 stated she did tell residents and families that they were trying to get residents out as soon as possible because they were afraid staff would start leaving and they needed staff to take care of the residents. V9 stated she told the families discharge would probably be more like two weeks because of staffing concerns. V9 stated she and V1 told the higher functioning residents about the facility closing. V9 stated the residents were really upset and it was sad. V9 stated she felt the time was sufficient notice for the residents because it was going to be hard no matter when they left. This surveyor clarified that V9 stated she was telling families that they needed to discharge within two weeks. When V9 was asked why she told families they needed to discharge within two weeks, she stated that is what she was told to do. When asked who that direction came from, V9 did not want to provide that information.

On 11/14/2024 at 1:50PM, V10 (RN/DON) stated she has been the Interim DON since January 2024. V10 stated they were told on 11/4/2024 about the closing of the facility. V10 stated when she got residents ready for transfers to other facilities, she would try to send a copy of physician orders, code status, medication sheets from that day only, treatment sheets and their medications. V10 was asked about other important information and V10 stated she did not send Care plans, MDS assessments, or behavior tracking. V10 was asked about Immunization

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

Records and V10 stated she has not seen an Immunization Record since she started here in January 2024, so they weren't sent. V10 stated she believed a few residents that transferred to another facility were not sent with paperwork. V10 stated, "I was working the medication cart and trying to get four people at a time ready for transfer and it was impossible to make sure it was done correctly." V10 was asked if she called report to the receiving facilities upon discharge, and V10 stated, "No, I never called report on any of them." V10 stated she was told V1 and V9 were taking care of calling the families to tell them when the residents were transferring to another facility. V10 stated some of the residents were upset. V10 stated it was sad as this was their home. V10 stated, "This was all rushed and it happened too fast and there was not enough time for the residents to be prepared."

On 11/14/2024 at 2:00PM, V1 (Administrator) stated she was informed on 11/4/2024 the facility was closing on 1/1/2025. V1 stated on that same day, she and V9 (BOM/SSD) started calling the families as the letters were getting printed and placed in envelopes with information of names of facilities for the families to decide for placement. V1 stated those were mailed on 11/4/2024. V1 stated she and V9 told the higher functioning residents about the closure. V1 stated moving upset a lot of people. V1 stated on 11/4/2024, two family members were in the facility and were handed the letter, but they also mailed them one. V1 stated some people were asking "why so fast" and V1 stated she replied, "we have until 1/1/2025, but we are trying to get this done quickly because the staff will be jumping ship, and we wouldn't have anyone to take care of the residents." V1 stated this is why we were trying to get residents out as soon as possible. When V1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 14	S9999		

was asked if she followed the policy for facility closure, V1 stated, "I didn't have the policy for the first 3 days, I got the policy when another surveyor came in and asked for it and Corporate sent it to me and I forwarded it to the surveyor." V1 stated, "I do not have a closure plan; I am trying to follow the policy now that I have it."

On 11/14/2024 at 3:05 PM, surveyor entered one of the receiving facilities where some residents were transferred/discharged. This surveyor interviewed V21 (Receiving Facility Administrator), V22 (Receiving Facility Social Service Director) and V23 (Receiving Facility Director of Nursing) and together. All stated they provided transportation for the residents they received via their facility van. V22 was asked if all important information came with the residents such as POLST (Physician Orders for Life Sustaining treatment), POA (Power of Attorney) paperwork, PASRR (Preadmission Screening and Resident Review), Care plans, or MDS Assessments, and V22 stated, "we did not get any of that stuff, we have requested all of that but have not received yet." V22 stated they have POLST forms and baseline Care Plans completed for all the residents they received. V23 stated she has also requested Immunization Records but has not received them yet either. V23 stated report was not called on any of the residents from the other facility. V23 stated they received 4 residents (R6, R8, R5, R17) from the other facility. V23 stated they did receive the medications, Physician Order Sheets, and Medication Administration Records upon admission.

On 11/15/2024 at 3:40PM, V19 (Regional Director of Operations/RDO) was asked if she was aware of the residents and residents' families being told

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 15	S9999		

that they had one to two weeks to be discharged. V19 stated, "The Ombudsman told me that she was told that some residents were made to leave in 2 days." V19 stated the Ombudsman didn't know what was going on. V19 stated she was not aware the residents/family were being told they had to be discharged that soon. V19 stated they gave a 60-day notice. V19 stated she did not have a copy of a notification letter that should have been sent to the Ombudsman but would try to get a copy of it and would send it to the surveyor. V19 stated, "We told the families that we would send the referrals out and once the residents were accepted, we sent them (the residents)." V19 stated the facility was never directed to get the residents moved out that fast. V19 stated they had hired agency staff just in case the staff got other jobs. V9 stated the information on arrangements of agency staff were not revealed to any staff or managers of the facility for fear the staff would panic and feel as if we were trying to replace them.

On 11/19/2024 at 9:58AM, V20 (Ombudsman) stated she was notified of the closing of the facility by another Ombudsman because the facility's corporation sent the letter to the wrong Ombudsman. V20 stated she actually received the letter of notification of closing on 11/5/2024 via email but V20 saw it on 11/6/2024. V20 stated she went into the facility on 11/8/2024 and there were only 4 residents left in the facility. V20 stated most of the dining room tables had been moved out. V20 stated she then talked to V1, V1 stated they had already lost 2 housekeepers because the staff do not want to be without a job. V20 stated she went to a receiving facility on Thursday (11/14/24) and while talking with their Social Service Director, V2 (R1's Family Member) was present. V20 stated V2 was upset because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 16	S9999		

she was not notified when R1 was transported to the receiving facility, and V2 was notified of this by the receiving facility. V20 stated she has not had any other concerns brought to her and she understood about the facility moving fast due to staff leaving and there would not be enough staff to take care of the residents. V20 stated she would be going out to other facilities to check on the residents and see how they are adjusting. V20 stated this is the fastest closure she has ever dealt with. V20 stated she has only been to one of the receiving facilities and she plans to go check on all the residents that were transferred to other facilities.

On 11/14/24 the facility's policy and procedures for Facility Closure and the facility's Closure Plan was requested from V1 (Administrator). An undated document titled, "Facility Closure Policy" was provided by V19 (Regional Director of Operations) that documents the Code of Federal Regulations Guidance §483.70(/) as it states, "The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (l) of this section. Policies and procedures must be in place at all times in order to be used in the case of a facility closure or in case of termination of a facility's Medicare and/or Medicaid Provider Agreement, in order to meet the requirements of §483.70 The policies and procedures must address: The administrator or designee's duties and responsibilities as required per §483.70(k) for submitting a closure plan and providing timely written notice to the State Survey Agency, the State LTC Ombudsman, residents of the facility, and the legal representatives of residents or other responsible parties, including the CMS Regional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005433	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO REHAB & HCC	995 STATE RT 127 JONESBORO, IL 62952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 17 Office (RO), the State Medicaid Agency, and staff responsible for providing care and services to residents; How facility staff will identify available settings in terms of quality, services, and location, by taking into consideration each resident's individual needs, choices, and best interests. The facility may not close until all residents are transferred, relocated or discharged in a safe and orderly manner to the most appropriate setting; and Assurance that no new residents will be admitted to the facility on or after the date that the written notice of impending closure was provided to the State Survey Agency ..." There were no Facility Closure Policies and Procedures provided. The facility policy titled, "Notice of Transfer and Discharge" (revision date 5/8/23) was provided along with the above referenced document and states: "Notice In Advance of Facility Closure: In the case of facility closure, the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents." An undated list provided by V19 on 11/15/24 documenting the names of residents transferred, their date of transfer, and transfer location, documents that a total of 30 residents were transferred from the facility due to the facility closure. (B)	S9999		