STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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 First Probationary Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 8 300.230a)2)5) 300.230b) Section 300.230 Information to Be Made Available to the Public by the Licensee a) Every facility shall conspicuously post for display in an area of its offices accessible to residents, employees, and visitors the following: 2) A description, provided by the Department of complaint procedures established under the Act and the name, address, and telephone number of a person authorized by the Department to receive complaints; 5) Phone numbers and websites for rights protection services must be posted in common areas and at the main entrance and provided upon entry and at the request of resident's representatives; and b) The administrator shall post for all residents and at the main entrance the name, address, and telephone number of the appropriate State governmental office where complaints may be lodged in language the resident can understand, which must include notice of the grievance procedure of the facility or program as well as addresses and phone numbers for the Office of Health Care Regulation and the Long-Term Care Ombudsman Program	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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	S9999		

and website showing the information of a facility's ownership. The facility shall include a link to the Long-Term Care Ombudsman Program's website on the home page of the facility's website. (Section 3-209(a) of the Act) If a facility does not have a facility-specific website, the link to the Long-Term Care Ombudsman Program's website shall be included on the facility's parent company website.

This REQUIREMENT was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure information about Medicare, Medicaid and the telephone number and agency where complaints may be lodged at the main entrance. This failure has the potential to affects all 53 residents residing in the facility.

Findings include:

The facility's Census Detail Report dated 2/20/25 shows 53 residents reside in the facility.

On 2/24/25 at 9:37 AM, no signs were posted near the entrance or surrounding area to indicate the nursing home hotline with the agency name and telephone number, Medicare or Medicaid information, or the procedure to file a grievance.

On 2/24/25 at 10:10 AM, V1, Administrator, said Medicare, Medicaid, and grievance procedure information should be posted for anyone who needs contact information or needs to file a complaint.

The facility's Mandatory Postings Compliance Policy (reviewed 12/24) shows the facility will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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		

ensure compliance with all local, state, and federal requirements for mandatory postings by displaying required notices in public entrance areas accessible to residents, employees, and visitors.

"AW"

Statement of Licensure Violations 2 of 8

300.682c)
300.682d)
300.682e)

Section 300.682 Nonemergency Use of Physical Restraints

A physical restraint may be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106(c) of the Act) Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact.

c) The informed consent may authorize the use of a physical restraint only for a specified period of time. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility throughout the period of time the physical restraint is used.

d) After 50 percent of the period of physical restraint use authorized by the informed consent has expired, but not less than 5 days before it has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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		

expired, information about the actual effectiveness of the physical restraint in treating the resident's medical symptoms or as a therapeutic intervention and about any actual negative impact on the resident shall be given to the resident, resident's guardian, or other authorized representative before the facility secures an informed consent for an additional period of time. Information about the effectiveness of the physical restraint program and about any negative impact on the resident shall be provided in writing.

e) A physical restraint may be applied only by staff trained in the application of the particular type of restraint. (Section 2-106(d) Act)

This REQUIREMENT was not met as evidenced by:

Based on observation, interview, and record review the facility failed to obtain informed consent, failed to remove a resident's restraint every two hours, failed to provide Range of Motion to a resident's affected extremity after removing a restraint, and failed to train staff on the use of a resident's restraint for 1 of 1 residents (R3) reviewed for restraints in the sample of 16.

Findings include:

On 02/20/2025 at 10:00AM, R3 way lying on his back. R3 had a mitt restraint to his right hand. R3's left hand's fingers were flexed into the palm, the wrist was hyper-extended, and the elbow was flexed with the shoulder adducted to the body. On 02/20/2025 at 1:45PM, V3 CNA removed right hand mitt restraint. R3's right fingers were contracted into the palm of his right hand. V3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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		

CNA-Certified Nursing Assistant did not provide any ROM to R3's right hand after the restraint was removed.

On 02/20/2025 at 10:05AM, V3 CNA-Certified Nursing Assistant said, I work in this facility on an as needed basis, I do not work with R3 often. I am not sure why R3 has a restraint. Removing his incontinent brief and pulling on his tube feeding is part of it. I placed the mitt restraint on about one hour ago, I have never observed any of those behaviors with R3.

On 02/20/2025 at 10:15AM, V4 RN-Registered Nurse said, R3's mitt restraint is to prevent him from grabbing the feeding tube. The mitt restraint is removed every two hours. I am not sure about R3's behavior tracking. We are not tracking any of R3's behaviors.

On 02/20/2025 at 1:45PM, V3 CNA said, I have not had any training on the use of R3's restraint.

On 02/24/2025 at 1:35PM, V2 DON-Director of Nursing said, we have not provided any restraint training to the CNA's specific to R3's restraint. The restraint should be removed every two hours to assess the skin and provide ROM.

R3's Restorative Functional Assessment dated 01/30/2025 shows, R3 has contractures, has decreased range of motion, does not have a splint, has potential for increased contracture development and needs assistance to perform joint mobility.

R3's Behavior tracking log dated 01/01/2025 through 02/21/2025 with behaviors being documented 2-4 times per day shows, R3 had no behaviors except for, 01/01/2025 on the evening

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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		

shift where he had a behavior of frequent crying and tearfulness.

R3's Restraint Consent dated 09/09/2022 shows, Duration: Continuous, No specified dates were provided. Alternatives tried: left blank.

R3's current Care Plan on 02/20/2025 shows, R3's Care Plan did not address the restraint, the needed assessments, and interventions for the use of R3's restraint.

The facility's Restraint policy dated 2024 shows, if the use of a restraint is determined to be necessary, the following protocols, including documentation in the medical record, are warranted: assessment and re-assessment of need, continued clinical justification, effectiveness, reduction efforts, continued education. The resident care plan is to be updated to reflect identified risks, interventions, and goals for restraint reduction.

"B"

Statement of Licensure Violations 3 of 8

300.696b)
300.696d)6)

Section 300.696 Infection Prevention and Control

b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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		

Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code.

d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340):

6) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings

This REQUIREMENT was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement and/or follow Enhanced Barrier Precautions (EBP) for 2 of 4 residents (R1, R2) reviewed for infection control in the sample of 16.

Findings include:

The facility's Enhanced Barrier Precautions Policy (reviewed 10/24) shows Enhanced Barrier Precautions involve gown and glove use during high contact resident care activities for residents at increased risk of acquiring MDROs (multidrug resistant organisms) such as those with wounds.

1. R1's Face Sheet dated 2/21/25 shows R1's diagnoses include but are not limited to wedge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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		

compression fracture of the second lumbar vertabra, malignant neoplasm of right bronchus or lung, pressure ulcer of other site, dementia, left bundle branch block, alcohol abuse, nicotine dependence, epilepsy, anemia, pressure induced deep tissue damage of left heel.

R1's Physician's Orders dated 2/21/25 show current orders for daily wound treatment orders for his pressure ulcer of the left upper and lower buttocks and deep tissue injury of the left heel. There are no EBP or other isolation orders.

On 2/20/25 at 11:01 AM, R1's room had no signs posted to indicate he had any isolation needs or enhanced barrier precautions (EBP) and no PPE (personal protective equipment) was located outside of his room.

2. R2's Face sheet dated 2/21/25 show R2's diagnoses include but are not limited to cerebral infarction, dementia, diabetes type 2, hypertension, hypothyroidism, bipolar disorder, schizoaffective disorder, depression, chronic pain, vitamin D deficiency, localized swelling, mass and lump, unspecified, and cutaneous abscess of back.

R2's Physician's Orders dated 2/21/25 show a current order for daily wound treatment orders to his wound on the left upper back. There are no EBP or other isolation orders.

On 2/20/25 at 10:00 AM, R2's room had no signs posted to indicate he had any isolation needs or enhanced barrier precautions (EBP) and no PPE (personal protective equipment) was located outside of his room.

The facility's Transmission Based Precautions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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 February 2025 document for Feb 16th through 22nd does not list R1 or R2 having EBP. On 2/20/25 at 1:22 PM, V8, Infection Prevention Nurse/Assistant Director of Nursing, said they follow the CDC guidelines for residents who require isolation precautions. If a resident requires isolation, she puts signs on the door indicating they type of isolation and the necessary PPE, informs staff through verbal and/or written report, and obtains a physician's order. V8 said residents with wounds such as pressure wounds, post operative wounds, or any open area require EBP. V8 said R1 and R2 both have wounds which require daily treatments. V8 said R1 and R2 should both be on EBP. "B" Statement of Licensure Violations 4 of 8 300.1210d)5) Section 300.1210 General Requirements for Nursing and Personal Care 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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		

services to promote healing, prevent infection, and prevent new pressure sores from developing.

This REQUIREMENT was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide pressure ulcer prevention interventions and failed to identify a stage 2 pressure ulcer for 1of 3 residents (R3) reviewed for pressure ulcers in the sample of 5. This failure resulted in R3 sustaining a stage 2 pressure ulcer to his right lateral ankle.

Findings include:

On 02/20/2025 at 10:00AM, R3 was lying on his back with his knees facing to the left. R3's left ankle was resting directly on the bed with his right leg resting on top of his left leg. R3 did not have a pressure reduction mattress. R3 did not have a pillow between his legs. R3 did not have pressure reductions boots or any other devices to reduce the pressure to the boney prominence of his legs and feet.

On 02/20/2025 at 1:41PM, V3 CNA-Certified Nursing Assistant and V6 CNA provided incontinent care to R3. As R3 was turned to his right side a stage 2 pressure ulcer was visible on the bony prominence of the left lateral ankle area. There was approximately 1.5 centimeter by 0.5 centimeter of granulation tissue present to the left lateral ankle area. No dressing was present and the open wound was exposed to the environment. After V3 CNA and V6 CNA provided incontinent care to R3 they did not apply a protective barrier to R3's perineal-area. R3's left ankle was then positioned so the open area of the stage 2 pressure ulcer rested directly on the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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		

On 02/20/2025 at 1:51PM, V7 Wound Nurse said, R3 does not have any wounds. At 1:55PM, V7 Wound Nurse, stated V7 identified R3's wound to the left lateral ankle, a stage 2 pressure wound.

On 02/24/2025 at 1:15PM, V2 DON-Director of Nursing said, residents that are assessed to be high risk for pressure ulcer development are placed on pressure reducing air loss mattress, pressure reduction heel boots. Skin Assessments are done weekly and with showers. R3 has a Physicians Order for daily skin checks. The nurses are documenting in the TAR-treatment administration record, they are not documenting their assessment of the skin that should show, clear, rash, other, or pressure. The nurse should be documenting an assessment in the TAR not just sign the document without an assessment.

R3's Treatment Administration Record: Daily Skin Check, dated January 2025 and February 2025 shows, no skin assessment was documented for R3.

R3's Physician Order initiated 11/16/2024 shows, Daily Skin Check: C=CLEAR R=RASH O=OTHER P=PRESSURE S=SKIN TEAR. Scheduled: Every Day at 10:00PM-6:00AM.

On 02/20/2025 R3's last Skin Assessment dated 02/11/2025 shows, stage 1 pressure ulcer to abdomen. No wounds to the legs or feet area.

R3's last Pressure Ulcer Risk assessment dated 10/2/2024 shows, R3 was assessed to be High Risk for pressure ulcer development.

R3's current Care Plan on 02/20/2025 shows, R3 is at risk for skin breakdown. Interventions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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		

implemented 12/01/2024: Provide pressure reducing mattress, off load heels when in bed.

R3's Restorative Functional Assessment dated 01/30/2025 shows, R3 is dependent on staff for bed mobility.

The facility's Pressure Ulcer Prevention policy dated 12/24 shows, residents assessed for HIGH RISK the following preventative measures will be implemented upon admission, Daily skin checks will be conducted by the nurse and documented on the treatment records. Preventative mattress, Repositioning per resident's specific need. Apply protective barrier every shift and as needed.

"B"

Statement of Licensure Violations 5 of 8

300.1630a)3)

Section 300.1630 Administration of Medication

a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents.

3) Self-administration of medication shall be permitted only upon the written order of the licensed prescriber.

This REQUIREMENT was not met as evidenced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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		

by:

Based on observation, interview, and record review the facility failed to ensure a resident had a physicians order to self-administer medications which applies to 1 of 4 residents (R4) reviewed for medication administration in a sample of 16.

Findings include:

The facility's Census Detail Report dated 2/20/25 shows 53 residents reside in the facility.

R4's Face Sheet printed on 2/24/25 showed R4 was admitted to the facility on 3/17/22 with diagnoses which include Chronic Obstructive Pulmonary Disease (COPD) and dependence on supplemental oxygen.

R4's Albuterol Sulfate HFA 90 micrograms/actuation aerosol inhaler order was renewed on 11/13/24.

On 2/20/25 at 9:00 AM, V5 Registered Nurse administered R4's morning medications. At this time R4 had a medication inhaler sitting on his bedside table. After exiting R4's room V5 stated R4 was okayed to have his inhaler and take the medication himself.

On 2/20/25 at 10:35 AM, R4 stated they get short of breath off and on. R4 stated they have used their inhaler multiple times without help from the nurses. R4 stated when they need it, they need it fast.

On 2/20/25 at 11:50 AM, This writer reviewed R4's electronic medical record. R4's medical record had no assessment, physician order, or care plan for R4 to be able to self-administer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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		

medications.

On 2/24/25 at 10:45 AM, V2 Director of Nursing stated R4 did not have a previous order, assessment, or care plan for medication self-administration.

The Self Administration of Medication Policy dated 10/2024 showed the interdisciplinary team needs to assess the resident, have physicians' orders permitting self-administration and to keep medications at bedside, and to have the resident's care plan reflect the responsibility of storage and administration of the medication.

"B"

Statement of Licensure Violations 6 of 8

300.2100

Section 300.2100 Food Handling Sanitation

Every facility shall comply with the Department's rules entitled "Food Code."

This REQUIREMENT was not met as evidenced by:

Based on observation, interview, and record review the facility failed ensure the sanitizing solution from the three-compartment sink was at the proper concentration. This has the potential to affect all 52 residents in the facility.

Findings include:

On 02/20/2025 at 9:30AM, V12 Dietary Manager placed a test strip in the sanitizing solution from the three-compartment sink. The sanitizing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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		

solution from the three compartment sink was unable to change the color of the test strip. A fresh sanitizing solution was obtained from the three-compartment sink mixing station. V12 Dietary Manager placed a test strip in the solution. The test strip did not change color. At 11:00AM, and 2:00PM, V12 confirmed the sanitizer mixing station did not work.

On 02/20/2025 at 9:30AM, V12 Dietary Manager said, we test the sanitizer daily. It should read 200 parts per million or more. The sanitizer is not reaching the proper concentration to sanitize.

The facility's Manual Sanitizing in Three Compartment Sink policy dated 2017 shows, a test strip is used to accurately determine the concentration of the sanitizing solution.

"C"

Statement of Licensure Violations 7 of 8

300.2210b)2)

Section 300.2210 Maintenance

b) Each facility shall:

2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.

This Requirement was not met as evidenced by:

Based on interview and record review the facility failed to collect resident room and facility hot water temperatures to ensure these temperatures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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 were in a safe range for resident which applies to all 53 residents in the facility. Findings include: The facility's Census Detail Report dated 2/20/25 shows 53 residents reside in the facility. On 2/20/25 at 1:45 PM, V7 Regional Maintenance Director stated the facility had not started monitoring resident rooms or hot water temperatures in the facility. V7 stated the room and facility water temperatures need to be monitored for resident safety, and to make sure the systems are working. The undated Hot Water Temperature Policy showed water temperatures to residents' rooms, bathrooms, and showers will be taken daily and logged on the water temperature log. The Resident Room Temperature Policy dated 4/2024 showed the purpose of the policy to ensure resident rooms are comfortable and safe. This policy showed room temperatures should be kept between 68 and 79 degrees Fahrenheit in the winter and 73 to 79 degrees in the summer (modified per humidity). No documentation of hot water temperatures or resident room temperatures were provided during the survey. "C" Statement of Licensure Violations 8 of 8 300.3320a) 300.3320b) 300.3320c)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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 Section 300.3320 Confidentiality a) The Department, the facility and all other public or private agencies shall respect the confidentiality of a resident's record and shall not divulge or disclose the contents of a record in a manner which identifies a resident, except upon a resident's death to a relative or guardian, or under judicial proceedings. This Section shall not be construed to limit the right of a resident or a resident's representative to inspect or copy the resident's records. (Section 2-206(a) of the Act) b) Confidential medical, social, personal, or financial information identifying a resident shall not be available for public inspection in a manner which identifies a resident. (Section 2-206(b) of the Act) c) The facility shall ensure the rights of all residents to confidentiality of their personal and medical records. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident medical records containing confidential information were not located in a public area. This failure affects all 53 residents residing in the facility. Findings include: On 2/24/25 at 9:37 AM, four binders labeled "Medical Record Do Not Remove" were on a shelf near the front entrance with the facility's Survey Binder where anyone could access them.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008718	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ELGIN LIVING & REHAB CENTER	746 WEST SPRING STREET SOUTH ELGIN, IL 60177

(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 Each binder was labeled with the unit, 100, 200, 300, 400 and contained documents listing the residents' names and either one or both documents titled "Skilled ADL Report for Resident," "ADL Flow Records." The documents were filled out to various degrees indicating personal medical information about the residents and were dated November 2024. On 2/24/25 at 10:10 AM, V1, Administrator, said the survey binder is kept at the front door entrance for anyone to access. V1 said no resident information should be available to anyone not caring for the resident. On 2/24/25 at 9:46 AM, V9, Registered Nurse, said patient information should be kept confidential and no one should be able to access it who is not caring for the resident. On 2/24/25 at 9:58 AM, V10, Certified Nursing Assistant (CNA), said resident information is confidential and only the nurses and CNAs should be looking at it. The facility's Census Detail Report dated 2/20/25 shows 53 residents reside in the facility. The facility's Resident's Rights Policy (reviewed 3/24) shows residents have the right to confidentiality of their medical, financial, or other records. "C"	S9999		