

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Nokomis Rehab & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Stevens Street Nokomis, IL 62075	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review, the facility failed to provide supervision and assistance required to prevent accidents for one (R3) of three residents reviewed for accidents and supervision. Findings Include: R3's face sheet, dated 9/5/24, documented R3 has diagnoses of sepsis, urinary tract infection, bipolar disorder, acquired absence of right leg below knee, acquired absence of left leg below knee, chronic pain, atherosclerotic heart disease, heart failure, hypertension, obstructive and reflux uropathy, hyperlipidemia, fibromyalgia, type 2 diabetes mellitus, COPD (chronic obstructive pulmonary disease, and aphasia following cerebral infarction. R3's MDS (Minimum Data Set), dated 7/19/24, documented R3 has severe cognitive impairment. R3's MDS, dated [DATE], documented R3 has impairment on one side of upper extremities secondary to cerebral infarction and impairment of both lower extremities secondary do bilateral lower leg amputations. This MDS documented R3 is dependent on staff for all ADLS (Activities of Daily Living). R3's care plan, undated, documented R3 has a communication deficit related to an old stroke and cannot speak. Makes preferences known by yelling sounds and making hand gestures. This care plan also documented R3 requires a mechanical lift with two assists for all transfers. R3's care plan does not address falls nor fall risk. R3's Quality Care Reporting Form, dated 8/23/24 at 2:00 pm, documented resident had an unwitnessed fall in the courtyard. Intervention is resident isn't to be alone outdoors. R3's paper nurse's notes, dated 8/23/24 at 2:00 pm, documented notified resident was on ground. ROM (range of motion) WNL (within normal limits). Noted an abrasion to above her right knee. Area cleansed and left OTA (open to air). DON (Director of Nursing), MD (Medical Doctor) and Administrator made aware. R4's face sheet, dated 9/5/24, documented R4 has diagnoses of osteoarthritis, depression, hypertension, unspecified dementia, neuropathy, type 2 diabetes mellitus, and chronic pain. R4's MDS, dated [DATE], documented R4 is cognitively intact. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145478	Facility ID: 145478 If continuation sheet Page 1 of 2

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NAME OF PROVIDER OR SUPPLIER Nokomis Rehab & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Stevens Street Nokomis, IL 62075	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's care plan, undated, documented R4 requires a sit to stand lift and assistance of 2 for all transfers and requires a wheelchair for mobility. R4's care plan also documented R4 is a fall risk and that R4 has risk factors that require monitoring and intervention to reduce R4's potential for self injury. Risks include incontinent of bowel at times, use of psychotropic medication, and diabetes. On 9/5/24 at 10:00 AM, R4 stated she was outside on the patio with her friend/fell ow resident (R3) about a week or two ago. R4 stated she attempted to push (R3's) wheelchair up to the table and (R3's) wheelchair hit a dip in the concrete by a drain causing (R3) to fall out of the wheelchair. R4 stated no staff were around and she had to use her cell phone to call the facility to get staff out on the patio to assist (R3). R4 stated staff had pushed (R3) out on the patio, but they did not stay out there. R4 stated she was very upset by this and was crying because she felt so bad about (R3) falling out of her wheelchair. On 9/5/24 at 9:10 AM, V5, Activity Director, stated she was out of the building on a van transport the day (R3) fell out on the patio. V5 stated (R3) should not have been outside unless an employee was present. On 9/5/24 at 9:42 AM, V3, CNA (Certified Nurse Assistant), stated she was not working on the day (R3) fell out on the patio. V3 stated (R3) was not supposed to be outside without an employee being out there with her. On 9/5/24 at 12:25 PM, V1, Administrator, stated R3 should have never been outside without staff present. V1 stated an employee had been outside supervising the residents who smoke and when the residents were done smoking, the employee left R3 outside with R4. V1 stated =she cannot recall who the employee was that left R3 unattended. On 9/5/24 at 2:20 PM, V9, LPN (Licensed Practical Nurse), stated she was R3's nurse the day she fell out on the patio. V9 stated R4 called the facility from her cell phone to alert staff R3 was on the ground. V9 stated she and the CNAs had to use a mechanical lift to get R3 up off the concrete patio. V9 stated R3 should not have been outside without staff present. The facility's Fall Prevention Policy, dated 11/10/18, documented the policy is to provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Responsibility: all staff. Procedure: 1. Conduct fall assessments on the day of admission, quarterly, and with a change in condition. 2. Identify, on admission, the resident's risk for falls. It continues, all staff must observe residents for safety.		