STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bloomington Rehabilitation & Hcc	1925 South Main Street Bloomington, IL 61701

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 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on interview and record review the facility failed to protect a resident's right to be free from misappropriation of funds which resulted in the resident feeling distraught, fearful, and angry. This failure affected one of three residents (R1) reviewed for abuse in the sample of three. Findings Include: The facility Abuse Policy dated 9/15/23 documents residents are to remain free from misappropriation of property. The facility is to establish an environment that promotes resident sensitivity, resident security, and prevent mistreatment. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. R1's Medical Diagnoses List dated January 2025 documents R1 is diagnosed with Type 2 Diabetes, Anxiety, Congestive Heart Failure, Major Depression, and Neuromuscular Disorder. R1's Minimum Data Set, dated dated dated [DATE] documents R1 is cognitively intact, uses a manual wheelchair, and is dependent on staff for transfers. R1's Care Plan dated 12/20/24 documents R1 has the potential for abuse/neglect due to a personal history of physical vulnerability such as poor ambulation or inability to ambulate/propel wheelchair, and frailty/weakness. Underlying factors that increase vulnerability include dementia, confusion, poor judgment, wandering and giving away personal property. R1 also has a psychosocial well-being problem related to anxiety, disease process, ineffective coping, lack of acceptance to current condition, lack of motivation, and pain. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025

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F 0602

Level of Harm - Actual harm

Residents Affected - Few

On 1/3/25 at 1:45 PM R1 stated on Monday 11/25/24 before a smoke break, he realized $305 cash was missing from his coat pocket. R1 stated he doesn't know what happened to the money but he believes someone stole it. R1 stated the money was given to him on Sunday 11/24/24 by his sister (V12) who came to visit him at the facility. V12 gave him three $100 bills. R1 stated he put the money in his coat pocket because he does not trust the facility to keep his money safe or to give him access to his money when he wants/needs it. R1 stated he went to bed that night and the money was in his coat pocket. Staff member V7 Certified Nurses Assistant (CNA) helped him to bed. R1 stated staff members (V8 and V9 CNAs) got him dressed and up and ready in the morning. R1 stated when he got his coat on to go smoke, he noticed the money ($300) was gone. R1 stated he knows someone took it because there were only staff that came in and out of his room and he did not take the money out of his pocket or do anything with it himself. R1 stated he wants to move out of the facility, and he is tired of living in a place where you can't trust the people who are supposed to help you and take care of you to do the right thing. R1 stated he is angry about the situation and nothing ever gets resolved. R1 stated that was the last of his money and now he has nothing. R1 stated he feels he can't have anything nice in the facility because it will come up missing, he can't keep his own money because it will get stolen, and he can't rely on the people (staff) that he is supposed to be able to rely on.

On 1/3/25 at 3:20 PM V7 CNA stated he saw R1 with the $300. V7 stated R1's sister (V12)had been there that day and given him hundreds of dollars. V7 stated he put R1 to bed and R1 slept with his money in his jacket and his jacket by his bed so he would feel it was safe. V7 stated R1 doesn't trust anyone and doesn't trust the front office to keep his money either. V7 stated R1 and others have had money come up missing in the past. V7 stated the next day (11/25/24) R1 noticed his money was no longer in his coat pocket. V7 denied knowing what happened to R1's money.

On 1/8/24 at 11:50 AM V12 (R1's Sister) stated on 11/24/24, she brought R1 two cases of pop, clothes, and $325 cash which included three- $100 dollar bills. V12 stated R1 wanted to keep the money because he did not trust the facility staff to keep his things safe. V12 stated she feels the facility has a big issue with theft because whatever she brings in for R1, will end up missing within a short time.

On 1/3/25 at 12:33 PM V6 Social Service Director stated on 11/25/24, R1 reported he had $300 missing from his coat. V6 alerted V1 Administrator and began an investigation. V6 confirmed the money was never found and the facility is not sure what happened to R1's money.

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	145610	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bloomington Rehabilitation & Hcc	1925 South Main Street Bloomington, IL 61701

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on interview and record review the facility failed to report an allegation of potential misappropriation of property to the state surveying agency. This failure affected one of three residents (R3) reviewed for abuse in the sample of three. Findings Include: The facility Abuse Policy dated 9/15/23 documents residents are to remain free from misappropriation of property. The facility is to establish an environment that promotes resident sensitivity, resident security, and prevent mistreatment. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The facility will report all allegations of abuse immediately to the Administrator and timely to the proper authorities to include the state surveying agency, police, physician, and ombudsman. R3's Medical Diagnosis List dated January 2025 documents R3 is diagnosed with Heart Disease, Shortness of Breath, Spinal Stenosis, Orthostatic Hypotension, Repeated Falls, and Major Depression. R3's Minimum Data Set, dated dated dated [DATE] documents R3 requires modified independence due to cognition. On 1/8/25 at 1:12 PM V13 (R3's Secretary) stated in September of 2024 R3 was missing his cell phone, wallet, and checks from his checkbook. V13 stated the facility found R3's wallet in the laundry but never investigated what happened to the other items and they were never found. On 1/8/25 at 3:07 PM V16 Registered Nurse (RN) stated I know R3 stated he was missing a wallet, a cell phone, and some checks from his checkbook. Administration at the time was already aware of the missing items. V16 stated she does remember R3 having a phone. On 1/8/25 at 2:20 PM V1 Administrator stated September 2024 R3's wallet, cell phone, and some checks from his checkbook were reported missing. V1 stated he remembers R3's wallet was found in the laundry but he does not know if an investigation was done concerning the other missing items, as he was not the Administrator at the time. V1 looked but could not find documentation concerning R3's missing items. V1 confirmed there was no documentation regarding the facility reporting the allegations to the state surveying agency or the police. V1 confirmed allegations such as these should be reported and investigated as potential theft/misappropriation.

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NAME OF PROVIDER OR SUPPLIER Bloomington Rehabilitation & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 1925 South Main Street Bloomington, IL 61701	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on interview and record review the facility failed to investigate of potential misappropriation of property to the state surveying agency. This failure affected one of three residents (R3) reviewed for abuse in the sample of three. Findings Include: The facility Abuse Policy dated 9/15/23 documents residents are to remain free from misappropriation of property. The facility is to establish an environment that promotes resident sensitivity, resident security, and prevent mistreatment. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The facility will immediately and thoroughly investigate all allegations of abuse. R3's Medical Diagnosis List dated January 2025 documents R3 is diagnosed with Heart Disease, Shortness of Breath, Spinal Stenosis, Orthostatic Hypotension, Repeated Falls, and Major Depression. R3's Minimum Data Set, dated dated dated [DATE] documents R3 requires modified independence due to cognition. On 1/8/25 at 1:12 PM V13 (R3's Secretary) stated in September of 2024 R3 was missing his cell phone, wallet, and checks from his checkbook. V13 stated the facility found R3's wallet in the laundry but never investigated what happened to the other items and they were never found. On 1/8/25 at 3:07 PM V16 Registered Nurse (RN) stated I know R3 stated he was missing a wallet, a cell phone, and some checks from his checkbook. Administration at the time was already aware of the missing items. V16 stated she does remember R3 having a phone. On 1/8/25 at 2:20 PM V1 Administrator stated September 2024 R3's wallet, cell phone, and some checks from his checkbook were reported missing. V1 stated he remembers R3's wallet was found in the laundry but he does not know if an investigation was done concerning the other missing items, as he was not the Administrator at the time. V1 looked but could not find documentation concerning R3's missing items. V1 confirmed there was no documentation regarding the facility investigating the allegations. V1 confirmed allegations such as these should be reported and investigated as potential theft/misappropriation.

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F 0689

Level of Harm - 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 32172

Based on observation, interview and record review the facility failed to safely transport a resident in his wheelchair resulting in the resident falling forward out of the wheelchair and sustaining a subarachnoid hemorrhage. This failure affected one of three residents (R1) reviewed for falls in the sample of three.

Findings Include:

The facility Fall Prevention Program/Protocol dated 9/6/23 documents the purpose of the protocol is to guide facility staff regarding the prevention of falls within the facility. Environmental factors and certain medical conditions can place residents at risk for falls. The interdisciplinary team with implement a resident-centered fall prevention plan to reduce specific risk factors for each resident.

R1's Medical Diagnoses List dated January 2025 documents R1 is diagnosed with Type 2 Diabetes, Anxiety, Congestive Heart Failure, Major Depression, and Neuromuscular Disorder.

R1's Minimum Data Set, dated dated dated [DATE] documents R1 is cognitively intact, uses a manual wheelchair, and is dependent on staff for transfers.

R1's Care Plan dated 12/23/24 documents R1 is at risk for falls and staff were retrained to transfer/transport residents safely on 12/19/24 after R1's fall.

On 1/3/25 at 1:45 PM R1 stated a couple weeks ago (12/19/24) a staff member (V6 Social Service Director SSD) was pushing him in his wheelchair from outside back inside. R1 stated V6 was going too fast as she pushed his wheelchair through the door threshold and the wheel of the chair hit the door frame which propelled him forward out of his chair onto the ground. R1 stated he went face first into the ground and was in extreme pain. R1 stated he was sent to the emergency room and had a brain bleed and skin tear to his right hand. R1 stated the ramp on the threshold of the door was in need of repair and he thinks his wheel slipped off the ramp ledge and went into the door frame.

The Follow-up Investigation Report dated 1/2/24 documents R1 fell on [DATE] at 2:10 PM when returning inside after a smoke break. The report documents R1 was brought inside by staff (V6 SSD) in his wheelchair and the wheel of his chair got caught on the door jam/frame and resident fell from his wheelchair onto the floor. R1 was transported to the hospital where he received treatment for several abrasions and a subarachnoid hemorrhage that was sustained from the fall. V6 was inseviced regarding proper wheelchair usage and safe transport. The doorframe was repaired and made safe.

R1's emergency room Notes dated 12/19/24 document R1 was seen in the emergency room post fall at the facility. R1 is wheelchair bound and has a right above the knee amputation. R1 fell out of the wheelchair and struck the right side of his head on the ground.

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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 - Actual harm Residents Affected - Few	R1's Head Computed Tomography Scan results dated 12/19/24 document R1 was seen for head trauma related to a fall out of his wheelchair. The scan revealed R1 sustained an acute subarachnoid hemorrhage. On 1/8/25 at 2:00 PM V6 SSD stated she was transporting R1 back inside after a smoke break on 12/19/24. V6 stated there was a gap in the ramp on the doorway. V6 stated as she brought R1 through the doorway, the wheelchair wheel hit the door frame the jerking motion/sudden stop of the chair made R1 fall forward and hit his face on the floor. The side of R1's face was bleeding and he had a skin tear to his hand. R1 was yelling out in pain. On 1/8/25 at 11:28 AM V1 Administrator stated the door entrance frame/ramp did need repair. The ramp did not extend all of the way across the entrance and created a ledge on one side. R1's wheelchair wheel must've hit on the side of the door frame and it created enough force that he fell forward out of the chair. V1 confirmed R1 did go to the emergency room and he sustained a Subarachnoid Hemorrhage and skin tear on his hand due to the fall. V1 confirmed the facility did repairs to the doorway and installed a new ramp that went all the way across the entrance. V1 also confirmed staff were educated regarding safe transfers/transporting residents.