STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002 Based on observation, interview, and record review, the facility failed to ensure dignity was maintained by allowing resident's catheter bag to be visible in clear view of residents, visitors, and staff. This failure affected two resident (R17, R20) of 3 residents reviewed for dignity on the sample list of 21. Findings include: 1. R17's Facility Census documents R17 was admitted to the facility on [DATE], and has the following medical diagnoses; Cognitive Communication Deficit, Need for Assistance with Personal Care, Obesity, Dementia, Alzheimer's Disease, and Urinary Retention. R17's Minimum Data Set, dated dated [DATE], documents R17's Brief Interview for Mental Status (BIMs) score 6, severe cognitive impairment, and having an indwelling catheter. On 9/15/24 at 8:25 am, R20 was observed in bed with R20's catheter bag attached to R20 bed rail, not in a dignity bag, and visible from the hallway to residents and staff. At 8:30am, R17 was propelling down the hallway with R17's catheter bag secured under R17's wheelchair, not in a dignity bag, visible to residents and staff. 2. R20's Facility Census documents R20 was admitted to the facility on [DATE], and has the following medical diagnoses: Chronic Kidney Failure Stage 3, and Urological Trauma. R20's Minimum Data Set, dated dated [DATE], documents R20's Brief Interview for Mental Status (BIMs) score 15, cognitively intact, and having an indwelling catheter. On 9/15/24 at 8:15am, R20 stated My catheter bag should be placed in a privacy bag or something so that other residents and staff don't see it, and I need staff to do this; I'm not able to. R20 stated, Staff always forget to do this, and it upsets me, that everyone can see my urine bag. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/15/24 at 8:35am, V3, Licensed Practical Nurse (LPN), confirmed R17 has an indwelling catheter, R17's catheter bag was not in a dignity bag hanging under R17's wheelchair while R17 is propelling down the hallway, and R17's catheter bag is visible to everyone. V3 also confirmed R20 has an indwelling catheter, R20's catheter bag was hanging on R20's bed rail, not in a dignity bag, and it visible from the hallway. V3 stated, (R17's) and (R20's)catheter bag should be placed in a dignity bag so that no one is able to visible observe it, and that is a dignity issue. On 9/17/24 at 10:15am, V1, Administrator, confirmed R17's and R20's catheter bags should be placed in a dignity bag at all times, and doesn't understand why staff is not placing them in dignity bags so that they are not visible to other staff, residents, and guests. V1 confirmed this is a residents rights dignity issue, and all residents who have a catheter should have their privacy. Resident's Rights for People in Long Term Care Facilities, developed by Illinois Long-Term Care Ombudsman Program documents privacy: Your medical and personal care are private.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38780 Based on interview and record review, the facility failed to accurately complete a residents comprehensive assessment. This failure affects one resident (R24) of 16 residents reviewed for accuracy of assessments on the sample list of 21. Findings include: R24's Comprehensive Assessment (MDS), dated [DATE], documents R24 has received insulin for the past 7 days. R24's August 2024 Physician Order Sheet does not document R24 having any orders for insulin. R24's Medical Record documents R24 went on Hospice on 5/17/24. On 9/17/24 at 8:53am, V8, Registered Nurse, stated R24's insulin was discontinued once R24 started receiving Hospice services. On 9/19/24 at 10:40am, V1, Administrator, stated the facility follows the RAI (Resident Assessment Instrument) to complete resident comprehensive assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002 Based on interview and record review, the facility failed to provide multiple showers as scheduled, and timely toileting assistance for dependent residents. These failures affect two residents (R2, R7) of 21 reviewed for activities of daily living in the sample of 21. Findings include: 1. R7's Facility Census documents R7 was admitted to the facility on [DATE] and has the following medical diagnoses; COVID-19, Sepsis, Dysphagia, Muscle Weakness, Need for Assistance with Personal Care, Chronic Respiratory Failure with Hypoxia, Asthma, Morbid Obesity, Diabetes Mellitus, Chronic Migraine, Hyperlipidemia, GERD, Acquired Absence of Right Leg Below Knee, Gastritis, HTN, Acquired Absence of Left Leg Below Knee, Obstructive Sleep Apnea and Hypotension. R7's Minimum Data Set, dated dated [DATE] ,documents R7's Brief Interview for Mental Status (BIMs) score 15, cognitively intact, and is totally dependent on staff with Activities of Daily Living. On 9/15/24 at 9:00am, R7 stated, I have only received one shower and a couple of bed baths since being admitted to the facility on [DATE]. I am totally dependent on staff due to having both lower legs amputated. I have asked staff to give me showers and they give me a bed bath. I prefer to get a good shower at least once a week. R7 stated, My wife will wash me while she is visiting so that I am clean. On 9/16/24 at 9:15am, V16, Certified Nursing Assistant, stated, All residents are scheduled for 2 showers a week, and if a resident refuses a shower after 3 attempts, a bed bath is offered, and if they still refuse, a nurse is notified and documents it in the residents chart. After giving the resident a shower, it is documented on a shower sheet with any skin alterations, and a shower sheet must be completed for bed baths and refusals. On 9/17/24 at 10:15am, V1, Administrator, acknowledged R7 has only one documented shower on 8/31/24, and there are no other shower sheets that document bed bath or refusals. V1 stated, (R7) should be getting 2 showers a week, and if (R7) gets a bed bath or refuses, staff should be completing a shower sheet. The facility's shower schedules document R7's showers are scheduled twice per week on Tuesdays and Fridays on the 6:00pm-6:00am shift. Shower schedule also documents: All showers to be completed by Certified Nursing Assistant (CNA) and signed by a nurse. Nurse to document refusal and education after CNA attempts x 3. Nurse to document ass assess all skin issues noted for new issues follow skin protocol. Our residents deserve their showers, please offer them shower room first before offering bed bath, residents have the right to choose. R7's July, August September 2024 shower sheets provided by V1, Administrator, documents R7 had only received a shower on 8/15/24. There are no other documented showers, bed baths, or refusals. 35347 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R2's diagnosis list (undated/printed 9/18/2024) documents R2 has the diagnosis of Spastic Quadriplegic Cerebral Palsy (abnormal development or damage to the parts of the brain that control movement, balance, and posture affecting a person's ability to move, balance, and maintain posture). R2's quarterly assessment (8/14/2024) documents R2 is cognitively intact and requires substantial/maximal staff assistance to transfer to a toilet and complete toileting hygiene. R2's Care Plan (undated/printed 9/198/2024) documents R2 is at risk for bowel and bladder complications related to limited mobility and staff should provide toileting cares to R2 as-needed. On 9/16/2024 at 11:10am, R2 reported having toileting accidents while waiting on staff assistance when R2 is in the facility dining room. R2 reported facility staff will decline R2's request to be taken to R2's room to use the toilet when R2 is in the dining room. R2 reported staff will tell R2 they are getting ready to pass meal trays, so R2 will have to wait. R2 stated, I don't like it. On 9/19/2024 at 11:15am, V18 (Certified Nurse Aide) reported the facility doesn't always have enough staff to respond to R2's toileting requests during lunch time without requiring R2 to wait until staff have served lunch and provided care and dietary supervision to other residents in the dining room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002 Based on observation, interview, and record review, the facility failed to follow physician orders and administer multiple prescribed treatments for one of three residents (R7) reviewed for following physicians orders on the sample list of 21. Findings include: R7's Facility Census documents R7 was admitted to the facility on [DATE], and has the following medical diagnoses; Sepsis, Dysphagia, Muscle Weakness, Need for Assistance with Personal Care, Morbid Obesity, Acquired Absence of Right Leg Below Knee, and Acquired Absence of Left Leg Below Knee. R7's Minimum Data Set, dated dated [DATE], documents R7's Brief Interview for Mental Status (BIMs) score 15, cognitively intact, and is totally dependent on staff with Activities of Daily Living. R7's Physicians Order Sheet (POS), dated September 9/4/24, documents: abdominal folds, groin creases, apply antifungal power twice a day. 9/9/24 Apply hydrocortisone cream twice a day to rash. On 9/15/24 at 9:05am, R7 was observed to have redness in R7's abdominal folds and R7's groin creases. On 9/15/24 at 9:00am, R7 stated, I don't always get the prescribed treatments to my abdominal folds and groin crease. R7 stated, The nurse only does them every once in a while, and that's why they won't heal. On 9/15/24 at 8:35am, V3, Licensed Practical Nurse (LPN), confirmed R7 has treatment orders for antifungal cream to be applied to R7's abdominal folds and groin creases. V3 stated, After a treatment is administered by a nurse, it is signed off on the residents Treatment Administration Record (TAR). V3 confirmed R7's TAR shows R7's treatments were not completed on numerous days in September On 9/17/24 at 10:15am, V1, Administrator, stated, (R7) and all residents should be getting their prescribed treatments, and after the nurse completes the treatment, it should be documented on the residents Treatment Administration Record (TAR). V1 confirmed R7's TAR documents R7 did not receive R7's treatments on numerous days in September. R7's Medication Administration Record (MAR), dated September 2024, documents R7 did not receive antifungal cream to abdominal folds and groin creases on 9/4 and 9/5- 6:00pm-6:00am shift, 9/6 and 9/8/24- 6:00am-6:00pm and 6:00pm-6:00am shift, 9/9, 9/10, 9/11, 9/12, 9/13, 9/14 and 9/15/24 on the 6:00pm-6:00am shift. R7 did not receive hydrocortisone cream to left side rash on 9/10, 9/11, 9/12, 9/14 and 9/14/24 6:00pm-6:00am shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facilities Charting and Documentation Policy, revised 11/21/20, documents. Purpose: To provide guidance to the facility on required charting and documentation on residents care. Policy: All services provided to the resident, progress toward the care plan goals, or any changes in the residents medical, physical, functional, or psychosocial condition, shall be documented in the residents medical record. The medical record should facilitate communication between the interdisciplinary team regarding the residents condition and response to care. Policy Interpretation and implementation. 2. The following information is to be documented in the resident medical record: c. Treatments or services performed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38780 Based on observation, interview, and record review, the facility failed to provide catheter care for dependent residents and failed to obtain a physician's order for an indwelling urinary catheter for three (R17, R20 and R24) of four residents reviewed for incontinence care/indwelling urinary catheters on the sample list of 21. Findings include: On 9/15/24 at 8:25 am, R20 wasobserved in bed with an indwelling catheter, on 9/15/24 at 8:30am, R17 was observed in R17's wheelchair with an indwelling catheter, and R24 qA observed in bed with an indwelling catheter. 1). R17's Facility Census documents R17 was admitted to the facility on [DATE] and has the following medical diagnoses; Cognitive Communication Deficit, Need for Assistance with Personal Care, Obesity, Dementia, Alzheimer's Disease and Urinary Retention. R17's Minimum Data Set, dated dated [DATE], documents R17's Brief Interview for Mental Status (BIMs) score 6, severe cognitive impairment, having an indwelling catheter and needing assistance from staff for toileting needs. R17's Physicians Order Sheet (POS), dated September 2024, documents catheter care every shift, no documented order for R17's indwelling catheter. R17's Treatment Administration Record (TAR), dated September 2024, documents R17 did not receive catheter care on 9/1/24 on the 6:00pm-6:00am shift, 9/2 and 9/3/24 on the 6:00am-6:00pm and 6:00pm-6:00am shift, 9/4 and 9/5/24 on the 6:00pm-6:00am shift, 9/6/24 and 9/8/24 on the 6:00am-6:00pm and 6:00pm-6:00am, 9/10/24 on the 6:00pm-6:00am shift, 9/11 and 9/12/23 on the 6:00am-6:00pm and 6:00pm-6:00am shift, 9/13 and 9/14/24 on the 6:00am-6:00pm shift and 9/15/24 on the 6:00am-6:00pm and 6:00pm-6:00am shift. 2). R20's Facility Census documents R20 was admitted to the facility on [DATE] and has the following medical diagnoses; Need for Assistance with Personal Care, Chronic Kidney Failure Stage 3, and Urological Trauma. R20's Minimum Data Set, dated dated [DATE], documents R20's Brief Interview for Mental Status (BIMs) score 15, cognitively intact, having an indwelling catheter and needing assistance from staff for toileting needs. R20's Physicians Order Sheet (POS), dated September 2024, documents catheter care every shift, no documented order for R20's indwelling catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's Treatment Administration Record (TAR), dated September 2024, documents R20 did not receive catheter care on 9/2/24 on the 6:00am-6:00pm and 6:00pm-6:00a, shift, 9/3/24 on the 9/4/24 6:00pm-6:00am shift, 9/6 and 9/8/24 on the 6:00am-6:00pm and 6:00pm-6:00am shift, 9/9, 9/10, 9/11, 9/12, 9/14 and 9/15/24 on the 6:00pm-6:00am shift. 3.) R24's Face Sheet, dated 9/18/24, documents R24 has diagnoses including Type 2 Diabetes, Congestive Heart Failure, Neuromuscular Dysfunction Bladder, Infection, and Inflammatory Reaction due to Indwelling Urethral Catheter, and Morbid Obesity. R24's Comprehensive Assessment (MDS), dated [DATE], documents R24 is cognitively intact, dependent on staff for toileting needs and has an indwelling urinary catheter. R24's Physician Order Sheet, dated September 2024, does not have an order for use of a urinary catheter. R24's Treatment Administration Record (TAR), dated September 2024, documents the following: Check Urinary Catheter Every Shift (6a-6p and 6p-6a) and Urinary Catheter Bag Change Every Two Weeks. R24 did not receive catheter care on both shifts on 9/1/24, 9/2/24 and 9/6/24. R24 did not receive catheter care on the 6p-6a shift on 9/5/24, 9/8/24 through 9/12/24, 9/15/24 and 9/16/24. There is no documentation that R24's urinary catheter bag was changed during the month of September 2024. R24's ADL (Activities of Daily Living) Flow Record, dated September 2024, confirms R24 did not receive catheter care on multiple dates in September. On 9/19/24 at 8:37am, V17, Certified Nursing Assistant (CNA), stated the CNA's do the catheter care and tell the nurse on duty, who charts it on the TAR. V17 stated CNA's do not chart in the TAR, but do chart on flow sheets that are in a binder. On 9/19/24 at 8:45am, V8, Registered Nurse, confirmed R24 has an indwelling urinary catheter, and the nurses are to chart the catheter care in the resident TAR. V8 stated there should be an order for a resident to have a catheter in place. On 9/15/24 at 8:35am, V3, Licensed Practical Nurse (LPN), confirmed R17 and R20 have indwelling catheters, and R17 and R20 did not have a physicians order to have them. V3 also confirmed and order for R17 and R20 to receive catheter care every shift, and the care given was documented in R17 and R20 Treatment Administration Record. V3 acknowledge R17's and R20's TAR had numerous days that they did not receive catheter care. On 9/17/24 at 10:15am, V1, Administrator, confirmed R17 and R20 have indwelling catheters and R17 and R20 should have a physicians orders to have them. V1 acknowledges R17 and R20 did not have a physicians order to have indwelling catheter, but had orders for catheter care every shift ,and it should be documented in the residents chart. V1 acknowledges according to R17 and R20's Treatment Administration Record, R17 and R20 did not receive catheter care every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facilities Indwelling Catheter Care Policy, revised 10/7/22, documents: Purpose: To provide guidance to facility staff on the care of residents with an indwelling catheter within the facility to prevent catheter-associated urinary tract infections. Policy: The facility shall maintain and care for catheters per facility, following orders and adhering to facility infection control and best nursing practice and standards.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 35347 Based on observation, interview, and record review, the facility failed to provide nutritional supplementation as-ordered for a nutritionally at-risk resident. This failure affects one resident (R14) of five reviewed for nutrition in the sample list of 21. Findings include: R14's comprehensive assessment (8/24/2024) documents R14 is cognitively intact. R14's diagnoses list (undated/printed 9/17/2024) documents R14 has the diagnosis of protein-calorie malnutrition. R14's dietary notes (8/22/2024) document R14 is at nutritional risk with the intervention of adding nutritional supplements to R14's meals three times a day. R14's care plan (undated/printed 9/19/2024) documents R14 is supposed to receive a nutritional supplement three times a day. On 9/16/2024 at 10:07am, R14 reported R14 is supposed to receive a protein nutritional supplement three times a day with meals, but facility staff only provide one once in awhile. On 9/19/2024 at 12:05pm, R14 was seated in bed eating lunch. R14 did not have any nutritional supplement present with R14's lunch meal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002 Based on observation, interview, and record review, the facility failed to change the oxygen tubing and humidifier bottle for two of three residents (R8, R10) reviewed for respiratory care on the sample list of 21. Findings include: On 9/15/24 at 8:10am, R8 was being administered oxygen via nasal cannula and humidification bottle at two liters per hour, and at 8:20pm, R10 was being administered oxygen via nasal cannula and humidification bottle at two liters per hour. R8 and R10's oxygen tubing and humidifier bottle were not dated or initialed. 1). R8's Facility Census documents R8 was admitted to the facility on [DATE], and has the following medical diagnoses; Combined Systolic (Congestive) Heart Failure, Acute Cystitis with Hematuria, Arthropathy, Pulmonary Embolism and Asthma. R8's Minimum Data Set, dated dated [DATE], documents R8's Brief Interview for Mental Status (BIMs) score 15, cognitively intact and receives oxygen therapy. R8's Physicians Order Sheet (POS), dated September 2024, documents Oxygen two liters per minute as needed to keep oxygen saturation above 92 percent but has no documented order regarding changing oxygen tubing cannula or humidification bottle. R8's Treatment Administration Record (TAR), dated September 2024, has no documentation R8's oxygen tubing/nasal cannula or humidification bottle were changed as ordered. On 9/15/24 at 8:10am, R8 stated, I get oxygen all day long through my nose. R8 stated,Staff sometimes changes my oxygen tubing and water bottle but I don't know when they last time they did. 2). R10's Facility Census documents R10 was admitted to the facility on [DATE], and has the following medical diagnoses; Type 2 Diabetes, Cardiomyopathy, Asthma, Systolic (Congestive) Heart Failure, Chronic Obstructive Pulmonary Disease, Atherosclerotic Heart Disease, and Pneumonia. R10's Minimum Data Set, dated dated [DATE], documents R10's Brief Interview for Mental Status (BIMs) score 14, cognitively intact and receives oxygen therapy. R10's Physicians Order Sheet (POS), dated September 2024, documents Check Oxygen Saturation (O2) every shift, O2 at 2 liters per minute vial nasal cannula during the night from bedtime to morning (AM) as needed to keep O2 saturation above 90 percent. R10's Treatment Administration Record (TAR), dated September 2024, has no documentation R10's oxygen tubing/nasal cannula or humidification bottle were changed as ordered. On 9/15/24 at 8:20am, R10 stated, I have been getting oxygen since I was admitted . I can't remember the last time staff changed my tubing or water bottle.: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/15/24 at 8:35am, V3, Licensed Practical Nurse (LPN), confirmed R8 and R10 were receiving prescribed oxygen per physicians orders. V3 acknowledged R8's and R10's oxygen tubing and humidifier bottles were not dated or initialed. V3 stated, All residents oxygen tubing gets changed on Saturday evening, and it get documented on the residents Treatment Administration Record (TAR). V3 confirmed R8 and R10's TAR has no documentation R8's or R10's oxygen tubing or humidifier bottles were changed in the month of September. Facilities Oxygen Administration Policy, revised 3/17/22, documents; Policy; Oxygen therapy will be administered to the resident upon written order of a licensed physician or may be given in an emergent life-sustaining situation without an order, until an order may be obtained by a licensed physician. It will be administered by way of an oxygen mask, nasal cannula and/or a nasal catheter. 16. Care and use of prefilled humidifiers: A. Prefilled disposable humidifiers will be changed when necessary. I. Label humidifier with date opened. Tubing will be changed and dated weekly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 38780 Based on interview and record review, the facility failed to complete psychotropic medication assessments, failed to identify and track targeted behaviors necessitating use of psychotropic medication, and failed to implement non-pharmacological interventions for behavior management for one (R37) of five residents reviewed for unnecessary medications on the sample list of 21. Findings include: R37's Physician Order Sheet (POS), dated September 2024, documents the following orders: Buspirone (Antianxiety) 10 milligrams (mg) one tablet by mouth twice daily; Amitriptyline (Antidepressant) 25mg one tablet by mouth at bedtime and Olanzapine (Antipsychotic) 15mg one tablet by mouth at bedtime. R37's Medical Record does not document any psychotropic medication assessments, behavior tracking, or psychotropic medication side effects. R37's Care Plan, dated 8/30/24, documents R37 has Schizoaffective Disorder Depressive Type and Borderline Personality Disorder. It also documents R37 takes the following psychotropic medications: Olanzapine, Buspirone, and Amitriptyline for these diagnoses. R37's Care Plan does not document any specific behaviors or non-pharmacological interventions to manage behaviors. On 9/19/24 at 10:05am, V17, Certified Nursing Assistant (CNA), stated CNA's used to have behavioral tracking sheets for R37. V17 stated R37's behavioral tracking sheets are no longer in the ADL (Activities of Daily Living) binder. V17 stated R37 does not have any behaviors. On 9/19/24 at 11:48am, V2, Director of Nursing, stated R37 did not have a psychotropic medication assessment. V2 stated behavior tracking should be on the resident medication administration record (MAR). The facility Psychotropic Medication Protocol (undated) documents the following: Initial Psychotropic Assessment shall be completed. Behavior tracking shall be initiated specific to the medication and the targeted behaviors in POC (Plan of Care). Every shift medication side effect monitoring shall be initiated on the MAR. Care Plan shall be updated to address medication (type and potential side effects) and the diagnosis and behaviors being targeted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 35347 Based on observation, interview, and record review, the facility failed to employ a clinically qualified Director of Food and Nutrition Services. This failure has the potential to affect all 37 residents in the facility. Findings include: On 9/17/2024 at 11:15am, V10 (Dietary Manager) was actively supervising Dietary operations in the facility kitchen. V10 reported being the full-time manager of the facility food service, and reported not being a clinically qualified Certified Dietary Manager, or having equivalent training. V10 denied meeting the State of Illinois standards to be a Food Service Manager or Dietary Manager. V10 reported the facility Dietician only works in the facility one day per month. V10 denied: -being a Dietician; -being a Certified Dietary Manager; -having an associate's or higher degree in food service management or in hospitality; -having 2 or more years of experience in the position of Director of Food and Nutrition Services in a nursing facility setting; -being a graduate of a dietetic and nutrition school or program authorized by the Accreditation Council for Education in Nutrition and Dietetics, the Academy of Nutrition and Dietetics, or the American Board of Nutrition; -being a graduate, prior to July 1, 1990, of a Department (Illinois Department of Public Health) approved course that provided 90 or more hours of classroom instruction in food service supervision and having experience as a supervisor in a health care institution which included consultation from a dietician; -or having completed an Association of Nutrition & Foodservice Professionals approved Certified Dietary Manager or Certified Food Protection Professional course. Throughout the duration of the survey from 9/15/2024-9/17/2024, the facility failed to prevent direct cross-contamination of ice, failed to date and label TCS (time/temperature control for safety) food, failed to prevent the potential for physical cross-contamination of food, and failed to maintain sanitary food storage equipment. The Facility Assessment (4/26/2024) documents a full-time Dietician or other clinically qualified nutrition professional to serve as the Director of Food and Nutrition Services is needed to provide competent support and care for the facility's resident population every day and during emergencies. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/18/2024 at 3:15pm, V10 reported food from the facility kitchen is available for all residents to eat. The facility Long-Term Care Facility Application for Medicare and Medicaid (9/15/2024) documents 37 residents reside in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35347 Based on observation, interview, and record review, the facility failed to prevent direct cross-contamination of ice, failed to date and label TCS (time/temperature control for safety) food, failed to prevent the potential for physical cross-contamination of food, and failed to maintain sanitary food storage equipment. These failures have the potential to affect all 37 residents residing in the facility. Findings include: 1. On 9/15/2024 at 9:57am, the kitchen ice machine bin was completely full of ice. Shiny, pink-colored biological growth (resembling characteristics of Serratia marcesens) was located along an approximate ten inch section of the bottom edge of the condenser cover in direct contact with the ice. On 9/15/2024 at 12:04pm, the ice machine remained as above. On 9/17/2024 at 10:08am, the ice machine remained the same as 9/15/2024. On 9/17/2024 at 10:16am, V10 (Dietary Manager) observed the ice machine, and reported facility Maintenance staff are supposed to clean the machine every three months. V10 reported showing Maintenance staff the machine on 9/16/2024, and telling Maintenance staff the machine needed to be cleaned. 2. On 9/15/2024 at 9:57am, a plastic ice scoop was stored in a caddy located on top of the kitchen ice machine. A dark substance resembling mildew growth was located inside of the caddy where the tip of the scoop rested and outlined the entire tip of the ice scoop. On 9/15/2024 at 12:04pm, the ice scoop remained as above. On 9/17/2024 at 10:08am, the ice scoop remained the same as 9/15/2024. At 10:25am, V10 observed the scoop and stated, Yes the black substance inside of the scoop caddy was mildew, and Dietary staff should be cleaning the scoop and caddy. 3. On 9/15/2024 at 9:59am, the kitchen reach in cooler contained an opened and partially used pillow pack of bologna deli meat, and also a portion of cubed ham in plastic wrap. Neither the bologna pillow pack not the cubed ham package were labeled with the date or time opened or a use-by date for Dietary staff to know when each item must be used or discarded for safety. On 9/15/2024 at 12:04pm, the bologna and cubed ham remained as above. On 9/17/2024 at 10:15am, the cubed ham from above remained the same as 9/15/2024. V10 (Dietary Manager) was present, and reported the ham was supposed to be labeled, and now has to be discarded. 4. On 9/15/2024 at 10:00am, the kitchen table-mounted can opener was excessively soiled with accumulations of metal shavings and deposits of of dark colored, sticky food debris. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/17/2024 at 11:26am, the can opener remained as above. V10 (Dietary Manager) was present, and reported the opener needs to be cleaned, and staff will put it through the dishwasher. 5. On 9/15/2024 at 9:59am, 17 individual servings of nutritional shakes were located in a metal bin on the floor of the kitchen reach in cooler. The shakes, bin, and surrounding cooler floor were covered with sticky orange and red deposits resembling spilled beverages. On 9/17/2024 at 12:04pm, the shakes, bin, and flooring, remained as above. On 9/18/2024 at 3:15pm, V10 reported the food from the facility kitchen is available for all residents to eat. The facility Long-Term Care Facility Application for Medicare and Medicaid (9/15/2024) documents 37 residents reside in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35347 Based on interview and record review, the facility failed to develop a water management plan that included the required risk assessment, control measures, and testing protocols to reduce the risk of growth of Legionella and other pathogens in the facility's water system. This failure has the potential to affect all 37 residents in the facility. Findings include: On 9/18/2024 at 11:50pm, the facility water management plan (undated) fails to document the required facility water system risk assessment where Legionella and other pathogens could grown and spread in the facility water system. The same record did not document the required consideration of the ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) standard or the (CDC) Centers for Disease Control and Prevention Water Management Program toolkit. The plan did not identify any specific testing protocols, acceptable ranges for control measures, or any corrective actions when control limits are not maintained to reduce the risk of waterborne pathogens in the facility water system. On 9/18/2024 at 11:55am, V1 (Administrator) reported the facility did not have any additional policies or records related to Legionella/waterborne infection prevention. On 9/19/2024 at 12:45pm, V19 (Maintenance Director) reported the facility has not completed any water system survey or risk assessment, and has not developed any written policies related to waterborne infection prevention. The facility Long-Term Care Facility Application for Medicare and Medicaid (9/15/2024) documents 37 residents reside in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 38780 Based on interview and record review, the facility failed to document resident infections and antibiotic treatments as required, failed to ensure antibiotic prescriptions were limited to residents meeting nationally recognized surveillance criteria, and failed to document residents' responses to antibiotic therapy. This failure has the potential to affect all 37 residents in the facility. Findings include: The facility Antibiotic Stewardship Policy/Procedure, revised 12/13/23, documents the following: It is the policy of this facility to maintain an Antibiotic Stewardship Program (ASP) with the mission of promoting the appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use. Components of this policy were developed by using evidence-based practice guidelines and are aligned with the Core Elements of Antibiotic Stewardship for Nursing Homes, published by Centers for Disease Control and Prevention (CDC). This Policy did not list what the Core Elements of Antibiotic Stewardship in Long Term Care are. Antibiotic stewardship actions are conducted to enable or to measure these key elements of care: knowing when to be concerned about an infection in a resident, what clinical and historical information to gather for the provider, when to submit diagnostic specimens to the laboratory, how to quantify and assess appropriateness of antibiotics prescribed, and how to identify adverse outcomes that might be associated with antibiotics. Tracking: We will monitor antibiotic use and outcome(s) from antibiotic use. Infection Preventionist will develop a protocol for tracking antibiotic use. The CDC (Center for Disease Control) website lists the Core Elements of Antibiotic Stewardship in Long Term care as enhancing infection prevention and control, controlling source control, prescribing antibiotic when they are truly needed, prescribing appropriate antibiotics with adequate dosages, reassessing treatment when culture results available, using the shortest duration of antibiotics based on evidence, educating staff, supporting surveillance if active medical infections and healthcare acquired infections and supporting an interdisciplinary approach. The facility antibiotic stewardship binder containing monthly Resident Infection Control and Antimicrobial Logs, dated January 2024 through September 2024, fails to document residents' clinical responses or resolutions of infections after beginning antibiotic therapy. The same record fails to provide documentation whether cultures were obtained (where appropriate), whether any testing was done to confirm infections (where appropriate), or if there were any trends in infections, location or any other sources that could be controlled. The same record failed to document any attempts to use a standardized tool to decipher the need for the use of the antibiotic. On 9/18/24 at 11:19am, V2, Director of Nursing, stated all documentation related to antibiotic use, tracking, and cultures should be in the antibiotic stewardship binder. The facility Resident Census and Conditions of Residents report, dated 9/15/24, documents 37 residents reside in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 38780 Based on interview and record review, the facility failed to provide education and offer immunizations for three (R8, R13 and R24) of five residents reviewed for immunizations on the sample list of 21. Findings include: 1.R8's Medical Diagnosis List (current) documents R8 has diagnoses including Congestive Heart Failure, Hypertension, Asthma, and Morbid Obesity. R8's Immunization Record documents R8 received PPSV23 on 10/25/21. Based on the Centers for Disease Control (CDC) and Prevention Pneumococcal Vaccine Recommendations, R8 should have received one dose of PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23. There is no documentation in R8's medical record or Immunization Record the facility provided education regarding the Pneumococcal vaccine, offered the vaccine, or the vaccine was given or declined. On 9/18/24 at 10:08am, R8 stated R8 has not been offered a Pneumococcal vaccine since R8's last Pneumococcal vaccine (10/25/21). R8 stated R8 has requested the vaccine in the past, but has not received it, and would accept the vaccine if it was offered. 2. R13's Face Sheet, dated 9/18/24, documents R13 has diagnoses including Cerebral Infarction, Aphasia, and Thrombocytopenia. R13's Immunization Record documents R13 received PPSV23 on 3/4/22. Based on the CDC's Pneumococcal Vaccine Recommendations, R13 should have received one dose of PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23. There is no documentation in R13's medical record or Immunization Record the facility provided education regarding the Pneumococcal vaccine, offered the vaccine, or the vaccine was given or declined. 3. R24's Face Sheet, dated 9/18/24, documents R24 has diagnoses including Type 2 Diabetes, Congestive Heart Failure, Neuromuscular Dysfunction Bladder, and Morbid Obesity. There is no documentation in R24's medical record or Immunization Record the facility provided education regarding the Influenza vaccine, offered the vaccine, or the vaccine was given or declined for the 2023 Influenza season. On 9/18/24 at 11:19am, V2, Director of Nursing, stated V2 went through R8, R13, and R24's medical charts, and was unable to locate any documentation other than what was provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Pneumococcal Vaccine policy, revised 5/18/22, documents all residents will be offered Pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. The facility Influenza-Prevention and Control revised 9/1/22 documents this facility follows current guidelines and recommendations for the prevention and control of seasonal influenza. It is the responsibility of the Infection Preventionist and/or Director of Nursing, with coordination of the medical director, to ensure all staff, visitors and residents are kept abreast of the influenza policy. It is the responsibility of all staff to adhere to the guidance. 1. The Infection Preventionist organizes and oversees an annual influenza vaccine campaign. 2. All residents and staff are offered the vaccine prior to the onset of the influenza season. 3. All residents and staff are encouraged to receive the vaccine unless there is a medical contraindication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145610	A. Building B. Wing	09/19/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 35347 Based on observation, interview, and record review, the facility failed to maintain a functional wheelchair arm rest in use by a resident. This failure affects one resident (R2) of three reviewed for resident equipment in the sample list of 21. Findings include: R2's quarterly assessment (8/14/2024) documents R2 is cognitively intact and uses a wheelchair for mobility. R2's diagnosis list (undated/printed 9/18/2024) documents R2 has the diagnosis of Spastic Quadriplegic Cerebral Palsy (abnormal development or damage to the parts of the brain that control movement, balance, and posture affecting a person's ability to move, balance, and maintain posture). R2's Care Plan (printed 9/18/2024) documents R2 is at risk for pain related to Cereral Palsy and at risk for impaired skin integrity including pressure injuries, and has medications/diagnoses that may affect skin integrity. On 9/16/2024 at 11:10am, R2 was seated in R2's wheelchair, with R2's right arm resting on R2's lap. R2's wheelchair was missing the entire right-side arm rest ,with the narrow tubular steel frame normally located below the arm rest fully exposed. R2 stated a retaining screw broke, and the padded arm rest had been missing for quite a while, and reported facility staff being aware of the concern. On 9/19/2024 at 11:30am, R2's missing wheelchair arm rest remained the same as above.