

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145964	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER McLeansboro Rehab & Hlth C Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 405 West Carpenter McLeansboro, IL 62859	
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** 49714 Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded for 1 (R8) of 12 reviewed for accuracy of assessments in the sample of 23. Findings Include: R8's Admission Record documented R8 is [AGE] years old with an Initial admitted to the facility of 01/03/2019. Diagnoses listed on this document included anxiety disorder, schizophrenia, anemia, depression, and unspecified dementia. The OBRA Initial Screen for R8 dated 09/04/2017 documented under Part III, The individual has been formally diagnosed with a mental illness verified by a DSMIV classification which subsequently impairs the person's cognitive, emotional and/or behavioral functioning, excluding organic disorders/dementia, developmental disabilities, and alcohol/substance abuse. This section had an X marked to indicate the answer Yes. This OBRA Initial Screen also documented that R8 had a history of psychiatric hospitalization , a history of outpatient mental health services and listed R8's mental illnesses. The document further notes that R8 was referred to a health system for services on 09/11/17. R8's Interagency Certification of Screening Results dated 09/11/2017 documented screening indicated that nursing facility services are appropriate. R8's MDS with an Assessment Reference Date of 01/16/2024 documented this MDS as being an annual assessment. Section A1500 Preadmission Screening and Resident Review (PASRR) asked Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability .or a related condition? This question had a 0 marked to indicate the answer No. This same MDS in Section I Active Diagnoses had a checkmark under Psychiatric/Mood Disorder with an X marked for I6000 Schizophrenia, indicating this was an Active diagnosis for R8. On 6/05/24 at 8:55 AM, V2 (MDS/Care Plan Coordinator) stated that no one in the facility is a Level II. V2 further stated that R8's dementia diagnosis outweighs her schizophrenia diagnosis, so a Level II was not needed. V2 stated she will check into it. On 06/05/24 at 2:43 PM, V2 stated that she had submitted a new PASARR. On 06/06/2024 at 11:35 AM, V2 stated that the facility should have completed a new PASARR when she was diagnosed with Dementia.		

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

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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** 49663 Based on interview and record review, the facility failed to add new person centered fall interventions to prevent falls for 1 (R120) of 2 residents reviewed for falls in the sample of 23. The findings include: R120's Admission Record documented R120 was [AGE] years old with an admitted to the facility of 3/11/2023. Diagnoses listed include unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, coronary artery dissection, essential (primary) hypertension, disorder of thyroid, unspecified, hyperlipidemia, unspecified, type 2 diabetes mellitus without complications, insomnia unspecified, unspecified osteoarthritis, unspecified site, muscle weakness (generalized), hypomagnesemia and other forms of dyspnea. R120's Minimum Data Set (MDS) section C, dated 5/8/2024, documents that R120 has a Brief Interview for Mental Status (BIMS) score of 5, indicating R120 has severe cognitive impairment. The same MDS section GG0170, Mobility documents that R120 needs supervision or touching assistance and device uses a cane/crutch. R120's Fall Risk assessment dated [DATE] documents a score of 20, which indicates that R120 was a high risk for falls. R120's Investigation Report for Falls dated 5/8/2024 documents resident was found sitting on buttocks on the floor with back against her bed. Resident attempted to get out of bed related to confusion (chronic) without assist. No new interventions were listed or noted on this document. R120's Care Plan dated 3/11/2023 documents a focus area of The resident is at risk for falls, risk for injury from fall with a documented goal of the resident will be free of falls, free of injury from falls through the next review date. Interventions included call light in reach, personal items in reach, proper footwear, staff assist/standby for all transfers with an implementation date of 3/11/2023 and walk per staff to dining room with an implementation date of 2/15/2024. There were no new interventions listed as being added/implemented to the care plan to prevent further falls after the 5/8/24 fall incident. On 6/05/2024 at 1:42 PM, V3 (Director of Nursing/DON) stated she was not aware that R120 had a fall on 5/8/2024. V3 stated she found the fall investigation today in the to be filed paperwork. V3 stated there was no new intervention put in place for R120 after the 5/8/2024 fall. V3 stated the facility policy does document new interventions should be immediately put in place, the fall reviewed in morning meetings and then additional fall interventions if needed after reviewing the fall investigation. On 6/06/2024 at 9:15 AM, V2 (MDS Coordinator) stated all falls are communicated to V1 (Administration) and V3 (DON) and discussed in the morning meetings. V2 stated new interventions are entered into resident Care Plans by V2 and/or V3. V2 stated she was not notified of R120's fall on 5/7/2024 and no new intervention was added to her care plan. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fall Prevention policy with revised date of 11/10/2018 documents .5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the certified nurse assistant assignment worksheet .		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 36384 Based on interview and record review, the facility failed to have a Registered Nurse working 8 consecutive hours a day, 7 days a week. This failure has the potential to affect all 30 residents residing in the facility. The Findings Include: On 6/6/24 at 11:00 AM, V3 (Director of Nursing/DON) stated that there are weekends that she sometimes cannot get covered with a Registered Nurse (RN) working. V3 further stated that they do not use a staffing agency, but they have a PRN (as needed) float pool within the company and a list of facility specific PRN RN's that they attempt to have cover these shifts. V3 stated that they do have advertisements out to hire RN's but if there are times they cannot get RN's to cover the shift they use their LPN (Licensed Practical Nurses) staff. On 6/6/24 at 11:13 AM, V1 (Administrator) stated that there are days that no RN works 8 hours a day minimum, but that all her nursing staff are either licensed or registered. Nursing schedules reviewed for May revealed that no RN worked on 5/18/24, 5/19/24 and 5/31/24. The June scheduled revealed that no RN worked on 6/1/24 or 6/2/24. The Long Term Care Facility Application for Medicare and Medicaid dated 6/4/24, documents that 30 residents reside in the facility.		