

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Monmouth Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  117 South I Street Monmouth, IL 61462	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interview and record review the facility failed to ensure a resident's rights were maintained for one of three residents (R2), reviewed for resident rights, in sample of 5.</p> <p>Findings include:</p> <p>The (undated) facility Resident Rights for People in Long Term Care Facilities form documents, As a long-term care resident in (State), you are guaranteed certain rights, protections and privileges according to state and federal laws. Your rights to safety: You must not be abused, neglected or exploited by anyone- physically, financially, verbally, mentally or sexually. Your facility must be kept safe, clean, comfortable and homelike.</p> <p>R2's current Minimum Data Set Assessment, dated 5/21/25 documents, Section C-Cognitive Patterns: 13:15 (Cognitively intact).</p> <p>R2's Nursing Progress Notes, dated 3/12/2025 at 9:38 P.M. document, (R2) was sitting in her room and (R1) entered (R2)'s room and was seen having a shoe in her hand and it appeared that (R1) struck (R2) on the shoulder. No injuries were noted, (R2) stated that she was not hurt but was fearful of (R1).</p> <p>R2's Nursing Progress Notes, dated 5/23/2025 at 4:06 A.M. document, (R2) called for this nurse to ask me to get (disinfectant) out of her closet and spray her room as (R1) pooped all over her floor. (R2) states that she was sleeping and opened her eyes to (R1) pooping on the floor right by her chair and there was poop all over her bed as well as (R1) climbed into (R2)'s bed afterward.</p> <p>On 6/28/25 at 8:52 A.M., R2 was seated in a wheelchair in her room. R2 was alert and oriented to person, place, time. R2 states she has had an adjoining room with (R1) for the past few months. R2 states she currently has a slide lock on the outside of her bathroom door, that she shares with (R1). R2 states staff finally placed it there as (R1) comes through the bathroom door frequently. R2 states (R1) has come into her room many, many times and urinated and defecated on her floor and bed. R2 states at one time, (R1) came in her room and threw a shoe at her and hit her with the shoe. R2 states (R1) has come into her room and thrown a pitcher of water at her. R2 states she keeps the bathroom door locked, but (R1) will enter her room through the room door at all times of the day and night. R2 states she feels afraid in the facility, that (R1) acts menacing towards her and states she has told (V1/Administrator) and (V2/Director of Nurses) multiple times of these incidents, and the only thing they have done is placed the lock on the bathroom door, which does not stop (R1) from still entering her room.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/30/25 at 9:43 A.M., V11/Social Services Director (SSD) stated she is aware of a situation where (R1) came into (R2's) room while (R2) was sleeping and was standing over her. V11/SSD stated (R2) came to her very upset about the situation and (R2) stated she was afraid of (R1). V11/SSD states (R2) told her she woke up in the middle of the night and was very frightened as (R1) was standing over her bed and took some of her clothing that was laying in her chair. (R2) also stated that (R1) removed her pants and defecated and urinated on her floor and bed. (R2) stated she was able to pull her call light and when staff came, they removed (R1) from (R2's) room. V11/SSD stated the solution the facility came up with was to place a lock on (R2's) bathroom door, so that (R1) couldn't enter via the adjoining room. V11/SSD acknowledged that the lock doesn't stop (R1) from entering (R2's) room via the room door.</p> <p>On 6/30/25 at 11:48 A.M., V1/Administrator confirmed the incident on 3/12/25 when (R1) hit (R2) with a shoe. V1/Administrator confirmed (R1) wanders and frequently goes into (R2's) room.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on interview and record review, the facility failed to protect two of two residents (R2 and R5) from physical abuse by another resident (R1), in a sample of five.</p> <p><b>FINDINGS INCLUDE:</b></p> <p>The facility policy, Resident Right to Freedom from Abuse, Neglect and Exploitation, dated October 16, 2023, directs staff, The facility's residents have the right to be free from abuse, neglect, misappropriation of their property and exploitation. The facility shall review altercations from resident to resident as a potential situation of abuse. Staff shall monitor for any behaviors that may provoke a reaction by residents or others which include Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects.</p> <p>1. The facility form, Physical Aggression, dated 3/12/2025 at 6:50 P.M., documents, Staff member reported that when she entered (R2)'s room, she saw (R1) strike (R2) on the shoulder with a shoe. (R1) was redirected back to her room. (R1) was experiencing increased agitation and demanded that her daughter be called and (R1) thought (R2) had her belongings. POA (Power of Attorney), M.D. (Medical Doctor) and (V1) Administrator notified. Statements: (V12/Certified Nursing Assistant) was in the bathroom with (R2). (R1) kept opening the door and told them to get out. (V12/CNA) told (R1) she was helping someone. (V12/CNA) finished with (R2) and wheeled her out of the bathroom and took dirty clothes to the utility room. When (V12/CNA) arrived back to room, (R1) was in (R2)'s room with two shoes in her hand and (R1) tapped (R2) on the back. (State Agency) notified on June 30, 2025. Local Police Department notified on 3/12/25.</p> <p>R1's Nursing Progress Notes, dated 3/12/2025 at 9:38 P.M. document, (R2) was sitting in her room and (R1) entered her room and was seen having a shoe in her hand and it appeared that (R1) struck (R2) on the shoulder. No injuries were noted and (R2) stated that she was not hurt but was fearful of (R1). POA, Administrator, MD were all notified.</p> <p>On 6/28/25 at 8:52 A.M., R2 stated she has an adjoining bathroom with R1. States at one time, R1 came in her room and threw a shoe at her and hit her with the shoe. States R1 has come into her room and thrown a pitcher of water at her. States she keeps the bathroom door locked, but R1 will enter her room through the room door at all times of the day and night. States she feels afraid in the facility, that R1 acts menacing towards her and states she has told (V1/Administrator) and (V2/Director of Nurse) multiple times of these incidents, and the only thing they have done is placed the lock on the bathroom door, which does not stop R1 from entering her room.</p> <p>On 6/30/2025 at 11:48 A.M., V1/Administrator confirmed the incident on 3/12/25 when R1 hit R2 with a shoe. V1 confirms that the incident was a potential abuse incident but states she did not do an abuse investigation nor notify the State Agency of a potential abuse incident as she states despite the fact (V12/CNA) witnessed R1 hitting R2 with a shoe, when she interviewed R2, the resident stated R1 did not make contact with her.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/30/2025 at 12:15 P.M., R2 stated the facility administrator (V1) did not interview her concerning the incident with R1 (on 3/12/25). R2 also states she would not have said R1 didn't hit her, as R1 did in fact pick up a shoe, come into R2's room and hit her with the shoe. R1 states (V12/CNA) witnessed R1 hit R2.</p> <p>On 6/30/2025 at 12:50 P.M., V13/Licensed Practical Nurse stated, I did not witness the incident when (R1) hit (R2) with a shoe. I did talk to (R2) about the incident, and she told me that R1 entered her room and hit her hard with a shoe. I reported it to (V1/Administrator) and (V2/Director of Nurses).</p> <p>On 6/30/2025 at 2:08 P.M., V12/Certified Nursing Assistant states she did witness (R1) tap (R2) on the shoulder with a shoe. V12 states she didn't know how hard R2 was hit, but she did immediately report the incident to (V13/LPN) who was the nurse on duty at the time.</p> <p>2. R1's Nursing Progress Notes, dated 6/27/2025 at 9:37 A.M., document, (R1) was noted to be sitting in wheelchair with oxygen on self-propelling around nurses station area. When another resident (R5) came up the hallway (R1) proceeded to grab (R5)'s hair. When (R5) hollered out (R1) released (R5) and grabbed (R5)'s walker attempting to take the walker from (R5). Separated both parties immediately. HCPOA (Health Care Power of Attorney), (Physician), V1/Administrator) and (V2/Director of Nurses) notified at this time.</p> <p>On 6/30/2025 at 10:06 A.M., V9/Licensed Practical Nurse (LPN) stated she was the nurse present on 6/27/25 when R1 reached up and grabbed R5's hair, when (R5) was walking past. (V9/LPN) states (R5) yelled out when her hair was grabbed. (V9/LPN) states she reported the incident to V1/Administrator and V2/DON as she felt the incident was potential abuse. V9 states she documented the incident in R1's Progress Notes.</p> <p>On 7/1/2025 at 9:00 A.M., V1/Administrator stated she only became aware of the 6/27/25 situation involving R1 pulling R5's hair and grabbing at her clothing, yesterday. At that time, V1 confirmed she had not immediately begun an investigation of the allegation of abuse, nor had she reported the incident to the State Agency.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on interview and record review, the facility failed to implement its abuse policy of immediately reporting abuse to the State Agency and investigating an allegation of resident-to-resident physical abuse for two separate occurrences, for three of three residents (R1, R2, and R5) reviewed for abuse in the sample of 5.</p> <p>Findings include:</p> <p>The facility policy, Resident Right to Freedom from Abuse, Neglect and Exploitation, dated October 16, 2023, directs staff, When the facility has identified abuse, the Facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The Facility will increase enforcement action, including, but not limited to: Taking steps to prevent further potential abuse; Reporting the alleged violation and investigation within required timeframe's pursuant to Federal and State statutes and regulations; Conducting a thorough investigation of the alleged violation.</p> <p>1. The facility form, Physical Aggression, dated 3/12/2025 at 6:50 P.M., documents, Staff member reported that when she entered (R2)'s room, she saw (R1) strike (R2) on the shoulder with a shoe. (R1) was redirected back to her room. (R1) was experiencing increased agitation and demanded that her daughter be called and (R1) thought (R2) had her belongings. POA (Power of Attorney), M.D. (Medical Doctor) and (V1) Administrator notified. (State Agency) notified on June 30, 2025. Local Police Department notified on 3/12/25.</p> <p>On 6/30/2025 at 11:48 A.M., V1/Administrator confirmed the incident on 3/12/25 when R1 hit R2 with a shoe. V1 confirms that the incident was a potential abuse incident but states she did not do an abuse investigation nor notify the State Agency of a potential abuse incident.</p> <p>2. R1's Nursing Progress Notes, dated 6/27/2025 at 9:37 A.M., document, (R1) was noted to be sitting in wheelchair with oxygen on self-propelling around nurses station area. When another resident (R5) came up the hallway (R1) proceeded to grab (R5)'s hair. When (R5) hollered out (R1) released (R5) and grabbed (R5)'s walker attempting to take the walker from (R5). Separated both parties immediately. HCPOA (Health Care Power of Attorney), (Physician), V1/Administrator) and (V2/Director of Nurses) notified at this time.</p> <p>On 7/1/2025 at 9:00 A.M., V1/Administrator stated she only became aware of the 6/27/25 situation involving R1 pulling R5's hair and grabbing at her clothing, yesterday. At that time, V1 confirmed she had not immediately begun an investigation of the allegation of abuse, nor had she reported the incident to the State Agency.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to ensure two allegations of abuse were immediately reported to the State Agency for three of three residents (R1, R2, and R5) reviewed for abuse in the sample of 5.</p> <p>Findings include:</p> <p>1. R2's Nursing Progress Notes, dated 3/12/2025 at 9:38 P.M. document, (R2) was sitting in her room and (R1) entered her room and was seen having a shoe in her hand and it appeared that (R1) struck (R2) on the shoulder. No injuries were noted and (R2) stated that she was not hurt but was fearful of (R1). POA (Power of Attorney), Administrator, MD (Medical Doctor) were all notified.</p> <p>On 6/30/2025 at 11:48 A.M., V1/Administrator confirmed the incident on 3/12/25 when R1 hit R2 with a shoe. V1 confirms that the incident was a potential abuse incident but states she did not do an abuse investigation nor notify the State Agency of a potential abuse incident.</p> <p>2. R1's Nursing Progress Notes, dated 6/27/2025 at 9:37 A.M., document, (R1) was noted to be sitting in wheelchair with oxygen on self-propelling around nurses station area. When another resident (R5) came up the hallway (R1) proceeded to grab (R5)'s hair. When (R5) hollered out (R1) released (R5) and grabbed (R5)'S walker attempting to take the walker from (R5). Separated both parties immediately. HCPOA (Health Care Power of Attorney), (Physician), V1/Administrator) and (V2/Director of Nurses) notified at this time.</p> <p>On 7/1/2025 at 9:00 A.M., V1/Administrator stated she only became aware of the 6/27/25 situation involving R1 pulling R5's hair and grabbing at her clothing, yesterday. At that time, V1 confirmed she had not immediately begun an investigation of the allegation of abuse, nor had she reported the incident to the State Agency.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on observation and record review, the facility failed to investigate two allegations of abuse for three of three residents (R1, R2, and R5) reviewed for abuse, in the sample of 5.</p> <p>Findings include:</p> <p>The facility policy, Resident Right to Freedom from Abuse, Neglect and Exploitation, dated October 16, 2023, directs staff, When the facility has identified abuse, the Facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The Facility will increase enforcement action, including, but not limited to: Conducting a thorough investigation of the alleged violation.</p> <p>1. The facility form, Physical Aggression, dated 3/12/2025 at 6:50 P.M., documents, Staff member reported that when she entered (R2)'s room, she saw (R1) strike (R2) on the shoulder with a shoe.</p> <p>On 6/30/2025 at 11:48 A.M., V1/Administrator confirmed the incident on 3/12/25 when R1 hit R2 with a shoe. V1 confirms that the incident was a potential abuse incident but states she did not do an abuse investigation.</p> <p>2. R1's Nursing Progress Notes, dated 6/27/2025 at 9:37 A.M., document, (R1) was noted to be sitting in wheelchair with oxygen on self-propelling around nurses station area. When another resident (R5) came up the hallway (R1) proceeded to grab (R5)'S hair.</p> <p>On 7/1/2025 at 9:00 A.M., V1/Administrator stated she only became aware of the 6/27/25 situation involving R1 pulling R5's hair and grabbing at her clothing, yesterday. At that time, V1 confirmed she had not immediately begun an investigation of the allegation of abuse.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to implement fall precautions for one of three residents (R1), reviewed for falls, in a sample of 5.</p> <p>Findings include:</p> <p>The facility policy, Fall Reduction policy, dated (revised) November 5, 2019, directs staff, Purpose: To provide an environment that remains as free of accident hazards as possible. To identify residents who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent or minimize fall related injuries. Residents with a Fall Risk Assessment score greater than 10 should be considered to be at high risk for falling. Identified risk factors should be addressed in the resident's Care Plan to assure individualized interventions to reduce the risk are implemented.</p> <p>R1's facility admission Record documents that R1 was admitted to the facility on [DATE] with the following diagnoses: Paroxysmal Atrial Fibrillation, Unsteadiness on Feet, Dementia, Anxiety, Chronic Respiratory Failure and Osteoarthritis.</p> <p>R1's current Care Plan, dated 3/15/25 documents that R1 is, High Risk for Falls with previous falls on 4/23/25, 4/23/25, 4/27/25, 4/30/25, 5/14/25, 6/6/25, 6/7/25, 6/14/25, 6/15/25, 6/20/25, 6/22/25, 6/24/25 and 6/29/25. This same plan of care includes the following Interventions: Gripper socks.</p> <p>On 6/28/25 at 8:35 A.M., R1 was sitting in the hallway, across from nurse's station, in a recliner, with her feet on the floor. At that time, R1 had no socks or gripper grips on. V3/Registered Nurse was standing next to R1, preparing to pass morning medications. At 8:57 A.M., R1 remained seated in the recliner, with her bare feet on the floor, with no gripper socks on.</p> <p>On 6/30/25 at 8:34 A.M., R1 was seated in a wheelchair at nurse's station, attempting to stand from the chair. R1's feet were bare, with no gripper socks in place. V9/Licensed Practical Nurse (LPN) was seated at the nurse's station, attempting to get R1 to sit down. At that time V9/LPN verified R1 was to wear gripper socks at all times as she had sustained many falls and was at high risk for further falls.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to date and store oxygen equipment as ordered for two of three residents (R1 and R4) and failed to administer oxygen at the prescribed rate for (R4), reviewed for oxygen, in a sample of 5.</p> <p>Findings include:</p> <p>The facility policy, Oxygen Administration and Storage, dated (revised) March 8, 2022, directs staff, To ensure staff follow safety guidelines and regulation for storage and use of oxygen. Verify provider's order for the procedure. Turn on oxygen and set flow rate to prescribed amount. Label the tubing connected to the oxygen cylinder with time and date. The nasal cannula or mask should be changed weekly or when soiled. Nasal cannula should be stored in a manner to prevent touching the floor when not in use. The humidifier bottle is to be labeled with the date of application and changed weekly if refillable.</p> <p>1. R1's facility admission Record documents that R1 was admitted to the facility on [DATE] with the following diagnoses: Paroxysmal Atrial Fibrillation, and Chronic Respiratory Failure.</p> <p>R1's current Physician Order Sheet, dated June 2025 includes the following physician orders: Oxygen at 3 liters via nasal cannula continuously with humidification; Oxygen tubing change weekly, label each component with date and initials every 28 days; Change Humidifier Bottle weekly, date and time on bottle at change.</p> <p>On 6/28/25 at 8:35 A.M., R1 was sitting in the hallway, across from the nurse's station, in a recliner. R1's fingertips, feet and lower legs were cyanotic. R1 was not currently wearing oxygen, the oxygen tubing was lying in a wheelchair, next to R1. The oxygen tubing and humidifier bottle were undated. The oxygen tubing was connected to a portable oxygen tank that registered refill. V2/Registered Nurse was standing next to (R1), passing morning medications. At 8:55 A.M., an observation of (R1)'S room shows the oxygen concentrator in (R1)'S room still running, despite (R1) not being present in the room. Undated oxygen tubing was laying on the floor. At 8:57 A.M., while R1 remained seated at the nurse's station, V3/RN applied oxygen to 1) via a portable oxygen machine. At that time, V3/RN confirmed that R1 had a physician's order for continuous oxygen. V3/RN stated that R1 would frequently remove her oxygen. V3/RN also confirmed the undated oxygen tubing and oxygen humidifier.</p> <p>2. R4's facility admission Record documents that R4 was admitted to the facility on [DATE] with the following diagnoses: Acute and Chronic Respiratory Failure with Hypoxia, Chronic Cor Pulmonale, Chronic Congestive Heart Failure and Pan lobular Emphysema.</p> <p>R4's current Physician Order Sheet, dated June 2025 includes the following physician orders: Oxygen at 2 liters via nasal cannula continuously with humidification; Oxygen tubing change weekly, label each component with date and initials every 28 days; Change Humidifier Bottle weekly, date and time on bottle at change.</p> <p>On 6/28/25 at 9:07 A.M., R4 was seated in a chair in her room. R4 had continuous oxygen running at 3 liters via a nasal cannula, per an oxygen concentrator. R4's oxygen tubing and the humidifier were undated.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Monmouth Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  117 South I Street Monmouth, IL 61462	
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/28/25 at 9:20 A.M., The undated oxygen tubing and humidifier was verified with V3/Registered Nurse (RN). At that time V3/RN also confirmed that R4's oxygen flow rate should be 2 liters per minute.</p> <p>On 6/30/25 at 8:32 A.M., R4 was up in her wheelchair in her room. R4's oxygen was continuous at 3 liters via a nasal cannula. R4's oxygen tubing remained undated.</p>		