

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009328</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/21/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUNSET REHABILITATION &amp; HLTH C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>129 SOUTH 1ST AVENUE CANTON, IL 61520</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	Initial Comments  Complaint Investigation  1724421/IL95645	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.1210b) 300.1210d)6) 300.3240a)  Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:  d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:  6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>08/04/17</b>
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S9999	<p>Continued From page 1</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on record review and interviews the facility failed to prevent one of three residents (R1) reviewed for elopement risk in a sample of three from leaving the facility unsupervised. On 7/20/17 R1 walked out of facility undetected and fell across from the hospital. R1 suffered abrasions to his forehead and an avulsion to his nose.</p> <p>Findings include:</p> <p>R1's current care plan dated 5/9/17 notes that R1 is at risk for self harm due to "He wanders and will go into other residents rooms" which is related to his dementia.</p> <p>Facility incident investigation form notes that R1 left the facility on 7/20/17 by going out the door with another resident's visitor that would have dis-alarmed the door. Facility estimated that R1 left between 6 P.M. and 6:15 P.M. walked four tenths of a mile and fell around 6:20 P.M. across from the hospital. R1 was taken to the hospital per ambulance and treated for his abrasions on his forehead and nose.</p> <p>Hospital emergency room note report reads, "Long history of dementia, at least 5 years, hx of seizures on Dilantin. Medics called because patient (R1) seen to be on the ground close to the hospital, was bleeding from avulsion on the nose, was groggy on arrival of medics, fall not witnessed, unknown if seizure, mentation</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>improved enroute. Patient is a poor historian due to dementia but denies current illness. He struck right forehead and nose and says his cheeks hurt and left knee is a little sore but denies neck, back, rib or arm pain."</p> <p>On 7/21/17 at 9:13 A.M. E4 (R1's POA and Environmental Supervisor) stated that R1 had said that the reason he left the facility was he thought he had to go home and go to church.</p> <p>On 7/21/17 at 9:00 A.M. E1 (Administrator) stated that R1 must have gotten out with a visitor and that at that time there is no staff at the door to monitor. E1 stated that R1 is now on 15 minute checks and is now considered high risk for elopement.</p> <p>(B)</p>	S9999		
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