

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006555	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2022
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NAME OF PROVIDER OR SUPPLIER NOKOMIS REHAB & HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 STEVENS STREET NOKOMIS, IL 62075
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S 000	Initial Comments Complaint Investigations 2247454/IL151320 and 2247650/IL151543	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.3240 a) 300.3240 b) 300.3240 c) 300.3240 d) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator.</p> <p>c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department.</p> <p>d) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)</p> <p>These regulations are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident was free of physical abuse; failed to report allegations of abuse to the Administrator immediately and report to the Illinois Department of Public Health (IDPH); failed to investigate an allegation of physical and verbal abuse; and failed to protect</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>residents from further abuse by failing to remove the accused employee from resident contact for 1 of 4 residents (R2) reviewed for abuse in the sample of 7. This failure resulted in R2's physical and verbal abuse, sustaining bruising and swelling to her arms.</p> <p>Findings include:</p> <p>R2's Minimum Data Set (MDS), dated 8/25/2022, documents R2 is severely impaired for cognitive skills for decision making, requires extensive assistance with one person physical assist for dressing and toileting, requires supervision for walk in corridor and eating.</p> <p>R2's Care Plan, undated, documents R2 has impaired cognition results in repetitive verbalization and /or wandering behavior related to diagnosis to Dementia. Interventions, dated 9/13/2022, include provide supervision, approach calm, offer assistance and attempt to redirect, accompany resident to go where desired.</p> <p>R2's Nurse's notes, dated 9/3/22 at 8:52 PM, documents, "(R2) worked up all day/evening. (R2) tried to escape facility thirteen times throughout the day shift. At (9:47) AM writer notices some yellowish discoloration around (R2's) eyes and nose. CNA's approached writer about two blue areas on sides of bridge of nose. Writer tried to talk to (R2) about areas but (R2) unable to explain areas due to mental cognition. CNA went to take (R2) to the bathroom and upon approaching (R2) became fearful, and flinched when being spoken to. (R2) appears to have a swollen left wrist ascending to mid forearm and bruise present to top of left hand. (R2) would not allow writer to measure areas and appeared to be in pain when left arm was touched due to (R2)</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>grimacing and aggressiveness when trying to look at areas. Writer attempted to give (R2) PRN (as needed) Tylenol, (R2) refused. DON aware of areas at (1:13PM) and Administrator aware at (5:23 PM). MD (medical doctor) called at 11:52AM and areas explained to MD. MD gave order to mx (monitor) areas and to call MD with any changes in swollen/bruised areas. (R2) was one on one all day by writer or CNA's due to being exit seeking, aggressive, anxious/scared. Vital signs were unable to get due to (R2) being aggressive."</p> <p>There was no documentation of a report to the Department of R2's injury of unknown origin (IOU) on 9/3/2022 and no documentation of any investigation of IOU.</p> <p>On 9/20/2022 at 2:32 PM, V9, Certified Nursing Assistant (CNA) said on September 1, 2022 she and another CNA, V10, were going to redirect R2, as she was walking up and down the hallways. V9 stated around midnight, R2 was near an exit door, and they went to redirect her away from the door. V9 stated they didn't need any help, R2 wasn't having any issues except walking up and down the hallway. V9 stated then V13, Licensed Practical Nurse (LPN), walked down where they were with R2, and grabbed R2's left arm, turned her around fast, and R2 almost fell by tripping on her own feet. V9 stated then V13 forced R2 to walk with her to the TV room, told R2 to sit down in a stern voice, turned the lights off in the TV room, and shut the door. V9 stated V13 said to them "(R2) is laying down and going to bed." V9 stated R2 did not want to lie down, she didn't want to sleep right then. V9 stated, "I feel like this is abuse." V9 stated they were afraid to call V1, Administrator, because she just puts things under the rug and it doesn't do any good to report</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>anything to her, but V10 did call V1 later that night. V9 stated when V10 called V1, V1 said she would call V13. V9 stated, "I said, no, we are still here working with her. I told (V1) I felt like this is abuse." V9 stated the next morning V2, Director of Nursing (DON), was the relief nurse, and V9 reported to V2 what happened during the night with R2. V9 stated this abuse to R2 was not investigated because she (V9) was never questioned, or filled out any paperwork. V9 stated V13 remained working the entire shift, and is still working here.</p> <p>On 9/21/2022 at 6:08 AM, V10, CNA, said she witnessed V13, LPN, being physically and verbally abusive to R2. V10 stated it happened around midnight on 9/01/22 into 9/02/22. V10 said she and V9, CNA, were walking down the hallway, and saw R2 near the breakroom door. V10 stated they both walked down to R2 to redirect her from the exit door. V10 stated V13 was at the Nurse's station, then walked down the hall to where they were redirecting R2. V10 stated V13 grabbed R2 by her left arm, and "jerked her around to where (R2) almost fell by tripping on her own feet. (V13) was basically pulling her fast down the hallway, like dragging her feet, with (R2) saying 'you're hurting my arm.'" V10 stated V13 took R2 to the TV room, put her on the couch, turned off the lights, and shut the door. V10 stated V13 left R2 sitting alone. V10 stated around 3:00AM, R2 got up and was walking in the hallway. R2 appeared scared. V10 stated R2 typically does not follow them room to room. R2 would wait at the resident's door until V10 and V9 would come back out to the hallway, then would follow them to the next room. V10 stated they went inside to give care to other residents, and R2 waited for them to come back out. V10 stated, "I called (V1, Administrator) regarding the</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>abuse that happened. I called (V1) around 1 or 2 am. (V1) said she would call (V13, LPN) to discuss the incident. I said to (V1) not to because we was still working with (V13) who did the abuse. I told (V1) that's a 'conflict of interest.' (V1) asked if (R2) was in danger, I said, 'Yes' and (R2) was with us CNAs." V10 said she was afraid to call V1 because "nothing gets done around here when anything is reported in the past when other issues happened we don't get questioned."</p> <p>On 9/20/2022 at 1:40 PM, V10, CNA, said, "After I reported this abuse, no investigation has been done. I kept waiting two or three days for (V1) to call me and she (V1) never did. Two or three days after the incident, (R2) had bruises on her left arm."</p> <p>On 9/20/2022 at 10:26 AM, V6, CNA, said, "I came in that night of the incident at 2AM on Friday, September 2, 2022, and was told by two different CNAs (V10 and V9) what happened to (R2) by (V13, LPN). I found (R2) sitting on the couch in the TV room with (V9) because (V9) felt (R2) was unsafe with the nurse still here after what had happened that night." V6, CNA, stated she saw the CNAs unloading blankets from the washer when (R2) came out of the TV room by the door closest to the dining room, then V13 walked up to R2 and told her to "go sit the mother f***** down." V6 stated R2 was very frightened and then followed her and the other two CNAs the rest of the night until morning. V6 stated, "If we went into another resident's room, (R2) would stand outside the resident's room waiting on us and then continued to follow us. She (R2) seemed anxious, upset and scared." V6 stated, "(V13) bullies me and I was afraid to report to the Administrator because of the bullying by (V13) to myself. She (V13) is friends with (V1). (V1)</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>shoves anything under the rug and won't do anything. I did report the very next morning because (V2) DON (Director of Nursing) was working the next morning; she was (V13's) relief that morning." V6 stated V2 told her she would talk to V1 about the verbal abuse V6 heard V13 say to R2 that morning.</p> <p>On 9/20/22 at 1:15PM, V2, Director of Nursing (DON), said, she came into work about 5:50AM. V2 stated she was stopped outside the door by the night shift CNA (V6, CNA). V2 stated V10 began telling her about V13, LPN, and R2 saying she didn't agree with how V13 was being rough with R2. V2 stated she asked if V10 told V1, Administrator, and V10 said she did, and V1 offered to go to the facility and talk with V13, but V10 didn't want that since they were still there. V2 stated she would talk to V1 about it when V1 came in.</p> <p>On 9/20/22 at 11:02AM, V1, Administrator, stated she got a call around 2:00AM from V10 that V13 had a bad attitude that night, and very poor approach to R2. V1 stated V10 told her V13 took R2 to living room, turned off the lights, and shut the door. V1 stated she specifically asked if it was abuse, and asked V10 this four times. V1 stated she asked V10 if she (V1) needed to come in, but V10 told her that R2's not in danger. V1 stated she told V10 she would talk to V2, DON, and V3, RCC (Resident Care Coordinator), in the morning to talk with V13 about her attitude. V1 state she didn't ask more questions with V10 since it was the middle of the night and she wasn't really awake.</p> <p>On 9/20/2022 at 1:40 PM, V10, CNA, said, "After I reported this abuse (of R2 on 9/2/2022 by V13), no investigation has been done. I kept waiting two</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>or three days for (V1) to call me and she (V1) never did. Two or three days after the incident (R2) had bruises on her left arm."</p> <p>On 9/20/2022 at 4:12 PM, V13, LPN, stated, "There was no CNA with (R2) that night. (R2) was walking towards the North hall by the breakroom door. (V10) was by another resident's room. I grabbed her (R2's) left hand with (V9). I turned (R2) around had my right hand in the small part of her back. When I let go of (R2's) hand, then (R2) grabbed my hand. Me and (V9) put her in the TV room, she sat down on the couch, didn't say anything to her. I did turn the lights off, I left the door cracked open. I didn't yell at (R2)."</p> <p>On, 9/21/2022 at 9:39 AM, V3, Licensed Practical Nurse LPN/Resident Care Coordinator(RCC) ,said V1 Administrator told her around the first of September, that she was called by V10, Certified Nuring Assistant (CNA), "around 2 AM or 3 AM that morning. (V1, Administrator) told me that when (V10, CNA) called her, she asked (V10, CNA) four or five times if it was abuse, and (V10, CNA) told (V1, Administrator) "no not abuse". (V1, Administrator) told me that (R2) was trying to get out the door and (V13, LPN) walked (R2) to the TV room, closed the door, and turned off the lights. (V1, Administrator) told me she didn't do an investigation since (V10, CNA) said it wasn't abuse, and didn't think she had to do an investigation, or report to IDPH."</p> <p>On 9/21/2022 at 11:03AM, observed with V5, LPN, multiple areas in a finger imprint looking pattern of greenish and yellowish discoloration on R2's left posterior upper arm, left lower forearm reddish discoloration, left upper posterior arm swollen with yellowish/brown/green color, left anterior forearm that was red in color, left anterior</p>	S9999			

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S9999	<p>Continued From page 8</p> <p>upper arm swollen with light bluish color, and left wrist swollen.</p> <p>On 9/21/2022 at 11:05AM, notified V2, DON, of bruises, discoloration, swelling of upper arm, and swelling to left wrist on R2's left arm.</p> <p>On 9/21/2022 at 1:00PM, observed as V2, DON, and V5, LPN, assessed R2 and V5 measured the areas. Left arm: noted R2's left posterior upper arm had three small round greenish yellowish bruises in a finger imprint pattern, red discoloration to left lower forearm, left upper posterior arm with yellowish/brown/green discoloration and swollen, left anterior forearm that was red in color, left anterior upper arm with bluish discoloration and swollen. V2 and V5 confirmed the discolorations, bruising to R2's left arm, swelling to upper left arm, and left wrist swollen. At this same time, V5 stated they look like fingerprints.</p> <p>R2's Nurses notes, dated 9/21/22 at 1:00PM, documents, "(R2) full body assessment was completed by (V5, LPN), (V8, CNA), (V2, DON), and Surveyor watching. The following marks were found and reported to MD. New treatments were transferred to Treatment Assessment Record (TAR) for monitoring. A) left upper arm posterior blue/yellow colors documents 1.5 cm (centimeters) x 0.5 cm, 0.5cm x 0.3 cm, 2.1 cm x 1.3 cm. B) left lower (distal) forearm red color 1.03 am x 1.3 cm. C) left upper arm posterior yellow/brown/green color with swollen 2.0 x 1.4 cm, 2.7cm x 2.4 cm, and 2.5 cm x 0.7 cm. D) anterior left forearm red color 0.5c, x 0.2cm, 0.6cm x 0.2cm, 0.1c, x 0.2 cm. E) anterior left upper arm light blue color and swollen 5.1cm x 6.6cm."</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>R2's Physician Order Sheet (POS), dated 9/21/22, documents to monitor new skin areas until healed.</p> <p>On 9/20/22 at 9:58 AM, V5, LPN, stated, "Two CNAs (V9 and V10) messaged her that night with an incident that occurred and they were scared to call the Administrator because nothing gets done here with (V1, Administrator) and (V3, LPN/ Resident Care Coordinator -RCC) just sweeps things under the rug if any allegation or issue is reported." V5 stated she told V10 she still had to notify the Administrator of the incident of abuse.</p> <p>On 9/20/2022 at 10:26 AM, V6, Certified Nurse Aide (CNA), stated she came in at 2 AM on 9/2/2022, and witnessed verbal abuse of R2 by V13, Licensed Practical Nurse (LPN). V6 stated V13 bullies her and she was afraid to report to the Administrator (V1) because of that. V6 stated, "(V13) and (V1) are friends, (V1) shoves anything under the rug and won't don't anything about reports of allegations." V6 stated she did report the very next morning to V2, Director of Nursing (DON), who was V13's relief that morning. V6 stated V2 told her she would talk to V1 about the verbal abuse V6 heard from V13 to R2. V6, CNA, stated to her knowledge, no investigation was done because the Administrator, V1, never questioned her about the verbal abuse. V6, CNA stated, "I was never questioned, filled out any paperwork regarding the verbal abuse I reported, (V13, LPN, to R2) has been working here since that night. I thought when allegations were reported of any abuse - staff are to be removed immediately". V6 stated, "That Friday night, (V13) was on the phone talking to someone and stated, 'someone reported me for abuse - I so abuse people Ha Ha ha' ...(laughing) to the person she was on the phone talking to, and the person on</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>the other end said, 'yeah you are an abuser', then started laughing." V6 stated V13 had her speakerphone on where she heard the conversation.</p> <p>On 9/20/2022 at 11:02 AM, V1, Administrator, said she has only investigated resident to resident allegations and reported those to IDPH. V1 stated, "I have not investigated any employee to resident abuse investigations. I have not reported any employee to resident abuse investigation to IDPH because I have not done any abuse investigations."</p> <p>On 9/20/2022 at 10:06AM, the facility had no documentation of employee abuse to resident documented, and no documentation of any employee to resident reportables to IDPH.</p> <p>On 9/21/2022 at 10:20AM, V4, Minimum Data Set Coordinator (MDSC), said, "We've never had an investigation here since I've been here, which is April. There was an incident of (R2) having black eyes about 3 weeks ago. Was charted by (V5, LPN) regarding the bruises. I saw faint yellow discoloration underneath both her eyes. I think this was another incident but I don't know for sure."</p> <p>On 9/21/2022 at 10:20AM, V4, Licensed Practical Nurse (LPN/MDSC), stated, "We've never had an investigation in this building since I've been here which is April. There was an incident of (R2) having black eyes about 3 weeks ago."</p> <p>On 9/22/22 at 3:04PM, V2, DON, stated she expects Nurses, CNAs, or anyone to make sure residents are safe, prevent injury if able, follow the Abuse Policy, and call the Administrator.</p>	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006555	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2022
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NAME OF PROVIDER OR SUPPLIER NOKOMIS REHAB & HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 STEVENS STREET NOKOMIS, IL 62075
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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
S9999	<p>Continued From page 11</p> <p>On 9/22/2022 at 2:11PM, V19, Regional Director of Clinical Operations, stated, "I expect the staff Administrator to report and investigate the allegations of any abuse - I expect the Administrator to follow our policy and procedure. I expect any employee of this facility who have been accused of mistreating, exploitation, neglecting, abusing will be immediately removed from the resident and facility."</p> <p>The September 2022 calendar with schedule of nursing staff documents that V13 continued to work after this allegation of abuse, September 4, 7, 8, 9, 12, 13, 16, 17, 18, 2022 until surveyor report of this allegation to V1, Administrator, on 9/20/2022 at which time V13 was suspended. Initial report to the Department, dated 9/20/2022, documents allegation of rough treatment of R2 by V13</p> <p>There was no documentation of a report to the Department of the allegations of abuse of R2 on 9/2/2022 and no documentation of any investigation of the incident.</p> <p>The facility's Abuse Prevention Program policy and procedure, dated 11/28/2016, documents, "The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006555	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2022
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NAME OF PROVIDER OR SUPPLIER NOKOMIS REHAB & HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 STEVENS STREET NOKOMIS, IL 62075
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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
S9999	Continued From page 12 control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents." Under IV. Internal Reporting Requirements and Identification of Allegations, "Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator." It continues under V11. External Reporting of Potential Abuse, "1. Initial Reporting of Allegations. The facility must ensure that all alleged violations involving mistreatment, exploitation, neglect or abuse, including injuries of unknown source, misappropriation of resident property, and reasonable suspicion of a crime, are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures." It further documents, at the time of the occurrence but not later than 24 hours after forming the suspicion- "A written report shall be sent the Department of Public Health." It continues, "Within 5 working days after the report of the occurrence a complete written report of the conclusion of the investigation including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health." It continues, "Immediately protecting residents involved in identified reports of possible abuse; Implementing systems to investigate all reports and allegations of mistreatment, exploitation, neglect, abuse of residents and misappropriation of property, promptly and aggressively, and making the necessary changes to prevent further occurrences;" It also documents under V. Protection of Residents, "Employees of this facility who have been accused of mistreatment, exploitation, neglect, abuse or misappropriation of resident property will be immediately removed	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008555	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2022
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NAME OF PROVIDER OR SUPPLIER NOKOMIS REHAB & HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 STEVENS STREET NOKOMIS, IL 62075
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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
S9999	<p>Continued From page 13</p> <p>from resident contact until the results of the investigation have been reviewed by the administrator or designee. Employees accused of alleged mistreatment, exploitation, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct care provider to residents." The policy continues VI. Internal Investigation of Allegations and Response, "2. Following the Resident Protection Investigation Procedures. The appointed investigator will follow the Resident Protection Investigation Procedures, attached to this policy. The Procedures contain specific investigation paths depending on the nature of the allegation, procedures for investigation, interview parameters, and reporting requirements."</p> <p>(B)</p>	S9999		