FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED C B. WING IL6003420 02/15/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5533 NORTH GALENA ROAD CORNERSTONE REHAB & HC** PEORIA HEIGHTS, IL 61614 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S 000 **Initial Comments** S 000 Complaint Investigation: 2221168/IL143478 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210c) 300.1210d)6) 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. Section 300.1210 General Requirements for Nursing and Personal Care

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents'

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following

respective resident care plan.

seven-day-a-week basis:

and shall be practiced on a 24-hour.

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

STATE FORM

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in the state

If continuation sheet 1 of 8

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serious injury, or the risk thereof. Serious bodily

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came in at 6:00 am.

from 6:00 pm until 2/22/22 at 6:00 am, V10, V11. and V12 (Certified Nurse Aides/CNAs) worked 2/1/22 night shift (10:00 pm) until 2/2/22 day shift

On 2/10/22, V1 provided a document titled, "Quality Care Reporting Form," dated 2/2/22 by V9 LPN/Licensed Practical Nurse, regarding R1's

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1/8/22 with a closed non displaced fracture of pubis; and late onset Alzheimer dementia."

R1's hospitalization dated 1/8/22 through 2/1/22,

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to identify safety needs, and severe medical illness/Dementia." IDT (Interdisciplinary Team) has reviewed the resident's capabilities, needs and preferences and has determined the resident

R1's Facility "Investigation Report for Falls," dated

is at risk of leaving home unattended."

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hospital."

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(R1) did have a one to one sitter but she was

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