PRINTED: 07/10/2024 FORM APPROVED

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
IL6002711			B. WING) 8/2024	
	NAME OF PROVIDER OR SUPPLIER UNIVERSITY NSG & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1095 UNIVERSITY DRIVE EDWARDSVILLE, IL 62025						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
S 000	Initial Comments		S 000				
	Complaint Survey 2443994/IL173434 2443976/IL173413						
S9999	Final Observations		S9999				
	Statement of Licens	sure Violations:					
	300.610a) 300.1210b) 300.1210d)1) 300.1210d)6)						
	Section 300.610 R	esident Care Policies					
	procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory conformed and othe policies shall complete the facility and shall according to the written policies.	dvisory physician or the ommittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed					
	Section 300.1210 (Nursing and Persor	General Requirements for nal Care					
	care and services to practicable physical well-being of the re- each resident's com-	shall provide the necessary of attain or maintain the highest life. It mental, and psychological sident, in accordance with apprehensive resident care properly supervised nursing	t				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 06/14/24

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TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		IL6002711	B. WING		1	8/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1095 UNI\	ERSITY DR	•		
UNIVER	SITY NSG & REHAB C	EDWARD:	SVILLE, IL 6	S2025		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general					
		nclude, at a minimum, the be practiced on a 24-hour, basis:				
		s, including oral, rectal, enous and intramuscular, shall stered.				
	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.					
	These requirements	s are not met as evidenced by:				
	Based on interview and record review the facility failed to administer medications as ordered for residents (R1, R2, R3, R12) of 4 residents reviewed in a sample of 12. This failure resulted in R1 and R3 experiencing severe pain.					
	Findings include:					
	R1 was admitted or quadriplegia, hypert Obstructive Pulmon intervertebral disk d and cirrhosis of the	ted 5/23/24, documented that n 3/26/24 with diagnoses of tension, COPD (Chronic nary Disease), spinal stenosis, legeneration, osteoarthritis, liver. R1's MDS (Minimum 7/24 documented R1 is				
	On 5/23/24 at 6:40	AM, R1 stated that at the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SI IDENTIFICATI		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С		
		IL6002711	1	B. WING		05/28/2024	
NAME OF PROVIDER OR SUI	PPLIER				STATE, ZIP CODE		
UNIVERSITY NSG & RE	HAB (ENTER		/ERSITY DR SVILLE, IL 6			
PREFIX (EACH DEF	SUMMARY STATEMENT OF DEFICIENCIES			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE	
beginning of and that he do noon medical facility Admininformed her medications with the company of the medication, or never did recompany of the medication. For a level of 10 pain medication. For a level of 10 pain medication, with the medication of the medication. For a level of 10 pain medication. For a level of 10 pain medication of the medication, with the medication, with the medication, with the medication of the me	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		S9999				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED		
IL6002711			B. WING			C 28/2024
	PROVIDER OR SUPPLIER	CENTER 1095 UN	DDRESS, CITY, S' IVERSITY DRI' DSVILLE, IL 6	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
\$9999	R1's MAR document assessment to be oneeded. The MAR assessment was confolio 5/20/24. R1's MAR assessment was confolio 5/20/24 and R1 respectively. R2's face sheet, day was admitted to the diagnoses of chrongeneralized anxiety and tachycardia. R2'documented that Respectively. When the Monday, 5/20/24 here is the medications all day concerned because and it is essential his blood pressure and stated he asked a remedications and the allowed to help him the Administrator that him his morning medication or noon responsible.	inted an order for a pain completed every shift and as did not document a pain ompleted on the day shift on did document a pain ompleted on the evening shift rated his pain at a level of 10. Ited 5/28/24, documented R2 a facility on 6/2/22 with ic kidney disease, COPD, a disorder, depression, anemia 2's MDS, dated 5/8/24, 2 is cognitively intact. AM, R2 stated that on a did not receive any of his are receives them for his high a chronic liver disease. R2 hurse on another hall for his at she stated she was not at R2 stated that she was not a R2 stated then went to office and informed (V1) he needed someone to give edications and that she replied never did receive any of his medications.				
	adhesive medicated inhaler. The MAR of documented for the indicating they were dated 5/23/24 documents to receive the	en 7 AM and 10 AM: lidocaine d patch 4% and a steroid loes not have a nurse's initials ese medications on 5/20/24 e not administered. R2's MAR mented that R2 has physician e following medications every in 81 mg, folic acid 1 mg,				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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IL6002711		B. WING		C 05/28/2024			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
UNIVER	SITY NSG & REHAB (CENTER	VERSITY DR SVILLE, IL 6				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	(X5) COMPLETE DATE		
\$9999	SITY NSG & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		S9999				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6002711	B. WING		C 05/28/2024	
	PROVIDER OR SUPPLIER	:FNTER 1095 UNIV	DRESS, CITY, S /ERSITY DR SVILLE, IL 6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETE DATE	
\$9999	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	CENTER 1095 UNIV	DRESS, CITY, ST VERSITY DRIV SVILLE, IL 62	VE		
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S9999	R12's face sheet, d R12 was admitted t diagnoses of type 2 failure, history of er anemia and chronic dated 4/11/24, docu intact. R12's MAR, dated 3 physician orders for be administered ev AM: amlodipine 10 famotidine 40 mg fa allergy relief spray 3 insulin 13 units, ins Jardiance 10 mg, L 400 mg, metformin 81 mg, and spirono does not have thes administered on 5/2 an order for blood s morning between 6 does not document 5/20/24 between th R12's MAR, dated 3 an order to receive every day between does not document on 5/20/24. R12's progress note "we encountered a In this case residen normal. MD notified aware. Crisis mana education in place. hall for monitoring, Additional leadersh	ge 6 ated 5/28/24, documented to the facility on 9/15/21 with diabetes, congestive heart inbolisms, hypertension, cikidney disease. R12's MDS, amented R12 is cognitively 5/23/24, documented R12 has a the following medications to eryday between 7 AM and 10 mg, entrestro 24 mg, errous sulfate 324mg, flonase 50 mcg, folate 1 mg, Humalog ulin glargine 60 units, asix 40 mg, magnesium oxide 50 mg, toprol 100 mg, aspirin lactone 25 mg. R12's MAR e medications documented as 20/24. R12's MAR documents sugars to be tested every AM and 8 AM. R12's MAR a blood sugar result for e times of 6 AM and 8 AM. 5/23/24, documented R12 has 13 units of Humalog insulin 11 AM and 12 PM. R12's MAR this insulin was administered e, dated 5/22/24, documented staffing challenge on 5/20/24. Its' medications ran later than a Resident is own POA and is gement and in-service Additional CNA added to B VS q4 hrs until 5/24/2024. Its rounding in place. Staff will dents for any concerns."	S9999			

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	PROVIDER OR SUPPLIER	ENTER 1095 UNI	DDRESS, CITY, S VERSITY DR DSVILLE, IL 6			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
\$9999	On 5/23/24 at 1:45 she was not made a nurse assigned to V1 stated the Interior was scheduled to with the task of the attempted unsuccessful and the contract with a stafficurrent owner has restaffing agency. V1 the two floor nurses that this isn't ideal, medications to the other than the nurses refused. On 5/28/24 at 10:23 stated that she would nurse to pass the mB hall on 5/20/24. On 5/28/24 at 2:35 that if there are no immedications were not medications were not medications were not medicated. In Only by this state to prepulse and direct administer medications. 3. Staffin ensure that medical unnecessary interrutions.	PM, Administrator, V1 stated aware of the B hall not having it until 10:30 AM on 5/20/24. In DON (Director of Nursing) ork the floor on 5/20/24 but in on the evening shift on not come in on 5/20/24. V1 and to call a nurse in but was nat the facility does not have a fing agency because the not paid the bill with the stated on 5/20/24 she called at the her office and told them but she needed them to pass residents on B hall and that to do so. B AM, V17, Regional Director and have expected a licensed nedications to the residents on PM, V1, Administrator stated initials on the MAR then the				

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		IL6002711	B. WING			C 2 8/2024
	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S VERSITY DR SVILLE, IL (, 50.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	orders, including an continues, 7. Medic	ny required time from. It cations are administered within r prescribed time, unless	S9999			
		(B)				

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