STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057356	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSON REHAB AND NURSING	600 EAST ROBINWOOD DRIVE , ROBINSON, Illinois, 62454

(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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation #2558244/2602765	S0000		09/03/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)3 300.1230e) 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 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. 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to	S9999		09/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. Section 300.1230 Direct Care Staffing e) The facility shall schedule nursing personnel so that the nursing needs of all residents are met. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to respond to residents' requests for assistance in a timely manner to promote dignity and respect for 1 (R1) of 4 residents reviewed for call light response in the sample of 4. This failure resulted in R1 having to urinate on herself, causing her feelings of discomfort, anxiety, humiliation, and embarrassment. Findings Include: R1's Admission Record documented an admission date of 4/27/25 and included diagnoses of morbid (severe) obesity due to excess calories, spinal stenosis, need for assistance with personal care, presence of right artificial hip joint, pain in right hip, presence of artificial knee joint, bilateral, essential tremor, anxiety, and muscle weakness. R1's Minimum Data Set (MDS) assessment dated 07/07/2025 documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. This MDS also documents under Functional Abilities and Goals, R1 is dependent for toileting hygiene, shower/bathe self, upper body dressing, and putting on/taking off footwear. R1's current Care Plan included a focus area of "I currently have an alteration to my ability to care for self and need assistance d/t (due to) Anxiety, Cognitive impairment, Weakness" initiated on 1/31/25. Corresponding interventions include: encourage resident to participate to the fullest extent possible with each interaction, encourage resident to use bell to call for assistance, praise all efforts at self care, PT (physical therapy), OT (occupational therapy) and ST (speech therapy) evaluation and treatment. R1 also has a focus area of "I am currently able to perform mobility with 2 assist, gait belt and walker" initiated on 5/7/25 with corresponding interventions of: encourage (R1) to use bell to call for assistance if	S9999		

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S9999	Continued from page 2 needed and monitor/document ability to perform ADLs (activities of daily living). Facility “Resident Council” meeting minutes dated 7/18/25 document under “4. New Business: (R1) says only one CNA (Certified Nurse Assistant) at night needs more.” A facility Resident/Family Concern/Grievance Form dated 07/18/2025 documented “Resident Council” by the Resident Name. Under Section 1, the Nature of Concern documented “Resident states not enough CNA’s on the floor at night. Says she needs things like ice water and there is no one to get it.” In Section 2 under Review and Action Taken, V2 (Director of Nursing/DON) documented Nurse managers come in to assist as needed, assured resident council that there is always at least 3 CNAs overnight. Staff more assist b/t (between) 6 – 10p and 4-6a to help during busy X’s (times). Facility “Resident Council” meeting minutes dated 8/15/25 under #4, New Business documented “Still not enough CNAs at night…” On 08/29/2025 at 10:53 AM, R1 stated she sometimes has trouble getting her call light answered. R1 stated on night shift, there is one CNA per hall. R1 stated that she has been told staff have been hired but she has yet to see any new faces. R1 stated that she has "peed on herself" waiting for her call light to be answered. R1 stated she knows of three times that this has happened and added that this has only occurred on weekends. R1 stated it's embarrassing when she's in the hall and has to pee on herself. R1 said she does not like that she had to pee on herself, but she had to wait too long. R1 stated there isn’t a problem on day shift, that shift always has plenty staff. R1 said on weekends the staff number is much lower than during the week. R1 stated she has complained about staffing in resident council meetings and has even sent a text message to V7 (Assistant Director of Nursing/Licensed Practical Nurse - ADON/LPN) on 08/22/2025 and told her that she has had her call light on for over an hour. R1 stated the staff that work here are really good, there just isn’t always enough staff to take care of all the residents. On 08/29/2025 at 11:09 AM, V3 (Family Member) stated that R1 called him about 6 weeks to 2 months ago crying and upset. V3 couldn’t recall the exact date, but stated R1 told him her call light had been on for 2 hours and no one was answering. V3 stated he told R1 that if she had an accident that was ok, she couldn't help that no one was answering. V3 said he told R1 “if you go in the hallway and have pee on yourself then	S9999		

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S9999	Continued from page 3 maybe they will help you." V3 stated he hated to tell R1 that, but he did not know what else to do. V3 stated that he was furious, so he called the facility and sternly told them to go take care of R1. V3 stated the nurse who answered the phone told him "if you think you can do it better then you need to come here and help." V3 stated he then got on social media and found V7 (ADON/LPN) and explained to her what happened. V3 stated V7 said she would take care of the problem. V3 stated he had no issues with this until last weekend 08/23/2025 and 08/24/2025. V3 stated on 08/23/2025 around 8:00 PM, R1 called because her call light had been on since she came back from the dining room after supper. V3 stated R1 said she told the staff member pushing her that she needed to use the restroom but R1 ended up having to relieve herself and was incontinent. V3 said R1 didn't say who the staff member was. V3 stated he checked with R1 on 08/24/2025 and R1 had no complaints at that time, but R1 called V3 later that night on 08/24/2025 around 8:30 PM and told V3 that R1's call light had been on for over an hour, and no one had answered it. V3 stated that R1 is very proper and that it is degrading that the facility does not have enough help to the point R1 is having to urinate on herself. V3 stated he told R1 that he will notify the proper people and will get this handled. V3 stated on the weekends, the staffing is much lower than during the week. V3 stated if it is happening to R1 who is alert and with it, it is happening to other residents who cannot speak. On 08/29/2025 at 11:35 AM, V7 (ADON/LPN) stated she was contacted by V3 (Family Member) months ago about an issue and it was addressed. V7 stated that R1 sent her a text and told her R1's call light had been on for over an hour, and no one was answering it. V7 stated that it was between 6:00 and 7:00 PM and that time frame is very busy for the staff. V7 stated as soon as staff was available, they went in the room and took care of R1. V7 stated they try to keep a staff member on the hall during meals, but it is hard to meet all the needs after supper. V7 stated they try to schedule enough staff and sometimes if a call in occurs, it doesn't pan out. On 08/29/2025 at 11:39 AM, V2 (DON) stated when R1 was incontinent a couple months ago, she couldn't remember exactly when but she was aware of it as she was working as a CNA that night. V2 stated she went and toileted/cleaned R1, changed her clothes, and placed her in bed. V2 stated they educate the staff all the time about answering call lights promptly. V2 stated she was not aware of any issues that occurred over the weekend with R1. V2 stated call lights should be	S9999		

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S9999	Continued from page 4 answered within 10-15 minutes. V2 stated for the weekend of 08/23/2025 and 08/24/2025, there were 3 or 4 CNA's scheduled to work. V2 stated she thinks that one called in and was not replaced. V2 stated in those situations, they try to have a CNA stay late until around 10 PM and then have a day shift person come in around 2:00 - 04:00 A.M. V2 stated they must have not found someone to come in. V2 stated that ideally, she would like to have 4 CNA's every night, but it does not matter what she thinks staffing should be. V2 stated there are two nurses on night shift. V2 stated there are 35 residents in the facility that require two staff assist. V2 stated that on evening/nights, the toughest time is from 6:00 PM to 10:00 PM. V2 stated they attempt to cover when needed but it doesn't always happen. V2 stated they are attempting to hire more staff and get them trained. On 08/29/2025 at 11:44 AM, V1 (Administrator) stated she was not made aware of the call light concerns regarding R1 on the weekend of 08/23/2025 and 08/24/2025 until now. V1 stated the call light does not have a report that can be viewed to see how long the call light was going off. V1 stated she has never been made aware of any resident complaining about call lights going off for an hour. On 08/29/2025 at 2:04 PM, V12 (CNA) stated "at times I feel like we are understaffed." V12 stated it is hard to get to call lights on night shift because there are not a lot of staff working. V12 stated there are a lot of times there are only three CNA's in the building for the entire night. V12 stated lately when there are 4 scheduled and someone calls in, they are not replaced on the schedule. V12 stated she gets the bare basics done for the residents, but there are too many that require two-person assist and they have to wait for up to an hour. On 08/29/2025 at 3:21 PM, V11 (CNA) stated R1 had incontinent episodes over the weekend of 08/23/2025 - 08/24/2024. V11 stated that it is not typical for R1 to be incontinent. V11 stated "we cannot get to all the residents after supper in a timely manner." V11 stated it happens more often than not. V11 stated a lot of residents have to wait when they shouldn't. V11 stated the staff try to get everyone out of the dining room, residents changed who are wet, the ones who want laid down, laid down and answer the call lights. V11 stated management is aware of the issues as the night shift staff have complained. V11 stated they are told to ask the other CNA's or the nurse for help. V11 stated that all the staff are busy including the nurses and it is hard to get the call lights answered. V11 stated the	S9999		

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S9999	Continued from page 5 staff issues are mostly on the weekends. V11 stated she does not do as well as she could because “it is impossible.” V11 stated "if I would have been able to get to R1 in time she would not have been incontinent." V11 stated if a resident is a two assist, they have to wait until there are two staff available and it can easily take an hour. V11 also stated that the weekend laundry staff recently quit so they have to do the laundry on night shift too. On 09/02/2025 at 2:21 PM, V15 (LPN) stated she was working and was R1's nurse the weekend of 8/23-8/24/25 when R1 had an incontinent episode. V15 stated R1 is normally continent, and she thought it was odd that this happened. V15 stated it wasn't until later in the shift, R1 told her that she was incontinent because the call light was on for over an hour. V15 stated that one nurse and one certified nurse assistant is not enough for the 30 residents that reside on R1’s hall. V15 stated this last Saturday 08/30/2025 a CNA called in and the nurse on call (V7) did not find any coverage and did not come in to help. V15 stated it seems every weekend they are short staffed. V15 stated all the residents cannot receive the care they need with the current staffing they have. A facility provided census sheet documented there are 27 residents that reside on R1’s hall. Of those 27 residents, V2 indicated by placing a dot beside resident names that there were 15 residents who require the assist of two staff for transfers and care, with R1 being one of those residents. V2 indicated by yellow highlight that 10 residents on that hall require the assist of one staff member for transfers and care. Facility policy titled “Facility Resident Rights Policy and Procedure with no date documents under section “V. Respect and dignity. Every resident has a right to be treated with respect and dignity.” (B)	S9999		