STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046896	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE HALL NURSING & REHAB CENTER	620 WEST BRIDGEPORT , WHITE HALL, Illinois, 62092

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S0000	Initial Comments Annual Licensure Survey	S0000		09/19/2025
S9999	Final Observations Statement of Licensure Violations: ONE OF TWO: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)5) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow	S9999		09/19/2025

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

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S9999	Continued from page 1 the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 2) All treatments and procedures shall be administered as ordered by the physician/ 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to implement interventions to prevent skin breakdown for 1 of 5 residents (R4) reviewed for pressure sores in the sample of 62. This failure resulted in R4 developing an unstageable pressure ulcer to Right lateral heel. Findings include: On 8/25/2025 at 9:53AM R4 in bed in his room. R4 stated	S9999		

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S9999	Continued from page 2 he has a pressure sore on his heel. R4 stated he got sore from foot rubbing on foot of bed. R4's face sheet dated 8/27/2025 documents in part a diagnosis of Diabetes Mellitus with Neuropathy and Acquired Absence of left leg below the knee. R4's Minimum Data Set (MDS) dated 7/16/2025 documents R4 is cognitively intact with Brief Interview of Mental Status (BIMS) of 15. R4's MDS documents R4 had an unstageable, unhealed pressure ulcer4. R4's progress notes dated 7/8/2025 at 5;16PM documents R4 out with family and fell. Notes dated 7/8/2025 document family contacted facility and R4 will be having emergency surgery for fractured R hip. R4's progress notes dated 7/28/2025 at 12;05 documents writer informed resident has a spot on lateral right heel pressure injury that is unstageable a this time wound will see this week. R4's wound assessment and plan dated July 31, 2025, documents active/initial phase and treatment, wound location right lateral heel, wound type pressure injury, unstageable depth obscured. Assessment documents wound onset date 7/29/2025. Assessment documents wound measurement 1.5 Centimeters (CM) Length 2.5CM width. Assessment documents peri wound within normal limits no exudate. Assessment documents signs and symptoms of infection: Erythema. Assessment documents treatment order: every day wound gel- cleanse wound with normal saline or sterile water- apply to wound bed cover with dry clean dressing and as instructed. Comments encourage offloading and repositioning per facility protocol. R4's assessment documents wound risk factors Type 2 Diabetes Mellitus with diabetic neuropathy, peripheral vascular disease, acquired absence of left leg below the knee, nondisplaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing. The facility Weekly Pressure wounds dated 8/3/20025-8/9/2025 document R4 wound to right lateral foot pressure ulcer, unstageable measurements 1.5x1.50 cloudy tan drainage with eschar/necrotic tissue wound bed. The facility weekly pressure wounds dated 8/10/2025-8/16/2025 documents R4 wound right lateral foot, pressure ulcer, measurements 0.9x0.9 drainage cloudy tan, eschar/ necrotic tissue wound bed with green wound drainage, wound bed type granulation	S9999		

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S9999	Continued from page 3 eschar/necrotic tissue with macerated peri wound. The facility weekly pressure wounds dated 8/17/2025-8/23/2025 documents R4 wound location R lateral foot, pressure ulcer, stage 3, measurements 1.0x1.0x.10 R4's wound assessment and plan dated 8/212025 documents R4 lateral heel pressure injury, healing status same/stable. Wound measurement 1CM lengthx1CM width X 0.1cm depth, Peri wound macerated with minimal exudate. Documents treatment order medical honey gel- cleanse wound with normal saline or sterile water- apply to wound bed, cover with dry clean dressing daily and as instructed. Wound assessment and plan documents: encouraged offloading and repositioning per facility protocol, discontinue hydrogel gauze due to indurated peri wound R4's Treatment Administration Record (TAR) dated 8/1/2025-8/31/2025 documents to cleanse right lateral heel with wound cleanser, pat dry, apply medihoney to wound bed, cover with foam dressing daily and prn until resolved every shift. R4's TAR documents to apply heel protector boots to Right heel while in bed and every shift. R4's care plan dated 8/2/2025 documents R4 has and arterial /ischemic ulcer of the right lateral heel. Care plan documents assist with turning and repositioning as tolerated, collaborate with dietitian and (wound company), enhance barrier precautions, inspect the feet daily On 08/26/2025 at 9:50AM V18, wound nurse treatment to pressure sore R heel cleansed area with wound cleanser applied medihoney to circular black area to r lateral heel. V18 wound nurse stated the pressure ulcer was facility acquired. V18 stated R4 had an air mattress that was faulty causing R4 to slide to the end of the bed, and pressure area from R4 rubbing foot on bed. The facility policy Preventive Skin Care dated history 11/17 documents it is the practice of the facility to provide routine preventative skin care. The policy documents the policy will serve as a guide to facility staff with regard to clinically acceptable techniques to be applied for skin care prevention. The policy documents evaluation of resident diagnosis, conditions and medications is to be completed to identify risk factors that may present complications. The policy documents complete a weekly skin evaluation on all residents.	S9999		

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S9999	Continued from page 4 (NO VIOLATION) TWO OF TWO 300.610a) 300.1210a) 300.1210b) 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 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	S9999		

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S9999	Continued from page 5 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to investigate and provide progressive interventions to prevent falls for one of 10 residents (R34) reviewed for accidents and supervision in the sample of 62. These failures resulted in R34 sustaining a laceration to the face requiring 5 sutures. Findings include: R34's Face sheet documented she was admitted to the facility on 10/15/19 with diagnosis of, in part, dementia, muscle weakness, difficulty in walking, and need for assistance with personal care. R34's MDS dated 6/12/25 documented she was rarely/never understood, had a memory problem and her cognitive skills for daily decision-making regarding tasks of daily life were severely impaired. R34's Fall Risk Assessment dated 2/25/25 and 6/12/25 documented she was a high fall risk and to implement high fall risk fall prevention interventions. R34's current Care plan requested and provided by the facility documented she had an actual fall with no injury initiated 11/22/24 with interventions as follow: on 4/23/25 R34 had a fall with minor injury on 4/23/25 and for staff to redirect her from ambulating through crowded space; intervention on 5/19/25 documented she had an actual fall with minor injury and for staff to assist her out of dining room chair after dinner and	S9999		

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S9999	Continued from page 6 assist with toileting as tolerated. Care plan initiated on 7/9/25 (24 days after her 6/15/25 fall) documented R34 is a high fall risk related to confusion, gait/balance problems, incontinence, poor communication/comprehension, unaware of safety needs. Interventions for this care plan were initiated on 7/9/25 to anticipate and meet her needs, ensure proper footwear, and for physical therapy to evaluate and treat as ordered or as needed. R34's Progress note dated 6/15/25 at 2:31 AM, documented, "Writer was informed by staff that R34 was on the floor and was bleeding from her head. Writer observed R34 at a 90-degree angle on the floor. Writer observed wound to be actively bleeding, unable to assess the size. Pressure applied. R34 assessed for any additional injuries. R34 noted to have bruising to the back of her right hand." R34's Progress note dated 6/15/25 at 6:35 AM, documented, "writer spoke with local ER (emergency room) nurse and was informed that R34 received 5 sutures to her laceration, XR (x-ray) was performed of her right hand and no fx (fracture) has been found: DX (diagnosed) as a contusion. R34 will be returning to the facility via EMS (emergency medical services) per local ER nurse." On 8/27/25 at 9:15 AM, in a joint interview with V12 (LPN) and V26 (CNA), V26 looked up R34's electronic chart and stated R34 was moved closer to the nurse's station but not sure of what other measures are put in place. V26 stated she finds out details on concerns for the residents from the night shift before starting her shift but could not state who was at a high risk for falls or specific intervention/measures put in place for R34's fall prevention besides moving her closer to the nurse's station. On 8/28/25 at 10:10 AM, V38 (Physical Therapy) stated the last time R34 was evaluated was on 1/7/25. On 8/27/25 at 1:25 PM in a joint interview with V1 (Administrator), V2 DON (Director of Nursing), and V30 (Regional Nurse), V30 stated all residents have a right to fall. V2 stated they have an admission process for fall assessments and fall interventions to be put in place following. The facility's Interdisciplinary Fall Reduction/Injury Prevention Protocol dated 1/2025, documented the intent is "an interdisciplinary approach at reducing falls, preventing injury, and increasing safety awareness ultimately resulting in improved quality of care for	S9999		

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S9999	Continued from page 7 our residents." The policy continued to document recommendations included "nursing to complete a fall risk evaluation up admission, re-admission, quarterly and with significant change. the total score places the resident at risk, determine appropriate interventions. Once selected, implement the interventions and then add to the resident's plan of care and resident Kardex. Consider an icon system for facilities with high fall percentage. Note that this type of system will need close monitoring and need a process owner. Examples, "Falling Star" and "Falling Leaf" programs." The policy further documented the environmental checklist to be reviewed monthly on facility round with executive director, maintenance, housekeeping. (B)	S9999		