		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE S COMPLI	URVEY
		146121	B. WI	NG .	·	03/0	8/2012
	ROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE 1409 NORTH MAIN STREET, PO BOX 8	347	
BENTON	REHAB & HCC				BENTON, IL 62812		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F9999	FINAL OBSERVATI	ONS	F9	999	9		
	LICENSURE VIOL	ATIONS					
	300.1210a) 300.1210b) 300.1210b)2) 300.1210b)4) 300.1210b)5) 300.1210c) 300.1210c)6) 300.3240a) 300.3240b) 300.3240c) 300.3240c) 300.3240e)						
	Nursing and Person a) Comprehensive with the participatio resident's guardian applicable, must de comprehensive carrincludes measurabl meet the resident's and psychosocial nor resident's comprehe allow the resident to practicable level of provide for discharg restrictive setting ba	General Requirements for nal Care Resident Care Plan. A facility, n of the resident and the or representative, as velop and implement a e plan for each resident that e objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which o attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care ment shall be developed with					

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		AND HUMAN SERVICES				FORM	07/11/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146121	B. WI	NG _		03/08	8/2012
NAME OF P	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENTON	N REHAB & HCC				1409 NORTH MAIN STREET, PO BOX 847 BENTON, IL 62812		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	-IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	the active participat resident's guardian applicable. (Section b) The facility shall and services to atta practicable physical well-being of the re- each resident's com plan. Adequate and care and personal of resident to meet the care needs of the re- care needs of the re- demonstrates that a is unavoidable. All re- and encourage resident imited range of mo- treatment and servi motion and/or to pro- range of motion. 4) All nursing perso- encourage resident in activities of daily circumstances of th demonstrate that di This includes the re- dress, and groom; the eat; and use speech functional communi who is unable to ca shall receive the se good nutrition, groo 5) All nursing perso-	tion of the resident and the or representative, as a 3-202.2a of the Act) provide the necessary care ain or maintain the highest il, mental, and psychological sident, in accordance with nprehensive resident care d properly supervised nursing care shall be provided to each e total nursing and personal	F9	999	9		

Facility ID: IL6005391

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/11/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY
		146121	B. WI	NG _		03/08	3/2012
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
BENTON	REHAB & HCC				1409 NORTH MAIN STREET, PO BOX 847 BENTON, IL 62812		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	effort to help them r practicable level of c) Each direct care- be knowledgeable a respective resident 6 All necessary pre assure that the resi as free of accident nursing personnel s	s often as necessary in an retain or maintain their highest functioning. giving staff shall review and about his or her residents' care plan. ecautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see eceives adequate supervision revent accidents.	F9	999	}		
	 a) An owner, license agent of a facility shresident. (Section 2) b) A facility employed aware of abuse or rimmediately report administrator. (Section 2) c) A facility administrator of report the matter by the resident's repret the Act) d) A facility administration (Section 3-610 of the Employee as per investigation of a regresident indicates, b) 	ee, administrator, employee or hall not abuse or neglect a 2-107 of the Act) ee or agent who becomes heglect of a resident shall the matter to the facility tion 3-610 of the Act) trator who becomes aware of a resident shall immediately telephone and in writing to sentative. (Section 3-610 of trator, employee, or agent who abuse or neglect of a resident e matter to the Department.					

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		AND HUMAN SERVICES				FORM	07/11/2012 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY	
		146121	B. WI	NG _		03/08/2012		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
BENTON	I REHAB & HCC				1409 NORTH MAIN STREET, PO BOX 847 BENTON, IL 62812			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F9999	perpetrator of the a immediately be bar with residents of the of any further inves disciplinary action a 3-611 of the Act) Based on record re failed to implement residents (R11) revi 11. This failure resu Fractured Right Kno The findings include 1. R11's Fall Risk A documents that she coordination, loss of walking, and had a home before admis 05-03-11. The Mini for R11 documents dependent on 2 or surfaces including of The nurse's notes, state that while tran the wheelchair, R11 knee. This note co complained of seve R11's nurse's notes that R11 was admit diagnosis of Fractu The facility Incident 06-18-11 at 4:20 pm	buse, that employee shall red from any further contact e facility, pending the outcome tigation, prosecution or against the employee. (Section view and interview, the facility safety measures for 1 of 5 iewed for falls in the sample of ulted in R11 sustaining a ee. e: Assessment dated 05-03-11 e had decreased muscle of balance while standing and previous fracture from a fall at asion to the facility on imum Data Set dated 05-17-11 that R11 was totally more staff for transfer between	F9	999	9			

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		AND HUMAN SERVICES				FORM	07/11/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		146121	B. WI	NG	i	03/08	8/2012
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BENTON	REHAB & HCC				1409 NORTH MAIN STREET, PO BOX 84 BENTON, IL 62812	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	was assisting her o E1, Administrator, v	 vhile E8, Certified Nurse Aide, nto the toilet. verified on 03-08-11 at 2 pm y staff person assisting with v5)6) (2) (2) (3) (4) (5) (5) (5) (6) (7) <li< td=""><td>F9</td><td>99</td><td></td><td></td><td></td></li<>	F9	99			
		Comprehensive Assessments Serious Mental Illness					

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		AND HUMAN SERVICES				FORM	07/11/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146121	B. WI	NG _		03/08	8/2012
	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1409 NORTH MAIN STREET, PO BOX 847		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	BENTON, IL 62812 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Residing in Facilitie Section 300.4010 (for Residents with S Residing in Facilitie a) The facility s Interdisciplinary Tea The IDT is a group those professions, of that are relevant to strengths and need to meet those need minimum, the resider including an RN or the medical needs of a social worker; an other appropriate pr as determined by the resident or his or he other individuals to participate in the pro- resident's strengths 300.4040 a) The psychiatric refa- major domains of fu- development: self- community living, out	s Subject to Subpart S Comprehensive Assessments Serious Mental Illness subject to Subpart S shall establish an am (IDT) for each resident. of persons that represents disciplines, or service areas identifying an individual's ls, and that designs a program ls. The IDT includes, at a ent; the resident's guardian; a itation Services Coordinator nt's primary service providers, an LPN with responsibility for of the individual; a psychiatrist; activity professional; and rofessionals and care givers ne resident's needs. The er guardian may also invite meet with the IDT and occess of identifying the	F9!	999			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/11/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		146121	B. WI	NG _		03/08	8/2012
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	7	
BENTON	REHAB & HCC				1409 NORTH MAIN STREET, PO BOX 847 BENTON, IL 62812		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 19	F9	999	Э		
		Psychiatric Rehabilitation es Subject to Subpart S					
	psychiatric rehabilit contract with an out part of the psychiate long as individual re subsection (c)(4) is designed to allow a	shall develop and implement a ation program. A facility may side entity to provide all or ric rehabilitation program as esidents' needs are met and met. The program shall be wide array of group and ic activities, including, but not ring:					
	Services to Persons for Facilities Subject a) Psychiatric Media 1) The facility shall psychiatric rehabilit Illinois licensed phy board certified in ps Board of Psychiatry psychiatric medical advising the admini Rehabilitation Servi psychiatric manage residents. 2) There shall be co between the psychi medical director. 3) The psychiatric m the administrator, s annually approving policies and proced rehabilitation progra 4) Each resident sh	cal Director have a consultant for the ation program who is an sician and is board eligible or sychiatry from the American and Neurology. The director is responsible for strator and the Psychiatric ces Director on the overall ment of the program's ommunication linkages atric medical director, working with hall be responsible for in writing the facility's written ures for the psychiatric					

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		AND HUMAN SERVICES				FORM	07/11/2012 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146121	B. WI	NG .	i	03/0	8/2012
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENTON	I REHAB & HCC				1409 NORTH MAIN STREET, PO BOX 847 BENTON, IL 62812	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	January 1, 2002 an served as the resid resident may contin that physician uses needed, for the resis 5) A psychiatrist sha psychiatric treatmen management of the residents' guardian choice of psychiatri 6) Each resident sha least every 90 days ensure adequate ps b) Psychiatric Reha 1) A Psychiatric Reha 1) A Psychiatric Reha (PRSD) shall be: A) A licensed, regis psychologist, social therapist, rehabilita nurse or licensed p a minimum of at leas experience and at I working directly with illness and who has Department of Pub or B) A person with a services field with a experience and at I working directly with illness who has atter program. 2) An individual who nursing home in a c Psychiatric Rehabil January 1, 2002 an	a resident since prior to d a psychiatrist has never ent's primary physician, the nue with the current physician if psychiatric consultation, as ident. all be available for the nt and psychiatric medication e residents. All residents or s shall be permitted their	F9	999	9		

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		AND HUMAN SERVICES				FORM	: 07/11/2012 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146121	B. WI	NG		03/08/2012	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	_	
BENTON	NREHAB & HCC				1409 NORTH MAIN STREET, PO BOX 847 BENTON, IL 62812	ſ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	role even if the indiv registered, or certifi social worker, rehal nurse or licensed p Department will cor accordance with su deciding whether to Department may re fails to continue to r or to complete the r 3) Each facility shal psychiatric rehabilit responsibility for: A) Developing and psychiatric rehabilit B) Developing and training and in-serv psychiatric rehabilit C) Ensuring the coo the residents' partic rehabilitation progra 4) The PRSD shall ITP is developed by is individualized, sta treatment, includes written in behaviora acknowledged by re implemented. 5) The PRSD shall are met through ap and community res possible, that reside significant others ar of their plan of care 6) The PRSD shall	proval to continue to act in that vidual is not a licensed, ied psychiatrist, psychologist, bilitation counselor, psychiatric rofessional counselor. The nsider information submitted in ubsection (h) of this Section in o grant approval. The evoke approval if the individual meet professional standards required training. If have a PRSD for the ation program who is assigned implementing the facility's ration program; implementing the facility's staff ice programs relating to the ation program; and ordination and monitoring of cipation in the psychiatric am ITP. ensure that each resident's y an Interdisciplinary Team and ates the progressive goals of measurable objectives, is al terms, is understandable and esident and staff, and is ensure that residents' needs propriate staff interventions ources and, whenever ents and their families or re involved in the preparation	F9	999			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 07/11/2012 APPROVED 0938-0391
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146121	B. WI	NG _		03/0	8/2012
NAME O	F PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	_	
BENT	ON REHAB & HCC				1409 NORTH MAIN STREET, PO BOX 847 BENTON, IL 62812	ſ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F999	 c) Psychiatric Reha 1) A Psychiatric Re Coordinator (PRSC) therapist or posses human services fieles sociology, special ecounseling or psychol of one year of superimedential on present of the second of the	abilitation Services Coordinator habilitation Services C) shall be an occupational is a bachelor's degree in a ld (including but not limited to: education, rehabilitation hology) and have a minimum ervised experience in mental ervices. o is employed at a licensed capacity similar to that of a litation Services Coordinator 2 and who has at least five e in that capacity may petition approval to continue to act in e individual does not possess a in human services. The nsider information submitted in ubsection (h) of this Section in o grant approval. The evoke approval if the individual meet professional standards uired training. dmitted to the facility shall have a case manager. The PRSC the staff member to whom the elates for the coordination of ties of the PRSC are: esident with a stable uship;	F9	999			

Facility ID: IL6005391

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/11/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		146121	B. WI	NG		03/0	8/2012
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	_	
BENTON	I REHAB & HCC				409 NORTH MAIN STREET, PO BOX 84 BENTON, IL 62812	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	 F) To monitor the reself-directed care a the treatment plan. 5) There shall be a participants. 6) If the PRSC is a (c)(4)(A) and (E) wifacility staff. d) In a facility with 1 serious mental illner PRSC. e) Registry of Certif Services Aides 1) An individual will Registry as a psychaide when he/she h training program ap Long-Term Care As Programs Code (77 met background ch Section 300.661 of no findings of abuse of property in accorr and 3-206.02 of the 2) An individual will Registry if he/she h information required Part and submits do of the following equal A) Documentation of the following equal A) Documentation of PRSA training courras evidenced by a ownitten verification for the following courras evidenced by a formation required part and response to the following equal A) Documentation of the following equal A) Docume	ation services programs; and esident in the areas of nd for overall compliance with PRSC for each 30 consultant, then subsections II also be the responsibility of 0 or fewer residents with ss, the PRSD may act as the fied Psychiatric Rehabilitation be placed on the Nurse Aide hiatric rehabilitation services has successfully completed a oproved in accordance with the esistants and Aides Training 7 III. Adm. Code 395) and has eck information required in this Part, and when there are e, neglect, or misappropriation dance with Sections 3-206.01 e Act. be placed on the Nurse Aide as met background check d in Section 300.661 of this pocumentation supporting one ivalencies: of current registration from psychiatric rehabilitation	F9	999			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/11/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SL COMPLE	JRVEY
		146121	B. WI	NG		03/0	8/2012
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	-	
BENTON	I REHAB & HCC				1409 NORTH MAIN STREET, PO BOX 84 BENTON, IL 62812	¥7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	PRSAs in the Long Aides Training Prog f) Psychiatric Rehal 1) Beginning Janua employ PRSAs or p completed a psychi program to provide program services to 2) If a facility does n psychiatric rehabilit following minimum certified nursing as after the CNA's firs A) Understanding th illness; B) Understanding th rehabilitation, includ psychiatric disabiliti discrimination; C) Confidentiality; D) Preventative stra aggression and cris E) Goals and functi F) Appropriate verb G) Communication residents; and H) Basic psychiatric service delivery. g) Consultants 1) A facility may use professional degree requirements as fac Subpart to provide services and to pro development and in psychiatric rehabilit	exceeds, the requirements for -Term Care Assistants and grams Code. bilitation Services Aides ry 1, 2003, facilities shall bersons who have successfully atric rehabilitation certificate psychiatric rehabilitation o residents. not employ PRSAs to provide ation program services, the training shall be provided to sistants (CNAs) within 30 days t day of employment: ne impact of serious mental he role of psychiatric ding how to manage es and countering stigma and ategies for managing	F9	9999			

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DEPART CENTE	PRINTED: 07/11/2012 FORM APPROVED OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146121	B. WIN	IG		03/08	8/2012
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
BENTON REHAB & HCC					409 NORTH MAIN STREET, PO BOX 84 ENTON, IL 62812	7	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F99	999			

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	PRINTED: 07/11/2012 FORM APPROVED OMB NO. 0938-0391						
STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146121	B. WI	NG _		03/08	8/2012
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	_	
BENTON	I REHAB & HCC				1409 NORTH MAIN STREET, PO BOX 847 BENTON, IL 62812	ſ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 not engage in activities, does not participate in groups, is totally dependent dependent on others for shopping, personal finances, traveling without getting lost, and self-medication, and does not have employable skills. R7 was observed on 03-07-12 at 1:30 pm and 2:20 pm watching television by herself. On 03-07-12 at 11:45 a.m., R7 was observed with her head down, not looking at or speaking to her table mates. E6 was interviewed on 03-07-11 at 7:50 am and stated that R7 will not talk to the staff, refuses programming, will not take to any of the other residents. E6 also stated that R7 was assessed by the facility as having severe mental illness but they do not provide any specialized rehabilitative services for her. Review of the CMS-672 Resident Census and Condition of Residents completed by E10, Care Plan Coordinator on 03-06-12, documents that no resident is receiving health rehabilitative services for mental illness. The CMS-671 Long Term Care Facility Application for Medicare and Medicaid completed by E1, Administrator, documents that the facility does not employ any mental health services professional. (B)		F9	999			

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