FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 145239 B. WING 09/05/2013 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 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 371 Continued From page 20 F 371 orders for health shakes. The review of the list identified that 7 of 17 sampled residents (R2, 4, 11, 14, 17, 20 and 21) and 9 residents in the supplemental sample, (R36, 39, 40, 59, 62, 72, 73, 74 and 75) receive health shakes on a daily occasion. The Centers for Medicare and Medicaid Services form, 672 completed by facility staff during this survey states there are 83 residents living in the facility. F9999 FINAL OBSERVATIONS F9999 LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)3)5) 300.1220b)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 21 of 26

PRINTED: 02/10/2014

## **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 145239 B. WING 09/05/2013 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 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 21 F9999 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 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. Restorative measures shall include, at a minimum, the following procedures: 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. 3) Objective observations of changes in a resident's condition, including mental and

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 22 of 26

PRINTED: 02/10/2014 FORM APPROVED OMB NO 0938-0391

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 145239 B. WING 09/05/2013 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 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 22 F9999 emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: IL6003420

If continuation sheet Page 23 of 26

PRINTED: 02/10/2014

		I AND HUMAN SERVICES				FORM	02/10/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145239	B. WING	;		09/(	05/2013
NAME OF F	PROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE REHAB & HO			-	5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	indicated by the resisent of a facility shall be reviewed a Section 300.3240 A a) An owner, licens agent of a facility shresident. These requirement by: Based on interview review, the facility for preventative interved development of a presidents (R16), an two of three resider for pressure ulcers resulted in R16 devulcer. Findings Include: R16's Physician Or an indwelling urinar to R16's Stage III P Scale for Predicting 07/18/13 document for pressure ulcer of Facility's Turning and tated March 2003 of will occur as indicat care." R16's currer dated 07/22/13 doc positioning schedul	g with the care needed as sident's condition. The plan t least every three months Abuse and Neglect ee, administrator, employee or hall not abuse or neglect a s were not met as evidence , observation and record ailed to implement entions prior to the ressure ulcer for one of three d failed to turn and reposition hts (R12 and R16) reviewed in a sample of 17. This failure reloping a Stage III pressure der dated 08/21/13 documents ry catheter to be inserted due ressure Ulcer. R16's Braden g Pressure Ulcer Risk dated is R16 is at, "Moderate Risk," levelopment. and Positioning Program policy documents, "Turning schedule ted by the resident's plan of nt Pressure Ulcer Care Plan suments, "Reposition per	F9	999			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: IL6003420

If continuation sheet Page 24 of 26

DEPAR <sup>-</sup> CENTEI	RINTED: 02/10/2014 FORM APPROVED MB 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	
		145239	B. WING	i		09/(	05/2013
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE REHAB & HO	;			5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	without assist of on Order dated 08/22// multiple times but of more than one hour R16 was continuou 10:05 a.m. to 11:32 R16's wheelchair th 09/03/13 at 12:55 p wheelchair. R16 st in R16's wheelchair staff) got me out of On 09/03/13 at 12:4 Nurse, stated that F repositioned every f On 09/03/13 at 12:4 Stated that R16 is s repositioned, "at leas review of R16's Phy that documents, "M cannot be in a sittin at a time," E2 verifier repositioned at leas position. On 09/04/13 at 12:4 Nursing, stated R16 discovered on 08/15 is a Stage II." E2 s wheelchair seat wa care on 08/15/13, "I were instituted until pressure ulcer) had	s, "unable to position self e staff." R16's Physician 13 documents, "May be up an not be in a sitting position r at a time." sly observed on 09/03/13 from c.a.m. R16 remained seated in proughout this timeframe. On 0.m., R16 was sitting in R16's ated that R16 had been sitting r, "all day since they (facility bed this morning." 45 p.m., E3, Licensed Practical R16 should be turned and	F9	999			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: IL6003420

If continuation sheet Page 25 of 26

		HAND HUMAN SERVICES				FORM	02/10/2014 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145239	B. WING	;		09/0	05/2013
NAME OF F	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE REHAB & HO	0			5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	dated May 2007 do skin breakdown, a Report will be comp Director of Nurses. On 09/05/13 at 9:00 stated E2 was unal Acquired Skin Cond already looked for i 2. R12's Braden sc be a moderate risk a history of pressur scale notes that R1 repositioning scheo On 9/4/13 R12 was 8:40AM until 11:35 position. This was a minutes.	Care/Pressure Areas policy ocuments, "Upon notification of Newly Acquired Skin Condition pleted and forwarded to the " 0 a.m., E2, Director of Nursing, ble to provide a Newly dition Report for R16, "I've t and cannot find it." cale dated 8/7/13 notes R12 to for pressure sores and having re sores on her coccyx. Braden 12 is on a 2 hour turning and	F9	999			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: IL6003420

If continuation sheet Page 26 of 26