CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391								
CENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	145517		B. WING			C 06/22/2016		
NAME OF F	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
	AK REHABILITATION	I & HCC			WHITE STREET NT VERNON, IL 62864			
(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 SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	F 00	0					
F 242 SS=B	Complaint Investig 483.15(b) SELF-DE MAKE CHOICES	F 24	2					
	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to follow their smoking policy for 7 of 8 residents (R1, R2, R4 through R8) reviewed for smoking in the sample of 8. Findings Include:							
	smoking schedule a 1:30 PM, 4:30 PM, Council Minutes, da documents the resi	oking Policy documents the as follows: 8:30 AM, 10:30 AM, and 7:30 PM. The Resident ated 5/18/16 and 6/15/16, dent's concerns of the ere was no documentation of to these concerns						
	the staff is seldom t scheduled smoke b Smoking Policy. Fre minutes or more. T smoke breaks are s	45AM R4, R6, and R7 states to never on time for the preaks as stated in the equently the staff is late 30 hey went on to say that the scheduled at 8:30AM, 4:30PM and 7:30PM. On						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDICAID SERVICES							0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. DOILDI	NG			C	
		145517	B. WING			06/22/2016		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
	AK REHABILITATION	I & HCC		1700 WHITE STREET				
				N	IOUNT VERNON, IL 62864			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI)	~	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	Υ.	CROSS-REFERENCED TO THE APPROP		DATE	
					DEFICIENCY)			
F 242	Continued From no	ao 1	Го	40				
1 242	Continued From pa	ge i R5 stated the staff is late	F 2	42				
		0-30 minutes late. R5 stated						
		are supposed to be at 8:30AM,						
	10:30AM, 1:30PM, 4:30PM and 7:30PM. On							
	6/22/16 at 10:31 AM, R8 stated the staff is							
	sometimes an hour late to take the residents out to smoke. On 6/22/16 at 12:55 PM, R1 and R2							
		not stay with us during the						
		ne staff is frequently late. They						
	both went on to say in the evening the staff will take a smoke break when it is time for the							
	residents to smoke							
	3. On 6/22/16 at 8:35 AM, E2 (Certified Nurse Aide/CNA) stated she does take the residents out to smoke. She stated the scheduled times for the							
		reaks is 8:30AM, 10:30AM,						
		nd 7:30PM. E2 stated						
		ate if residents are sleeping or						
		d help getting up to go to at 8:25 AM E3 (CNA) stated						
		e the residents out to smoke.						
	She stated the sche	eduled time is 8:30AM,						
		4:30PM and 7:30PM. E3						
		West hall CNAs take turns						
		out for smoke breaks. On E1 (Administrator) state she						
		take the resident's out for the						
		continued by stating the						
		netimes late due to the						
		1 stated the residents do get t taken out to smoke 'on the						
	dot'							
		15 AM E4 (Licensed Practical						
		ta Set Coordinator) provided a owing residents marked as						
		residents are as followed: R1,						
	R2, R4, R6, R7, and							

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		AND HUMAN SERVICES				FORM	06/23/2016 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
145517		145517	B. WING			C 06/22/2016		
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
WHITE C	OAK REHABILITATION	N & HCC	1700 WHITE STREET MOUNT VERNON, IL 62864					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 242	Continued From page 2		F 2	242				
	REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 5. On 6/22/16 at 10:30AM residents were on the patio smoking with E5 (Medical Records/CNA). On 6/22/16 at 1:30PM residents were taken to the patio by E5. At this time E5 stated this is the first day she has been asked to take the residents out to smoke.							

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Facility ID: IL6004881

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