	-	ID HUMAN SERVICES				FORM	APPROVED			
		MEDICAID SERVICES					<u>). 0938-0391</u>			
		ì í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
145446		B. WING _			C 06/02/2016					
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.				
				27	75 EAST CARL SANDBURG DRIVE					
MARIGOL	D REHABILITATION HCC	;		GALESBURG, IL 61401						
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)			
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIZ TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE			
					DEFICIENCY)					
F 000	INITIAL COMMENTS		F	000						
	Complaint #1622020	/11 95939								
F 279	Complaint #1622920 483.20(d), 483.20(k)(279						
SS=D	COMPREHENSIVE (219						
00-0										
	A facility must use the	e results of the assessment								
		d revise the resident's								
	comprehensive plan	of care.								
	The facility must develop a comprehensive care plan for each resident that includes measurable									
		bles to meet a resident's								
	-	mental and psychosocial								
	needs that are identifi assessment.	ied in the comprehensive								
	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).									
	by: Based on observatio review the facility faile isolation precautions	is not met as evidenced n, interview, and record ed to develop a care plan for for two of three residents d for infections in a sample								
	Findings:									
	The Facility's Compre	hensive Care Planning								
	I DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE			

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.

PRINTED: 06/09/2016

CENTERS FOR MEDICARE & MEDICAD SERVICES OMB NO. 0938-0391 MARGOLD REHALTATION IDENTIFICATION NUMBER: (A: MULTIPLE CONSTRUCTION A MULTIPLE CONSTRUCTION C 0 06/02/2016 000000000000000000000000000000000000			ID HUMAN SERVICES					FORM	D: 06/09/2016 MAPPROVED D. 0938-0391
Induction 146446 NUMBER Description Description INMAGE OF REVIDER OF SUPPLIER STREET ADDRESS, CITY STATE JPF CODE 275 EAST CARL SANDBURG DRVE CALESBURG, IL 61401 Continued From Page 1 276 EAST CARL SANDBURG PAVE CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY PULL) REGULATION OF USC DESTITIVES INFORMATION) D PROVIDER SPL NO CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY PULL) REGULATION OF USC DESTITIVES INFORMATION) D PROVIDER SPL NO CORRECTION (EACH CORRECTIVE ACTION SHOULD BE provided \$11/16 documents "Care Plan-Plan of Care descripting approaches/Interventions to be instituted to assist the resident in maintaining/receiving care in relation to the need/problem, and indicating approaches/Interventions to be instituted to assist the resident in maintaining/receiving care in relation to the need/problem." F 279 F 27	STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE COMP	SURVEY PLETED
MARIODURE REHABILITATION HCC 275 EAST CARL SANDBURG DRIVE CALESSURG, IL 61401 PRETX TAC SUMMARY STATEMENT OF DEFICIENCIES USANDBURG DRIVE (LISEN) D D DATE PRETX DATE D D DATE PRETX DATE D D DATE PRETX DATE D D DATE D D DATE D D DATE D D DATE D D D D D D D D D D D D D D D D D D D	145446		B. WING						
MARROGLD REHABILITATION HCC GALESBURG, IL 51401 (04) ID PREFIX TWO ISUMMARY STATEMENT OF DEFICIENCIES. (PADI DEFICIENCY WLST ER PRICED BY LLL) REGULTORY OR LS: IDENTIFYING INFORMATION) ID PREFIX TAS PROVINCERS PLAN OF CORRECTING (CADIS REFERENCY) 0004.1 (in) CADIS REFERENCY F 279 Continued From page 1 policy dated 5/1/16 documents "Care Plan-Plan of Care describing a need/problem." F 279 F 279 <t< td=""><td>NAME OF PF</td><td>ROVIDER OR SUPPLIER</td><td></td><td></td><td>!</td><td>STREET ADDRESS, CITY, STATE, 2</td><td>ZIP CODE</td><td></td><td></td></t<>	NAME OF PF	ROVIDER OR SUPPLIER			!	STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
PREFIX To B (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX To B (EACH CORRECTIVE ACTION SHOULD BE CROSS-HEERENCE DT OT HE APPROPRIATE DEFICIENCY) F 279 Continued From page 1 policy dated 5/1/16 documents "Care Plan- Plan of Care describing a need/problem." F 279 1. R2's face sheet documents TCare Plan- Plan of Care describing a need/problem." F 279 1. R2's face sheet documents R2 was admitted to the facility on 5/21/16. On 6/1/16 at 9/47 a.m. R2's room had Personal Protection Equipment which included a mask, gown and gloves hanging on the door. There was not a sign indicating R2 was in isolation. F 279 E5/ LPN (Licensed Practical Nurse) stated R2 was in isolation for MRSA (MethioIIIII-resistant Staphylococcus Aureus) in the nares (nose nostrils). R2's Physician Orders dated 5/23/16 document "Contact isolation per facility protocol due to MRSA in the bilateral lower extermities. R2's undated current Interim Care Plan did not document R2's MRSA infection nor the isolation precautions to follow. 2. On 6/1/16 at 9.43 a.m. R3's room had a sign on the door. There was, not asses. 1. On 6/1/16 at 9.43 a.m. R3's room had a sign on the door. That read "Stop and see nurse before entering." Outside of R3's norm was a cart which contained gloves, gowns, and masks. 1. M1/16 at 10.05 a.m., E4/ LPN stated R3 was in isolation for ESBL (Extended-Spectrum Beta-lactamase) in the urine. 1. M1/16 at 10.05 a.m., E4/ LPN stated R3 was in isolation for ESBL (Extended-Spectrum 1. M1/16 at 10.05 a.m., E4/ LPN stated R3 was in isolation for ESBL (Extended-Spectum 1. M1/16 at 10.05 a.m., E4/ LPN sta	MARIGOL	D REHABILITATION HCC	;				RIVE		
policy dated 51/1/16 documents "Care Plan- Plan of Care describing a need/problem, and indicating approaches/interventions to be instituted to assist the resident in maintaining/receiving care in relation to the need/problem." 1. R2's face sheet documents R2 was admitted to the facility on 5/21/16. On 61/1/16 at 9.47 a.m. R2's room had Personal Protection Equipment which included a mask, gown and gloves hanging on the door. There was not a sign indicating R2 was in isolation. E5/ LPN (Licensed Practical Nurse) stated R2 was in isolation. R2's Physician Orders dated 5/23/16 document "Contact isolation per facility protocol due to MRSA in the blateral lower extremities. R2's undated current interim Care Plan did not document R2's MRSA infection nor the isolation precautions to follow. 2. On 61/116 at 19.43 a.m. R3's room had a sign on the door that read "Stop and see nurse before entering." Outside of R3's room was a cart which contained gloves, gowns, and masks. On 61/116 at 10.05 a.m., E4/ LPN stated R3 was in isolation for 5/19/16 C-Diff (Clostridium Difficile) pending fecal transplant.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD B		COMPLETION
	F 279	policy dated 5/1/16 dc of Care describing a r approaches/interventi the resident in mainta relation to the need/pu 1. R2's face sheet doo the facility on 5/21/16. R2's room had Person which included a mas on the door. There wa was in isolation. E5/ LPN (Licensed Pr was in isolation for MI Staphylococcus Aureu nostrils). R2's Physician Orders "Contact isolation per MRSA in the bilateral undated current Interi document R2's MRSA precautions to follow. 2. On 6/1/16 at 9:43 a on the door that read entering." Outside of I contained gloves, gov On 6/1/16 at 10:05 a.t in isolation for ESBL (Beta-lactamase) in the R3's medical record d (Clostridium Difficile) i	bouments "Care Plan- Plan need/problem, and indicating ions to be instituted to assist ining/receiving care in roblem." cuments R2 was admitted to . On 6/1/16 at 9:47 a.m. nal Protection Equipment sk, gown and gloves hanging as not a sign indicating R2 ractical Nurse) stated R2 RSA (Methicillin-resistant us) in the nares (nose s dated 5/23/16 document facility protocol due to lower extremities. R2's im Care Plan did not A infection nor the isolation a.m. R3's room had a sign "Stop and see nurse before R3's room was a cart which wns, and masks. m., E4/ LPN stated R3 was (Extended-Spectrum e urine. documents on 5/19/16 C-Diff pending fecal transplant.	F	279				

Facility ID: IL6005797

If continuation sheet Page 2 of 5

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 06/09/2016 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED	
		145446	B. WING				C 06/02/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	TE, ZIP CODE	-	
MARIGOLD REHABILITATION HCC					75 EAST CARL SANDBURG GALESBURG, IL 61401	G DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 279 F 323 SS=D	until the doctor decide the fecal transplant. R document R3's C-Diff precautions to follow. On 6/1/16 at 3:00 p.m care plans contained record is what staff us care plan coordinator chart. E2 verified R2 a indicate R2 or R3 had R3 were in isolation. 483.25(h) FREE OF A HAZARDS/SUPERVIS The facility must ensu environment remains as is possible; and ea	on isolation precautions es if he is going to perform (3's current care plan did not infection nor the isolation a. E2 stated R2 and R3's in R2 and R3's medical se to guide cares until the places a new one in the and R3's care plans did not infections, or that R2 and ACCIDENT SION/DEVICES are that the resident as free of accident hazards		323				
	by: Based on record revi failed to ensure an ele was used in accordan recommendations for reviewed for exit seek of five. Findings include: The electronic monito	is not met as evidenced ew and interview the facility ectronic monitoring bracelet ice with the manufacturer's one of three residents (R1) ing behaviors in the sample ring bracelet manufacturer's 2, document, "The device						

If continuation sheet Page 3 of 5

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
145446		B. WING			06/02/2016			
NAME OF PI	ROVIDER OR SUPPLIER		1	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
MARIGOL	D REHABILITATION HCC				275 EAST CARL SANDBURG DRIVE GALESBURG, IL 61401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 323	has a date stamped of 'Do not use past date should be used on a final The facility's (Electron Check List dated 4-26 documents R1's elect expired on 4-24-16, b R1. R1's Current Elopeme (electronic monitoring the bracelet should be protocol. R1's Elopement Evalue documents R1 require and an anklet as inter elopement. On 6-1-16 at 1:10 p.n stated, "I noticed (R1' (R1) won't leave the b that states 'Do not us On 6-1-16 at 1:50 p.n Supervisor) verified th monitoring bracelet w stated, "When I check still was working so I was expired. The bra dollars to replace."	on the side of the case. This ' is the last date the device resident." hic Monitoring Bracelet) 5-16 through 5-23-16, tronic monitoring bracelet out was still being used on ent Care Plan documents ment and requires an bracelet) at all times, and e checked per the facility's uation dated 5-19-16, es a door alarm, bracelet, ventions to prevent h., Z2 (Family Member) 's) bracelet that is used so building has a stamp on it e past April 24, 2016'." h., E3 (Maintenance hat R1's electronic 'as expired on 4-24-16. E3 ked (R1's) bracelet weekly it didn't change it out when it acelets cost one hundred h., E2 (Director Of Nursing)	F	323	3			
	bracelet) is the last da	the (electronic monitoring ay the bracelet should be R1's) bracelet should have						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/09/2016 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
145446		B. WING			C 06/02/2016		
NAME OF PI	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
MARIGOL	D REHABILITATION HC	c			275 EAST CARL SANDBURG DRIVE		
					GALESBURG, IL 61401		(15)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
F 000							
F 323	Continued From page been replaced with a		F	323			
		cording to (R1's) care plan					
	(R1) should have a ci						
	elopement."						

Event ID: NQ2W11

Facility ID: IL6005797

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