

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E897	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/02/2016
NAME OF PROVIDER OR SUPPLIER OAK TERRACE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1750 WEST WASHINGTON SPRINGFIELD, IL 62702		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 354 SS=C	<p>Complaint #1642790/IL85691</p> <p>483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide the required Registered Nurse coverage. This failure has the potential to affect all 44 residents living at the facility.</p> <p>Findings include:</p> <p>1. The Facility's Nurses Working Schedule, dated 5/15-6/11/16, documents that on 5/15, 5/28, 5/29 and 6/11/16, no Registered Nurses (RN) were on duty.</p> <p>On 6/2/16 at 11:30 AM, E1, Administrator, said there were no RNs on those dates of the schedule. E1 stated "We have had an ad (advertisement) out for RNs, but no reply, they</p>	F 354			

LABORATORY DIRECTOR'S OR PROVIDER/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.

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F 354	<p>Continued From page 1 just aren't out there."</p> <p>On 6/2/16 at 1:00 PM, E2, Director of Nurses (DON), stated "We don't have an RN working every day. We haven't had to use Agency nurses, we usually patch together enough help." E2 also stated that the only Facility Policy related to staffing is Mandatory-Mandating policy</p> <p>The Mandatory-Mandating policy, dated 10/24/13, documents, in part, "It is (the facility's) responsibility to provide adequate staff coverage per the IDPH (Illinois Department of Public Health) guidelines. These guidelines are for the benefit and safety of out residents and staff."</p> <p>2. The Facility Date Sheet, dated, 6/2/16 documents that the facility has 44 residents living in the facility.</p>	F 354			