

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEWMAN REHAB & HEALTH CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 418 SOUTH MEMORIAL PARK DRIVE NEWMAN, IL 61942
---	--

(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) COMPLETE DATE
S9999	<p>Final Observations</p> <p>STATEMENT OF LICESNURE VIOLATIONS:</p> <p>300.670c) 300.1230k) 300.2010a)1)</p> <p>300.670 Disaster Preparedness</p> <p>c) Disaster drills for other than fire shall be held twice annually for each shift of facility personnel.</p> <p>This requirement was not met as evidenced by the following:</p> <p>Based on record review and interview, the facility failed to ensure that disaster drills were conducted twice on the day shift, on the evening shift, and on the night shift. This has the potential to effect all 44 residents.</p> <p>Finding include:</p> <p>The facility's fire and disaster drills records were reviewed for the past 12 months. Disaster drills were not conducted for twice on the day shift (6 AM to 2 PM), once on the evening shift (2 PM to 10 PM) and once on the night shift (10 PM to 6 AM). Disaster drills were conducted for the evening on 1-29-15 and the night shift on 6-7-15.</p> <p>On 6-24-15 at 10:00 A.M., E1, Administrator acknowledged that the facility only had two disaster drills in the past year. E1 also stated that</p>	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 07/09/15

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEWMAN REHAB & HEALTH CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 418 SOUTH MEMORIAL PARK DRIVE NEWMAN, IL 61942
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 1</p> <p>"here we are in tornado alley."</p> <p>According to the facility's "Resident Census and Conditions of Resident" signed 6-22-15, 44 residents reside at the facility.</p> <p style="text-align: center;">(B)</p> <p>-----</p> <p>300.1230k) Effective September 12, 2012, a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. This requirement is not met as evidenced by: Based on record review and interview the facility failed to meet minimum staffing requirements for nursing and direct care staff for eight of 14 days reviewed, by failure to have 10% provided by Registered Nurses and sufficient additional direct care staff hours. This failure has the potential to affect all 44 residents in the facility. Findings include:</p> <p>The facility spreadsheet for Staffing from 6/1/15 to 6/14/15, shows an average daily skilled and intermediate census of 40.21. This census number calculates to an RN (Registered Nurse) requirement of 11.36 hours per 24 hours, and an Additional Direct Care Staff requirement of 85.212 hours per 24 hours.</p> <p>These requirements are not met for the following days, along with actual hours worked. RNs - includes 50% Director of Nursing hours where applicable:</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEWMAN REHAB & HEALTH CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 418 SOUTH MEMORIAL PARK DRIVE NEWMAN, IL 61942
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>6/1/15 - 8 hours; 6/2 - 4.5 hours; 6/3 - 4.25 hours; 6/6 - 4.0 hours; 6/7 - 4.0 hours; 6/8 - 9.5 hours; 6/11 - 4.0 hours; 6/12/15 - 4.0 hours. Additional Direct Care Staff hours - includes therapy hours: 6/6 - 76.63 hours; 6/7/15 - 79.08 hours.</p> <p>These hours were confirmed with the Nursing and CNA (Certified Nurse Aide) schedule for June 2015.</p> <p>On 6/23/14, at 3:45pm, E1 (Administrator) confirmed hours are accurate and they are short RN hours.</p> <p>The Resident Census and Conditions of Residents report dated 6/22/15 documents a census of 44 residents in the facility.</p> <p style="text-align: center;">(AW)</p> <p>300.2010 Director of Food Services a) A full-time person, qualified by training and experience, shall be responsible for the total food and nutrition services of the facility. This person shall be on duty a minimum of 40 hours each week. 1) This person shall be either a dietitian or a dietetic service supervisor.</p> <p>300.330 Definitions: Dietetic Service Supervisor - a person who is a dietitian; or is a graduate of a dietetic technician or dietetic assistant training program, corresponding or classroom, approved</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEWMAN REHAB & HEALTH CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 418 SOUTH MEMORIAL PARK DRIVE NEWMAN, IL 61942
---	--

(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) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>by the American Dietetic Association; or is a graduate, prior to July 1, 1990, of a Department approved course that provided 90 or more hours of classroom instruction in food service supervision and has had experience as a supervisor in a health care institution which included consultation from a dietitian; or has successfully completed a Dietary Manager's Association approved dietary managers course; or is certified as a dietary manager by the Dietary Manager's Association; or has training and experience in food service supervision and management in a military service equivalent in content to the programs in the second, third, or fourth paragraph of this definition.</p> <p>These requirements are not met as evidenced by the following:</p> <p>Based on interview and record review, the facility failed to have a qualified Dietetic Services Supervisor who has completed the required training and works 40 hours per week in the dietary department. This has the potential to effect all 44 residents.</p> <p>Findings include:</p> <p>E8, Dietary Manager stated on 6-23-15 at 12:45 P.M. that became the Dietary Manager in August 2014. E8 stated she is enrolled in the University of North Dakota correspondence Dietary Manager course. E8 stated she has not completed any of the 16 lessons. E8 stated she has had the books and lessons since February of 2015.</p> <p>E8's personnel file was reviewed. E8 began as Dietary Manager on 7-28-14. E1, Administrator verified on 6-23-15 at 1:30 P.M. that E8 began as</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002091	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER NEWMAN REHAB & HEALTH CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 418 SOUTH MEMORIAL PARK DRIVE NEWMAN, IL 61942
---	--

(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) COMPLETE DATE
S9999	Continued From page 4 Dietary Manager on 7-28-14. According to the facility's "Resident Census and Conditions of Resident" signed 6-22-15, 44 residents reside at the facility. (AW)	S9999		