

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/05/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145933	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Apostolic Christian Skylines		STREET ADDRESS, CITY, STATE, ZIP CODE 7023 North East Skyline Drive Peoria, IL 61614	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>33973</p> <p>Based on interview and record review, the facility failed to notify resident/resident representative in writing of hospital transfers for two (R14 and R36) of two residents reviewed for hospitalization in a sample of 24.</p> <p>Findings include:</p> <p>The facility's undated Transfer to Hospital Checklist documents, A resident must have the below listed items prior to transferring to the hospital. Please check off and sign at the bottom indicating these were given. Place this form in Medical Records to be scanned into resident chart. This checklist includes Bed Hold & Return to Facility Policy and Transfer Referral Form (nurse to keep a copy).</p> <p>The facility's undated Transfer Referral Form includes but is not limited to Date of Transfer and Reason for Transfer with a place for nurse's signature at the bottom.</p> <p>1. R14's Nurse Progress note, dated 10/24/23, documents R14 was transferred out to a local hospital per ambulance.</p> <p>R14's clinical record does not document written notification was given to the resident/resident's representative.</p> <p>On 10/10/24, at 10:50am, V7, Social Service Director, could not locate a written notification to representative for R14's 10/24/23 hospital transfer.</p> <p>34131</p> <p>2. R36's medical record documents R36 went to the hospital on 9/19/24.</p> <p>R36's medical record has no documentation R36 and R36's representative was notified of the transfer or discharge, and the reasons for the move in writing.</p> <p>On 10/10/24, at 10:55 AM, V7, Social Service Director, could not produce written notification to R36 and R36's representative for R36's 9/19/24 hospital transfer.</p>		

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.

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

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145933	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Apostolic Christian Skylines		STREET ADDRESS, CITY, STATE, ZIP CODE 7023 North East Skyline Drive Peoria, IL 61614	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>33973</p> <p>Based on interview and record review, the facility to provide a copy of their bed hold policy for two (R14 and R36) of two residents reviewed for bed holds in a sample of 24.</p> <p>Findings include:</p> <p>The facility's Bed Hold and Return to Facility Policy, revised 10/21/19, documents, It is the policy of (named facility) to ensure that each resident (living in the Skilled Nursing and Memory Care) and their resident representative are made aware of the facility's and the State of Illinois bed-hold and reserve bed payment policy upon admission and before a resident is transferred to a hospital or goes on a therapeutic leave. For emergency transfers, notice must be given within 24 hours.</p> <p>1. R14's Nurse Progress note, dated 10/24/23, documents R14 was transferred out to the local hospital; R14 returned on 10/31/23.</p> <p>R14's clinical record does not document a bed hold policy was given to the resident or resident representative.</p> <p>On 10/10/24, at 10:50am, V7, Social Service Director, could not locate the bed hold notice for R14's 10/24/23 hospital transfer.</p> <p>34131</p> <p>2. R36's medical record documents R36 went to the hospital on 9/19/24.</p> <p>R36's medical record has no documentation R36 and R36's representative was notified of the facilities bed hold in writing.</p> <p>On 10/10/24 at 10:55 AM, V7, Social Service Director, could not produce written notification of the bed hold policy to R36 and R36's representative for R36's 9/19/24 hospital transfer.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145933	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Apostolic Christian Skylines		STREET ADDRESS, CITY, STATE, ZIP CODE 7023 North East Skyline Drive Peoria, IL 61614	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34131</p> <p>Based on observation, interview, and record review, the facility failed to develop a careplan to include oxygen and edema with compression hose for four (R5, R6, R11, R43) of 15 residents reviewed for care plan development in a sample of 24.</p> <p>Findings include:</p> <p>Facility Care Plan Process, dated 3/4/24, documents, (Facility) will create a resident-centered plan of care for each skilled resident residing at the facility.</p> <p>1. R6's current physician orders for October 2024 documents, Oxygen 2-4 L (liters) per NC (nasal cannula) as needed with an initial order date of 5/14/24.</p> <p>R6's online medical record documents R6 has Chronic Pulmonary Edema.</p> <p>On 10/8/24 at 1:18 PM, R6 had oxygen and an oxygen concentrator in her room.</p> <p>On 10/9/24 at 10:05 PM, R6 was in bed with 2 Liters of oxygen on by nasal cannula.</p> <p>R6's current careplan has no documentation R6 uses oxygen.</p> <p>On 10/10/24 at 11:44 AM, V4, Regional Nurse, verified R6 did not have oxygen on her careplan, and it should be.</p> <p>2. R11's current physician orders for October 2024 documents, (Trade name/Compression Dressing) to bilateral lower legs on in AM off at HS (hour of sleep- from just above toes to back of knee [NAME]) twice a day, with an initial order date of 3/17/23.</p> <p>R11's online medical record documents R11 has a history of Edema.</p> <p>On 10/8/24 at 12:47 PM, R11 was in her wheelchair, and R11's bilateral legs had compression hose on and were edematous (swollen).</p> <p>On 10/09/24 at 10:02 AM, R11 was in her wheelchair, and R11's bilateral legs had compression hose on and were edematous.</p> <p>R11's current careplan has no documentation R11 has edema and wears bilateral compression hose.</p> <p>On 10/10/24 at 11:36 AM, V4, Regional Nurse, stated, I don't see edema or (Trade name/Compression Dressing) on R11's careplan and it should be. She has been wearing her (Trade name/Compression Dressing) since 2023.</p> <p>33973</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145933	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Apostolic Christian Skylines		STREET ADDRESS, CITY, STATE, ZIP CODE 7023 North East Skyline Drive Peoria, IL 61614	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On 10/8/24, at 9:59 AM, R5 was lying in bed with an oxygen concentrator at the bedside.</p> <p>R5's current careplan does not include the use of or cares for oxygen.</p> <p>On 10/10/24, at 1:53 PM, V4, Regional Nurse, stated R5 returned from the hospital with the oxygen after a respiratory illness. At this time, V4 confirmed oxygen is not listed on V5's current careplan and should be.</p> <p>4. On 10/8/24, at 10:56 AM, R43 was lying in bed with oxygen infusing per nasal cannula.</p> <p>R43's current careplan does not include the use of or cares for oxygen.</p> <p>On 10/10/24, at 1:55 PM, V4, Regional Nurse, stated R43 uses oxygen for comfort and confirmed that oxygen is not listed on R43's current careplan and should be.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145933	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Apostolic Christian Skylines		STREET ADDRESS, CITY, STATE, ZIP CODE 7023 North East Skyline Drive Peoria, IL 61614	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide and implement an infection prevention and control program.</p> <p>33970</p> <p>Based on observation, interview, and record review, the facility failed to perform perineal care in a way to prevent cross contamination of environmental objects for one resident (R53) of two residents reviewed for perineal care in a total sample of 24.</p> <p>Findings Include:</p> <p>The Facility's undated Enhanced Barrier Precautions policy documents, Enhanced barrier precautions are designed to help reduce the transmission of multidrug-resistant organisms. Infection or colonization with an MDRO (Multidrug Resistant Organism) when Contact Precautions do not otherwise apply. During High Contact Resident Care Activities PPE (Personal Protective Equipment) Must be Used: Transferring and Providing hygiene.</p> <p>The Facility's undated Gloving policy documents, Gloves are to be worn in the following situations: non-intact skin, blood or body fluids, residents in isolation and potential or known contaminated surfaces or equipment. Change gloves when moving from a contaminated body site to a clean body site on the same resident Soiled gloves should always be changed before touching any clean surfaces.</p> <p>The Facility's Perineal Care policy, dated 10/28/22, documents, Perineal care, the washing of the genital and rectal areas of the body is an important basic care that helps prevent UTIs (Urinary Tract Infections) as well and other infections and irritation. The policy also documents Remove gloves before touching clothing, bed rail, curtain etc.</p> <p>R53's current Physician Order Sheet, dated October 2024, documents, Enhanced Barrier Precautions for colonization of ESBL (Extended Spectrum Beta-Lactamases) and VRE (Vancomycin Resistant Enterococci) in the urine.</p> <p>Throughout the survey R53's door had a sign on it documenting Enhanced Barrier Precautions.</p> <p>10/09/24 at 9:00 AM, V5(Certified Nursing Assistant/CNA) donned gown, gloves, mask, and eye protection. V5 pushed R53 into the bathroom, R53 stood, V5 pulled R53's brief and pants down, and R53 sat on the toilet and urinated. When R53 stood up, V5 wiped her perineal area with wipes from front to back two times, then threw the wipes in the trash can. V5 then proceeded to pull up R53's brief and pants. V5 zipped up R53's pants and then held both of her hands with R53's gloved hands and assisted her to sitting position in wheeled recliner. V5 then fixed R53's shirt, necklace, and head turban. V5 then put her hands on both arms of the wheeled recliner and backed R53 out of the bathroom, and then V5 removed PPE and washed her hands.</p> <p>On 10/9/24 at 2:30 PM, V5 (Certified Nurse Aid) confirmed she did not take her gloves off or perform hand hygiene throughout R53's toileting. V5 stated, I should have taken them (gloves) off after I wiped her, before I touched her clothes and chair.</p>		