STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. Building B. Wing	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watseka Rehab & Hlth Care Ctr	715 East Raymond Road Watseka, IL 60970

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Based on interview and record review R11 did not have resident centered interventions in place to address communication needs related to R11's dominant language being Spanish. R11 is one of three residents reviewed for communication in a sample list of 23 residents. Finding Include: R11's hospital discharge date d 6/17/22 includes the following diagnoses: Altered Mental Status, Dementia, Diabetes Mellitus and Encephalopathy. R11's Nursing Admission assessment dated [DATE] at 2:00PM by V3, Acting Director of Nursing documents R11 spoke limited English. Dominant Language: Spanish. On 6/23/22 at 1:00PM V3, Acting Director of Nursing stated (R11) spoke only a little English. On 6/23/22 at 3:30pm, V1, Administrator stated (R11) was brought to a strange place and could not understand English and we did not have a communication tool in place. On 6/23/22 at 3:45 pm, V4 Social Service Director confirmed that there was a language barrier with (R11) and staff and there was nothing in place to bridge that barrier.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 31284 Based on record review and interview, the facility failed to notify a resident's (R22) physician of treatment/services and medical condition changes. R22 is one of three residents reviewed for hemodialysis in the sample list of twenty-three. Findings include: R22's Physician Order Sheet dated July 2022 includes the following diagnoses: End Stage Renal Disease, Seizure Disorder, Diabetes Mellitus and Acute Respiratory Failure with Hypoxia. R22 has orders for hemodialysis three times a week, Tuesday, Thursday and Saturday. R22's Nursing Notes dated 6/19/22 document R22 as being positive for Covid. On 6/20/22 Nursing Notes document that (R22) remains on isolation protocols per Covid positive. There is no documentation in R22's Medical Chart that V28, Attending Physician was notified of R22 testing Covid positive. R22's Nursing Notes dated 6/30/22 at 8:00 am document the following: Noted to be very lethargic et (and) confused, skin cool et clammy. Responds only to name unable to sit up on bed. O2 (oxygen) 88% on 2 L (liters). (Local) ambulance here to transport to (local hospital) ER (emergency room). There is no notification to V28 documented. An emergency room Note dated 6/30/22 at 9:30 am documents the following: Prior to patients (R22) arrival, (V11) from (Nursing Home) called to give report regarding why sending patient (R22) in to the ER for treatment. (V11) stated that (R22) recently had Covid but has been out of quarantine for 2 days. However, throughout this Covid illness has missed dialysis, as (dialysis center) would not run (R22) and (R22) has not had a treatment in 11 days. This writer questioned (V11) if the dialysis situation was referred to management at their facility but (V11) was unsure. On 7/6/22 at 9:00 am, V28 stated the facility did not notify him of R22's testing positive for Covid nor did the facility notify him that R22 had missed 4 dialysis treatments, going 11 days without dialysis. V28 stated I am (R22's) Attending Physician and I should have been notified. The facility was unable to provide a policy on Physician Notification.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Failures at this requirement required more than one Deficient Practice Statement. A.) Based on observation, interview, and record review the facility failed to ensure R12 was not subjected to physical violence by another resident, (R11). R11 forcibly held a pillow over R12's face, impeding R12's breathing. R11 and R12 are two of ten residents reviewed for abuse in a sample list of 23 residents. An Immediate Jeopardy situation was identified on 6/29/22. The Immediate Jeopardy was identified to have begun on 6/20/22 when R11 was found over R12 with a pillow, pressing down on R12's face, impeding R12's breathing. While the immediacy was removed on 6/30/22, the facility remains out of compliance at a severity level 2. The facility continues to monitor the effectiveness of their behavior management/supervision plan and revised new resident admission screening policy implementation. Findings include: On 6/23/22 at 12:00PM V12, Certified Nurse's Aide (CNA) stated I was checking residents on the Dementia Unit on 6/20/22 at about 1:30AM. I went into the resident's room where (R11) and (R12) were roommates. (R11) was straddling (R12). (R11) was holding a plastic pillow without a pillowcase on (R12's) face. The pillow was interfering with (R12's) breathing. (R12) was too weak to push (R11) off him. (R12) did not lose consciousness. (R12) was visibly shaken. I was able to get (R11) off (R12). I called (V13), Licensed Practical Nurse. She called Emergency Medical Services. (R11) was taken to the hospital and has not returned. R11's hospital discharge date d 6/17/22 includes the following diagnoses: Altered Mental Status, Dementia, Diabetes Mellitus and Encephalopathy. R11's hospital transfer sheet dated 6/17/22 documents during hospitalization (R11) had recurrent episode of agitation and was started on Seroquel (antipsychotic) 25 milligrams twice daily. (R11) should follow-up with a facility doctor within 2-3 days. There is no documentation to support a facility doctor followed up on this as ordered. There is no documented Care Plan for R11 from 6/17/22 until he left the facility 6/20/22. Hospital Critical Care note also contained in R11's 6/17/22 transfer sheet documents (R11's) son reports that they have had difficulty managing with the patient at home. He (R11) does become angry and combative when questioned regarding his insulin and therefore is unclear if (R11) is compliant with his medication. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/29/22 at V20, (R11's) family member stated (R11) was getting violent at home before he fell and went to the (hospital). I asked him to show me his glucose monitor so I could get him the right test strips. (R11) got angry and pulled a knife from the sink and tried to cut me with it. We told the nurses at the hospital, so they knew. (While at the hospital) (R11) pulled (family member) (V21's) hair and would not let go. The nurses had to make him let go. The facility (nursing home) never talked to me to find out if (R11) had any aggressive behaviors. I thought the hospital would tell them. R11's nurse's note dated 6/17/22 at 7:00PM documents (R11) admitted and began wandering. Unable to assess or take vital signs related to language difference (R11's dominant language is Spanish). (R11) cannot be redirected. R11's nurse's note dated 6/17/22 at 10:00PM documents (R11) has moved furniture in his room blocking door to bathroom. There are no subsequent nurse's notes for (R11) until 6/20/22 at 1:30AM which documents CNA (Certified Nurse's Aide) (V12) called nurse (V13) to (R11's) room. (CNA) stated (R11) has a pillow over roommate's (R12's) head. Witness Statement was obtained. Emergency Medical Services were called after resident (R11) was removed to ensure roommate's safety. Resident (R11) threw (soda) pop can at CNA (V12). On 6/23/22 at 3:30pm, V1, Administrator confirmed that the facility is rushed to look at prospective (resident) admits and are not always aware of behaviors that may not be safe for the facility. V1 confirmed that Nursing looks at the medications and documented notes. V1 also confirmed that Nursing should have seen that R11 was started on Seroquel (anti-psychotic) in the hospital. V1 stated My opinion of (R11's) incident was because of the language barrier. (R11) was brought to a strange place and could not understand English and we did not have a communication tool in place. R11's Nursing Admission Assessment by V3, Acting Director of Nursing confirmed R11 spoke limited English. dated 6/17/22 at 2:00PM documents Dominant Language: Spanish Limited English. On 6/23/22 at 1:00PM V3, Acting Director of Nursing stated (R11) spoke only a little English. R12's Activity Admission Care Plan (unsigned) dated 6/17/22 documents (R12) is Alert, Cooperative, and Forgetful. R12's Activity Admission Care Plan (unsigned) dated 6/17/22 also documents under the heading Identified need Plan Areas: Intellectual challenges, wandering, cognitive/memory (issues), and communication. R12's psychosocial assessment dated [DATE] by V22, Dementia Director documents the only behaviors exhibited by (R12) are Wanders/Paces. On 6/27/22 at 3:00PM R12 was sitting on the patio. He was not able to verbalize his name or where he was. He has no recollection of the incident with R11 when questioned. R12 appeared weak and frail. He can ambulate but displayed a shuffling unstable gait. Both his ankles were edematous. He muttered to himself, but he is unaware of his surroundings. On 6/29/22 at 11:00 a.m. V1, Administrator was notified of the Immediate Jeopardy situation. The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the immediate jeopardy: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1.) V1, Administrator and V3, Acting Director of Nursing were in serviced by Regional Director of Clinical Operations concerning abuse procedures. This is documented on an in-service sign-in sheet dated 6/29/22. Per interview with V3 all staff who have not been in-serviced will be required to take this training prior to returning to work for next scheduled shift 2.) In-servicing of all staff concerning Abuse Prevention and reporting reasonable suspicion of a crime By V1 and V3 is documented on an in-service sign in sheet dated 6/29/22. 3.) Paperwork dated 6/29/22 was presented by V1 to document R11 was being involuntarily discharged and is not going to return to the facility. 4.) The facility notified the local police department 6/28/22 of the incident 6/20/22 involving R11 and R12. The local police were observed to be at the facility talking to V1. 5.) The facility's admission policy was updated to include a prescreen for the possibility of violent behaviors. The facility provided a copy of this policy 6/30/22. 6.) V1 provided a copy of the sign-in sheet for an in-service she provided to the members of the facility's Quality Assurance Team 6/29/22 regarding prescreening residents for harmful or violent behaviors. 7.) The facility assessed all residents for possible vulnerability to physical violence and some room changes were initiated related to resident safety and compatibility. This was verified to be in place on 6/30/22. 31284 B.) Based on record review and interview, the facility failed to ensure R1, R4 and R5 were not subjected to physical abuse by R3 on two occasions. The facility failed to ensure R2 was not subjected to physical abuse by R1. The facility failed to ensure R20 was not subjected to physical abuse by R21. R1, R2, R3, R4, R5, R20 and R21 are seven of ten residents reviewed for physical abuse in the sample list of 23. Findings include: 1.) A Facility Reported Incident dated 4/20/22 documents that R3 grabbed R1's face while R3 was being assisted back to R3's room to get a snack. R1 was sitting in the hall at this time. R3 and R1 were separated by V10, Certified Nursing Assistant (CNA). A statement by V10 documents the following: On 4/20/22, (R3) walked out of (R3's) room and I met (R3) in the hallway and asked if (R3) was hungry, (R3) said yes. So I went to walk (R3) to sit down to eat and (R3) went in the opposite direction and went to (R1) and started rubbing (R1's) head, (R1) started swinging on (R3) and I intervened between them and took (R3) away from the situation. On 6/23/22 at 11:05 am, V10 confirmed that R3 grabbed R1's head and also pulled R1's hair. V10 stated (R3) just deliberately walked over to (R1) and grabbed (R1). (R1) swatted (R3) away and I was able to separate them. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2.) A Facility Reported Incident dated 6/6/22 documents R3 striking another resident (R4) in the head/shoulder area while R4 was sitting in R4's wheelchair. R3 then struck another resident (R5) in the back area during this time. A statement dated 6/6/22 by V11, Registered Nurse documents the following: (R3) became agitated cursing and grabbing at items to break. Distracting ineffective. (R3) then double fisted (R4) on the shoulders. Residents were separated. (R3) then went out the patio door and when approached (R3) then turned and hit (R5) on the shoulders and back. On 6/17/22 at 11:15 am, V1 Administrator stated (R3's) actions of striking others are behaviors, but yes it is abuse. On 6/21/22 at 11:05 am, R5 who is alert and oriented to person, place and time confirmed that R3 struck R5 with R3's double fist. R5 stated It really shook me up, I was scared of (R3). I don't want to be anywhere near (R3). On 6/21/22 at 12:36 pm, R4 confirmed that R3 had purposely struck R4 with double fists. R4 stated (R3) is a bully. On 6/23/22 at 11:15 am, V11 confirmed witnessing R3 striking both R4 and R5 with R3's fists. V11 stated (R3) intentionally walked over to (R4) and clasped both of (R3's) hands together making a double fist and struck (R4) and (R5) hard around their shoulders, head and back. R3's Face Sheet (current) includes the following diagnoses: Prostate Cancer, Intellectual Disability and Hypertension. R3's Minimum Data Sets dated 2/28/22 and 4/14/22 document R3 with no behaviors and is not able to complete the Brief Interview for Mental Status (BIMS) section. R3's Care Plan (current) documents R3 has impaired communication related to intellectual delay. On 6/23/22 at 3:45 pm, R3 during interview had a speech impediment but R3 was understandable and was able to tell this writer where R3 is, R3's name and R3's needs. 3.) A Facility Reported Incident dated 6/5/22 documents R1 began yelling at R2 and then kicked R2 in the shin. A statement dated 6/5/22 by V3, Former Assistant Director of Nursing, (now Director of Nursing) documents the following: I came in to check email and supplies. I was met by peer stating (R1) was going after (R2). Responded to A Hall Resident Room and saw (R1) foot kicking (R2) on front of shin. (R1) was verbally yelling at (R2). Separated immediately. (R1) returned to (R1's) room. (R1) stated (R2) was in (R1's) room and (R1) was tired of it. R1's Face Sheet (current) includes the following diagnoses: Cerebral Vascular Accident, Aphasia, Disphagia, Bipolar and Hypertension. R1's Minimum Data Set, dated dated dated [DATE] documents R1 as being mildly cognitively impaired. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/16/22 at 10:00 am V3 confirmed that V3 witnessed R1 kick R2 in the leg. V3 stated (R1) knows exactly what (R1) is doing. (R1) thinks (R1) owns that alcove where both of their rooms (R1 and R2) were located. (R1) kicked R2 deliberately. On 6/21/22 at 10:55 am R1 was sitting in the hall and when asked a question, R1 told writer to get the (expletive) away from me. On 6/21/22 at 2:30 pm, R2 is not able to form words but is able to respond with head movements. R2 nods up and down in the yes gesture that R1 did kick R2 in the leg. R2 also nods in the yes gesture that it was a hard kick and it hurt. R2 nods yes that R2 is afraid of R1. On 6/23/22 at 3:35 pm V3 confirmed that R1 and R3 are mobile throughout the facility and are not on 1:1 supervision. 4.) R21's Physician's Order Sheet (POS) for June 1, 2022 through June 20,2022 includes the following diagnoses: Dementia, Depression, Anxiety, and Type 1 Diabetes. R21's Social Service Note dated 6/6/22 documents Resident observed being aggressive in hall. Staff redirected. R21's Social Service Note dated 6/8/22 documents (R21) irritated today. (R21) angry toward anyone who would approach her. R20's Physician's Order Sheet (POS) for June 1, 2022 through June 20,2022 includes the following diagnoses: Dementia, Psychosis, Anxiety, R21's Incident Report dated 6/19/22 documents (R21) struck (R20) across the face with an open hand. knocking (R20's) glasses off (R20's) face. On 6/27/22 at 2:39PM V17, CNA (Certified Nurse's Aide) stated I was working 6/19/22. I was in a resident's room when I heard a noise from the dining area. I went there as soon as I could. I saw (R21) raise her hand up and slap (R20) hard enough to knock (R20's) glasses off. I separated the residents and called the nurse. (R21) and (R20) are both very confused and (R21) will hit at staff sometimes. On 6/27/22 at 3:00PM V3, Acting Director of Nursing stated (R21) was seen striking (R20) in the face and knocking off (R20's) glasses. They both have Dementia. (R20) was not injured.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 37813 Based on interview and record review the facility failed to develop and implement a policy to screen residents for dangerous behaviors. This failure resulted in one resident (R11), who had a history of physically abusive behavior, holding a pillow over (R12's) face. This affected two residents (R11, R12) of ten residents reviewed for abuse in a sample list of 23 residents. Findings Include: Page four of the facility's policy Abuse Prevention Program dated 10/14/16 states Resident Assessment: As part of the resident's social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the Care Planning process, staff will identify any problems, goals, and approaches which would reduce that chances of mistreatment, neglect, and abuse of these residents. Staff will continue to monitor the goals and approaches on a regular basis. As written, the facility abuse prevention policy and admissions policy failed to incorporate pre-admission screening measures to determine if a prospective resident has any known history or predisposition to violent behaviors. (R11's) hospital discharge date d 6/17/22 includes the following diagnoses: Altered Mental Status, Dementia, Diabetes Mellitus and Encephalopathy. R11's hospital transfer sheet dated 6/17/22 documents during hospitalization (R11) had recurrent episode of agitation and was started on Seroquel (antipsychotic) 25 milligrams twice daily. (R11) should follow-up with a facility doctor within 2-3 days. There is no documentation to support a facility doctor followed up on this as ordered. There is no documented Care Plan for R11 from 6/17/22 until he left the facility 6/20/22. Hospital Critical Care note also contained in R11's 6/17/22 transfer sheet documents (R11's) son reports that they have had difficulty managing with the patient at home. He (R11) does become angry and combative when questioned regarding his insulin and therefore is unclear if (R11) is compliant with his medication. On 6/23/22 at 12:00PM V12, Certified Nurse's Aide (CNA) stated I was checking residents on the Dementia Unit on 6/20/22 at about 1:30AM. I went into the resident's room where (R11) and (R12) were roommates. (R11) was straddling (R12). (R11) was holding a plastic pillow without a pillowcase on (R12's) face. The pillow was interfering with (R12's) breathing. (R12) was too weak to push (R11) off him. (R12) did not lose consciousness. (R12) was visibly shaken. I was able to get (R11) off (R12). I called (V13), Licensed Practical Nurse. She called Emergency Medical Services. (R11) was taken to the hospital and has not returned. On 6/23/22 at 3:30pm, V1, Administrator confirmed that the facility is rushed to look at prospective admits and are not always aware of behaviors that may not be safe for the facility. V1 confirmed that Nursing looks at the medications and documented notes. V1 also confirmed that Nursing should have seen that R11 was started on Seroquel (anti-psychotic) in the hospital. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/29/22 at V20, (R11's) family member stated (R11) was getting violent at home before he fell and went to the (hospital). I asked him to show me his glucose monitor so I could get him the right test strips. (R11) got angry and pulled a knife from the sink and tried to cut me with it. We told the nurses at the hospital, so they knew. (While at the hospital) (R11) pulled (family member) (V21's) hair and would not let go. The nurses had to make him let go. The facility (nursing home) never talked to me to find out if (R11) had any aggressive behaviors. I thought the hospital would tell them. On 6/29/22 at 10:15AM V23, Corporate Community Relations Coordinator stated I am responsible for routing all admission packets to the appropriate facility. The Assistant Director of Nurse's has the final say on whether a resident is appropriate. I send the entire referral packet to the facility. On 6/29/22 at 10:30AM V3, Acting Director of Nursing stated I see the preadmission packet for a few minutes. I make recommendations, but if corporate thinks we should take the resident we do. We can have as many as four admission in one day. On 6/29/22 at 11:00AM V1, Administrator stated We get the packets and we have about fifteen minutes to accept or deny admission. We are pressured by corporate to take every admission. Social Services does not assess the resident until he/she is in the building. There is no opportunity to talk to family prior to admission.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Based on interview and record review the facility failed to initiate a baseline care plan for R11, one resident admitted to the facility with history of physically violent behaviors of 23 residents reviewed for Care Plans in a sample of 23 residents. Findings Include: (R11's) hospital discharge date d 6/17/22 includes the following diagnoses: Altered Mental Status, Dementia, Diabetes Mellitus and Encephalopathy. R11's hospital transfer sheet dated 6/17/22 documents during hospitalization (R11) had recurrent episode of agitation and was started on Seroquel (antipsychotic) 25 milligrams twice daily. (R11) should follow-up with a facility doctor within 2-3 days. There is no documentation to support a facility doctor followed up on this as ordered. There is no documented Care Plan for R11 from 6/17/22 until he left the facility 6/20/22. Hospital Critical Care note also contained in R11's 6/17/22 transfer sheet documents (R11's) son reports that they have had difficulty managing with the patient at home. He (R11) does become angry and combative when questioned regarding his insulin and therefore is unclear if (R11) is compliant with his medication. On 6/29/22 at V20, (R11's) family member stated (R11) was getting violent at home before he fell and went to the (hospital). I asked him to show me his glucose monitor so I could get him the right test strips. (R11) got angry and pulled a knife from the sink and tried to cut me with it. We told the nurses at the hospital, so they knew. (While at the hospital) (R11) pulled (family member) (V21's) hair and would not let go. The nurses had to make him let go. The facility (nursing home) never talked to me to find out if (R11) had any aggressive behaviors. I thought the hospital would tell them. On 6/22/22 at 2:00PM V3, Acting Director of Nursing stated (R11) was admitted [DATE]. He was involved in an altercation with (R12) on 6/20/22. (R11) did not have a base line Care Plan in place when he was transferred to the hospital at 1:30AM 6/20/22.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31284 Based on record review, interview and observation, the facility failed to develop and implement care areas in the Care Plan for a resident (R22) with End Stage Renal Disease and receiving hemodialysis three times a week. R22 is one of three residents reviewed for hemodialysis in the sample of twenty-three. Findings Include: R22's Physician Order Sheet (POS) dated July 2022 includes the following diagnoses: End Stage Renal Disease and Respiratory Failure with Hypoxia. This same POS includes an order for hemodialysis three times a week on Tuesday, Thursday and Saturday. There is no documented orders for the care of R22's vascular access shunt for dialysis. On 7/7/22 at 10:05 am, R22 was sitting on the bed and a vascular access shunt was located in the left lower forearm. R22's Care Plan (current) has no identified areas for R22's hemodialysis, vascular access shunt care or directives to staff on the above areas. End Stage Renal Disease is not documented in R22's Plan of Care. On 7/7/22 at 10:30 am, V16 Regional Nurse Consultant confirmed that the facility was lacking in many areas and Care Plans were part of their current audit to get things back on track.

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31284 Based on record review and interview, the facility failed to ensure that R22 received the scheduled services for hemodialysis per physician orders. R22 is one of three residents reviewed for hemodialysis in the sample of twenty-three. Findings include: R22's Physician Order Sheet dated [DATE] includes the following diagnoses: End Stage Renal Disease, Seizure Disorder, Diabetes Mellitus and Acute Respiratory Failure with Hypoxia. R22 has orders for hemodialysis three times a week, Tuesday, Thursday and Saturday. R22's Nursing Notes dated [DATE] document R22 as being positive for Covid. R22's Nursing Notes dated [DATE] document that (R22) remains on isolation protocols per Covid positive. There is no further documentation on R22's condition or status in the Medical Chart between [DATE] and [DATE]. R22's Nursing Note dated [DATE] at 7:40 am and documents that R22 reported being short of breath. R22's Medical Record had no documentation of R22 receiving or not receiving scheduled dialysis treatments on ,d+[DATE], ,d+[DATE], ,d+[DATE] and [DATE]. R22's Nursing Notes dated [DATE] at 8:00 am document the following: Noted to be very lethargic et (and) confused, skin cool et clammy. Responds only to name unable to sit up on bed. O2 (oxygen) 88% on 2 L (liters). (Local) ambulance here to transport to (local hospital) ER (emergency room). An emergency room Note dated [DATE] at 9:30 am documents the following: Prior to patients (R22) arrival, (V11) from (Nursing Home) called to give report regarding why sending patient (R22) in to the ER for treatment. (V11) stated that (R22) recently had Covid but has been out of quarantine for 2 days. However, throughout this Covid illness had missed dialysis, as (dialysis center) would not run (R22) and (R22) has not had a treatment in 11 days. This writer questioned (V11) if the dialysis situation was referred to management at their facility but (V11) was unsure. (V11) continued to give patient (R22) update including that (R22) is oriented at their facility but is having oxygen desaturations to 88% and requiring 2 L O2 per NC (nasal Canula) when (R22) is normally not on O2. I Called (V25, Assistant Administrator) at (dialysis center) to inquire about missed dialysis sessions. (V25) stated that they had arranged for (R22) to go to a facility in Chicago but the (Nursing Home) had told them they could not get (R22) there. (V25) further indicated that (R22) was scheduled to come back to the Kankakee facility on Tuesday [DATE]th but (R22) did not show up. (V25) stated (V25) called (Nursing Home) to inquire about (R22) coming back on that date but they did not bring (R22) in for (R22's) session. (continued on next page)

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F 0698 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 2:30 pm, V25 confirmed that R22 could not have dialysis in R22's usual location due to R22's diagnosis of Covid and no isolation room availability. V25 stated this was communicated to the facility (Nursing Home on [DATE]) and that the dialysis center would work on finding R22 a place that could accommodate R22's isolation. V25 stated V25 was able to find a dialysis chair in Chicago that had an isolation room available for R22 and a call was made to the facility (Nursing Home) the next day ([DATE]) and V25 spoke with V11 Registered Nurse. V25 stated V25 communicated to V11 that R22 could have dialysis at a different location in Chicago. V25 stated V11 told V25 that the facility (Nursing Home) could not transport R22 there. R22's Medical Record does not document any communication between V25 and V11 about dialysis appointment refusals by R22, missed dialysis appointments, or a location change that had been arranged. A facility report titled Nursing Daily Assignment Sheet dated [DATE] documents V11 as the Registered Nurse assigned to R22's care. On [DATE] at 9:00 am, Physician, V28 stated the facility did not notify V28 of any kind of transportation problems or that R22 would not be receiving R22's ordered dialysis treatments. V28 stated (R22) could have died in (R22's) bed. I am the Attending Physician and I should have been notified. On [DATE] at 2:00 pm, V3 Assistant Director of Nursing and Interim Director of Nursing confirmed that [DATE] was R22's last dialysis day before being admitted to the hospital on [DATE]. V3 stated We have had problems with (V11's) documentation and communication in the facility and we are addressing that.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to implement policies to accurately record and account for controlled medications for three (R18, R6, R3) of five residents reviewed for medications in the sample list of 21. Findings included: 1.) R18's June 2022 Physician's Orders documents an order for Lorazepam (scheduled IV controlled medication) 1 milligram (mg) by mouth daily at 8:00 AM and 2 mg by mouth daily at 8:00 PM. R18's Controlled Substance Proof of Use forms documents two cards of 30 tablets of Lorazepam 1 mg was dispensed to the facility on [DATE]. Each form documents Lorazepam one tablet was dispensed on 6/16/22 at 8:00 AM and two tablets on 6/16/22 at 8:00 PM. The entry on the 1st form for the 6/16/22 8:00 AM dose is recorded after the 6/16/22 8:00 PM dose. On 6/23/22 at 11:25 AM the B-Hall Medication cart and R18's Lorazepam 1 mg medication cards and count sheets were reviewed with V3 Director of Nursing/Assistant Director of Nursing. V3 confirmed the 1st count sheet documents on 6/16/22 at 8:00 AM 24 tablets remained, and on 6/16/22 at 8:00 PM 1 tablet was dispensed and incorrectly documents 22 tablets remained (not 23). V3 stated V6 Licensed Practical Nurse (LPN) signed out the 8:00 PM entry. On 6/23/22 at 11:32 AM V3 asked V6 about R18's 6/16/22 8:00PM Lorazepam entry. V6 stated V6 had given two tablets and incorrectly documented one tablet was dispensed. V6 then changed R18's controlled count sheet to reflect that two tablets were given instead of one. On 6/23/22 at 12:30 PM V3 confirmed controlled medications should be signed out at the time they are dispensed and the count sheet entries should be in chronological order. 2.) R6's June 2022 Physician's Orders documents an order for Morphine (Schedule II controlled medication) 20 mg/ml (milliliter) five 0.5 ml under the tongue every 4 hours at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. R6's orders do not include Norco (schedule II controlled medication) 5-325 mg every 6 hours as needed. R6's Telephone Order dated 6/16/22 documents to discontinue Norco 5-325 mg every 6 hours PRN (as needed) and change to scheduled three times daily at 6:00 AM, 2:00 PM, and 8:00 PM. R6's June 2022 Medication Administration Record (MAR) documents Morphine 20 mg/ml give 0.5 ml every 4 hours was changed to as needed on 6/16/22. This MAR does not document R6's PRN or scheduled Norco orders or that R6 was administered Morphine after 6/15/22. R6's Controlled Substance Proof of Use documents a 30 ml bottle of Morphine 20 mg/ml 30 ml was delivered on 6/3/22. This form documents R6's Morphine was dispensed three times on 6/16/22, two times on 6/17/22, two times on 6/18/22, two times on 6/21/22, and once on 6/22/22. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's Controlled Substance Proof of Use documents 28 tablets of Norco 5-325 mg was delivered on 6/10/22. This form documents R6's Norco was dispensed 14 times between 6/11/22 at 8:00 AM and 6/23/22 at 12:00 PM. On 6/23/22 at 1:30 PM V3 stated on 6/9/22 R6 changed hospice companies, and the Norco and Morphine orders were changed by hospice. V3 stated R6's physician's orders do not document R6's PRN Norco order. V3 stated Morphine every 4 hours was too much for R6, Norco PRN was ordered on 6/9/22 and changed to scheduled three times daily on 6/16/22. On 6/23/22 at 1:58 PM V3 stated the MAR and count sheet entries should match. V3 confirmed nurses should be signing out the MAR when medications are given, and the MAR is what prompts the nurse to administer a medication. On 6/23/22 at 3:35 PM V3 stated the Norco entries on R6's MAR were added on 6/23/22. 3.) R3's June 2022 Physician's Orders document an order for Lorazepam 0.5 mg by mouth twice daily. R3's Controlled Substance Proof of Use documents 60 tablets of Lorazepam 0.5 mg was delivered on 4/19/22. The last dispensed dose is documented as 6/5/22 at 3:00 PM, and 25 tablets remain. V3's signature is documented below this entry. This form does not document another nurse signature with V3's signature or that 25 tablets were destroyed. On 6/23/22 at 2:48 PM V3 stated two nurses are to sign when controlled medications are destroyed, and a destruction form is to be completed. V3 stated the remaining 25 tablets of R3's Lorazepam 0.5 mg was destroyed by V3 and V2 Former Director of Nursing. V3 confirmed R3's Lorazepam controlled substance form does not document V2's signature. On 6/23/22 at 4:01 PM V3 stated V3 was unable to locate a medication destruction form for R3's 25 tablets of Lorazepam. The facility policy titled Controlled Substances dated 11/6/18 documents the following directives: Policy: It is the policy of the facility that all drugs listed as schedule II drugs are subject to specified handling, storage, disposal and record keeping. Responsibility: All Licensed Nurses Procedure: 1. Schedule II drugs are to be kept under two separate locks requiring two separate keys. A permanently affixed locked cabinet within the locked medication cart may be used for safe keeping. The Schedule II cabinet must remain locked and the charge nurse shall have the key in her possession at all times. Only Licensed Nurses will have access to Controlled Substances. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. If a prepared injection of a narcotic is refused, or cancelled by a physician, expel the dose into the sink in the presence of another nurse and make notation on the disposition sheet with the nurse and witness both signing. Accidental destruction or contamination is handled in the same manner. 11. Scheduled drugs may not be returned to the pharmacy upon a resident's discharge/transfer/death. If the return of a resident is expected, scheduled drugs may be kept and counted for a period of up to 7days. Upon discontinuation of the medication or non-return of the resident within 7 days, the scheduled drug may be destroyed by the Director of Nursing and a Licensed Nurse, two (2) Licensed Nurses with documentation and signature of both on the drug disposition record. 12. Controlled Drugs may be discharged with the resident when the physician orders the medication specifically be discharged with the medication and the resident or legal representative signs the drug disposition record as receiving the medication. The following policy titled Medication Administration dated 11/18/17 documents the following directives to facility staff: Policy: Drugs and biologicals are administered only by physicians and licensed nursing personnel. Definition: Drug administration shall be defined as an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person n accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given. Responsibility: Licensed nursing personnel Procedure: 1. Routine Times of Medication Administration: 2. Each facility shall establish a policy for the routine time of medication administration. 3. Medications must be prepared and administered within one hour of the designated time or as ordered. (I.e. , Medication time is 9:00 AM. The medication can be administered as early as 8:00 AM and as late as 10:00 AM. Medication is ordered as daily then medication can be given during the day at resident's preference). 4. Set up medication cart to ensure all needed items are available (i.e., medication cups, water cups, applesauce, syringes, pill crusher, etc.). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Keep the medication cart in view at all times. If it is likely the medication cart will be out of visual control at any time, it must be locked. 6. Medications must be identified by using the seven (7) rights of administration: Right resident Right drug Right dose Right consistency Right time Right route Right documentation 7. All medications must be labeled with the resident's name, the medication, the dosage and instructions for administration. (If instructions have changed since original order, medication must contain an Order Change label). 8. When preparing medication for administration, check the label of the drug container at minimum three times for safety and accuracy: When reaching for the medication Immediately before pouring or punching medication When returning the container to its storage location 9. Do not use medications from containers when the label is difficult to read or when a label is missing. Return the container to the pharmacy and request additional medication is sent as replacement. 10. Check medications against the resident's allergy listing. 11. Avoid touching medication. If contact with the medication is likely, prepare medication using gloves. 12. Appropriate hand washing is to be completed and/or alcohol based gel rub or Theraworx must be used, throughout the medication pass. This should occur: Before and after medication pass. Before and after administering ophthalmics. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After administering a transdermal patch. Before performing invasive procedures. After any contact with mucous membranes, blood or body fluids, secretions, or excretions. After touching an oral medication during administration. Before and after administering a medication to a resident who is on isolation precautions of any type. After touching any inanimate object possibly contaminated with microorganisms. Handwashing between every resident is not required according to CDC guidelines. It is acceptable to use an antiseptic gel type solution between residents. 13. Identify each resident prior to medication administration. Two methods of verification must be utilized prior to administration of a medication: Check photograph Ask resident his/her full name Verify resident's identity with another employee familiar with the resident Call the resident by name and ask for confirmation 14. Observe the resident consume the medication to insure resident swallows medication. Never leave prepared medications unattended. No medications should be left at bedside unless specifically ordered by the physician and then only in limited amounts as described by the physician. 15. Ensure adequate fluids of 4 to 8 ounces are encouraged with medication administration. 16. After a drug is given, record the date, time, name of drug, dose and route on the resident's individual Medication Administration Record. 17. If a prn is administered, document on the PRN sheet the date, the time, medication and dosage, reason for administration and initials. Give prns for indications listed with attention to the parameters listed. Return to chart results as appropriate on the PRN sheet. PRN Pain mediation may be documented on the Pain Management Flow Record. 18. Omit giving a medication if the resident has symptoms suggestive of an undesirable reaction to the drug and report your observations to the physician as soon as practical. 19. Document any medications not administered for any reason by circling initials and documenting on the back of the MAR the date, the time, the medication and dosage, reason for omission and initials. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	20. Destroy medications prepared for a resident if not used immediately. Do not return a medication to its container. 21. If the medication is not available for a resident, call the pharmacy and notify the physician when the drug is expected to be available. Like medications are not to be Borrowed from one resident for another. 22. Notify the physician as soon as practical when a scheduled dose of a medication has not been administered for any reason. 23. Report errors in medication administration immediately per policy. 24. Report suspected adverse reaction immediately per policy.