STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145008	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Duquoin Nursing & Rehab	514 East Jackson St Du Quoin, IL 62832

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on record review and interview the facility failed to notify a residents responsible party of a change in condition and transport to the emergency room for 1 of 7 residents (R2) reviewed for notification of changes in the sample of 10. The findings include: R2's Admission Record documents an admitted [DATE], with diagnoses including: Chronic Obstructive Pulmonary Disease, type 2 diabetes, history of falling, unspecified atrial fibrillation, peripheral vascular disease, major depressive disorder, and suicidal ideations. R2's Minimum Data Set (MDS) dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 9, indicating that R2 is moderately cognitively impaired. On 03/19/25 at 9:16am, V18 (family member) stated on February 26th the facility sent R2 to the hospital around 12:30pm, and she was not notified until 10pm. On 03/19/25 at 2:27pm, V10 (Licensed Practical Nurse/LPN) stated when a resident has to be sent to the hospital, the first thing they do is contact the doctor, then the ambulance. V10 stated then they have to make sure the resident and all the paperwork is ready to go. V10 stated then after all of that they contact the family. V10 stated when R2 was sent to the hospital she actually did forget to contact the family, she had multiple incidents that day. V10 stated after she left, she called back to the facility and told the nurse that relieved her that she had forgotten and had her call the family. On 03/18/25 at 10:45am, V2 (Director of Nursing/DON) stated when someone is being sent to the hospital, they first call the doctor, ambulance, and then the family is notified as soon as the resident and paperwork are ready for them to go. R2's Progress Notes document on 02/26/25 at 11:45am, Resident not feeling well, was throwing up dark brown emesis, fruity smelling breath, vitals bp (blood pressure) 108/58 resp (respirations) 16, pulse 105, O2 (oxygen) 98 on 4 liters of oxygen. BS (blood sugar) 136, resident having c/o (complaints of) stomach bothering her, contacted (V9 Physician) who agreed that resident be sent out to ER (emergency room). Resident was picked up @ (at) 12:15 via ambulance. (continued on next page)

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	R2's Progress Notes document on 02/26/25 at 10:05pm, This nurse called (local hospital) for report on resident. Per Nurse resident has been admitted to (room and bed number). Resident is receiving IV (intravenous) ABTX (antibiotic) for UTI (Urinary Tract Infection), Pancreatitis and Right lower lobe PNE (pneumonia) .POA (Power of Attorney) informed and verbalized understanding. The facility policy titled Change in Resident's Condition/Status with a revision date of May 2017 documents under Policy Statement; Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care .)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on interview and record review, the facility to ensure that a resident's wound dressing was changed in accordance with physician's orders for 1 of 3 residents (R3) reviewed for wounds in the sample of 10. This past noncompliance occurred from 2/21/25 to 3/06/25. The findings include: R3's admission record documents an admitted [DATE], with diagnoses including: malignant neoplasm of unspecified site left female breast, infection following a procedure, superficial incisional site, subsequent encounter, and developmental disorder of speech and language, unspecified. R3's Minimum Data Set (MDS) dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 9, indicating R3 is moderately cognitively impaired. R3's electronic medical record documents the following physician's order from an outside specialty physician with an upload date of 02/24/25. This document has a printed fax date and time of 02/21/25 at 02:53pm; Please start one layer of Xeroform to open area on the left mastectomy incision. Cover with gauze and Tegaderm. Complete this daily. Call for any changes or worsening of the area. Please apply triple antibiotic ointment and dry dressing to the drain site opening. May stop dressings once areas are closed. Call for any changes or concerns. R3's February Treatment Administration Record (TAR) with a print date of 03/18/25, documents no treatment/dressing changes were administered to the surgical site on R3's Left breast. R3's March TAR with a print date of 03/18/25 documents the following order with a start date of 03/06/25 and a discontinue date of 03/17/25; apply one layer of xeroform to open area on left mastectomy incision, cover with gauze and Tegaderm once daily call (name of clinic) with any changes (phone number of clinic) orders from (name of clinic) V14 (Physician's Assistant) one time a day for Wound Care Left breast apply xeroform and cover with gauze and Tegaderm. There was no documentation of any treatment or dressing change orders to R3's surgical site of the left breast documented prior to 3/6/25. There were no initials on R3's TAR indicating that the dressing change was completed for the following date 03/08/25, 03/09/25, 03/13/25-3/15/25. R3's Progress Notes documents a Social Service note dated 02/21/2025 at 04:15pm, Took (R3) to (name of clinic) for follow up they sent new orders for some wound care, follow up in two weeks R3's Progress Notes document a Nurse's Note dated 03/06/2025 at 11:16am, contacted (name of clinic) follow up for wound orders not received, orders sent by fax today breast center stated was sent by fax on 2/21/25 orders never received to facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's current Care Plan documents the following focus related to breast surgery with an initiation date of 01/14/25, .had breast cancer and had her breast removed. She has been extra hormonal. R3's Care Plan did not include interventions regarding the treatment or care of R3's surgical site to the left breast. On 03/17/25 at 10:06am, R3, who is alert to person and place, stated she was pretty sure they took good care of her after her procedure. R3 stated she was not sure how long she had the IV (intravenous) antibiotics or a PICC (Peripherally Inserted Central Catheter) line. R3 stated she wasn't sure how to answer these questions and did not want to get them wrong. R3 stated sometimes her care is not good, but everyone is nice to her. On 03/18/25 at 10:45am, V2 (Director of Nursing/DON) stated that V4 (Social Services) schedules all appointments. V2 stated that orders are faxed most of the time and that V4 receives them and is supposed to get them to nursing. V2 stated it is not uncommon for nurses to have to follow-up with her to see what new orders have come from the physician because she will get them and not forward them along. V2 stated V4 is not just transport but also social services and does get overwhelmed at times. V2 stated V4 has rescheduled appointments, sometimes day of because the transportation van is shared between both long term care facilities in town. V2 stated she knew that there had been an issue with getting R3's PICC line placed but she was not the DON at that time and was also not the nurse for R3 and was not sure the details of the situation. On 03/18/2025 at 12:20pm, V14 (Physician's Assistant) stated what was of greater concern for her was R3's dressing was not changed for 13 days. V14 stated her main concern with R3 having this dressing not being changed for this long was that the wound is from a major surgery, that also had cellulitis of the chest wall had not been looked at for 13 days. V14 stated her concerns were further breakdown of the skin under and around the bandage, and that R3 recently had a major infection, and no one was laying eyes on the wound to notice signs or symptoms that it was worsening. V14 stated luckily for R3, she did not suffer any adverse events and her infection did not return or worsen. V14 stated it could have been a bad deal, with cellulitis of the chest wall, it could have gotten much more serious, even to the point of being life threatening. On 03/19/25 at 3:41pm, V3 (Licensed Practical Nurse/Infection Prevention) stated the reason she contacted the outside specialty physician about treatment orders for R3 on 03/06/25, was because the dressing that they had placed on 02/21/25 was hanging off. V3 stated she spoke to V4 (Social Services/Transportation) and asked if dressing orders were received on R3. V4 stated that their computers were down the day of the appointment but that they were going to fax them, but they were never received. V3 stated she called the outside specialty physician for orders, even though the wound looked great. On 03/19/25 at 02:27pm, V10 (Licensed Practical Nurse) stated she was not aware of any wound care/dressing orders not being done according to physician's orders on R3. V10 stated she knew she had a surgery and a dressing change, but was not aware it wasn't being done according to doctor's orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/20/2025 at 8:37am, V4 (Social Services/Transportation) stated the duties of her job include scheduling appointments and taking residents to appointments. V4 stated if orders are given to her, she will give them to someone in nursing or the DON. V4 stated if orders are faxed, she does not mess with them, they go to the fax machine at the nurse's station and they take care of them. V4 stated she was not given wound orders for R3 the day of 02/21/25 and the Dr's office was supposed to fax them, she told the nurses when they returned they were faxing orders over. V4 stated she knew nothing about it until V3 came and asked her about it about a week later. V4 stated she would not have had anything to do with those orders unless they were handed to her in the office, which they were not. The facility policy titled, Medication and Treatment Orders with a revision date of July 2016 documents under policy statement, Orders for medications and treatments will be consistent with principles of safe and effective order writing. Prior to the survey date, the facility took the following actions to correct the noncompliance: 1. The facility held a QAPI (Quality Assurance and Performance Improvement) meeting on 03/06/25 with V16 (Regional/Acting Administrator on 03/06/25), V15 (Regional Director of Clinical Operations) and V4 (Social Services) in attendance, V9 (Physician), V2 (DON) and V3 (Licensed Practical Nurse /Infection Prevention) via telephone. QAPI Agenda/Meeting Template documents a goal of add any new orders from outpatient. Under the section Quality of Life/Quality of Care, the first item documents Receiving proper documentation and any new orders from outpatient appointments and documents that re-education was initiated and completed to nursing personnel. Under the section Action Plan it documents under goal, Improved compliance with obtaining notes and re-education and monitoring of effectiveness . 2. The QAPI Agenda/Meeting Template documents, Nursing personnel have received reeducation. A QA (Quality Assurance) tool has been created to monitor deficiency to promote improved quality performance. 3. Inservice documentation for nursing (RN and LPN) and social services shows that all nursing staff were educated on 03/06/25 on the following topics: appointments, documentation, new orders and following physician's orders. 4. Policy reviewed was Medication and Treatment Orders. 5. Plan of Correction lists the corrective action as Resident's treatment orders were obtained, processed and applied. The plan of correction lists all residents have the potential to be affected. This document states that all staff were educated on obtaining proper documentation and any new orders during outpatient appointments; All nursing staff educated on calling the office to follow up if new orders are not received. 6. The DON/Admin/designee will monitor all outpatient appointments daily for 4 weeks to ensure all proper documentation and any new orders were received and processed. Any issues identified will be immediately corrected and reeducation will be offered. Results of the QA tools will be reviewed during the next regularly scheduled QAPI meeting.