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	07/25/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure a resident was free from unnecessary psychotropic medications for 1 of 3 residents (R3) reviewed for medications in a sample of 3. The findings include:R3's admission Record documents an admission date of 6/30/2023 and includes but not limited to diagnoses of Chronic Eosinophilic Pneumonia, Pneumonitis due to Inhalation of Food and Vomit, Unsteadiness on Feet, Unspecified Dementia, Hypomagnesium, Generalized Epilepsy, Anxiety, and Parkinson's disease. MDS (Minimum Data Set) dated 6/6/2025 includes documents R3 is rarely understood and is severely impaired. Section GG documents R3 is dependent on staff for transfers and showers and requires substantial/maximum assistance for lower body dressing and putting on and taking off footwear. Section E-Behaviors documents R3 has no hallucinations or delusions, and that R3 has physical behavioral symptoms directed towards others with behaviors of this type 4 to 6 days, but less than daily. R3 has no behaviors exhibited for rejection of care or wandering.R3's care plan documents focus potential for behaviors: resident to resident inappropriate touching, date initiated 5/7/2025. Goal is to decrease risk of behaviors dated 5/7/2025 with target date of 8/14/2025. Interventions/tasks include but not limited to 1:1 activity with be increased, as well as keeping him engaged in meaningful activities, medication review will be completed and referral to be made to geriatric behavioral unit for evaluation dated 5/7/2025, medications as ordered, observe behaviors and try to determine cause.R3's Progress Note dated 7/16/2025 at 2:19PM documents resident is unable to follow commands, use of accessory muscles to breathe, pupils pinpoint, increased lethargy, EMS (Emergency Medical Services) in facility at this time, transport directly to local hospital. Authored by V6 (Registered Nurse/RN). R3's Progress note Late Entry, 7/19/2025 at 1:55PM documents, resident returned to facility today. He has suffered noticeable change in level of consciousness, resident is not responding to verbal stimuli per his normal baseline, he is showing outward signs of distress, moaning, and writhing in bed. Power of Attorney (POA) and son are considering placing resident in hospice care, wife seems resistant and asks me when will he get better. Authored by V6.R3's admission Summary note on 7/21/2025 at 2:58PM documents, resident returned to facility on July 18th, 2025. Medication changes were made per hospitalist. Orders were not updated in computer by nurse on duty. Pharmacy called today questioning two antibiotics what were pulled from E-Kit. Upon further investigations, orders changed from hospital and were not updated in the system. Per V2 (Director of Nursing), we will update orders now and contact pharmacy. Authored by V4 (Licensed Practical Nurse/LPN).R3's Discharge Information for Receiving Facility with print date of 7/18/2025 at 8:52AM documents New Medications, included Haloperidol 5mg every 8 hours PRN (as needed) for a diagnosis of Hospice Care. R3's facility Order Summary Report, with a print date of 7/22/25 at 12:24PM, documents an order for Haloperidol oral tablet 5mg give 1 tablet every 8 hours for agitation related to unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety with an order date of 7/21/25 and a start date of 7/22/25.R3's Medication Administration Record (MAR) dated 7/1/2025 -7/31/2025 documents Haloperidol 5mg every 8 hours for agitation related to unspecified dementia, severe without behavioral or psychotic or mood disturbances and anxiety, scheduled for 12:00AM, 8:00AM and 4:00PM with start date of 7/22/2025 at 12:00AM. R3's MAR documents R3 received Haldol 5mg routinely on 7/22/2025 at 12AM, 8:00AM, and 4:00PM, on 7/23/2025 12AM, 8:00AM, and 4:00PM, and on 7/24/2025 at 12:00AM, and 8:00AM. On 7/22/2025 at 12:18PM, V3 (LPN) and V4 (LPN) were interviewed together as V4 is in training and was training on 7/21/2025. V3 stated on 7/21/2025 she was training on the floor and received a phone call from the pharmacy in regard to questions about R3's antibiotics. V3 stated as she started looking at R3's medications, she noticed R3 had returned to the facility on 7/18/2025 and orders were not taken care of until she and V4 took care of the orders. V4 stated there were medications given that were to be discontinued like blood pressure medications on return and new medications ordered that were not given due to the orders not being processed. V4 stated she was unsure of what happened but there are several medication errors that occurred.On 7/24/2025 at 1:03PM spoke with V11 (Medical Doctor/MD) in regard to R3's discharge summary medication orders. V11 was asked if he had a discussion with anyone about the Haldol. V11 stated they talked about the hospice type medications including Haldol. V11 was asked why they changed the Haldol from PRN (as per discharge orders) to routine every 8 hours. V11 stated he was unaware of this and was told the Haldol was every 8 hours as needed and only for 14 days and this is what he gave orders for. V11 stated he would talk with V2 and get that changed immediately On 7/24/2025 at 1:11PM spoke with V2 in

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to process and transcribe physician orders timely and accurately for 1 of 3 (R3) residents reviewed for medications in a sample of 3. R3's admission Record documents an admission date of 6/30/2023 and includes but not limited to diagnoses of Chronic Eosinophilic Pneumonia, Pneumonitis due to Inhalation of Food and Vomit, Unsteadiness on Feet, Unspecified Dementia, Hypomagnesium, Generalized Epilepsy, Anxiety, and Parkinson's disease. R3's MDS (Minimum Data Set) dated 6/6/2025 documents R3 is rarely understood and is severely impaired. Section GG documents R3 is dependent on staff for transfers and showers and requires substantial/maximum assistance for lower body dressing and putting on and taking off footwear. Section E-Behaviors documents R3 has no hallucinations or delusions, and that R3 has physical behavioral symptoms directed towards others with behaviors of this type 4 to 6 days, but less than daily. R3 has no behaviors exhibited for rejection of care or wandering. R3's care plan documents focus potential for behaviors: resident to resident inappropriate touching, date initiated 5/7/2025. Goal is to decrease risk of behaviors dated 5/7/2025 with target date of 8/14/2025. Interventions/tasks include but not limited to 1:1 activity with be increased, as well as keeping him engaged in meaningful activities, medication review will be completed and referral to be made to geriatric behavioral unit for evaluation dated 5/7/2025, medications as ordered, observe behaviors and try to determine cause. On 7/22/2025 at 11:00AM, V6 (Registered Nurse/RN) stated she was working on 7/18/2025 when R3 returned from the hospital. V6 stated she noticed R3 did not return with any paperwork, so she called the hospital. V6 stated she never received the orders before she left but later realized the orders were laying on the desk. V6 stated she did not process the orders received from the hospital discharge summary prior to leaving work at 6:00PM on 7/18/2025. V6 stated no medications were done on that day or assessments.On 7/22/2025 at 12:18PM, V3 (Licensed Practical Nurse/LPN) and V4 (LPN) were interviewed together as V4 is in training and was training on 7/21/2025. V3 stated on 7/21/2025 she was training on the floor and received a phone call from the pharmacy in regard to questions about R3's antibiotics. V3 stated as she started looking at R3's medications, she noticed R3 had returned to the facility on 7/18/2025 and orders were not taken care of until she and V4 processed the orders from the discharge summary from hospital return on 7/18/2025. V4 stated there were medications given that were to be discontinued on return and new medications ordered that were not given due to the orders not being processed. V4 stated she was unsure of what happened but there are several medication errors that occurred.R3's progress note documents on 7/21/2025 at 2:58PM (type of note is admission Summary) resident returned to facility on July 18th, 2025. Medication changes were made per hospitalist. Orders were not updated in computer by nurse on duty. Pharmacy called today questioning two antibiotics that were pulled from E-Kit. Upon further investigations, orders changed from hospital and were not updated in the system. Per V2 (Director of Nursing/DON), we will update orders now and contact pharmacy. Authored by V4 (LPN).R3's Discharge Information for Receiving Facility sheet with print date of 7/18/2025 at 8:52AM documents to stop medications of Amlodipine 10mg tablet, Aspirin 81mg tablet, Baclofen 10mg tablet, Avodart 0.5mg capsule, Lisinopril 5 mg tablet, and Metoprolol Succinate XL 25mg. R3's Medication Administration Record (MAR) dated 7/1/2025 -7/31/2025 documents R3 continues on Lisinopril 20mg with a discontinued date of 7/21/2025 and Metoprolol 50mg with a discontinued date of 7/21/2025.R3's Discharge Information for Receiving Facility with print date of 7/18/2025 at 8:52AM documents New Medications, Artificial saliva spray with pump ([NAME]-STIR) one spray mouth/throat every 2 hours PRN (as needed), Famotidine 20mg tablet every 12 hours, Haloperidol 5mg every 8 hours PRN, Ativan 1 mg every 2 hours PRN, Morphine concentrate 20mg/ml. every 2 hours PRN, Narcan as needed, scopolamine 1 mg 3 days patch every 72 hours as needed, Senna Plus one tablet as needed. R3's MAR dated 7/1/2025 -7/31/2025 documents Artificial saliva spray with pump ([NAME]-STIR) one spray mouth/throat every 2 hours (routinely) with start date of 7/21/2025 at 4:00PM and documents administration schedule of every 2 hours, Famotidine 20mg tablet every 12 hours, with start date of 7/21/2025 at 8:00PM with scheduled times of 8:00AM and 8:00PM, Haloperidol 5mg every 8 hours for agitation related to unspecified dementia, severe without behavioral or psychotic or mood disturbances and anxiety, scheduled for 12:00AM, 8:00AM and 4:00PM with start date of 7/22/2025 at 12:00AM. Ativan 1 mg every 2 hours PRN, Morphine concentrate 20mg/ml. every 2 hours PRN, Narcan as needed, scopolamine 1 mg 3 days patch every 72 hours as needed, Senna Plus one tablet as needed. R3's MAR dated 7/1/2025 -