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	08/30/2024

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40666 Based on interview, observation, and record review the facility failed to provide assistance with ADL's (Activities of Daily Living) to 1 of 3 residents (R157) reviewed for ADL care in the sample of 26. The findings include: R157's Admission record notes he was admitted to the facility on [DATE] from a local out of state hospital. The same document lists some of R157's diagnoses as Unspecified open wound, left ankle, Type 1 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Peripheral Vascular Disease, Acquired absence of Right Leg Below Knee. R1's care plan notes a focus area of ADL self care performance deficit. Some of the listed interventions are bathing: I require (1) staff participation with bathing. Personal Hygiene/oral care: I require (1) staff participation with personal hygiene and oral care. Due to R1 being admitted on [DATE], V3 (Regional Nurse) said that R1's MDS (Minimum Data Set) had not been completed. On 8/27/24 at 9:40 am, R157 was observed lying in bed and had 1-2 inches of facial hair. R157 said he does not wear a beard and has been asking and asking to be shaved and he is told they do not have time. R157 was alert and oriented to person, place and time. R1 then stated that staff woke him up at 3 am to get a bed bath. R1 was somewhat upset and said he was sleeping good. R1 said he does not want a bed bath at 2 am, he would prefer it to be on days. On 8/27/24 at 9:50 am, V7 (Infection Preventionist) was observed telling R157 that he just had to ask to get shaved and R157 told her he has asked several times and been told they do not have time. On 8/29/24, at 11:30 am, V6 (family member) removed R157's upper denture. Observation of the denture after it was removed noted that the denture was covered with thick greenish yellow matter. R157 said that no one has cleaned them or offered a cup and tablets to clean them with. On 8/29/24 at 11:35 am, V5 (LPN/Licensed Practical Nurse) said that dentures should be cleaned every night after seeing the dentures. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/30/24 at 10:30 am, V3 (Regional Nurse) said she would expect a resident's dentures to be cleaned every night and a resident to be shaved every other day at least or when needed. On 8/27/24 at 9:55 am, V7 said that R157 should have not been woke up at 2 am for a bed bath. V7 said they have so many showers to do, they were just trying to spread them out on shifts. V7 said they will change his shower/bed bath to the day shift. On 8/29/24 at 1:00pm, V2 (DON/Director of Nursing) said that a resident should not be woke up at 2 am for a bed bath and she would expect a resident to be shaved when they needed or wanted it. V2 also said she would expect mouth care to be provided daily also. Document labeled Facility Shower list notes that R157 gets shower/bed bath on Monday and Thursday night shift. Facility Document labeled Dentures, Cleaning and Storing (revised March 2018) notes to provide dentures care before bedtime if the resident will allow. The same document also notes to ask the resident to remove his or her dentures. Instruct the resident to rinse his or her mouth with water. After resident removes dentures, place dentures in an emesis basin or denture cup. take the emesis basin to the sink. Clean the dentures by brushing them with a denture cleaner or toothpaste. Hold the dentures in the palm of hand and over the sink while brushing to prevent them from dropping on the floor. Rinse dentures thoroughly. Fill the denture cup one-half full of fresh water and one-half full of mouthwash or denture tablet. Place the dentures into the denture cup. Take the denture cup and emesis basin to the bedside table. Leave dentures in the cup until the resident is ready to replace them in his or her mouth.

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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 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** 40666 Based on interview and record review, the facility failed to initiate physician's orders for wound care for 1 of 5 residents (R157) reviewed for skin conditions in the sample of 26. The findings include: R157's Admission record notes he was admitted to the facility on [DATE] from a local out of state hospital. The same document lists some of R157's diagnoses as Unspecified open wound, left ankle, Type 1 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Peripheral Vascular Disease, Acquired absence of Right Leg Below Knee. Facility Document dated 8/21/24 labeled Admit/Readmit Screener documents R157 has a wound to right front knee measuring 5.2 cm (centimeters) x 4 cm peri wound and a surgical incision to front right knee measuring 0.1 cm x 16 cm x 0.1 cm and an abrasion to left great toe. There was no mention of a wound on the left lateral ankle on the document. R157's discharge documents from a local out of state hospital dated 8/21/24 documents the following orders: Left great toe: Cleanse wound gently with soap and water (no hibiclens or bar soap), paint wound bed with betadine daily, cover with dry gauze and lightly secure with kerlix or conform gauze, remove dressing daily to reapply betadine and change dressing. Wound vac to left lateral ankle. If Vac loses suction or alarms and cannot be troubleshoot, please contact office and listed other facility numbers. If this occurs after hours or if vac alarms for more than 2 hours, please remove Vac dressing and replace with a saline moistened gauze dressing, and next consult placed or message left on voicemail for wound care office. Wound care will follow up on Wednesday (8/21/24) to change wound vac and weekly to reassessment left great toe. Consult/Contact wound care office for questions. Local hospital records with no date note Assessment: 77M s/p ([AGE] year old man status post) right below the knee amputation. Dressings: to remain in place until post-op visit, Follow up appointment: 4 weeks post-op in the office. R157's order summary report dated 8/29/24 note that from 8/21/24-8/27/24, there were no orders regarding wound care on either of the 3 wounds. The same order summary report note on 8/26/24 the following orders were received: Change wound vac Monday, Wednesday and Friday one time a day on odd days with an order date of 8/26/24 and start date of 8/27/24. Order status is noted to be discontinued. Change ABD (abdominal) pad et (and) kerlix daily, keep dry. If wet, change prn every day and night with a order date of 8/26/24 and start date of 8/27/24. Cleanse wound on Right leg BKA (below knee amputation) with antibacterial soap, apply xeroform to incision site and macerated area cover with ABD pads and wrap with kerlix gauze and reapply prostatic sock with an order date of 8/27/24 and a start date of 8/28/24. On 8/27/24 orders for the surgical incision to right BKA cleanse with normal saline or wound cleanser, apply calcium alginate with silver, collagen, crushed Flagyl 250 mg (milligrams), cover with ABD pad and wrap with kerlix. Change daily and prn (as needed) with an order date of 8/27/24 and start date of 8/28/24. Order dated 8/27/24 with a start date of 8/28/24 note orders for wound to left great toe: Cleanse gently with normal saline or wound cleanser, paint wound bed with betadine daily and leave open to air. Order dated 8/27/24 with a start date of 8/30/24 note an order for wound to left lateral ankle: Cleanse with normal saline or wound cleanser, apply foam with negative pressure wound vac at 125 mmHg (millimeters of mercury). Change on Mon-Wed-Fri and prn. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R157's TAR (Treatment Administration Record) dated 8/1/24-8/31/24 indicate there was no orders or wound care provided from 8/21/24-8/26/24 to the left lateral ankle, left great toe or Right BKA surgical site. On 8/27/24 at 9:30 am, V7 (Infection Preventionist) said there were no orders on the discharge papers from the hospital for R157. V7 said that R157 was supposed to have a wound vac to his left ankle. V7 said that R157 was supposed to see wound care on 8/21/24, but he was discharged to the facility. V7 said that R157's wife did not want to make the trip to go back to the out of state hospital. V7 said the night of 8/21/24, she was unable to apply the wound vac. V7 said that a wound vac was ordered for R157's left ankle and their wound vac did not fit the tubing, so she called R157's wife and she had one and brought it in the next day. V7 said that the night of admission (8/21/24), R157 did not have the wound vac on due to tubing not matching the wound vac. V7 said the wife brought the wound vac in on 8/22/24 and she cleansed it with normal saline and used a kit that was sent by hospital and applied the wound vac. V7 said she could not figure out why no orders were sent and that herself and V5 (LPN/Licensed Practical Nurse) both called the hospital for orders and never received a call back. V7 said she was not aware of any follow up appointment for follow up care with the surgeon. On 8/27/24 at 10:15 am, V4 (local wound provider Nurse Practitioner) said she was looking at R157's wounds while rounding with V7, but could not touch them since she did not have any orders for them. V4 said this was the first time she had looked at R1's wounds and is waiting on orders to be received from the surgeon/physician from the out of state hospital. On 8/27/24 at 11:00 am, V5 (Licensed Practical Nurse) said she admitted R157 to the facility and did not get any orders for wound care. V5 said she did call for them, but did not get a return call back. V5 said she was not aware of any follow up appointments with the surgeon when she admitted him. On 8/29/24 at 1:30pm, V14 (Physician) said it would be his expectation that if the facility did not have wound treatment orders on admission, they would have called him and he could have given orders.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36384 Based on observation, interview and record review the facility failed to ensure residents were free from unnecessary medications for 1 of 1 residents (R26) reviewed for unnecessary medications in the sample of 26. The Findings Include: R26's face sheet documents an admitted [DATE]. The diagnosis on this face sheet includes the following: senile degeneration of brain as of 6/13/24, anxiety disorder as of 6/13/24, Diabetes Mellitus as of 6/13/24, and Tourette's disorder as of 8/27/2024. R26's physician order summary report as of 8/30/24 documents the following medications: Haloperidol 5 milligram (mg) give one tablet by mouth two times a day related to senile degeneration of brain, anxiety disorder unspecified, Lexapro 10mg once a day for signs and symptoms of depression, Lorazepam 0.5mg every four hours as needed for anxiety, Morphine Sulfate 100mg/100 milliters (ml) by mouth every four hours as needed and Trazadone 25mg at bedtime for insomnia. R26's care plan has a focus area for 'risk of insomnia' dated 6/13/24. The goal for this focus area is 'resident achieve/maintain a consistent sleep pattern.' Interventions for this focus area are: evaluate for respiratory distress when laying flat or while sleeping, evaluate sleep pattern, maintain consistent schedule with daily routine, and monitor for factors that may contribute to poor sleep pattern. R26's care plan has a focus area for 'resident uses anti-anxiety medications related to Anxiety disorder' dated 6/13/24. The goal for this focus area is 'The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date.' The interventions for this focus area are: Administer anti anxiety medications as ordered by physician. Monitor for side effects and effectiveness, monitor/document/report as needed any adverse reactions to anti anxiety therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Monitor/record occurrence of for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others and document per facility protocol. On 8/27/24 at 12:15 PM, R26 was observed at lunch in the dining room during the lunch meal service. R26 was in a wheelchair pushed back from the table where his meal was on a tray. R26 made no attempt to eat his lunch meal and was chewing on his clothing protector. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 intermittent observations were made as follows: 11:31 AM, R26 was in the dining room sleeping in his wheel chair, at 12:30 PM, V9 (Minimum Data Set/MDS Coordinator/Licensed Practical Nurse/LPN) was attempting to wake R26 up to assist him with his meal, at 1:00 PM, R26 was in his room room with the lights off sleeping soundly. At 2:40 PM, R26 was still sleeping in his bed with the lights off. At 3:30 PM, R26 was still in his bed with the lights off sleeping soundly. On 8/29/24 at 1:15 PM, V11 (Certified Nurse Assistant/CNA) and V12 (CNA) stated, R26 is generally tired, but you can get him to talk and laugh with you too sometimes. V12 stated, R26 seemed tired after lunch today so they put him to bed to rest. On 8/29/24 at 3:00 PM, V17 (CNA) and V18 (CNA) stated that when R26 first was admitted he ate well independently and was more alert, and now it seems that he sleeps a lot and does not eat well and needs assistance and arousal from dozing off during meals times. A consultant pharmacist medication regimen review report dated 8/20/24 documents from the consulting pharmacist the following: The resident is currently receiving Haloperidol that requires a diagnosis of one of the following: schizophrenia, Tourette's syndrome, or Huntington's. On 8/27/24, V15 (Physician) wrote in the diagnosis of Tourette's Syndrome. On 8/29/24 at 1:23 PM, V2 (Director of Nursing) stated the process for gradual dose reduction, or any pharmacy consultation reports with recommendations, starts with the pharmacy monthly medication reviews. V2 stated the pharmacy sends the facility the report with the recommendation for the dose reduction or any other information needed for medications and then she sends it to the physician for review and signature. V2 stated that R26 has not really exhibited any behaviors of Tourette's, he is mainly just combative with staff during care and resistive. V2 stated that he has had outbursts with other residents, but none lately. V2 stated that she realizes some of his behaviors are not tracked and she is working with educating staff on properly documenting resident behaviors. V2 stated that due to R26 being on hospice they have not checked to see if any of his outbursts could be related to any medical issues, including a urinary tract infection, due to hospice not typically doing extra types of tests on residents. On 8/29/24 at 11:09 AM, V15 stated that he received the pharmacy consultation report requesting a diagnosis and while he feels it is part of his dementia. V15 stated that he filled out the pharmacy consultation report from his office. V15 stated that the reports of behaviors that the nursing staff report to him are mainly of him being resistive to care and at times combative. On 8/29/24 at 11:00 AM, V16 (Registered Nurse/Hospice) stated that hospice started the Haloperidol medication due to the staff reporting combative episodes during care and sometimes directed at other residents. V16 stated that she is unaware of any reports, nor has she seen R26 exhibit any Tourette's Syndrome like behaviors. V16 stated that the Haloperidol likely needs to be reduced if he is becoming too tired and lethargic throughout the day. July 2024 behavior tracking for R26 has a problem statement of 'insomnia.' R26 had two days tracked for this concern area in the month on July 10th and 11th. This same behavior tracking has 15 first shift dates with no tracking documented/filled out, 7 second shift dates with no tracking documented/filled out and 20 third shift dates with no tracking documented/filled out. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R26 was also tracked for Lorazepam in July 2024 for the problem statement of repeatable concern about wanting to go home. R26 had 13 days with this behavior occurring. R26 had 14 first shift dates with no tracking documented/filled out, 7 second shift dates not documented/filled out, and 20 third shift dates not documented/filled out. R26's August 2024 behavior tracking for Lorazepam for the behavior of 'reputable concern about wanting to go home' had no instances documented of occurring, but had 17 days first shift dates not filled out/documented if behavior occurred, 11 second shift dates not filled out/documented if the behavior occurred, and 14 third shift dates not filled out/documented if the behavior occurred. R26's August 2024 behavior tracking for Haloperidol has the problem statement of 'Cursing at staff' to be tracked. One date is documented of this behavior of cursing at staff is documented. First shift has 13 dates not filled out/documented if this behavior occurred, second shift has 9 dates of not filling out/documenting if this behavior occurred, and third shift has 14 dates not filled out/documented whether this behavior occurred. R26's August 2024 behavior tracking or Trazadone does not have any occurrences of 'insomnia' occurring. First shift has 17 dates not filled out/documenting of this behavior, second shift has 11 dates not filled out/documented on whether this behavior occurred and third shift has 14 dates not filled out/documented on whether this behavior occurred. R26's behavior tracking has no medication filled out for the use of the problem statement of aggressive behavior'. First shift has 16 dates of the behavior tracking not filled out/documented whether the behavior occurred, second shift had 11 dates not filled out/documented if this behavior occurred, and third shift had 14 days not filled out/documented on whether this behavior occurred. According to the National Institute of Neurologic Disorders and Stroke the diagnosis guidelines will ask you about the presence of both motor and vocal tics that occur several times a day, every day or intermittently for at least 1 year, onset of tics before age 18, and tics not caused by medications, other substances, or medical conditions. These guidelines can be found at https://www.ninds.nih.gov/health-information/disorders/tourette-syndrome#:~:text=Diagnosing%20TS,other%20substances%2C%20or%20medical%20conditions

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49663 Based on observation, interview and record review the facility failed to ensure medications were labeled as physician prescribed for 1 (R53) of 1 residents reviewed for controlled medication storage in the sample of 26. Findings Include: R53's Face Sheet documented an admitted to the facility as 7/18/2024 with diagnosis including anxiety disorder, unspecified, insomnia, unspecified, malignant neoplasm of unspecified site of left female breast. On 8/27/24 at 2:00 PM, observation of the locked medication storage room with V2 (Director of Nursing/DON) observed a white plastic cup containing white pills inside it that had been wrapped around the top portion of the cup with brown self-adhering bandage. The plastic cup had the number 423 written in a black sharpie marker with R53's name on the cup, locked in the narcotic box of the medication room. On 8/27/2024 at 2:03 PM, V2 stated on admission, R53's family brought in her lorazepam 0.5 milligram medications for the facility to use. V2 stated, the facility kept 40 of her lorazepam tablets in her prescription bottle and V8 (Family) had been contacted on the amount of medication that could be on hand at the facility and asked V8 what the family wanted to do with the rest of the medication. V2 stated, V8 requested the facility not to discard the medication and V8 would pick up the medication. V2 stated, R53's lorazepam had been locked up in this plastic cup for over a month. V2 stated, the nurses do attempt to count the lorazepam every night and verbally report it during nurse report in the morning, but there is no documentation log of the medication being counted because it is not the facility's medication. V2 stated, all medications that are classified as a controlled substance should be counted prior to each shift and logged in the narcotic medication book. V2 stated, all medication should be stored in a proper container with appropriate identifying information. On 8/27/2023 at 2:20 PM, V3 (Regional Nurse) stated when medication is brought in from resident families, the policy documents that medications should be sent to the pharmacy to be packaged and all medication should be stored in the proper container with identifying information. On 8/30/2024 at approximately 11:00 AM, V9 (Licensed Practical Nurse/LPN) stated, all controlled substances medication should be locked and counted prior to a shift and at the end of the shift. V14 stated, lorazepam is considered a controlled substance and is counted prior to and end of each shift and documented in the controlled substance book. V9 stated, all medication should be stored in the proper container with identifying information on the drug, resident name, physician, etc. R53's Physicians Order Summary dated 7/18/2024 through 9/09/2025 documents Lorazepam 0.5mg every 12 hours as needed for anxiety. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Storage of Medications (revised April 2007) documents under Interpretation and Implementation step 3. Drug containers that have missing, incomplete, improper or incorrect labels shall be returned to the pharmacy or to the family if there were medications from home. 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy, family if brought in or destroyed. According to https://www.federalregister.gov/documents/2010/06/29/2010-15757/dispensing-of-controlled-substances-to-residents-at-long-term-care-facilities under Long Term Care Facilities, 21. U.S.C 829(b) documents Prescriptions are required to contain specific information including: patient name and address; drug name, strength, dosage form, quantity prescribed, directions for use; and name, address, and DEA number of the issuing practitioner. 21 CFR 1306.05(a). All prescriptions for controlled substances must be dated as of, and signed on, the day when issued.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36384 Based on observation, interview and record review the facility failed to ensure proper levels of sanitizer were maintained inside the dish machine and bulk stored foods were kept free from potential contamination. This has the potential to affect all 53 residents residing in the facility. The Findings Include: During the initial tour of the kitchen on 8/27/24 at 8:00 AM a scoop with handle was found in the bulk food bins containing thickener and flour. At this time V13 (Dietary Manager) stated that there are containers right next to these bins that are supposed to be for the scoops. V13 removed the scoops at this time and was going to educate the staff on the proper procedure of not leaving the scoops in the food with the handle touching the food substance. During this same initial tour on 8/27/24 at 8:25 AM, V13 used a sanitizer strip to check the chlorine concentration in the dish machine. No sanitizer was registering in the machine. V13 stated that she would have the maintenance man come and check the machine to determine the issue. At this time V13 stated that there is no log of the sanitizer level kept and it is checked 'every couple days.' V13 was unable to verify the last time the machine was checked for the proper sanitization of dishes. A policy for Dishwashing: Machine Operation dated 2016 documents: The Dining Services staff shall maintain operation of the dishwashing machine according to established procedure and manufacturer guidelines posted or contained in this guideline to ensure effective cleaning and sanitizing of all tableware and equipment used in preparation and service of food.2. Check the dishwashing machine three times weekly and after the sanitizer has been changed. Check the dials to ensure that the wash and rinse cycles are achieving proper temperature per manufacturer guidelines. If a chemical sanitizer is used, check the concentration using the correct test tape for the type of sanitizer in use. If not at the correct hot water temperature or the proper chemical sanitizing concentration, do not proceed to wash dishes. Empty the dishwashing machine, check nozzles and empty bottom screen and restart the dishwashing machine. The Long Term Care Facility Application for Medicare and Medicaid dated 8/28/24 documents that 53 residents reside in the facility.