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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145239	A. Building B. Wing	05/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Rehab & Hc	5533 North Galena Road Peoria Heights, IL 61614

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 32189 Based on record review and interview, the facility failed to ensure call lights were answered in a timely manner for one of three residents (R1) reviewed for call light response time in a sample of seven. Findings include: The Rehab (Rehabilitation) Resident Council Meeting Minutes dated 4/30/24 documents Slow call light reaction 2nd shift and 1st shift. On 5/13/24 at 10:20 AM, R1 stated I came the end of December (2023). Sometimes the call light can take hours to get answered. It's not all the time. It's usually worse on day shift because the aides are so busy doing stuff. On 5/14 24 at 11:15 AM, V14 (Agency Nurse) stated There is a wait time for the call lights to be answered. Nurses try to help as much as possible, but we have our duties too. Like, the night before (5/12-13/24) we had one aide in the whole building. Everyone called off. We tried to get staff called in, but we can only do what we can do. On 5/14/24 at 11:45 AM, V2 (Director of Nursing) stated call light response time has been an issue and filling vacant positions and getting CNA's (Certified Nurse Aides) trained is a priority for resident safety. On 5/14/24 at 12:40 PM, V5 (Agency Nurse) stated The call light response time could be better. Some residents are demanding. I see CNA's leave after they take someone to the restroom and the resident puts the call light right back because they are done, and need help off the toilet, but the CNA is already doing something else. The residents just have to wait. Sometimes for a very long time.

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 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.

32189

Based on record review and interview, the facility failed to ensure staff provided care by assessing, evaluating, and providing immediate treatment of an acute condition for one of three residents (R1) reviewed for changes in condition in a sample of seven.

Findings include:

The Notification of Change in Resident Condition or Status policy dated 7/1/12, documents 1. The nurse supervisor/charge nurse will notify the residents attending physician or on-call physician when there has been e. A significant change in the resident's physical/emotional/mental condition; g. Refusal of treatment or medications; h. A need to transfer the resident to a hospital; j. Instructions to notify the physician of changes in the resident's condition; k. Onset of temperature of a temperature two degrees higher than baseline; l. Symptoms of any infectious process; 5. The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

The Nursing Documentation Guidelines policy, not dated, documents vital signs are to be done every shift for three days after an admission or readmission; vital signs documentation date and time vital signs were taken, any deviations from normal pattern, all pertinent observations, oxygen start time, flow rate and rationale for use, as well as physician notification.

The General Rule of Charting policy dated 1/05, documents any vital signs other than monthly should be documented in the nurse's notes.

On 12/26/24, the record documents R1 was admitted to the facility with the following diagnoses: sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body ' s response to their presence, potentially leading to the malfunctioning of various organs, shock, and death), type two diabetes mellitus with insulin dependence, chronic obstructive airway disease treated with inhalation medication, cellulitis (inflammation) of the buttocks and left lower limb, bilateral below the knee amputation, congestive heart failure and multiple other cardiac conditions.

On 4/3/24 and 5/6/24, The Quarterly MDS (Minimum Data Set) section C documents a BIMS (Brief Interview of Mental Status) score of 15.0, cognitively intact.

The Temperature, Heart Rate, and Blood Pressure Summary documented these vital signs were monitored on 12/27/23, 1/5/24 and 1/19/24 and the Oxygen Saturation Summary documented measurements on 12/27/23 and 1/5/24. The record lacked documentation vital signs were monitored after 1/19/24.

On 4/27/24, The Discharge Return Anticipated MDS section A documents R1 had an unplanned transfer to an acute care hospital.

On 4/27/24, the Progress Note lacked documentation of R1's condition, assessments conducted, physician notification and/or a request for interventions from the physician which led up to R1's transfer to the hospital.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/27/24 at 4:40 PM, V4's (Day Shift Nurse) Progress Note documents that approximately between 4:00 PM and 5:00 PM, R1 complained of being tired. A blood pressure and heart rate were assessed and was within normal limits, although V10 (R1's friend) told R1 I want you to go to the Hospital to get checked out. On 5/14/24 at 11:15 AM, V14 (Night Shift Nurse) stated on 4/27/24 V14 received report from V4 who said R1 was lethargic and was not acting like self-earlier in the day. R1 had slurred speech and seemed like R1 was worsening. V14 stated V2 (Director of Nursing) was notified (via text) that R1 needed to be sent to hospital. V14 tried to give R1 water to take medication but R1 couldn't hold the water and was mumbling. V14 did an assessment and R1 was oriented to name but couldn't hold arms up. V14 stated V4 was called to discuss R1's change in condition from day shift. V14 stated R1's vital signs were like 86% (oxygen saturation greater than 90% is within normal limits) I can't remember for sure. I put R1 on oxygen, notified (via text) V2 that R1 was being sent out (to hospital). I called the ambulance, sent records, called the POA (Power of Attorney) and the physician. I've worked with R1 four or five other times, and I knew there was a change, but I also asked V5 (Night Nurse) to come evaluate R1 before I sent R1 out because V5 has worked with R1 more than I have. On 5/14/24 at 9:00 AM, V2 stated V14 texted me on 4/27/24 and stated R1's right hand was slightly swollen but was able to make a fist and didn't complain of pain. There was a reddened rash to both forearms. V2 stated V14 texted her back at 9:00 PM and stated R1 was lethargic, temperature was 99.3 degrees Fahrenheit, pulse was 89 beats per minute, blood pressure was 96/54, respirations were 14 breaths per minute, oxygen saturation was at 85%, R1 was weak, slow to respond, supplemental oxygen was administered, the ambulance was called to transfer to hospital and the physician was notified. On 5/14/24 at 12:39 PM, V5 stated V14 wanted me to look at R1 because R1's oxygen was low. I did a sternal rub on R1 and told them to call (ambulance) and send R1 out (to hospital). It must have been around 8:30 PM. On 5/1/24, the Hospital Records documents R1 was admitted for septic shock, probable urinary tract infection and cellulitis to the left below knee amputation site. On 5/14/24 at 9:50 AM, V2 stated R1's vital signs should have been conducted more frequently although there was no physician's order. V2 stated It's nursing judgement but a baseline (vital signs) should be established to determine changes. R1 has a history of infections, and I would have been monitoring (vital signs) more frequently. R1 met criteria to be transferred simply for the altered mental status and decrease in oxygenation. V2 agreed that on 4/27/24, R1's Progress Note lacked documentation of V5 and V14's assessments/findings, lacked to notify the physician when change in condition started and/or a request for interventions from the physician which led up to R1's transfer to the hospital.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 31682 Based on observation, interview, and record review the facility failed to ensure residents had fresh water available between meals for six of seven residents (R2-R7) reviewed for hydration in the sample of seven. Findings include: The facility's Hydration policy dated 06/2006 documents, It is the policy of (the facility) that the facility will provide each resident with sufficient fluids to maintain proper hydration. Procedure: 1. Provide fluids (6-8 glasses per day) to residents during and in-between meals and during activities. 2. Provide fresh water and ice at the bedside except where contraindicated (example fluid restriction). 1. R2's current Physician's Orders document R2 has an order for thin liquids. On 5-13-24 at 10:15 AM R2 was sitting on the edge of his bed. R2 stated, We (residents) do not get served fresh ice water every shift. Whenever I need water, I have to get it myself out of the tap. The ice chest is locked up so I cannot get ice. A lot of residents cannot get themselves their own water. 2. R3's current Physician's Orders document R3 has an order for thin liquids. On 5-13-24 from 10:30 AM through 1:00 PM R3 was sitting in a chair in his room. R3 did not have fresh ice water in his room. On 5-13-24 at 10:30 AM R3 stated, Staff never give me fresh water. If I want water, I have to get tap water out of the sink myself. On 5-14-24 at 9:50 AM R3 was laying in his bed. R3 had no fresh water at the bedside or within reach. 3. R4's current Physician's Order Sheets document R4 has a history of urinary tract infections and has an order for thin liquids. On 5-13-24 at 10:40 AM and 5-14-24 at 9:55 AM R4 was lying in bed in her room. R4 did not have fresh ice water in her room during these times. On 5-13-24 at 10:40 AM R4 stated, I never get water unless it is on my meal tray. It would be great to get some. 4. R5's current Physician's Order Sheets documents R5 has history of sepsis and hypo-osmolality and has an order for thin fluids. On 5-13-24 at 10:42 AM and 5-14-24 at 9:58 AM R5 was lying in bed in her room. R5 did not have fresh ice water in her room during these times. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5-13-24 at 10:42 AM R5 stated, I never have water. 5. R6's current Physician's Order Sheets document R6 has an order for thin liquids. R7's current Physician's Order Sheets document R7 has a history of urinary tract infections and has an order for thin liquids. On 5-13-24 at 10:45 AM R6 and R7 were both sitting in wheelchairs in their room. Neither R6 nor R7 had ice water in their room. On 5-14-24 at 10:40 AM V2 verified R3, R4, R5, and R7 did not have water pitchers or fresh water in their rooms. On 5-14 24 at 10:45 AM V2 (Director of Nursing) stated, All residents are supposed to get fresh ice water served to them every shift in their rooms. All residents should have a water pitcher at the bedside.

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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. 31682 Based on record review and interview the facility failed to obtain scheduled physician prescribed medications from the pharmacy for one of three residents (R2) reviewed for medication availability in the sample of seven. Findings include: The facility's Conformance with Physician Medication Orders policy dated 9-27-17 documents all medications, including cathartics, headache remedies, or vitamins, etc. (etcetera) shall be given as prescribed by the physician and at the designated time. This policy also documents the resident's attending physician shall be notified to promptly renew prescription order to avoid interruption of the resident's therapeutic regimen. R2's Order Summary Report dated 5-13-24 documents the following current medication orders: Order date 3-22-24: Atenolol 50 mg (milligrams) one tablet by mouth two times a day for the diagnosis of Hypertension. Order date 4-26-24: Zolpidem Tartrate 10 mg one tablet by mouth at bedtime daily for the diagnosis of Insomnia. R2's Medication Administration Records dated 5-1-24 through 5-31-24 document R2 did not receive his scheduled dose of Zolpidem (Ambien) Tartrate 10 mg at 8:00 PM on 5-8-24 due to the medication being unavailable. R2's Medication Administration Records dated 5-1-24 through 5-31-24 document R2 did not receive his scheduled dose of Atenolol 50 mg at 8:00 PM on 5-6-24 due to the medication being unavailable. On 5-13-24 at 10:15 AM R2 stated, I did not get my Ambien one day and my Atenolol on one day. I am tired of hearing excuses from (V2/Director of Nursing/DON)) that the facility runs out of my medications. It is unacceptable. On 5-13-24 at 10:30 AM V2 stated, (R2) did not get his scheduled dose of Zolpidem on 5-8-24 due to the pharmacy not receiving the signed prescription refill order. (R2) did not get his scheduled dose of Atenolol on 5-6-24 because the pharmacy did not get the refill to the facility in time.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on record review and interview, the facility failed to ensure Physical Therapy/Occupational Therapy (PT/OT) was provided per physician order for one of three (R1) residents reviewed for therapy services in a sample of seven. Findings include: The Admissions Policy, dated 10/2006, documents To admit and/or retain only those residents whose health care needs can be met through services of the facility and staff, in cooperation with outside resources under contract with the facility. Prior to admission, a thorough pre-screening of potential residents shall be done with the resident or guardian or responsible party determining appropriate placement. The Facility assessment dated [DATE] documents Resident support/care needs the facility provided various services for the residents we care for. The resident's care is based on their individual needs and preferences and are reflected in the individuals care plan. The care and services provided are broken down by category: Therapy PT, OT . On 12/21/23, R1's New Referral form from the transferring hospital to the facility documents Patient is bilateral BKA (Below the Knee Amputation) and gets up via (mechanical) lift. Needs SNF (Skilled Nurse Facility) placement due to inability to care for self at home. Anticipated Services needed: Physical Therapy/Occupational Therapy. On 12/26/23, a Physician's Order documents to admit and receive skilled PT/OT services from the Skilled Nurse Facility. On 12/27/23, R1's Skilled Charting-12 Hr. (hour) section C documents R1's ADL's (Activities of Daily Living)/Functional Status as does not weight bear, unsteady gait, impaired balance, weakness, and section L documents skilled services needed are Therapy/Rehabilitative Services, Physical Therapy and Occupational Therapy. On 1/16/24, R1's Care plan documents R1 has bilateral BKA, R1 requires maximum assist of two staff members and the use of a mechanical lift to complete surface to surface transfers safely. R1 also requires substantial assistance from staff to complete daily tasks of dressing, grooming, toileting hygiene, and bed mobility. R1's medical record does not include evidence of R1 receiving PT/OT services or evaluations since admission. On 5/13/24 at 10:20 AM, R1 stated I came (to the facility) the end of December (2023). I want to go home but I need PT, but my insurance won't pay. I don't have a (mechanical lift) at home, and they haven't taught me how to use a slide board for transfer. I know other people are on Medicaid and they get therapy. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 10:00 AM, V1 (Administrator-In-Training) stated That just must be a standardized order (R1's PT/OT order). We didn't even have therapy services back then.