STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145454	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlinville Rehab & Hcc	751 North Oak Street Carlinville, IL 62626

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34964 Based on interview and record review, the facility failed to ensure a resident was free from misappropriation of their property for 1 of 3 residents (R2) reviewed for medications in the sample of 12. This past non-compliance occurred between 1/3/2024 and 1/5/2024. Findings include: R2's Face Sheet, printed 5/22/24, documented that she had diagnoses of Acute Respiratory Failure with Hypoxia, Saddle Embolus of Pulmonary Artery with Acute Cor Pulmonale, Malignant Neoplasm of the Cecum and Encounter for Palliative Care. R2's Physician Order Summary Report, dated 5/22/24, documented that she had an order that dated 5/18/23 for Lorazepam Tablet 1 MG (milligram) Give 1 tablet by mouth every 2 hours as needed for Anxiety. R2's Physician Order Summary Report, dated 5/22/24, documented that she had an order that was dated 5/16/23 for Morphine Sulfate (Concentrate) solution 20 mg/ml (milliliter) Give 0.25 ml by mouth every 2 hours as needed for Pain. R2's Minimum Data Set (MDS), dated [DATE], documented that R2 was moderately cognitively impaired. R2's Care Plan, dated 5/24/23, documented, (R2) is on pain medication therapy r/t (related to) cancer. Interventions for this focus included: Administer medication as ordered. The facility's document, Facility Reported Incidents, dated 1/3/24 at 5:33 PM, with the Resident/Victim identified as (R2), and the Incident Category as Drug Diversion. This document includes a narrative description signed by V2, Director of Nursing which documented, On January 3, 2024, at approximately 2:30 PM, the (consultant pharmacy) representative was conducting an audit of the facility medication carts. During the audit, a discrepancy was noted with the color of morphine sulfate 20 mg/ml for resident, (R2) (6/7/1930). MD (Medical Doctor), (local) Police Department (ref #24-300), and Responsible Party notified. Investigation in progress and final report to follow once the investigation complete. (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another Facility Reported Incident, dated January 9, 2024, identified R2 as the Resident/Victim, with the Incident Category as Drug Diversion, and Incident Descriptions as: Initial report of alleged drug diversion sent on 1/3/24. Follow up regarding the investigation sent on 1/8/24. On 1/8/24, a random audit was conducted of the medication carts as well as the narcotic counts. During this audit it was identified that there was a discrepancy with resident (R2) Lorazepam (1 mg tablet). Pharmacy, MD, Responsible Party, and (local) Police Department (#24-900) were notified of the discrepancy. (V9) LPN (Licensed Practical Nurse) was suspended pending outcome to the investigation. Please accept this as an update to the investigation and final report to follow once the investigation is complete. A Final Report, dated 3/15/24, was presented on 5/22/24 by V1, Administrator as part of the facility investigation of drug diversion of R2's Morphine Sulfate and Lorazepam 1mg. This final report documented, On 1/3/2024, the pharmacy representative was conducting an audit at the facility, and it was identified that the morphine belonging to (R2) (Date of Birth 6/7/1930) had been tampered with. Discoloration of the medication was identified and per lot number, this medication should be blue in color and was light green in color. The medication was immediately removed from the medication cart and an investigation was initiated. MD, (local) Police Department, Ombudsman, and Responsible Party were notified. An audit was completed of all narcotics on all medication carts and no other issues were identified. The facility replaced the morphine that was identified as being tampered with and there was no negative outcome for the resident. Through the QAPI program, the facility initiated a plan of correction related to the issue, which included random audits of the medication carts and narcotic counts. On 1/8/2024, an audit was completed on the C-Hall medication cart. During the audit it was identified the back of the Lorazepam 1 mg medication card belonging to (R2) was torn and the medication in the pill slot was an OTC (over the counter) medication, not the Lorazepam 1 mg pill. (V9) LPN, was immediately suspended pending the outcome of the investigation. MD, (local) Police Department, Ombudsman, and the Responsible Party were notified. (V26) Attorney General, was notified and provided with the information related to the findings along with details of the investigation and interviews outcomes. (Local) Police Department was contacted, and (V27) detective was provided with information related to investigation and assisted with follow up interviews. The facility has been pending a conclusion with this investigation due to outcomes of the interviews with (V27). Per follow up conversation with (V27), he is unable to substantiate that a person responsible for diverting the medication. Staff members with access to the medication cart during these two incidents were interviewed by the Administrator and Director of Nursing but were unable to substantiate the person responsible for diverting the medication. (V9) has remained suspended throughout this entire investigation. Audits have remained in place and no further issues have been identified. The facility will continue to work with (V27) related to any additional information obtained related to the investigation. (V9) is termed from the facility receiving a Category 1 Offense for improperly handling and notifying the proper nursing management of narcotics on 1/8/24, as identified through the investigation. Currently, the facility is unable to substantiate a perpetrator through this investigation. Please accept this as the final report for this investigation and the facility will report any additional findings, if identified. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy, Abuse, Prevention and Prohibition Policy, revised 10/22, documented, Statement of Intent: Each resident had the right to be free form abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It continues, Policy: this facility prohibits mistreatment, neglect or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and maintain physical, mental and psychosocial well-being. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain or mental anguish. The facility also prohibits misappropriation of resident property. The residents must not be subjected to abuse by anyone. the facility will educate all employees upon hire and at least annually of the definitions of the Abuse Prevention and Prohibition Policy including the definitions pertaining to abuse and neglect. Annually the Administrator will contact local law enforcement to review the requirements for reporting to law enforcement. This policy documents the definition of Misappropriation of Resident Property as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Prior to the Survey date, the facility took the following actions to correct the deficient practice: 1. A Quality Assurance and Performance Improvement meeting was held on 1/5/2024. In attendance was V2, Director of Nurses, V12, Former Administrator now Regional Staff, V16, MDS Coordinator and V24, Medical Director. 2. Measures put into place/systematic changes to ensure the deficient practice does not recur: a. 100% in-servicing with the nurses on the 5 Rights of medication administration. b. 100% in-servicing with the nurses on the inspections of seals on the controlled substances and inspection the medication for changes in color and consistency and to notify the DON or ADON of any discrepancies. c. An emergency QA meeting was held with the Medical Director (via Telephone), Administrator, DON, ADON, and MDS Coordinator to review the past non-compliance plan, and plan of correction. 3. Plan to monitor performance to ensure solutions are sustained: This will be done 3 times a week for 8 weeks, 2 times a week for 8 weeks and monthly to ensure there are no discrepancies noted. Any Deficient practice will be corrected immediately. Patterns or trends will be reported to QA Committee for further recommendations and follow-up.

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F 0684 Level of Harm - 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** 34964 Based on interview and record review, the facility failed to monitor and treat a resident with the diagnoses of Diabetes Type 2 for one of 3 residents (R10) reviewed for quality of care, in the sample of 12. This failure resulted in R10 being hospitalized with Uncontrolled Diabetes Mellitus with an initial blood glucose of 614 in the emergency room (ER). Findings include: R10's Hospital emergency room (ER) Records, dated 5/22/24, documented that he had a history of insulin dependent diabetes mellitus and that he was admitted to the hospital on that date with the diagnoses of Acute on Chronic Renal Failure and Uncontrolled Diabetes Mellitus. Per the hospital records, R10's blood glucose level was 614 when he was in the ER. R10's Face Sheet, printed 5/23/24, documented that he was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus without complications. R10's Minimum Data Set (MDS) dated [DATE] documents he is moderately cognitively impaired and is dependent on staff for Activities of Daily Living (ADLs). R10's Care Plan, dated 9/26/21, documented, (R10) has Diabetes Mellitus. The goal for this care plan was, (R10) will have no complications related to diabetes through the next review date of 5/19/24. Interventions for this care plan included, Check all of body for breaks in skin and treat promptly as ordered by doctor. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Dietary consult for nutritional regiment and ongoing monitoring. Discuss mealtimes, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, compliance with nutritional regimen. Don't use over the counter remedies for corns and calluses, refer to podiatrist to treat. Educate regarding medications and importance of compliance. Have resident verbally state an understanding. Educate resident/family/caregiver: Diabetes is a chronic disease, and that compliance is essential to prevent complications of the disease. Review complications and prevention with the resident/family/caregiver. Elicit a verbal understanding from the resident/family/caregiver, that nails should always be cut straight across, never cut corners. File rough edges with emery board. R10's Care Plan did not address monitoring blood glucose levels or signs and symptoms of hyper or hypoglycemia. R10's Care Plan, dated 9/26/21 and revised on 5/23/24, documented, (R10) has actual impairment to skin integrity related to (r/t) Diabetes, decreased mobility and urinary incontinence. (R10) had a pressure ulcer to the right trochanter, coccyx and right ischium, diabetic ulcer to left foot dorsal, and 2 arterial ulcers to RLE (right lower extremity). The goal for this care plan documented, (R10's) diabetic, pressure and arterial ulcers will show s/s (signs and symptoms) of healing through next review date of 5/19/24. R10's lab result, dated 5/8/24 at 7:05 AM documented that his blood glucose of 374, which is high, with normal limits being 74 to 106. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R10's most recent Order Summary Report, dated 5/24/24 with order date range from 5/1/24 to 5/31/24, documented an order, dated 5/9/24, Draw TIBC (Total Iron Binding Capacity), Iron, Folate, A1C, Occult Stool x 3 one time only for 1 day. No A1C result was found for that date (5/9/24) in R10's Electronic Medical Record (EMR). R10's lab result, dated 3/7/24, documented his HGB A1C as 9.4, which was high, with the goal being less than 7 if a resident is diabetic. There was no documentation in R10's EMR that his physician was notified of this abnormal lab. R10's Physician Order Summaries were reviewed for April 2024, March 2024, February 2024, January 2024, December 2023, November 2023, October 2023 and September 2023. Review of these physician order summaries documented R10 was receiving both Humalog Insulin (Order dated 9/26/23: Humalog (Insulin Lispro) 15 units (u) subcutaneously (SQ) before meals for diabetes and Insulin Glargine 20 u SQ one time a day for diabetes). R10 continued to receive these medications with blood glucose monitoring before meals and at bedtime until he was hospitalized on [DATE]. R10's December 2023 physician order summary documented that he was readmitted to the facility on [DATE]. The December physician order summary documented the order dated 12/13/23: May obtain blood sugar prn (as needed) for signs and symptoms of hyper/hypoglycemia as needed. If blood sugar is less than 70 and able to swallow, administer food or juice. Recheck blood sugar in 15 minutes and notify MD as needed. If blood sugar remains less than 70 and able to swallow, administer glucose gel orally. Recheck blood sugar in 15 minutes. If blood sugar remains less than 70 and unable to swallow, administer Glucagon per manufacturer's instruction. Obtain from EDK (Emergency Drug Kit). Recheck blood sugar in 15 minutes. If blood sugar remains less than 70, notify MD as needed. R10 did not have an order to resume scheduled blood glucose monitoring. On 2/25/24 R10 received an order for Metformin 500 mg one tab in the morning and 2 tabs at bedtime. There was no order for routine blood glucose monitoring after R10 returned from the hospital on 12/7/23. R10's Hospital Discharge Instructions, dated 12/7/24, documented, Discharge Follow Up Appointments-Endocrinology, Call office for appointment in 3-5 days. We were not able to confirm if he takes insulin and he largely refused a lot of things in the hospital including blood draws. Blood sugars remained well controlled on Metformin 500 mg BID (twice a day). Please reassess. The discharge instructions did document that R10 was to stop taking Insulin Glargine and Insulin Lispro but did not address if R10 was to continue to have blood glucose monitored routinely as he had prior to hospitalization . No documentation was found in R10's EMR regarding notification of his MD for reassessment of blood glucose monitoring and if insulin should be resumed. On 5/24/24 at 11:07 AM V21, Licensed Practical Nurse (LPN), during phone interview, stated that she was R10's nurse on the day he was sent to the hospital. She stated he was having a change in condition since she saw him the previous week, as she only works prn. She stated the previous week R10 had some shortness of breath, and his pulse ox was a little low and she called his doctor, and a chest x-ray was ordered, and he was started on antibiotics. She stated when she saw him the next week, he was not any better and he had just finished his antibiotics. She stated that R10 was holding his pills in his mouth when she gave them to him and then started chewing them which was not normal for him. She stated R10 was normally grouchy and yelling at people and on that day, he was not talking. He was not being able to cough up his phlegm and was still drooling some of the chocolate health shake with little bits of his medication mixed in. V21 stated that she did not do an accucheck on R10 because she didn't think his change in condition had anything to do with his blood sugar. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/24/24 at 1:55 PM, V23, Registered Nurse (RN) in R10's Primary Care Physician's (V24's) office, stated that she couldn't find in R10's records at the physician's office that they ever received notification of R10's A1C result of 9.4 that was done on 3/7/24. V23 also stated that they would have definitely ordered accuchecks to be done if his A1C was 9.4, and probably would have started something else to treat his diabetes. She stated that R10's glucose level on 5/8/24 was 347 and V24 ordered an A1C to be done but they have not received those results yet. On 5/24/24 at 2:37 PM V25, MD, Hospitalist, stated that he has seen R10 during this hospitalization . He stated that R10's blood glucose was 614 when he first came to the emergency room , and it continued to be high for a while. He stated R10 should have been getting routine accuchecks to keep an eye on his diabetes. He stated that if R10 was on insulin, he would expect accuchecks to be done at least a couple of times a day and if not on insulin, he should have been receiving accuchecks at least once a day to monitor his diabetic status because of his history of diabetes. V25 also stated that he does think it would have made a difference if R10's blood glucose levels had been monitored and his high blood glucose levels had been caught and treated in that it would have helped prevent his hospitalization , infections and poor wound healing. V25 stated that he reviewed R10's medical records and they indicated R10 should have been taking insulin. He also stated it would have been appropriate to be checking R10's blood glucose levels to see if he needed to be back on insulin. On 5/24/24 at 3:12 PM, V2, Director of Nursing, stated that she has the fax confirmation page showing that the lab did fax R10's A1C result from 3/7/24 to the physician's office, but she does not think the facility followed up to make sure V24 saw it. She stated that going forward, the facility has educated the nurses to compare previous orders prior to hospitalization , or home medications to current or hospital discharge orders to check for any differences, and then notify the MD to see if he wants any previous orders, including accuchecks, resumed upon readmit to the facility. She also stated she just started this process about a month ago, so it probably did not happen when R10 was readmitted to the facility on [DATE]. V2 also stated R10's A1C was not drawn as ordered on 5/9/24 because he had one done within the last 3 months, so they will draw it in June. V2 stated that the facility does not have a specific policy regarding diabetic management, and stated they just treat according to physician's orders.