STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fayette County Hospital	650 W Taylor St Vandalia, IL 62471

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review, the facility failed to implement new fall interventions to aid in fall prevention for 1 (R10) of 3 residents reviewed for falls in the sample of 22. Findings include: R10's Face Sheet documented an admitted [DATE] and included diagnoses of legal blindness, hallucinations, delusional disorders, major depressive disorder, restlessness and agitation, anxiety disorder, overactive bladder, and pain in thoracic spine. R10's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. This MDS also documented R10 needs substantial to maximal assistance for sit to stand. R10's Long Term Care Fall Log dated 08/26/24 documented a fall on 08/26/24 on the 2:00 PM to 10:00 PM shift. The summary of the incident documents: Certified Nurse Aide (CNA) had been in R10's room to ask about a shower and resident refused. CNA stepped out of room to notify nurse of refusal and heard alarm sounding. R10 was on the floor in front of the recliner. R10 stated, that she did not fall, but stood up and then laid down on the floor. The intervention for this fall is documented as: R10 has chair alarm and is on hourly rounds. CNA had just been in R10's room. Continue current interventions. R10's Long Term Care Fall Log dated 09/10/24 documented a fall during the 6:00 AM to 6:00 PM shift. The summary of the incident documents: resident (R10) slid out of recliner and was found sitting on the floor. The intervention for this fall is documented as: R10 has safety alarm and is on hourly rounds, checked 15 minutes prior to the incident. R10 has behaviors and no safety awareness. R10's Long Term Care Fall Log dated 09/24/24 documents a fall on 09/24/24 on the 6:00 AM - 6:00 PM shift. The summary of incident documents: CNA had just been in R10's room, no needs were voiced, three minutes later R10 was found sitting on her buttocks on the floor. R10 stated she stretched and slid to foot of recliner and slid to floor. R10's intervention for this fall is documented as: has an alarm, a low bed, soft mats and hourly rounds. R10 has behaviors, no safety awareness, no acute illness, and no environmental factors. R10 is in the safest environment possible. (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 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

R10's Care Plan documents under Focus Area fall risk, had previous fall on 08/02/24 resulted in fracture to her left distal radial arm. She recently was in the hospital and returned to the Long Term Care on 08/15/24. Resident slid from her recliner to the floor on 08/17/24 with no new injuries noted. Resident is experiencing hallucinations and delusions. She is not aware of her physical limitations, with poor balance, unsteady gait. Family have declined surgery to repair the fracture. Often tries to remove splint from left arm. She has pain to her left arm at times. She had another fall on 08/26/24, but she stated, she did not fall, she got on the floor to rest. No injury noted. 09/13/24 found on the floor. (The two open areas on the left thumb are healed on 09/23/24.) 10/21/24 resident has been picking at a reddened area on her mid forehead. The care plan's revision date is documented as 10/21/2024. There were no new fall interventions documented on R10's Care Plan following the falls on 8/26/24 and 9/24/24.

On 10/24/24 at 12:45 PM, V2 (Director of Nursing) stated they do not have a new intervention for the fall on 8/26/24 or the other fall on 9/24/24, it is just to continue the interventions that are currently in place.

On 10/24/24 at 12:50 PM, V1 (Administrator) stated it is hard to come up with new interventions for her, but they will talk to her son and see if they can figure some out.

R10's Care Plan documents under Focus Area fall risk, had previous fall on 08/02/24 resulted in fracture to her left distal radial arm. She recently was in the hospital and returned to the Long Term Care on 08/15/24. Resident slid from her recliner to the floor on 08/17/24 with no new injuries noted. Resident is experiencing hallucinations and delusions. She is not aware of her physical limitations, with poor balance, unsteady gait. Family have declined surgery to repair the fracture. Often tries to remove splint from left arm. She has pain to her left arm at times. She had another fall on 08/26/24, but she stated, she did not fall, she got on the floor to rest. No injury noted. 09/13/24 found on the floor. (The two open areas on the left thumb are healed on 09/23/24.) 10/21/24 resident has been picking at a reddened area on her mid forehead. The care plan's revision date is documented as 10/21/2024. There were no new fall interventions documented on R10's Care Plan following the falls on 8/26/24 and 9/24/24.

The undated facility policy titled, Fall Prevention Program documents in part: Post-fall management: Post fall assessment includes, but not limited to: what happened, how it happened, why did it happened, (vital signs, blood glucose level, neuro checks at the time of the fall), were appropriate interventions in place Specific considerations as to why the fall might have occurred, including, but not limited to: .How similar outcomes can be avoided. How the care plan will change.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 39744 Based on interview and record review, the facility failed to provided the services of a Registered Nurse (RN) for 7 days a week for 8 consecutive hours per day. This failure has the potential to effect all 29 residents living at this facility. Findings Included: On 10/22/2024 at 1:50 PM, V2 (Director of Nursing/DON) stated the facility did not have the required 8 hours per day, 7 days a week of RN coverage for the dates of 5/11/24, 5/19/24, 5/27/24, 6/9/24 and 6/30/24. V2 said they did not have a policy for Registered Nurse coverage. On 10/22/2024 at 10:00 AM, V1 (Administrator) stated that nurse's calling off has contributed to a few days of not having Registered Nurse coverage. The facility nursing schedule for May and June of 2024 revealed the facility did not have the required 8 hours of Registered Nurse coverage for the following dates: 5/11/24, 5/19/24, 5/27/24, 6/9/24 and 6/30/24. The Long Term Care Application for Medicare and Medicaid (Form CMS 671) dated 10/21/24 documents that there are 29 residents living in the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on interview and record review, the facility failed to document the findings of monthly Medication Regimen Review's (MRR) for 5 (R6, R17, R18, R22, R26) of 5 residents reviewed for unnecessary medications in a sample of 22. Findings include: 1. R6's Admission Record documented an admitted [DATE] with diagnoses that included major depressive disorder, adjustment disorder with mixed anxiety and depressed mood. R6's Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 13, indicating that R6 was cognitively intact. R6's Order Summary sheet documented an active order for twenty-two oral medications. R6's Progress Notes documented that Medication Regimen Reviews (MRR's) were completed for R6 on 3/20/24, 4/22/24 and 5/22/24. A facility document titled Consultant Pharmacist Medication Regimen Review (MRR) and Physician Notification was provided that documented R6 had MRR's completed on 3/20/24, 4/22/24 and 5/22/24. There was no documentation produced to show that MRR's were completed for the months of June, July, August and September 2024. 2. R17's Admission Record documented an admitted [DATE] with diagnoses that included Alzheimer's, major depressive disorder, delusional disorders, anxiety and insomnia. R17's MDS dated [DATE] documented a BIMS score of 13, indicating R17 was cognitively intact. R17's Order Summary sheet documented an active order for seventeen oral medications. R17's Progress Notes documented that MRR's were completed for R17 on 4/22/24, 5/22/24 and 6/5/24. A facility document titled Consultant Pharmacist Medication Regimen Review (MRR) and Physician Notification was provided that documented R17 had MRR's completed on 3/20/24, 4/22/24 and 5/22/24. There was no documentation produced to show that MRR's were completed for the months of June, July, August and September 2024. 3. R18's Admission Record documented an admitted [DATE] with diagnoses that included dementia with mild anxiety, major depression disorder, generalized anxiety disorder, and post-traumatic stress disorder. R18's MDS dated [DATE] documented a BIMS score of 7, indicating R18 was severely cognitively impaired. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R18's Order Summary sheet documented an active order for seventeen oral medications. R18's Progress Notes documented MRR's were completed for R18 on 3/20/24, 4/22/24, 5/22/24 and 6/5/24. A facility document titled Consultant Pharmacist Medication Regimen Review (MRR) and Physician Notification was provided that documented R18 had MRR's completed on 3/20/24, 4/22/24 and 5/22/24. There was no documentation produced to show that MRR's were completed for the months of June, July, August and September 2024. 4. R22's Admission Record documented an admitted [DATE] with diagnoses that included Alzheimer's disease with late onset, insomnia, hallucinations, anxiety, restlessness and agitation. R22's MDS dated [DATE] documents a BIMS score of 3, indicating that R22 was severely cognitively impaired. R22's Order Summary sheet documented an active order for eighteen oral medications. R22's Progress Notes documented a MRR was completed for R22 on 5/22/24. A facility document titled Consultant Pharmacist Medication Regimen Review (MRR) and Physician Notification was provided that documented R22 had a MRR completed on 5/22/24. There was no documentation produced to show that MRR's were completed for the months of June, July, August and September 2024. 5. R26's Admission Record documented an admitted [DATE] with diagnoses that included anxiety disorder, Alzheimer's disease, depression, and insomnia. R26's MDS dated [DATE], documented a BIMS score of 7, indicating R26 was severely cognitively impaired. R26's Order Summary sheet documented an active order for sixteen oral medications. R26's Progress Notes documented MRR's were completed for R26 on 3/20/24, 4/22/24, 5/22/24 and 6/5/24. A facility document titled Consultant Pharmacist Medication Regimen Review (MRR) and Physician Notification was provided that documented R26 had MRR's completed for 3/20/24, 4/22/24 and 5/22/24. There was no documentation produced to show that MRR's were completed for the months of June, July, August and September 2024. On 10/22/24 at 2:41 PM, V2 (Director of Nursing/DON) stated the missing months of MRR's were because the pharmacist ran out of MRR papers. On 10/23/24 at 2:40 PM, V2 stated there would be a progress note if a MRR had been done. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/24 at 10:03 AM, V11 (Consultant Pharmacist) stated he did MRR's for the residents every month at the pharmacy but was not in the facility. V11 stated that he had not documented them in the resident's medical record. V11 stated he had just recently discussed with V2 (DON) how they were going to document the MRR's. V11 stated that he used to chart in the resident's medical record before they started using this new program for electronic medical records. V11 stated when they switched, he started using a paper form. V11 stated he ran out of the paper form and was unable to order more because they had been discontinued. A facility document titled (Name of Facility) Monthly Summary September 2024 signed by V11 (Consultant Pharmacist) states that all charts were reviewed and signed on September 25, 2024 and that all charts were in order. The facility was unable to produce any resident specific documentation by V11, to show that the medications were reviewed, or charts were signed in June, July, August and September 2024. The undated Facility Policy titled Pharmacy Provider documents under Section II, titled Consultant Pharmacist that it is the responsibility of the consultant pharmacist to maintain a log of all visits and activities within the facility and to submit written reports to the LTC (Long Term Care) manager on a monthly basis. It further documents that it is the responsibility of the consultant pharmacist to review the drug regimen of each resident on a monthly basis and report any irregularities to the medical director, LTC manager, and the resident's personal physician. Under Section III, titled Resident Drug Regimen Reviews it documents that the consultant Pharmacist shall provide the facility with documentation that he/she has reviewed each resident's drug regimen at least monthly. If the Consultant Pharmacist determines that there are no irregularities, he/she shall record in the resident medical record that he has performed the review and shall sign and date the entry.