

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/20/2024
NAME OF PROVIDER OR SUPPLIER  Mar Ka Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  201 South 10th Street Mascoutah, IL 62258	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45302</p> <p>Based on interview and record review the facility failed to to monitor/supervise a resident from wandering into resident rooms at night for 4 of 4 residents (R4, R8, R25, R39) reviewed for resident rights in the sample of 24.</p> <p>Findings include:</p> <p>Grievance Report Form dated 7/28/2024, documents R4 stated another resident (R37) wanders in her room looking for a facility owned remote. Actions/recommendations: he should be monitored more closely. Action taken: resident (R37) will be given a sitter.</p> <p>Grievance Report Form dated 8/25/2024 documents R10 stated another resident (R37) wanders into resident's room in search of a facility owned remote.</p> <p>On 9/19/2024 at 1:55 PM R4, R8, R25 and R39 stated a resident by the name of (nickname) (R37) wanders into their rooms at night and steals the television remote control. All residents stated they have told the facility time and time again about cowboy doing this but nothing stops him. R25 stated if he comes into my room again I'm going to have to hurt him. R4 stated being a female she doesn't feel comfortable sleeping with (R37) randomly going in her room at night, she said it's freaky.</p> <p>R37's Undated Face Sheet documents he was initially admitted on [DATE] with diagnosis of schizophrenia.</p> <p>R37's Quarterly Minimum Data Set (MDS) dated [DATE] documents resident is severely cognitively impaired with diagnoses of Alzheimer's disease, anxiety, insomnia and schizophrenia. No upper or lower extremity impairment and no cane or walker mobility devices.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R37's Progress Note, dated 8/31/2024 at 1:30 PM, documents res (resident) was noted numerous times on the 6 a-2 p shift going into other res's rooms. Res noted down Ash hall several times and was in the breakroom. Res noted with a remote with the initials DK on it. Housekeeping retrieved it and gave it to the nurses, then, it was returned to the res. Other residents advised to close their doors when leaving their rooms. This res was told numerous times to stay on his hall and only go into his room. Res voiced, Okay. A little bit later, res would be noted coming out of another res's room. Staff aware of res's roaming &amp; pacing and entering rooms other than his. Staff tried to keep an eye on res and keep him from entering someone else's room. Res cont to roam halls. Progress Note at 3:36 PM, documents Res noted continuing to go in other res rooms trying to take belongings. Res redirected numerous times by staff.</p> <p>R37's Progress Note, dated 9/2/2024 at 1:32 PM, documents Res noted going into other res's rooms numerous times this shift &amp; taking belonging. Res redirected out of their rooms and belongings returned. Progress Note at 4:48 PM, documents Resident noted with remote control to another residents room, this nurse redirected resident, and provided education on only using remote control assigned to resident tv in room, resident had blank stare and chuckled. Progress Note at 7:51 PM, documents Resident caught in another resident bathroom, this nurse redirected resident to main dining room, nurse provided education and reminded resident where assigned room was at. Resident shook his head and walked away from this nurse. Resident now pacing hallways, CNA staff walking with resident. will continue to observe.</p> <p>On 9/19/2024 at 2:30 PM, V1 Administrator stated she is aware the resident (R37) wanders into other residents room but he has a sitter from 4:00 PM - 10:00 PM and she didn't think it was a problem anymore. V1 hired a sitter for (R37) a few months ago and she didn't know it was still an issue. She has consulted with a psychiatrist for medication review and referred (R37) to other, more appropriate facilities but no facility accepted him as a resident. V1 stated she will increase the sitter times with (R37) and have the nurse check on him every two hours while he's asleep to ensure he doesn't wander in other resident rooms.</p> <p>The facility's resident's rights policy dated revised 1/2024, documents the facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility will also provide the resident with prompt notice (if any) of changes in any State or Federal laws relating to resident rights or facility rules during the resident's stay in the facility. Receipt of any such information must be acknowledged in writing. Grievances: the resident has a right to and the facility must make prompt effort by the facility to resolve grievances the resident may have.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42636</p> <p>Based on interview, observation and record review, the facility failed to implement a resident centered behavior care plan on 1 of 13 residents (R36) reviewed for development/implementation of a comprehensive care plan in the sample of 20.</p> <p>Findings include:</p> <p>R36's Face Sheet, undated, documents R36 has a diagnosis of Major Depressive Disorder and Generalized Anxiety Disorder.</p> <p>R36's Minimum Data Set (MDS), dated [DATE], documents R36 has a BIMS (Brief Interview for Mental Status) score of 10, which indicates R36 has moderate cognitive impairment.</p> <p>R36's Care Plan, dated 9/14/24, documents R36 has a behavior problem, depression and dementia with interventions to give anti-anxiety medications ordered by the physician, monitor/document/report to the physician as needed any ongoing signs or symptoms of depression unaltered by the antidepressant medications and to arrange for psychiatric consult to follow up as needed. The care plan fails to document the behaviors that are exhibited by R36 or resident specific interventions to aid in the management of behaviors. The care plan also fails to document any non-pharmacological interventions to manage the behaviors.</p> <p>R36's Progress Note, dated 3/25/24 at 5:55 PM, documents the following: Resident sitting next to this nurse at nurses station, very agitated and exit seeking. Resident stated if she didn't get to leave and go home she was going to fall out of the chair. This nurse attempted to redirect resident several times. Behavior continues. Will continue to monitor and observe.</p> <p>R36's Progress Note, dated 3/27/24 at 1:24 PM, documents the following: Reported by therapy that resident stated that she would rather die than to have to do all of this. This referred to social services at this time and social services is speaking to resident. No distress evident.</p> <p>R36's Progress Note, dated 4/5/24 at 12:31 PM, documents the following: Social worker observed resident during lunch today. Resident was overheard saying she is not hungry and does not want to eat. COTA (Certified Occupational Therapy Assistant) at lunch table tried to encourage resident to eat with no avail. Resident then stated she did not want to eat because she is depressed. Resident has had an assessment with a score of 12.0, indicating moderate depression. Social worker has contacted psychiatric physician for an evaluation.</p> <p>R36's Progress Note, dated 5/30/24 at 4:43 PM, documents the following: Resident noted by this nurse, being rude to staff, stating that she does not like her CNA (Certified Nursing Assistant), when asked why, she stated I just don't. This nurse explained to resident that staff was here to help her and that she needed to use her call light for assistance. This nurse asked if CNA had done anything to her and she stated No, I just don't like her, and I don't like you either. Incident reported to social services.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R36's Progress Note, dated 6/27/24 at 11:00 AM, documents the following: Call placed to the physician's office to ask about Lorazepam order being reinstated. Resident has been requesting pill the last 2 days. She is very anxious and says she hasn't slept in 3 days. Awaiting return call at this time.</p> <p>R36's Progress Note, dated 7/1/24 at 11:09 AM, documents the following: The NP (Nurse Practitioner) here to see resident, new order received for Lorazepam 0.5 mg (milligrams) every 8 hours as needed. Order entered and faxed to pharmacy.</p> <p>On 9/18/24 at 1:05 PM V18, SSD (Social Services Director), stated the only behavior R36 has is she gets out of bed without asking. V18 stated R36 does not have any kicking, screaming or foul language. V18 stated she is involved in completing the behavior care plans but not on R36.</p> <p>On 9/18/24 at 1:51 PM V2, DON (Director of Nurses), stated she doesn't see where the interventions are resident specific for R36's behaviors.</p> <p>The Care Planning Policy, with a review date of 2/2021, documents the following: Every resident will be assessed using the MDS according to the guidelines set forth in the resident assessment instrument manual. The purpose is to assess each resident's strengths, weaknesses, and care needs and to use this assessment to develop a comprehensive plan of care for each resident that will assist a resident in achieving and maintaining the highest practical level of mental functioning, physical functioning, and well being as possible.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33110</p> <p>Based on interview, observation and record review, the facility failed to have fall interventions in place and implement progressive interventions in 3 of 7 residents (R6, R19, R36), reviewed for falls in the sample of 24. This failure resulted in R36 sustaining a head injury, requiring emergency room evaluation and treatment including but not limited to glue and adhesive skin closure strips to the right temple area.</p> <p>Findings include:</p> <p>1. On 9/17/24 at 9:05 AM, R36 was observed in her room in a low bed with a mat to left side of the bed, the call light was behind the bed, not within reach. R36 had bruising noted to the bilateral eyebrow areas with adhesive closure strips in place to the right eyebrow area. R36 stated she fell recently and that is how she got the bruising. R36 stated she has fallen 3-4 times and has gotten hurt each time. R36 stated she tries to get up on her own and falls, unsure of why she falls, she just does. R36 stated she uses her call button when she needs help and stated it's usually clipped here (reaching on the right side of the bed), but it's not here. Surveyor moved the call light within resident's reach and she pushed it. Staff came into the room to see what R36 needed and R36 stated she was just checking to make sure it worked. R36 stated she had a headache and would like something for it.</p> <p>R36's Face Sheet, undated, documents R36 has a diagnosis of Dementia, Tremors and Hypertension.</p> <p>R36's MDS (Minimum Data Set), dated 7/16/24, documents R36 has a BIMS (Brief Interview for Mental Status) score of 10, indicating R36 has moderate cognitive impairment, requires partial/moderate assist with toileting, requires substantial/maximal assist with sitting to standing, requires substantial assist with transfers and has a history of falls.</p> <p>R36's Care Plan, dated 5/23/24, documents R36 has actual/potential risks for falls with the following interventions: 5/23/24 be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; 8/24/24 continue to educate resident that she needs to be patient and wait for staff to be available to assist; 8/28/24 continue to educate resident to wait for staff to assist her and she will need to ask for assistance; 9/12/24 sent to the emergency room for evaluation and treatment, received 2 adhesive skin closure strips and glue to the right temple and then was sent back to the facility; 9/14/24 continue to educate resident on waiting for staff for transfer needs and encourage her as much as she will allow to stay in high traffic areas. The Care Plan goes on to document R36 has an ADL (Activities of Daily Living) self-care performance deficit with an intervention to encourage her to use the call light and she requires 1-2 staff to assist in all transfers using a mechanical lift. The care plan fails to identify progressive interventions to prevent falls but utilizing the same intervention for multiple falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R36's Progress Note, dated 7/11/24 at 9:40 AM, documents the following: Writer called into residents room by CNA. Resident was attempting to transfer herself into bed unassisted, she stood up and slid down the front of her chair onto the fall mat on the floor. Skin assessment completed, no injury or wounds noted. Resident denies any pain or discomfort. Resident assisted up into bed and is now resting quietly in bed with HOB elevated and call light in reach. Fall mat in position and bed in low position, will continue to monitor.</p> <p>R36's Progress Note, dated 8/24/24 at 12:16 AM, documents the following: Resident roommate summoned this nurse to resident room. Upon entering room resident was found in a sitting position on floor near bed. No internal/external rotation noted. Fall unwitnessed neuro checks initiated at this time. Assisted off floor with the help of two and placed into bed. Resident able to [NAME] WNL. Denies pain or discomfort.</p> <p>R36's Progress Note, dated 8/29/24 at 9:56 AM, documents the following: Resident noted to be sitting on the floor in the hallway, in front of wheelchair. Resident noted with a 2 cm (centimeter) hematoma to the left side of the forehead. Resident stated I leaned forward to pick something up and fell out of w/c.</p> <p>R36's Progress Note, dated 9/12/24 at 4:35 PM, documents the following: Resident found on floor in room after this nurse was notified by resident's roommate. BP: 116/66, P: 76 Temp: 98.4, O2: 96, res complaining of head pain, 3 cm laceration noted to right temple, ecchymosis noted to left temple, no other injuries noted. MD and POA notified. EMS (Emergency Medical Services) transported resident to the hospital. report given to ER (emergency room ) charge nurse.</p> <p>R36's Progress Note, dated 9/12/24 at 9:46 PM, documents the following: Resident returned to facility from the hospital via EMS. Resident was transferred into bed via 2 EMS attendants. 2 Steri-strips and Dermabond was applied to resident's right eyebrow in hospital. Resident had no complaints of pain or discomfort.</p> <p>R36's Progress Note, dated 9/14/24 at 9:30 AM, documents the following: This nurse was alerted to resident being on the floor by resident's roommate. I went into room, found resident laying on the floor next to bed, resident was assessed for injuries, no injuries were found, resident's neuro-check was normal &amp; vitals were stable. Once assessment was completed, resident was transferred from the floor to the bed. Resident states she was trying to transfer self from wheelchair to bed &amp; fell , denies any pain or discomfort at this time, will continue to monitor for changes. POA, MD &amp; DON notified.</p> <p>R36's Hospital After Visit Summary, dated 9/12/24, documents a diagnosis of Fall and Laceration to the Right Eyebrow.</p> <p>2. R19 Fall Risk Data Collection Form dated 8/24/24 documents R19 is high risk for falls.</p> <p>R19 Minimum Data Set, dated dated dated [DATE] documents for rolling right to left R19 is dependent and going from chair to bed R19 is dependent.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R19's Care Plan dated 8/5/24 documents (R19) is at risk for falls 7/30/24 fall with no injury and 8/9/24 fall with no injury. The resident will be free of minor injury through review date. The resident (R19) will be free of minor injury through review date. Interventions: The resident (R19) will be free of minor injury through review date. Hospice nurse to review medications resident has a floor mat next to bed while in bed. Bed in lowest position. Resident is in a broda chair</p> <p>R19's Fall Investigation dated 12/2/23 documents resident fell out of wheelchair to floor and hit head.</p> <p>R19's Fall Investigation dated 1/17/24 documents notified by CNA (Certified Nursing Assistant) that the resident (R19) had fell . Upon entry to the room resident (R19) noted sitting on the floor next to her bed. Sitting on floor on bottom with legs extended forward resident moving all extremities CNA stated resident (R19) fell backward onto floor.</p> <p>R19's Fall Investigation dated 2/8/24documents resident (R19) found on the floor lying on her left side near the bed. The fall (was) unwitnessed, (and) neuro checks started at this time. The resident (R19) assisted off the floor.</p> <p>R19's Fall Investigation dated 2/25/24 documents resident (R19) found on the floor near her bed, in her room there was a small goose egg area near the top of her scalp. small amount of blood from a small skin tear. Pressure applied, dry dressing applied, seemed a bit restless PRN tramadol and Ativan was given.</p> <p>R19's Fall Investigation dated 3/6/24 documents resident (R19) found on floor by her bed.</p> <p>R19's Fall Investigation dated 6/6/24 found resident (R19) sitting on her buttocks in the doorway resident unable to explain what happen.</p> <p>R19's Fall investigation dated 6/20/24 resident (R19) noted by staff sliding out of bed onto the floor mat. med review completed floor mat.</p> <p>R19's Fall investigation dated 7/30/24 resident (R19) taken to room to see if resident needed to be changed. Resident note to be screaming louder resident was noted actively sliding out of bed.</p> <p>R19's Fall investigation dated 8/3/24 resident (R19) found lying on her left side in the dining room.</p> <p>R19's untitled Fall Intervention form dated 1/17/24 documents the fall intervention is med review completed continue with med A.</p> <p>R19's untitled Fall Intervention form dated 2/1/24 documents continue with skilled therapy services for safety transfers.</p> <p>R19's untitled Fall intervention Form dated 2/8/24 documents care plan meeting held 2/7/24 via phone with POA (power of attorney) discussed hospice for next level of care. R19's untitled Fall Intervention form dated 3/6/24 documents contacted hospice nurse to perform a med (medication review).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R19's untitled Fall intervention form dated 6/6/24 documents hospice nurse updated and came out for a visit will review medications.</p> <p>R19's untitled Fall intervention form dated 6/20/24 documents floor mat. The untitled Fall Intervention form dated 7/30/24 documents hospice nurse to review medications due to increased anxiety.</p> <p>R19's Untitled Fall Intervention form dated 8/5/24 documents spoke with hospice nurse to review different medication for anxiety regimen. R19's POS (Physician Order sheet) Dated 8/5/24 documents Alprazolam 1mg every four hours when ever needed for anxiety.</p> <p>R19's untitled Fall Intervention form dated 8/24/24 documents resident is in a Broda chair.</p> <p>On 9/18/24 at 4:20 PM V3 Minimum Data Set (MDS) coordinator stated, she has had a lot of falls, and we have to reuse some of the interventions. We resolve them and use them again.</p> <p>3. R6's Face Sheet documents R6 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, muscle weakness, unsteadiness on feet, and need for assistance with personal care.</p> <p>R6's Minimum Data Set (MDS) dated [DATE] documented R6 was severely cognitively impaired, independent with bed mobility and transfer, and used wheelchair.</p> <p>R6's Care Plan initiated 8/3/19 documents R6 is at risk for falls related to history of falls, need for assistance with activities of daily living, incontinence of bowel and bladder, and diagnosis of dementia with poor safety awareness.</p> <p>R6's Care Plan Intervention initiated 8/3/19 documents R6 will have anti-tippers to wheelchair at all times.</p> <p>On 9/18/24 at 11:30 AM, R6 was sitting in her wheelchair in the dining room with other residents. There were no anti-tippers on the wheelchair.</p> <p>On 9/19/24 at 12:40 PM, R6 was sitting in her wheelchair in the dining room feeding herself lunch. There were no anti-tippers on the wheelchair.</p> <p>R6's Fall Risk assessment dated [DATE] documented R6 was at risk for falls.</p> <p>R6's Unwitnessed Fall Report dated 5/10/24 documents, CNA came to the nurse saying res (resident) had blood all over her &amp; was all over the floor beside the bed. Upon entering room, this nurse noted res's (resident's) face to be covered with dried blood and blood droplets were noted on the floor beside the res's WC (wheelchair). As CNA was wiping the dried blood off the res, a 2cm (centimeter) x 1cm hematoma with a 1cm gash in the middle was noted over the res's L (left) eyebrow. Resident Unable to give Description.</p> <p>R6's After Visit Summary from (Local) emergency room documents R6 was seen for a fall with the diagnoses forehead cut, head injury, and laceration repair with glue.</p> <p>R6's Care Plan Intervention updated 5/10/24 documented, Resident educated to ensure w/c (wheelchair) brakes are locked. (R6's 4/11/24 MDS documented R6 was severely cognitively impaired.)</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R6's Unwitnessed Fall Report dated 6/3/24 documents resident was found on the floor in her room sitting on bedside mat, and R6 was unable to explain what she was trying to do.</p> <p>R6's Care Plan Intervention updated 6/3/24 documents, (R6) will continue to work with Med B therapy services on strengthening. No new interventions were added following R6's 6/3/24 fall.</p> <p>R6's Unwitnessed Fall Report dated 6/13/24 documents Resident Unable to give Description. There was no Nursing Description, and there were no details of the fall or potential causative factors.</p> <p>R6's 6/13/24 Care Plan Intervention documents, Continue with therapy services. No new interventions were added following R6's 6/13/24 fall.</p> <p>On 9/18/24 at 1:12 PM, V17, Certified Nursing Assistant (CNA), stated most of R6's falls happened because she would forget to put on her wheelchair brakes when she was self-transferring.</p> <p>On 9/18/24 at 2:40 PM, V19, CNA, stated R6 does not let staff know when she needs to transfer, so they often do not know she needs help until she is already done.</p> <p>On 9/18/24 at 3:17 PM, V26, Occupational Therapist (OT), stated R6 has a tendency to do things herself and is unlikely to ask for help due to cognitive deficits, so they requested increased supervision by staff.</p> <p>On 9/19/24 at 12:10 PM, V16, Licensed Practical Nurse (LPN)/Wound Nurse, stated R6 forgets her limitations and can take herself to the bathroom, but sometimes she rushes, and that is the problem. She stated interventions have been put in place, but there have been no changes in her level of supervision. She was unsure if R6 ever had anti-tippers on her wheelchair.</p> <p>On 9/20/24 at 9:18 AM, V21, CNA, stated she does not think R6 has ever had anti-tippers on her wheelchair.</p> <p>On 9/19/24 at 1:44 PM, V1, Administrator, stated she will have to check into R6's anti-tippers. She stated she expects progressive interventions to be implemented after each fall and followed.</p> <p>The Facility's Fall Policy reviewed 9/2024 documents, The purpose of the Fall Management Program is to develop, implement, monitor and evaluate an interdisciplinary team falls prevention approach and manage strategies and interventions that foster resident independence and quality of life. The Fall Management Program promotes safety, prevention and education of both Staff and residents. The Facility shall ensure that a Fall Management Program will be maintained to reduce the incidence of falls and risk of injury to the resident and promote independence and safety. Following any falls, the facility staff completes an Occurrence Report. Details of the fall will be recorded and potential causal factors identified and investigated. Interventions will be implemented and Care Plan Updated.</p> <p>The Falls and Fall Risk, Managing Policy, dated 12/2007, documents the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Mar Ka Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  201 South 10th Street Mascoutah, IL 62258	

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

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F 0689  Level of Harm - Actual harm  Residents Affected - Few  Note: The nursing home is disputing this citation.	42636  45947

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33110</p> <p>Based on interview, observation and record review the facility to assess and renew whenever necessary psychotropic medications for two of two residents (R19, R21) reviewed for unnecessary medications in the sample of 24.</p> <p>Findings Include:</p> <p>1.R19's Electronic Health Record Diagnoses section documents R19 has Alzheimer's Disease late onset, Unspecified Dementia, Panic Disorder, MDDR, and Unspecified Psychosis.</p> <p>R19's Minimum Data Set (MDS) dated [DATE] documents R19 is severely cognitively impaired.</p> <p>R19's Physician Order Sheet (POS) dated 8/5/24 documents Alprazolam 1milligram (mg) every 4 hours whenever necessary (PRN). ( this medication was not assessed and reordered after 14 days.)</p> <p>R19's POS dated 8/11/24 documents Xanax 2 mg twice daily and every 6 hours PRN. ( this medications was not assess or reordered in 14 days)</p> <p>R19's Care Plan dated 8/5/24 documents ( )R19 has depression, anxiety, psychosis and receives psychotropic medication. will exhibit indicators of depression, anxiety or sad mood less than daily by review date,R19's intervention: Monitor/document/report to MD (Medical Doctor) prn ongoing s/sx (signs and symptoms) of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons.</p> <p>R19's Health Status Note dated 9/3/24 documents res (resident R19) was up for AM meal and did eat approx (approximately) 25% with and sips of fluid taken. took meds (medications) without diff (difficulty) gen (generalized) weakness evident.res (resident) moves about on and off in chair. Comfort maintained and hospice care continues.</p> <p>R19's Health Status Note dated 9/8/24 documents res has been up in chair. T and R Q2 (turned and repositioned every) hours and prn. Res was fed this am and consumed 100% of meal and good fluids taken. Drowsy on and off. comfort maintained. will continue to monitor.</p> <p>On 9/18/24 at 2:00 PM V25 Licensed Practical Nurse (LPN) stated, we give morphine for breakthrough pain when she is trying to climb out of her chair. If she is still restless trying to climb out of the chair hollering, we give PRN Xanax at 12:00 Noon We try to reposition her we add cushion or give her shakes.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/19/24 at 2:30 PM V2 Director of Nursing stated, (V29) Doctor has never been in our building, and the hospice cannot send over their review, because it has other residents on it they review all 200 hundred of their residents on the same day.</p> <p>2. R21's Electronic Health Record Diagnoses section documents R21 has diagnoses of Unspecified Psychosis, Bipolar, Major Depression Recurrent, and Anxiety Disorder.</p> <p>R21's MDS dated [DATE] documents R21 is severely cognitively impaired.</p> <p>R21's Care plan dated 8/31/24 documents the resident (R21) has behavior problems, (R21's) believes she needs to be taken to the second floor. She (R21) believes that is where her room is. She (R21) yells out at times looking for her mother and husband. Intervention is Room in direct visualization of Nurse's Station.</p> <p>R21's MDS dated [DATE] documents Haldol 1mg/1milliter (ml) give 1ml every 6 hours PRN.</p> <p>R21's Health Status Note Dated 9/17/24 documents resident cont on hospice services. no coc (change of condition) noted at this time. no behaviors noted so far this shift. no c/o pain or discomfort at this present time. resident currently resting in bed with nonlabored breathing noted. call light within reach.</p> <p>R21's Health status Note dated 8/5/24 documents hospice notified at this time of res noted to have increased anxiety this am and yells aloud momma, I can't walk and help me anxiety increased from previous. will continue to monitor. request for med adjustment made.</p> <p>On 9/19/24 R21's Hospice Notes from 8/8/24 through 9/12/24 and did not find a note where the hospice physician wrote in the patient record to renew the prn Haldol.</p> <p>On 9/18/24 at 2:00 PM V25 Licensed Practical Nurse (LPN) stated, usually we assess her (R21) she gets Haldol for increased restlessness and hollering. We usually give her a snack or ensure. We try to reposition her, (R21) and if that doesn't help give Haldol.</p> <p>The facility policy dated 2/2021 documents use of psychotropic medications residents will only receive psychotropic medications when necessary to treat a specific condition. Diagnoses alone do not warrant the use of psychotropic medications.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>45302</p> <p>Based on observation, interview and record review the facility failed to date insulin for 4 of 4 residents (R10, R7, R28 and R196) reviewed for medication storage in the sample of 24.</p> <p>Findings include:</p> <p>1. Observation on 9/17/2024 at 9:15 AM the 100/300 medication cart showed R10 Novolog insulin vial was not dated.</p> <p>R10's Physician's Order Sheet (POS) dated, 9/2024, documents Novolog insulin inject 4 unit subcutaneously before meals.</p> <p>2. Observation of the 100/300 medication cart showed R7 Lantus insulin vial was not dated.</p> <p>R7's POS dated, 9/2024, documents Lantus insulin inject 5 units subcutaneously one time a day for diabetes.</p> <p>3. Observation of the 100/300 medication cart showed R28 Insulin Aspart insulin vial was not dated.</p> <p>R28's POS dated, 9/2024, documents Insulin Aspart inject 5 units subcutaneously before meals for diabetes.</p> <p>4. Observation of the 100/300 medication cart showed R196 Toujeo Solostar insulin pen was not dated.</p> <p>R196's POS dated, 9/2024, documents Toujeo Solostar inject 22 units subcutaneously two times a day for diabetes.</p> <p>On 9/17/2024 at 9:22 AM V7, Licensed Practical Nurse (LPN) stated insulin vials should be dated the day they are opened.</p> <p>Review of the facility's Medication Storage In the Facility policy, effective date 6/1/2018, documents when the original seal of a manufacture's container or vial is initially broken, the container or vial will be dated. The nurse shall place a discard date sticker on the medication. (NOTE: the best stickers to affix contain both a date opened and expiration notation line.) The expiration date of the vial will be 30 days unless the manufacturer recommends another date or regulations/guidance require different dating.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45947</p> <p>Based on observation, interview, and record review, the Facility failed to ensure food was stored, prepared, and served in a manner that prevents foodborne illness. This has the potential to affect all 42 residents living in the Facility.</p> <p>Findings include:</p> <p>On 9/17/24 at 7:12 AM, in the dry storage area there was a large clear tub with unpackaged, individual tea pods. There was no lid on the tub, leaving the contents open to air. There was a rolling cart with three pitchers of liquid on top. Two of the pitchers contained a clear liquid, and one contained a red liquid. None of the pitchers were labeled or dated. There was a tall rack with bottles of pancake syrup, lemon juice, peanut butter, and white vinegar that were previously opened, but were not dated upon opening.</p> <p>On 9/17/24 at 7:14 AM, in the standing freezer there was a large plastic bag of donuts and a large bag of garlic bread. Both bags had been opened, and the plastic bags were tied in knots, but neither were labeled or dated.</p> <p>On 9/17/24 at 7:16 AM, in the standing refrigerator there was a zip lock bag with brown lettuce that was dated 9/9. There was a sealed, unopened bag of lettuce with the commercial label, Best if used by 9/7/24.</p> <p>On 9/17/24 at 7:20 AM, the second store room refrigerator across from the other refrigerator and freezer contained three gallons of unopened milk with the commercial label, Best by 9/16/24. There was a stainless steel container with beets that was covered with aluminum foil and was not labeled or dated. There was a large stainless steel bowl of chocolate pudding that was covered in plastic wrap and was not labeled or dated. V6, Dietary Aid, brought in a plastic container of fruit cocktail that was not labeled or dated and placed it in the refrigerator. V6 stated that was fruit cocktail, the brown substance was chocolate pudding and she thought the red items looked like beets.</p> <p>On 9/17/24 at 7:23 AM, there was a portable fan on the sink area that was covered in dust and dirt and was blowing directly toward a bowl of pancake batter next to the cooktop.</p> <p>On 9/17/24 at 7:24 AM, there was a shelf across from the steam table containing eight one gallon containers of kitchen chemicals within six inches of a rack holding cups. There were two 20 quart containers of dry cereal on a shelf to the left of the steam table that were not labeled or dated.</p> <p>On 9/17/24 at 7:27 AM, in the standing refrigerator next to the kitchen entrance there was a quart of buttermilk with the commercial label, Best by 16 Sept (September), an opened gallon of 2% milk with the commercial label, Best by 9/16, and an opened jug of apple juice with the hand written date, 9/4, in black marker. There were two cups with milk inside the door that were uncovered and were not labeled or dated. There was an opened carton of prune juice with the hand written date, 3/8, in black marker and the commercial label, Best if used by 20 June 2023. There was a pitcher containing an orange liquid with no label or date. V5, Cook, stated it was Kool-Aid.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 9/17/24 at 11:50 AM, during lunch service V5, Cook, was not wearing any covering over his beard which measured approximately three inches in length.</p> <p>On 9/17/24 at 12:29 PM, food temperatures were obtained from steam table using a metal calibrated thermometer after the last resident tray was served. The pineapple measured 68 Fahrenheit (F), the honeydew melon measured 62 F, the peaches measured 73 F, the cottage cheese measured 42 F, the pureed pineapple measured 72 F, and the pureed peaches measured 73 F. The cold items were placed on the steam table, along with the hot items.</p> <p>On 9/17/24 at 12:40 PM, V5, Cook, stated he thought they used to have beard nets, but may have run out of them. V8, Dietary Manager (DM), stated they do have beard nets, but sometimes they get knocked down when people come in and out of the kitchen, so she will put them back out.</p> <p>On 9/17/24 at 12:43 PM, V8, Dietary Manager (DM), stated she is going to have staff keep the cold and hot foods separate during meal service to make sure the cold items do not get too warm.</p> <p>On 9/18/24 at 2:52 PM, V1, Administrator, stated she expects staff to follow their food service policies for storage and labeling and serving temperature.</p> <p>The Facility's Date Marking for Food Safety Policy revised 4/7/24 documents, The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. The discard day or date may not exceed the manufacturer's use-by-date, or four days, whichever is earliest. The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly.</p> <p>The Facility's Food Labeling and Storage Policy dated 3/29/21 documents drinks should be discarded within a maximum of three days. It documents all foods must be labeled and dated right away when going into the cooler, and the expiration date is the most important. It documents one employee must check all coolers once per day for outdated food.</p> <p>The Facility's Storeroom/Freezer Food Storage Policy dated 6/22/21 documents, All open food items in the freezer must be labeled and dated. For example, if you open a bag of hash browns and place that open bag into a zip lock or plastic wrap. You must write the use by date from the manufacturer or a 6-month use-by-date on the zip lock bag or plastic wrap.</p> <p>The Facility's Meal Service Temperature Policy reviewed 8/2024 documents, Foods shall be provided at point of service to support resident/patient satisfaction. Temperatures of hot food shall be supported to promote service temperatures of hot foods to about 120 degrees and cold foods to below 50 degrees.</p> <p>The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 9/17/24 documents there are 42 residents living in the Facility.</p>		