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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
	145620	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercy Rehab and Care Center	100 Rosewood Village Drive Swansea, IL 62220

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview and record review, the facility failed to properly care for a hospice resident with Dementia residing at the facility for Respite Care, including Activities of Daily Living (ADLs) and Medication Administration for 1 of 1 resident (R2) reviewed for proper nursing care. This failure resulted in R2 having significant behaviors resulting in R2 obtaining a leg injury. Findings include: R2's Face Sheet, undated, documents R2 was admitted to the facility on [DATE] for a 5-day Respite stay and was discharged on [DATE]. R2's diagnosis include Dementia and Parkinsonism. R2's Care Plan and Minimum Data Set (MDS) was not completed due to short stay at the facility. R2's Admission Functional Ability Assessment, dated 5/2/24, documented that R2 was dependent on staff for all ADLs, and mobility. On 5/9/24 at 9:53 AM, V5 (R2's Daughter) stated (R2) went to the facility last Thursday (5/2/24) for Respite Care for five days as I had to go out of town. When he got there, the Hospice Nurse did a Tuck-In assessment on him, and he was fine and without injuries. On Friday (5/3/24), the Hospice bath lady went and gave (R2) a bath, and she didn't notice anything wrong with him either. The facility called me on Saturday (5/4/24) and said that (R2) scratched his leg, which I told them he does that when he is anxious and to give him his anxiety medication. On Sunday (5/5/24), my aunt visited (R2) and told me that he had a bandage covering the lower left shin and when I called the facility to ask about it, they told me he was banging his legs against the rail and caused a scratch. I told them to put something on the rails to avoid him hurting himself. Then on Monday (5/6/24), the Hospice bath lady noticed bruising and the wound on his legs. I sent all his medications with him to the facility and only one medication was given the entire time he was there. They gave him his Seroquel every day, but they did not give any of his anxiety medications. He has Clonazepam and Lorazepam for his restlessness and anxiety. The Director of Nursing (DON) called me yesterday (5/8/24) after they spoke with the Hospice team about (R2), and she told me she did an investigation and afterwards, fired one Certified Nursing Assistant (CNA) and suspended two nurses. (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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NAME OF PROVIDER OR SUPPLIER: Mercy Rehab and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 100 Rosewood Village Drive Swansea, IL 62220	

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/9/24 at 12:15 PM, V1 (Administrator) stated that R2 was admitted for a five-day Respite stay and the family brought scheduled and as needed (PRN) medications with him. V1 stated that R2 was discharged in the morning of Tuesday (5/7/24) and his daughter (V5) called them later that day and herself and V2 (Director of Nursing/DON) talked to her about her concerns. V1 stated that R2 wasn't in the same condition going home as he was when admitted . V1 stated R2 had multiple areas of bruising/injury to his legs and was not clean when he was discharged . V1 stated that the nurse had called V5 and told her that R2 had a scratch on his leg and when R2 got home, his leg wound was much more extensive than a scratch. V1 stated that V5 did state that R2 scratches himself when he is anxious, but this was much worse than a scratch. V1 stated that they reviewed R2's Medication Administration Record (MAR) and that R2 did not receive any of his PRN anxiety medications while he was in the facility. V1 stated that V5 was very unhappy about R2's condition and V1 stated she understands why and that R2's care was unacceptable. V1 stated that she talked to the CNA who was responsible for cleaning R2 prior to discharge and ended up terminating his employment because of R2's condition at discharge. V1 stated she then disciplined the nurses, one nurse for documenting R2's wound as a scratch, when it was much worse, and the other nurse who was responsible for R2 the day of his discharge. V1 stated that they also talked to the Hospice Nurse about R2's stay and they concurred with V5's description of R2's leg wound. V1 stated that best practice was not followed, and she was embarrassed about the situation. V1 stated that this was not what she would expect from her nurses and CNAs. On 5/9/24 at 11:15 AM, V2 (DON) stated that she spoke with the Hospice Nurse who explained the concerns with R2's condition at discharge. V2 stated that the daughter was told of a scratch on R2's leg and was not told of the extent of the injury. V2 stated she called V5 yesterday (5/8/24) and V5 described things to her that she felt was not best practice and not what a normal nurse would do. V2 stated that the bedrails go halfway down the bed, so R2 was able to bend his legs up and, being restless, was able to hit his legs on the siderails, causing his injury. V2 stated that she suspended the two nurses and will be reeducating them, and all staff, when they return. On 5/9/24 at 1:10 PM, R8 (R2's previous roommate) stated that R2 was always talking, yelling, and was restless in his bed. On 5/9/24 at 1:18 PM, V7 (CNA) stated that she took care of R2, and he would only answer questions with a one-word answer. V7 stated that R2 would yell while in his bed and it was usually about pancakes. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/9/24 at 3:08 PM, V6 (Hospice Nurse) stated (R2) arrived at the facility on Thursday (5/2/24) and I went in to do an assessment on him. (R2) was in good spirits, was calm, in no distress, and had no skin issues. I went over his orders for his Respite stay with the nurse. On Monday (5/6/24) V5 (R2's daughter) came home from out of town early because she received a phone call from the nurse at the facility that (R2) had scratched his leg. (V5) called me and asked me if I would go see (R2) so I did. When I got to the facility, (R2) had an area to his left leg that was reddened, he was very anxious and restless, so I asked the nurse to give him a dose of his PRN medication, so she did, and I called (V5) and updated her. His order was for Ativan 0. 5 MG every four hours PRN, and normally gets Ativan three times per day at home. (R2) got back home on Tuesday (5/7/24) and (V5) notified me that he got home and had dried stool on him and had marks on his legs. The facility was given a case of (nutritional supplement drink) to give to (R2) because he usually drinks five to six of them a day, there was only two of them missing out of the case. (V5) asked me to follow-up on what happened at the facility, so I called the facility and spoke with V2 (DON), who looked in (R2's) chart and said that (R2) hit his leg on a bedrail. I updated (V5), my managers, and let (R2's) Practitioner know and received orders to treat (R2's) leg. (R2) had several scabs on his right leg from his knee down to his ankle and had a large, reddened area to his right knee and hip. (R2's) right leg had an 8 CM long reddened area to his left shin with open areas of blood and Serosanguineous fluid, it appeared similar to a sheering injury where a few layers of skin were sheared off. We are cleaning the wound and applying (name brand of a dressing) and wrapping with (gauze wrap) every two to three days and PRN. R2's Braden Scale Assessment, dated 5/2/24, documented that R2 was a High Risk for skin impairments. R2's Skilled Nursing Assessment, dated 5/7/24, documented, Behavioral Symptoms-Short tempered/easily annoyed: Yes, and Behavioral Symptoms-Fidgety or restless: Yes. R2's Nursing Note, dated 5/2/24 at 10:22 AM, documented, admitted to facility from home for five-day Respite Care. Transported by ambulance from home. Remains on service with (Hospice Company). Bedbound, reported by EMT's (Emergency Medical Technician) resident has not been in w/c (wheelchair) since February. Non-weight bearing. Alert and oriented to self. May respond with yes or no, but no conversation. Inc. (incontinent) of B&B (bowel and bladder). Total care needed. Meds brought by EMT's. Dr. notified of respite admit. R2's Nursing Note, dated 5/4/24 at 11:48 PM, documented, Skin check complete. Upper extremities and body are clear of any concerns. BLE (bilateral lower extremity) have abrasions and discoloration. Left shin has a clean, dry, and intact dressing. 2nd left toe have (sic) 2 scabs. Right greater toe have (sic) one small scab. Right malleolus have (sic) a old scab noted. R2's Nursing Note, dated 5/4/24 at 12:09 PM, documented, This nurse noted resident's leg was rubbing against bed rails causing skin abrasion measuring 8.5 CM (centimeter) x 6 CM; no bleeding noted; area was cleansed and tx (treatment) in place; made aware to hospice nurse and resident's daughter. R2's Physician Order (PO), dated 5/2/24, documented, Lorazepam 0.5 MG (milligram) Q (every) 4 hrs (hours) PRN. R2's PO, dated 5/2/24, documented, Clonazepam 0.5 MG Q 6 hrs PRN. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R2's PO, dated 5/2/24, documented, Quetiapine 50 MG BID (twice daily) 8:00 AM and 4:00 PM. R2's PO, dated 5/2/24, documented, Olopatadine 1 drop to each affected eye Q 6 hrs PRN. R2's PO, dated 5/6/24, documented, Cleanse left leg shin with wound cleanser, then apply double layer (name brand of a dressing) then wrap with (gauze wrap); change daily and PRN. R2's Event Report, dated 5/4/24, documented, Description: Skin abrasion. Event Details: Skin Tear/Laceration. Activity during skin tear/laceration occurrence: Friction in bedrails. Interventions: Cleansed with wound cleanser, apply (name brand of a dressing) or hydrogel and wrap with (gauze wrap) (no skin flap). Evaluation: Event still open. The facility's investigation into R2, dated 5/9/24, documented, During our investigation, (V5) called the Administrator and talked about concerns. She stated that the nurse who called about the abrasions on the legs did not adequately describe what she witnessed upon the resident returning home. She also stated that when she spoke with the nurse, (V16), she let her know that (R2) gets anxious and that there were medications ordered to take care of anxiety. Upon reviewing the MAR (Medication Administration Record), it was noted that one dose of Lorazepam was given throughout his stay for anxiety. (V16) stated that when she took care of him, that he did not appear in any distress and that she did not feel he was displaying signs of anxiety. (V5) also stated that (R2) now had pink eye and that his PRN medications for eyes were not given. In reviewing the progress notes and orders, it appears that (R2) has order for Natural Tears and an antihistamine eye drop. There is no indication in the notes that the resident required this PRN medication during his stay. (V5) alleged that (R2) was soiled upon return home. Resident was incontinent of bowel and bladder, and we feel it would be difficult to determine when this incontinence occurred. The progress notes revealed skin assessments and events. A treatment was put into place and the measurements were documented. It is also noted that sheets were applied to the bedrail and pillows were placed between the rail and mattress to attempt prevention of skin issues. While reviewing documentation, (R2) did not have any decreases in cognition during stay and he had no symptoms of pain or distress. Administrator, DON, and ADON (Assistant Director of Nurses), interviewed CNA (V17), LPN (V16), and LPN (V18). Disciplinary actions were taken at the discretion of the facility. Because (V5) felt as if the expectation of her father's care was not met, the facility determined disciplinary action was necessary to stress the importance of customer satisfaction. The Facility's Respite Care Policy, dated 11/2023, documented, 1. It is the facility's responsibility to provide medical care when needed in the absence of family. It continues, 6. The residents may bring in their own medications to be used during their stay at (the facility) if the stay is for 14 days or less. Respite stays beyond 14 days will require medications be ordered from (the facility's) pharmacy. The Nursing staff at (the facility) will dispense all medications.