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	07/26/2024

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** 35156 Based on interview and record review the Facility failed to seek medical interventions in a timely manner for 1 of 5 residents (R39) reviewed for medical interventions in the sample of 37. This failure resulted in R39 having a fall and not being sent out to the hospital for 2 hours and 34 minutes and sustaining a fracture of her left ankle. Findings include: R39's Physician Order Sheet (POS) July 2024, documents a diagnosis of Pneumonia, unspecified organism; Unspecified severe protein-calorie malnutrition; Hypertensive encephalopathy; Memory deficit following unspecified cerebrovascular disease; Unspecified osteoarthritis, unspecified site; Essential (primary) hypertension; Other specified nutritional anemias; dry eye syndrome of unspecified lacrimal gland; Polyarthritis, unspecified; Gastro-esophageal reflux disease without esophagitis; Anxiety disorder, unspecified; Hyperlipidemia, unspecified; Overactive bladder; Pain, unspecified; Allergy, unspecified, subsequent encounter; Major depressive disorder, recurrent, unspecified; Constipation, unspecified; Alzheimer's disease, unspecified; Personal history of COVID-19; Acute cough; Urinary tract infection, site not specified (History of); Constipation, unspecified; Pneumonia due to other specified infectious organisms; Deficiency of other vitamins; Other chronic pain; Opioid use, unspecified, uncomplicated; Unspecified fracture of left lower leg, subsequent encounter for closed fracture with routine healing; Dyspnea, unspecified; Other pancytopenia; Encounter for desensitization to allergens; Unspecified dementia, unspecified severity, with other behavioral disturbance; Hypokalemia; Altered mental status, unspecified; Unspecified open-angle glaucoma, stage unspecified; Encounter for prophylactic measures, unspecified; Vitamin D deficiency, unspecified; Vitamin deficiency, unspecified. R39's Minimum Data Set (MDS) dated [DATE] documents R39 was moderately impaired for cognition for activities of daily living. R39's Care Plan documents, Requires assistance with ADL's (activities of daily living) due to decreased strength and balance, decreased activity tolerance, decreased safety, impulsive, impaired cognition. Category: ADLs Functional Status/Rehabilitation Potential Start Date: 3/15/2024. R39's Care Plan: Problem: At risk for falls due to history of falls, dementia, poor safety awareness, behaviors of refusing care, medications, high blood pressure, pain, arthritis, left knee problems (gives out), poor vision, abnormal labs. 6/9/23 Fall, 7/28/2023 Fall, 03/05/2024 Fall. Resident will be free from injury/harm over the next 90 days. Target Date: 06/15/2024 (Long Term Goal). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145620	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024
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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(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.	R39's Progress Notes dated 3/5/2024 at 2:50 AM, Resident found on floor beside bed, resident assessed and noted to have small lump on internal LL (left leg). Resident has complaints of pain. No other complaints of pain or injuries noted elsewhere. Resident stated when asked what occurred my legs became twisted, and I fell out of bed Neuro checks WNL (within normal limits) resident assisted back to bed per 2 staff with a gait belt. Resident continued to complain of LL leg pain, call placed to POA (Power of Attorney) who stated, it was too late in the night to send to emergency room , I want STAT (immediately) x-rays done. (V19 Nurse Practitioner) notified and ordered stat L ankle and L tib/fib x-rays. (X-ray company) notified of stat x-ray order, on call nurse notified. R39's Progress Notes dated 3/5/2024 at 2:52 AM, This nurse spoke with (V22 POA) and explained to her that (X-ray company) does not perform stat x-ray services overnight anymore and that they start x-ray services again at 8:00 AM, in the morning, and couldn't guarantee when (x-ray company) would arrive at the facility and (V22 POA) stated that's fine. This nurse explained to (V22) that resident had a small bulge in her left lower extremity and that resident was holding her leg and repeatedly stating that her leg hurt. (V22) again stated that she wanted stat x-rays done that it was too late in the night to send her to the hospital. R39's Progress Notes dated 3/5/2024 at 5:24 AM, Resident has continued to hold her left leg and scream out in pain, resident is screaming I don't care what my daughter said, I want to go to the hospital. DON notified. Left voicemail for (V22) to return call. Ambulance notified of need for transport. R39's Progress Notes dated 3/5/2024 at 10:49 AM, Resident returned to the facility via ambulance at 10:50 a. m. and was transferred to bed by EMT's. Resident is alert and oriented. Resident has a fractured L (left) ankle with a standard order for (acetaminophen). On 7/25/2024 at 9:24 AM, V18 (Certified Nursing Assistant/CNA) placed the gait belt around R39's waist and as she was placing the gait belt around R39, V18's foot was touching R39's left foot, R39 yelled out, ouch you hurt my leg, I broke my leg, be careful, V18 stated, you did not break your leg. On 7/25/2024 at 9:28 AM, V18 was asked if she was positive R39 had never broke her leg and she stated she was agency and did not know anything and was not aware R39 had broken her ankle previously. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R39's Final Fall Report documents, (R39) is a [AGE] year-old female that admitted to the facility on [DATE] with the following diagnosis: Alzheimer disease, unspecified dementia with Behavioral disturbances, hypertensive encephalopathy, unspecified osteoarthritis, essential hypertension, polyarthritis, generalized anxiety disorder, hyperlipidemia, pain, vitamin D deficiency, unspecified severe protein-Calorie Malnutrition, and Major depression disorder. According to her most recent MDS, (R39) has a BIM (Brief Interview of Mental Status) score of 8 (moderately impaired for cognition). (R39) resides in the facility long term with no plans to discharge. On 3/5/2024 at approximately 2:50 AM, (R39) was in her room in the bed. (R39) had pulled all the linen away from the mattress and her bilateral lower extremities became tangled in the sheets. She rolled over in the bed and fell to the floor twisting her left leg and foot. The charge nurse completed an assessment and palpated an abnormal raised area to left shin/ankle. (R39) did have complaints of pain with tactile stimuli. The charge nurse proceeded to notify the doctor and POA (Power of Attorney). The POA requested to have a STAT x-ray performed in house and refused transfer to the ER (emergency room). When scheduling the x-ray, the charge nurse was notified the STAT x-rays were no longer offered overnight, and exam would have to be scheduled for after 8:00 AM. The exam was scheduled, and the charge nurse informed the POA. The POA continued to refuse transfer to the ER at that time. At approximately 5:15 AM. (R39) continued to exhibit symptoms of pain and informed the DON (Director of Nursing). It was decided that she be transferred to the ER (emergency room) for treatment. The following was completed immediately: skin pain evaluation, PROM (Passive Range of Motion) to extremities (Medications evaluated), Care Plan reviewed, most recent labs reviewed, MD/POS/DON notifications, Transfer to ER (emergency room). Investigations completed. (R39) returned from the ER with a diagnosis of Closed fracture of Distal end of Fibula, unspecified fracture, Morphology, initial encounter. During record review and staff interviews, it was reported that (R39) often uses profanity and can be verbally aggressive at time. She had an increase in behavior over a short period. (R39) required more redirection, verbal cueing, and one-on-one care with staff including family phone calls. (R39) had been refusing to seek assistance, yelling out, making false allegations towards peers and staff, and attempting to propel herself in the wheelchair when asked to remain in common areas. (R39) reported that she wrapped in bed covers and rolled from the bed. However, it is believed that due to her cognition and poor safety awareness, (R39) was attempting to turn and position herself in the bed and was lying close to the edge when she rolled and fell . (R39) has a history of falls and bone/joint issues. It has been determined that she is at an increased risk for fractures due to a decreased bone density. R39's Initial Serious Injury Incident Report, with incident date of 3/5/2024 documents, Resident observed on floor from bed wrapped in sheet and cover. Stated that she got tangled and rolled out of bed. Sent to ER for x-ray. Fracture of distal end of fibula. Investigation started immediately. Final/Summary to follow. R39's Hospital Records dated 3/5/2024 at 6:24 AM, documents, (R39) [AGE] year-old female presenting to the ED (emergency department) from (Facility) complaining of left knee and foot pain. Patient states she fell out of bed. Episode occurred around 2:30 AM, given Tylenol. Still complained of pain. R39's Hospital records document she was given 5-325 mg (milligrams) tablet of hydrocodone-acetamonophen (Norco) (narcotic) and was given an splint/Brace immobilizer to wear as directed with no weight bearing for her fractured distal end of fibula. R39's Hospital Records dated 3/5/2024 at 6:24 AM, documents XR (x-ray ankle) left 3 or more views, XR knee left 1 of 2 views: Diagnosis: Closed fracture of distal end of fibula, unspecified fracture morphology, initial encounter. Clinical fracture of distal end of fibula, unspecified fracture morphology, initial encounter. Findings: Mildly displaced fracture of the distal left fibular shaft. (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 7/25/2024 at 4:39 PM, V19 (Nurse Practitioner) stated, I was contacted by the facility on 3/5/2024 regarding (R39) having a fall and ordered a STAT x-ray. The facility never contacted me again telling me the STAT x-rays were no longer be performed overnight and or they would not be available until 8:00 AM the following morning. I normally give them a four-hour window. If the resident was still in pain and if they would have contacted me and the resident was yelling and screaming, I would know there was not much else we could do for her and would have had her sent out to the emergency room right away and would not wait. On 7/26/2024 at 5:15 PM, V2 (Director of Nursing) (R39) was trying to get herself out of bed and got caught up tangled in the sheets. (R39) was complaining of pain and when we contacted her daughter, she told them not to send her out to the hospital and to get an x-ray in house. I was not present for the conversation. I was told that later (R39) was still complaining of pain and I was contacted by the nurse, and I told her to send her out. On 7/26/2024 at 9:32 AM, V31 (Registered Nurse) stated, I remember (R39) falling. I was at the nurse's station, and I heard her scream. When I went to her room, I found her sitting Indian style on the floor on her mat. Her leg had a bulge to it, and she was in pain. I called the daughter (V22) and told her I wanted to send her out and she was adamant about not wanting to send her out to the hospital and to get a STAT x-ray in the facility. I told her it would be better for her to be seen in the ED, but she refused. I do not remember much else except (R39) was screaming and was in a lot of pain and we finally sent her out. I do not remember one way or the other about calling the doctor again. The Change of Condition Reporting Policy with a revision date of 2/2018 documents, (Facility) will notify the resident's physician and the resident's representative whenever, there is a significant change in the resident's health, mental or psychosocial status. Assess the resident condition as warranted which may include, but is not limited to checking vital signs, completing a physical assessment as indicated speaking with the resident about the symptoms and noting the presence or absence of pain. Notify the physician of the change/incident/accident There is an accident (incident or unusual occurrence). Notify the physician of the change of condition/incidents/accidents/unusual occurrences and accident findings. may be reported to the physician. (Changes of condition/incidents/accidents/unusual occurrences may be reported to the physician.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42636 Based on interview, observation and record review, the facility failed to provide appropriate care for an indwelling urinary catheter to prevent infection in 1 of 4 residents (R45), reviewed for catheters in the sample of 37. Findings include: On 7/23/24 at 9:05 AM, R45 was observed lying in bed with an indwelling urinary catheter in place draining cloudy yellow urine. The catheter drainage tubing was touching the floor and the drainage bag was in a privacy bag. On 7/24/24 at 1:50 PM, catheter care was observed on R45 with V12 (Certified Nursing Assistant/CNA) and V15 (CNA). V12 completed hand hygiene and donned clean gloves and removed R45's incontinence brief. There were incontinence wipes that had been removed from the package and were sitting on top of the package with no barrier between them. V12 then took one of the wipes and wiped down the catheter tubing, then using the same wipe, wiped down the catheter tubing again touching the urethra. V12 then disposed of the wipe and attempted to get another wipe from the top of the wipe package, V12 was unable to grab the wipe and turned the wipes over several times trying to get the wipe to pull away from the others, contaminating the wipes. Then wearing the same gloves and using the contaminated wipe, V12 wiped down the outside of R45's labia. V12 then using the same contaminated gloves and not maintaining a clean/dirty field, grabbed another wipe and wiped again down the center of R45's labia, touching the urethra. V12 removed her gloves, performed hand hygiene, donned clean gloves and R45 was turned onto her left side and then her right side, cleansing her buttocks and anal area. R45 was then placed on her back and using the same contaminated gloves, V12 placed a clean incontinence brief and mesh underwear on R45, repositioned her in bed and covered her up with a blanket. R45's Face Sheet, undated, documents R45 has a diagnosis of UTI (Urinary Tract Infection) and Retention of Urine. R45's MDS (Minimum Data Set), dated 7/2/24, documents R45 has a BIMS (Brief Interview for Mental Status) score of 3, which indicates R45 has severe cognitive impairment. The MDS goes on the document that R45 is dependent with toileting, utilizes an indwelling urinary catheter and is always incontinent of bowel. R45's Care Plan, dated 1/4/24, documents R45 has the potential for UTI's due to the use of an indwelling urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R45's Progress Note, dated 1/1/24 at 8:26 AM, documents the following: During med pass Resident was observed to be flushed, diaphoretic, and un-alert. Resident could not open eyes or take medication and her face was bright red. After assessing Resident VS (vital signs) were 104.0-100.8, 104, 22, 113/55, 93%-95%. Resident was negative for COVID and BS (blood sugar) was 185. Resident was given (acetaminophen) to help with fever and air condition was turned on, then this nurse reached out to on call NP (Nurse Practitioner) who advised to send resident out for further assessment. Emergency contact, on call nurse, and DON (Director of Nurses) was made aware. Report was called to ER (emergency room) nurse. R45's Progress Note, dated 1/2/24 at 7:45 AM, documents the following: Call placed to (local) hospital. Resident admitted with dx of UTI and Sepsis. R45's Progress Note, dated 3/1/24 at 9:30 AM, documents the following: Resident continues on MED A. Alert with confusion this shift. Yelling out most of this shift. I have to Pee. Resident has had no urine noted in bag this AM. Resident laid down and assessed, Foley (indwelling urinary catheter) intact. Foley flushed with 60cc (cubic centimeters) of NS (normal saline) x (times) 2. Foley now patent and draining, yellow cloudy urine 900cc noted. The resident has had U/A (urinalysis) recently collected, awaiting the final results. No voiced pain. Vitals are stable. Fluids are encouraged and at the bedside. Resident now resting in bed call light within reach. R45's Progress Note, dated 3/5/24 at 11:44 AM, documents the following: FNP (Family Nurse Practitioner) responded to UA results from 3/2. Contaminated specimen. May need to change Foley and then send urine sample after clean Foley placed. Made all parties aware. R45's Progress Note, dated 3/8/24 at 1:45 PM, documents the following: Received urine C&S (culture and sensitivity) results from (facility contracted) lab. Copy faxed to (doctor) and called to verify receiving. Explained specimen taken straight from catheter and urine is cloudy with sediment. Office to call new orders to facility. R45's Progress Note, dated 4/4/24 at 7:06 PM, documents the following: Resident returned to nursing station after being lethargic @ (at) the dinner table, she responds to name and able to state her name. Responds to tactile stimulation. Blood pressure 98/62-p82-sat 97. Blood sugar at 430p was 182 now 274. No indication of pain. In bed sleeping, respiration even and non-labored. Called placed to doctor's office, message was left on the voicemail @ 7:24p.m. Will continue to assess the resident for changes in respiration and level of consciousness. R45's Progress Note, dated 4/5/24 at 1:39 PM, documents the following: (Doctor's) office notified resident sleeping more than usual. Quiet most of day. Poor appetite at meals. Urine output less than normal thru Foley catheter. Difficult to arouse. Waiting on response from (doctor). VS 97.5-81-18 122/78. R45's Progress Note, dated 4/5/24 at 4:33 PM, documents the following: ADON (Assistant Director of Nurses) called with orders that was given from MD (medical doctor) to get stat labs CBC (complete blood count), CMP (comprehensive metabolic panel), Troponin, and UA. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R45's Progress Note, dated 4/6/24 at 9:54 AM, documents the following: Stat lab result received; made aware to on-call NP; received a new order for Rocephin 1gm (gram) IM (intramuscular) daily x 5 days, sub-q (subcutaneous) 1 liter of NS, RUN 100ml (milliliters)/hr (hour), repeat BMP (basic metabolic panel) and CBC in the AM; lab order carried out; made aware to on-call nurse and left (voicemail) to family. R45's Progress Note, dated 5/8/24 at 11:30 PM, documents the following: Resident returned from the hospital via ambulance transport. Resident transferred into bed 2 assist via ambulance service. Resident is sleeping w/o (without) signs of discomfort or distress. Resident returned with a new order for Cefdinir 300 mg, take 1 cap po BID (twice daily) for 7 days. Resident also returned with a newly inserted Foley 16F/10mL. R45's Progress Note, dated 5/9/24 at 2:33 PM, documents the following: Resident has increased confusion after lunch, leaning forward unable to assist herself back to position. Resident has had x2 loose stools with a moderate amount of mucous noted. Resident POA (Power of Attorney) was contacted and made aware. Requested resident to be sent to (local) hospital ED (emergency department). EMS was contacted to transfer resident to ED. MD contacted and made aware via fax. Resident clean and dry, resting in bed at this time. No s/s (signs/symptoms) of pain or distress, call light in reach. R45's Progress Note, dated 5/9/24 at 3:15 PM, documents the following: Resident transferred to (local hospital) ED via (local) EMS in stable condition. R45's Progress Note, dated 5/9/24 at 9:19 PM, documents the following: Resident returned to facility via EMS. NNO (no new orders) at this time. Abx (antibiotic) administered as prescribed. Resident afebrile. Resting comfortably in bed at this time, call light in reach. No c/o pain, discomfort, or distress noted. R45's Progress Note, dated 5/13/24 at 11:57 AM, documents the following: Remains on ABT (antibiotic) for UTI. Fax received from (local) hospital related to recent ED visit on 5/9/24. Fax showed E-Coli (Escherichia coli) in the urine with Bactrim DS and Doxycycline being two of the PO (by mouth) meds resident's results are susceptible to. Results sent to (doctor's) office and to FNP with explanation and present order for Cefdinir. Awaiting return call or fax. R45's Progress Note, dated 5/13/24 at 2:31 PM, documents the following: New order related to results from (local) hospital for urine C&S received. Doxycycline 100 BID x 7 days ordered. R45's Urine Culture, dated 3/11/24, documents R45 had Escherichia Coli and Enterococcus Faecalis in her urine. R45's U/A, dated 4/5/24, documents R45's urine was abnormal, and no culture was performed. R45's Urine Culture, dated 5/8/24, documents R45 had Escherichia Coli in her urine. On 7/26/24 at 10:00 AM, V2, DON (Director of Nurses), stated they utilize a catheter competency that goes through the steps of how catheter care should be performed. V2 stated staff are to wash their hands and put on clean gloves. Staff can perform hand hygiene with alcohol hand gel three times and then after the 3rd time, they are to wash their hands and put on clean gloves. V2 stated they are to utilize one wipe per swipe and change their gloves twice during catheter care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Foley Catheter Care Policy and Procedure, undated documents the following: All staff will adhere to the evidence-based guidelines for the performance of routine catheter care utilizing the proper procedure to prevent urinary tract infections. Procedure: #4 - Wipe around area where catheter enters meatus in a downward motion. Use wipe only once, change wipes between each swipe.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 Based on interview and record review the Facility failed to ensure there was a RN (Registered Nurse) working in the facility for 8 consecutive hours a day, 7 days a week. This has the potential to affect all 82 residents living in the facility. Findings include: On 7/23/2024 at 9:00 AM, Schedules were requested for the past 14 days, including Registered Nurse (RN). The schedule coverage did not document any RN working on 7/13/2024 and 7/14/2024. The PBJ (payroll-based journal) Report for the second quarter (January 1- March 31) of 2024 documents concerns for RN coverage and one star rating for fiscal quarter 2, 2024 for the facility. On 7/23/2024 at 10:11 AM, V3 (Assistant Director of Nursing) stated, I am a Registered Nurse along with the Director of Nursing. I know we are currently trying to hire more RNs and we struggle on the weekends. I know we are supposed to have a RN on duty every day for 8 consecutive hours every day. On 7/23/24 at 11:34 AM V1 (Administrator) stated I am going to be honest we did not have a Registered Nurse (RN) for 7/13/2024 and 7/14/2024. We are in the process of attempting to hire more Registered Nurses. I hired two RNs, and they did not even last a day. I am not going to lie I know the weekends are where we are getting hit. I am just having issues finding staff. The Facility assessment dated [DATE] documents, Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies. Nursing Services, RN. Great need for RN's and continued struggle. Areas Facility Assessment Informed, Action to be taken/already taken this year, Need RNs to stabilize nursing department. On 7/24/2024 at 4:18 PM, V2, Director of Nursing stated there was no staffing policy. The 672 Long Term Care Facility Application for Medicare and Medicaid form dated 7/24/2024 documents, there are 82 residents living in the facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 Based on interview and record review the Facility failed to ensure Physician Orders were followed and the physician was notified if the orders could not be carried out for 1 of 4 residents (R65) reviewed for physician orders in the sample of 37. Findings include: R65's Physician Order Sheet (POS) for July 2024 documents a diagnosis of Rhabdomyolysis; Unspecified superficial injury of unspecified great toe, subsequent encounter; Unspecified hemorrhoids (History of); Anemia, unspecified; Benign prostatic hyperplasia with lower urinary tract symptoms; Chronic kidney disease, unspecified; Chronic metabolic acidosis; Depression, unspecified; Rheumatoid arthritis, unspecified; Testicular hypofunction; Unilateral primary osteoarthritis, left knee; Unspecified fall, subsequent encounter; Pain, unspecified; and Constipation. R65's Minimum Data Set (MDS) dated [DATE] documents R65 was moderately impaired for cognition for activities of daily living. R65's Care Plan does not address weight loss and/or nutrition. R65's Nurse's Notes dated 5/17/2024 at 5:34 AM, documents, resident seen in clinic today by (V16 Medical Director) during routine rounds. New order received for Marinol 2.5mg (milligrams) by mouth twice daily. Resident & family both notified. Order processed & carried out. R65's Dietary Note dated 5/28/2024 at 10:31 AM, Dietitian weight note. [AGE] year-old male triggering for significant (-9#; -8.5%) weight loss x 30 days. BMI (body mass index). R65'S Nursing Notes dated 5/30/2024 at 2:00 PM, IDT (Intradisciplinary Team) weight meeting held. Resident noted with 9.4% loss in 3 months. Resident had order for Marinol for appetite, but medication is on backorder with pharmacy unsure of availability date. Pharmacy recommendation sent to MD (Medical Director). Supplements ordered, alternatives and snacks offered. Resident will request item, take 1-2 bites and then state he is done. R65's Progress Notes dated 5/31/2024 at 11:41 AM, documents, Fax sent to (V16's) office regarding new order received to start Remeron 7.5 mg. New order was to replace Marinol 2.5 mg, but resident is already prescribed Remeron. Awaiting response. R65's dietary notes dated 5/31/2024 at 11:41am, Dietitian weight note: 84 YOM (year old male) triggering for significant (-9#; -8.5%) wt (weight) loss x 30 days. CBW 97# (5/7/24), BMI 13.15 underweight for age, weight history [DATE]#, [DATE]#, [DATE]#, [DATE]#, [DATE]#, [DATE]#. Diet/Meds reviewed, Marinol 2.5mg BID, prednisone BID. No recent uploaded labs to review. Continue with current nutrition therapy General/Regular with House supplement 60ml/4x per day (480kcal/19gm protein) and (nutritional supplemental dessert) (270kcal/9gm protein per serving) with meals. Noted poor meal intakes and refusing supplements, nutrition therapy as ordered will exceed needs if consumed. Recommend continue with nutrition therapy as ordered, assistance with meals and encourage fluids throughout the day. Continue to monitor nutritional parameters and refer to RD (Registered Dietician) prn (As needed). (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R65's Dietary Notes dated 2/20/2024 at 10:54 AM, Dietitian weight note: (R65) who triggers for significant (-12#; 10.2%) weight loss x 90 days. BMI 14.37 underweight for age. Weight history November 2023 112# On 7/26/2024 at 9:03 AM, attempted to call Medical Director and left a message but no message was returned. The Medication Administration Policy with a revision date of 12/2020 documents, (Facility) will administer medications per a standardized liberal schedule except when the physician's order dictates it to be given another time. Manufacture's recommendations will be considered when scheduling certain medications. Residents' preferences and quality of life issues will be considered in medication administration schedules as much as is safe and practicable.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33110 Based on interview, record review, and observation the facility failed to monitor medications to ensure the resident is not receiving unnecessary medications for one of five residents (R67) reviewed for unnecessary medications in the sample of 37. Findings Include: R67's MDS (Minimum Data Set) dated [DATE] documents R67 has moderately impaired cognitive skills for decision making. R67's EHR (Electronic Health Record) dated [DATE] documents R67's Unspecified Dementia Unspecified severity without behavioral disturbance, mood, disturbance, and anxiety. Vascular Dementia Unspecified Severity with behavioral disturbance, Restlessness and Agitation, and Major Depressive Disorder Single Episode Unspecified. Consultant Pharmacist's Medication Regimen Review dated [DATE] documents Regarding Previous Pharmacy Recommendation from [DATE] (V30 Consulting Psychiatrist) marked, signed and dated [DATE] to discontinue PRN (as needed) Haldol however this order is still active on the POS (Physician Order Sheet) Please discontinue as PRN antipsychotics can only be ordered for 14 days. Haldol was Scheduled (not PRN) on [DATE]. Note to Attending Physician/Prescriber dated [DATE] documents this hospice resident continues to have a PRN order for the antipsychotic Haldol. Resident (R67) also has routine Haldol order. However, CMS (Central Management Service) considers the PRN use of antipsychotics inappropriate as of [DATE]. The Maximum order for an antipsychotic is 14 days and a new order can only be written with a) Direct physical assessment by the Physician b) documents clinical rationale for the new order which includes what is the benefit of the medication to the resident and has the resident's expressions or indications of distress improved as a result of the PRN. Agree discontinue Haldol PRN. Consultant Pharmacist's Medication Regimen Review dated [DATE] V30 Consulting Psychiatrist marked, signed, and dated [DATE] to discontinue PRN Haldol please discontinue as PRN Antipsychotic orders can only be ordered for 14 days. Haldol was scheduled [DATE]. R67's Medication Administration History (MAR) dated [DATE] documents that R67 is receiving Buspirone 15mg (milligrams) twice a day for Major Depressive Disorder, Quetiapine 100mg twice a day for restlessness and agitation. Sertraline 100mg twice a day for Major Depressive Disorder, Haloperidol Lactate concentrate 2mg/ml 1ml (milliliter) every 8 hours for Vascular Dementia unspecified severity with other behavioral disturbances, Lorazepam 1mg at bedtime for Restlessness and agitation. R67's July MAR documents R67 is receiving the same medications. R67's Behavior/Intervention Monthly Flow Record dated [DATE] to [DATE] documents depression was only completed 4 times on the day shift with no behaviors, twice on evening shift with no behaviors, and thirteen times on the night shift with one behavior with redirection. R67's Behavior/Intervention Monthly Flow Record dated [DATE] through [DATE] was only completed 15 days with her being returned to her room [ROOM NUMBER] times for restlessness. The monthly Flow sheet also documents that she was behavior tracked 10 times on the night shift for restlessness and she was redirected twice. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R67 Hospice Plan of Care Note dated [DATE] documents Pt (patient) is awake with confusion answers some questions appropriate awoke to follow commands anxious trying to get out of her chair. She was refusing medications yesterday and throwing things. R67 Hospice Plan of Care Note dated [DATE] documents patient increase somnolence Ativan given prior to shift. R67's Hospice Plan of Care Note dated [DATE] patient confused poor to fair appetite intermittent restlessness no agitation. R67's Hospice Plan of Care Note dated [DATE] documents patient sleeping prior to visit some restlessness noted easily redirected. R67's Hospice Plan of Care Note dated [DATE] documents patient alert to self-able to follow commands can track with eyes. R67's Hospice Plan of Care Note dated [DATE] documents patient alert to self-patient can answer questions that are simple patient follows commands. R67's Hospice Plan of Care Note dated [DATE] documents patient sleeping 16 to 18 hours in 24 hours patient alert to self-tracks with eyes follow commands. R67's Hospice Plan of Care Note dated [DATE] documents patient will become anxious with care at times. R67's Hospice Plan of Care [DATE] documents appetite poor patient sleeping addition of Haldol more effectively manage symptoms. R67's Facsimile Sheet dated [DATE] she has a diagnosis of severe vascular dementia with behaviors disturbances. R67's Electronic Health Record documents R67's medications are Buspar 15mg BID ordered on [DATE], Haldol Concentrate 1ml po QD ordered on [DATE]. Seroquel 100mg BID ordered on [DATE]. Ativan 2mg Q4 HR PRN ordered on [DATE]. Ativan 1mg PO QD 8 PM. On [DATE] at 1:50 PM V25 (Certified Nursing Assistant/CNA) stated I assist her (R67) with feeding I assist her with incontinent care. Her husband just recently died , and sometimes she will call out for him. She is not violent. She does not cause any problems. She does not hallucinate. On [DATE] at 1:55 PM V15 (CNA) stated sometimes she sees things that are not there. She reaches for things on the floor. Sometimes she sleeps a lot sometimes no. On [DATE] at 2:00PM V27 (Licensed Practical Nurse/LPN) stated she was sleeping a lot, easy to arouse. She took her medications. Sometimes she is in bed. Sometimes she is in the Geri chair with no issues. On [DATE] at 2:00 PM V28 (LPN) stated we mostly monitor her for safety. She sleeps throughout the night on low bed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:02 PM V26 (CNA) stated she's a feeder, not with it. We do what we know she needs. No, she does not see things. Sometimes she can feed herself. The Facility Policy Psychotropic Drug Orders undated documents in order to ensure Psychotropic drugs are used appropriately according to physician's order and to protect residents' rights. (The Facility) will follow uniform procedures. Psychotropic drugs are used for documented resident's need and not staff convenience. Residents will not be given unnecessary drugs including excessive dose, duplicative therapy, for excessive duration without adequate monitoring, without adequate indication for it's use or in the presence of adverse consequences that indicate the drug should be reduced or discontinued. Informed consent will provide for dosage changes to establish the lowest effective dose that will achieve the desires outcome. The informed consent will include benefits and side effects.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35156 Based on observation, interview, and record review the facility failed to have an air gap present for the ice machine in the kitchen. This has the potential to affect all 82 residents living in the facility. Findings include: On 7/23/2024 at 4:24 PM, the ice machine in the kitchen had no air gap present. The white drainage hose from the ice machine went directly into the round drain hole with no air gap present. This allows for potential backflow into the ice machine from the sewage drain. On 7/23/2024 at 4:28 PM, V11 (Dietary Manager) stated, I see the hose going into the drain I did not realize or think about any backflow. We use this ice for all of the residents' drinks during meal services. The State Plumbing code Section 750.290 document, Ice Dispensing Ice for consumer use shall be dispensed only with scoops, tongs, or other ice-dispensing utensils or through automatic self-service ice-dispensing equipment. Ice-dispensing utensils shall be stored on a clean surface or in the ice with the dispensing utensil's handle extended out of the ice. Between uses, ice transfer receptacles shall be stored in a way that protects them from contamination. Ice storage bins shall be drained through an air gap. Section 750.1080 Backflow, The potable water system shall be installed to preclude the possibility of backflow. Devices to protect against backflow and back siphonage shall be installed at all fixtures and equipment where an air gap at least twice the diameter of the water inlet is not provided between the water outlet from the fixture and the fixture's flood-level rim and wherever else backflow or back siphonage may occur. A hose shall not be attached to a faucet unless a backflow prevention device is installed. Section 750.1100 Drains a) Commercial dishwashing machines, dishwashing sinks, pot washing sinks, pre-rinse sinks, silverware sinks, bar sinks, soda fountain sinks, vegetable sinks, potato peelers, ice machines, steam tables, steam cookers, and other similar 29 30 30 30 29 30 30 29 29 Installed Cross-connected Siphonage Backflow Installed Backflow Back-siphonage Installed *Keyed to IDPH Retail Food Establishment Inspection Report 67 fixtures shall be indirectly connected in compliance with 77 Ill. Adm. Code 890.1410(a). The only exception shall be when such fixtures are located adjacent to a floor drain, the waste may be directly connected on the sewer side of the floor drain trap provided the fixture waste is trapped and vented as required by the Illinois Plumbing Code (77 Ill. Adm. Code 890) and the floor drain is located within four feet horizontally of the fixture and in the same room. The indirect piping from the fixture to the air gap shall not exceed five (5) feet developed length. All indirectly connected fixtures shall discharge to a vented trap located in the same room in compliance with 77 Ill. Adm. Code 890.1410(a). In the case of direct connection, no other fixture waste shall be connected between the floor drain trap and the fixture protected. b) Drain lines from equipment shall not discharge wastewater in such a manner as will permit the flooding of floors or the flowing of water across working or walking areas or into difficult-to-clean areas, or otherwise create a nuisance. The 672 Long Term Care Facility Application for Medicare and Medicaid form (CMS 671) dated 7/24/2024 documents, there are 82 residents living in the facility.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34964 Based on observation, interview, and record review, the facility failed to ensure staff had passed their required licensure exam for Licensed Practical Nurse before allowing them to work in the facility in the capacity of a license-pending graduate practice nurse. This has the potential to affect all 82 residents in the facility. Findings include: On 7/25/24 at 9:00 AM V29 (Assistant Administrator) provided employee files for V10 (Graduate Practice Nurse/GPN) and V23 (GPN). According to their files, V10 and V23 were hired for the positions of Licensed Practical Nurse (LPN) but their employee files did not include confirmation by the Illinois Department of Financial and Professional Regulation that either V10 or V23 have a valid LPN license or a copy of their license. On 7/25/24 at 9:50 AM V2 (Director of Nursing/DON) stated V10 and V23 are working as license pending LPNs. She stated they have passed some medications under the supervision of the LPNs who are working the floor. She stated they have not taken their test to obtain their LPN license yet and never work independently. She stated that she only schedules them to work when either she or V3 (Assistant Director of Nursing/ADON) is working because V10 and V23 have to work under the supervision of a Registered Nurse (RN). On 7/25/24 at 9:55 AM V1 (Administrator) stated they hired V10 and V23 to work as license pending because it is very difficult to hire nurses so they hired them so they will fill in LPN slots when they are licensed. V1 stated until V10 and V23 are licensed, they are being orientated and doing observations with other nurses. V1 stated she was not aware V10 or V23 had not already taken their tests for LPN licensure, or that they were not even scheduled to take their tests. V1 stated she was not aware that V10 or V23 had administered medications to residents because they were only supposed to be shadowing V2 or the other nurses and should not be passing medications. V1 stated she does not have a job description for GPN position and does not have a policy regarding GPNs, but just goes by what the regulations say. On 7/25/24 at 11:30 AM V10 (GPN) was observed in the facility wearing a Staff Identification Badge that identified her as Licensed Practical Nurse (LPN). V10 stated she is a GPN and has not taken her test to become an LPN and stated she has no plans to take the test yet. V10 stated she is not going to take the test until she is ready and stated she is not ready. V10 stated she has administered medications to some of the residents in the facility and signs out the medications she administers in the residents' electronic Medication Administration Records (e-MARs). V10 stated she does not do any other LPN duties besides passing medications which she does under the direct supervision of V2. She stated she is mostly doing observations with other nurses. V10 stated she has been working in the facility for a few weeks. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/25/24 at 3:30 PM V10's employee file was reviewed. V10's Payroll Authorization and Employee Pay Change & History form documents V10's job description as LPN and documents the effective date as 6/27/24 as a new hire. V10's Emergency Contact Form dated 6/27/24 documents her position as LPN. On 7/25/24 at 11:33 AM V23 (GDR) stated she has administered medications to residents under the supervision of V2. V23 stated when she passed medications, she passed to 7 or 8 residents in the dining room, and she signed out the medications in the residents' e-MARs. V23 stated she has not registered to take her test to obtain her LPN license because she stated she does not feel like she is ready to take the test yet. She stated she has been working in the facility as a GPN for about a month. V23 was wearing an employee ID badge that identifies her as an LPN. V23's Application for Employment dated 6/19/24 documents GPN under the question, What job are you applying for? V23's Payroll Authorization & Employee Pay Change & History form documents, under job description: LPN, with effective date of 6/24/24 as a new hire. On 7/25/24 at 3:27 PM V29 (Administrative Assistant) stated she does background checks on all the new hires in the facility. V29 stated she has asked V10 and V23 when they are planning to schedule their tests to obtain their LPN license and they have never given her a definite answer. She stated the facility has never hired any GPNs before while she has been employed, and if someone did not have a license they had to work as a Certified Nursing Assistant (CNA) until they could provide a license. V29 stated the only information she received from V10 and V23 was what is on their applications. She stated she does not have any documentation that they completed LPN schooling. V29 stated she did bring up her concerns regarding V10 and V23 working as GPNs but was told by V1 (Administrator) that it was fine. V29 stated they do not have a job description for the position of a GPN. V29 confirmed V10 and V23 are paid LPN wages. On 7/25/24 at 3:33 PM V2 stated both V10 and V23 graduated from (local school of nursing) and they showed her emails that confirmed they are eligible to take the test to obtain their LPN license. She stated they got the letter after they graduated, and they have time before they have to take their tests, and neither of them are ready to take the test yet. V2 stated, I messed up. I gave my permission for them to pass medications under the supervision of the other nurses. I didn't know this was not allowed. The other nurses who are orienting V10 or V23 log into the e-MARS and when V10 or V23 administer a medication, they check them off, but it is under the LPN's log in. V2 stated V10 and V23 do not have accesses of their own to log into the e-MARs. V2 stated she was not aware that the regulations do no allow GPNs to work as license pending. until they take and pass their LPN test. V2 confirmed that V10 and V23 were supervised by herself, V3 (ADON) or one of the LPNs who were orientating V10 and V23. She stated they were not always directly supervised by her, but either she or V3 were in the facility when V10 and V23 were working. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Illinois General Assembly Public Act [PHONE NUMBER], Section 55-10(d)1, 2,3,4 documents, (d) A licensed practical nurse applicant who passes the Department-approved licensure examination and has applied to the Department for licensure may obtain employment as a licensed-pending practical nurse and practice as delegated by a registered professional nurse or an advanced practice registered nurse or physician. An individual may be employed as a license-pending practical nurse if all of the following criteria are met: (1) He or she has completed and passed the Department-approved licensure exam and presents to the employer the official written notification indicating successful passage of the licensure examination. (2) He or she has completed and submitted to the Department an application for licensure under Section as a practical nurse. (3) He or she has submitted the required licensure fee. (4) He or she has met all other requirements established by rule, including having submitted to a criminal history records check. The CMS form 671, Long Term Care Facility Application for Medicare and Medicaid, dated 7/24/24 documents there are 82 residents residing in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35156 Based on observation, interview, and record review the Facility failed to follow CDC Infection Control Guidelines during an COVID outbreak and staff providing patient care were not wearing the proper PPE (Personal Protective Equipment). This has the potential to affect 82 residents living in the facility. Findings include: On 7/24/24 at 8:12 AM, R36's room had PPE (Personal Protective Equipment, Gowns, Gloves, Face shields and mask), on the outside of his door. On 7/24/2024 at 8:15 AM, V10 (Licensed Practical Nurse/LPN) entered R36's room and was only wearing a N95 mask. V10 was not wearing any gown or any eye protection. On 7/24/2024 at 8:18 AM, V10 left R36's room and walked into the main dining room and began assisting with breakfast meals. V10 was carrying trays to the residents in the main dining room. On 7/24/2024 at 9:02 AM, V10 stated I did not realize (R36) was on droplet precautions. I found out later he was COVID positive. I guess I was not looking at the door and did not see he was on contact isolation. I should have been wearing a gown and eyewear. On 7/26/2024 at 10:12 AM, V2 (Director of Nursing) stated, I would expect any staff in COVID positive rooms to be in full PPE, N95 mask, gown and faces shield or goggles. 34964 On 7/24/24 at 8:05 AM V1 (Administrator) stated R23 tested positive for COVID this morning along with 2 other residents. On 7/24/24 at 8:10 AM R23's door had PPE (Personal Protective Equipment) caddy hanging on her door with gloves, face masks, gowns and N95 masks on it. V9 (Housekeeper) was in R23's room cleaning and was observed walking in and out of the room to grab items off her housekeeping cart which was parked right in front of the door. V9 was wearing a gown, gloves and N95 mask, but no eye protection. After she went back in room to wipe off table and walked back to cart, she looked at the sign on R23's door indicating R23 is on droplet and contact isolation. V9 stated, Yes, I should be wearing a face shield also when I am in R23's room. R23 was in her bed in the room while V9 was cleaning her room. R23's Physician Order dated 7/24/24 documents: COVID positive charting, s/s (signs and symptoms) of COVID, respiratory assessment, and full set of vitals every 4 hours while on isolation. Contact and droplet isolation precautions for COVID 19. On 7/26/24 at 12:45 PM V1 (Administrator) provided the following policies when asked for their most up to date policies regarding infection control practices and use of PPE: (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's undated policy, Droplet Precautions, documents, Objective: Droplet Precautions will be used for residents known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the resident during coughing sneezing, talking, etc. Transmission of the droplets require close contact between source and recipient because droplets do not remain suspended in the air and generally travel short distances (3 feet or less). Droplet transmission involves contact of mucous membranes of the nose or mouth of a susceptible person with the infectious droplets. The facility's policy, Infection Control--Fundamentals of Isolation Precautions revised 5/19/04 documents, Policy: In order to decrease the transmission of pathogenic microorganisms, (facility) will follow fundamentals of isolation precautions according to CDC (Centers for Disease Control) guidelines and IDPH (Illinois Department of Public Health) regulations. Personal Protective Equipment-Masks, Respiratory Protection, Eye Protection, Face Shields: A mask that covers both nose and mouth, and goggles or a face shield will be worn by staff during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, excretions, or secretions to provide protection of the mucous membranes of the caregiver's eyes, nose, and mouth from contact transmission of pathogens. A mask which covers both nose and mouth will be worn to provide protection for the caregiver when a resident is on droplet precautions. This provides protection against spread of infectious large particles droplets that are transmitted by close contact and generally travel only short distances (up to three feet). The CMS form 671, Long Term Care Facility Application for Medicare and Medicaid, dated 7/24/24 documents there are 82 residents residing in the facility. 42636