

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145727	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2024
NAME OF PROVIDER OR SUPPLIER  Polo Rehabilitation & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE  703 East Buffalo Polo, IL 61064	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35119</p> <p>Based on interview and record review the facility failed to ensure a resident was free from verbal abuse for 1 of 13 residents (R16) reviewed for abuse in the sample of 13.</p> <p>The findings include:</p> <p>On 07/30/24 at 12:42 PM, R16 was in her room up in her wheelchair. R16 said she had room mate and they had recently moved her. R16 said that night that R18 was moved, R18 woke up and started messing with her brief. V6 Certified Nursing Assistant (CNA) came in and told R18 to lay down. R18 told V6 no and called her a B***. R18 said that she (R16) had her phone and went on and on. R16 said she told her that she didn't have her phone. R16 stated R18 she was mad, she is usually quiet and [NAME], but that night she was yelling at me and cussing at me. She called me a B**. If she could walk she would have been right here in my face. The nurse came in, it was at bedtime, and I had just started getting ready for bed. R18 kept on and on still yelling at me. It didn't make sense about the phone. She accused me getting information for the staff to use her account. They called V1 Administrator and she told them to move R18. V6 heard her cussing at me. The way her face looked, like she could kill me. It never looked like that before, it was kind of scary. I know they wouldn't let her hurt me but I was upset, it was intimidating.</p> <p>On 07/30/24 at 01:13 PM, V6 Certified Nursing Assistant (CNA) said she walked into help R16 to bed and R18 said R16 took her cell phone. V6 said she told R18 that is wasn't her phone and R18 said it was and it was her account. V6 said R18 then called her a F**** B*** and a liar and R18 was going to turn her in. V6 said then R18 started calling R16 a F***** B****. V6 stated R18's face was very scary. She kept yelling. I've never seen her act that way before. V6 said she let the nurse know and called V1 Administrator like she is supposed to do for abuse. V6 said she told V1 that R18 was calling R16 a F**** B****. V6 said V1 told her to move R18 to another room and herself and another CNA moved R18.</p> <p>R18's Nursing Progress Note dated 7/26/2024 06:18 shows Resident accused roommate of stealing her phone and her account to her phone putting it in hers. Resident used profanity toward roommate calling her a B***H multiple times. Administration made aware of situation. resident was removed from room and place into another one for the remainder of the night per administration orders. Writer explained to resident she did not have a phone.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/30/24 at 12:38 PM, V1 Administrator said the CNA called her and said R18 was yelling at R16 about a phone. V1 said R16 didn't take R18's phone. R18 accused R16 of having her phone, R18 never even had a phone. V1 said she had staff move R18 to another room.</p> <p>The facility's Abuse, Prevention and Prohibition Policy dated 1/24 shows Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Verbal Abuse is defined as the oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within the hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35119</p> <p>Based on interview and record review the facility failed to follow their abuse policy by not identifying, investigating or reporting abuse for 1 of 13 residents (R16) reviewed for abuse in the sample of 13.</p> <p>The findings include:</p> <p>On 07/30/24 at 12:42 PM, R16 was in her room up in her wheelchair. R16 said she had room mate and they had recently moved her. R16 said that night that R18 was moved, R18 woke up and started messing with her brief. V6 Certified Nursing Assistant (CNA) came in and told R18 to lay down. R18 told V6 no and called her a B***. R18 said that she (R16) had her phone and went on and on. R16 said she told her that she didn't have her phone. R16 stated R18 she was mad, she is usually quiet and [NAME], but that night she was yelling at me and cussing at me. She called me a B**. If she could walk she would have been right here in my face. The nurse came in, it was at bedtime, and I had just started getting ready for bed. R18 kept on and on still yelling at me. It didn't make sense about the phone. She accused me getting information for the staff to use her account. They called V1 Administrator and she told them to move R18. V6 heard her cussing at me. The way her face looked, like she could kill me. It never looked like that before, it was kind of scary. I know they wouldn't let her hurt me but I was upset, it was intimidating. R16 said V1 had not come and talked to her about it yet.</p> <p>On 07/30/24 at 01:13 PM, V6 Certified Nursing Assistant (CNA) said she walked into help R16 to bed and R18 said R16 took her cell phone. V6 said she told R18 that is wasn't her phone and R18 said it was and it was her account. V6 said R18 then called her a F**** B*** and a liar and R18 was going to turn her in. V6 said then R18 started calling R16 a F***** B****. V6 stated R18's face was very scary. She kept yelling. I've never seen her act that way before. V6 said she let the nurse know and called V1 Administrator like she is supposed to do for abuse. V6 said she told V1 that R18 was calling R16 a F**** B****. V6 said V1 told her to move R18 to another room and herself and another CNA moved R18.</p> <p>R18's Nursing Progress Note dated 7/26/2024 06:18 shows Resident accused roommate of stealing her phone and her account to her phone putting it in hers. Resident used profanity toward roommate calling her a B***H multiple times. Administration made aware of situation. resident was removed from room and place into another one for the remainder of the night per administration orders. Writer explained to resident she did not have a phone.</p> <p>On 07/30/24 at 12:38 PM, V1 Administrator said the CNA called her and said R18 was yelling at R16 about a phone. V1 said R16 didn't take R18's phone. R18 accused R16 of having her phone, R18 never even had a phone. V1 said she had staff move R18 to another room. V1 said she didn't take the situation as abuse, she looked at it more like dementia like behavior. V1 said she didn't do an investigation or report.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Abuse, Prevention and Prohibition Policy dated 1/24 shows Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Verbal Abuse is defined as the oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within the hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. The facility's abuse prohibition program includes the following seven components: Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to obtain treatment orders for non-pressure wounds for 1 of 13 residents (R15) reviewed for quality of care in the sample of 13.</p> <p>The findings include:</p> <p>On 07/29/24 at 09:19 AM, R15 was sitting up in his wheelchair in his room. R15's right arm was covered with a protective sleeve that had a small amount of dark red dried blood. R15 said he was not sure what happened to his arm, it happened a few days ago. R15 said he probably bumped it on something.</p> <p>On 07/29/24 at 11:26 PM, R15 was in his room sitting in his wheelchair. R15 still had the protective sleeve on his right arm. R15's legs were edematous and red in color. R15's right lower leg had an undated bandaid in place. R15 lowered the protective sleeve on his right arm and R15 had a pool of blood trapped under a clear occlusive dressing with a stream of blood leaking out the edge of the dressing. R15 said the bandaid had been on his leg for a few days and had not been checked or changed since the nurse put it on. R15 said the bandage on his arm had not been looked at since they put the dressing on it.</p> <p>On 07/30/24 at 9:57 AM, the same dressing was on R15's right arm and the bandaid on R15's leg remained. R15 said no one had looked at either. V2 Director of Nursing removed tegaderm and soaked up the dark red serous blood pool. R15 had a small skin flap intact with serous fluid draining. V2 said R15 is on antibiotics for his leg wound. R15 slowly peeled off the stuck on, undated bandaid on R15's right leg. There was yellow drainage on the bandaid. V2 stated this looks worse. V2 cleaned both wounds and measured the wounds. The arm wound was 1.8 cm long (no measurements were done on the width) and the leg wound was 2.5 cm x 1.5 cm. V2 applied triple antibiotic ointment and an occlusive dressing to both wounds.</p> <p>On 7/30/24 at 12:18 PM, V2 said there is no current treatment orders for R15's wounds. V2 said whoever identifies a wound, should call the doctor and get treatment orders, and should notify me and the family.</p> <p>R15's Physician Orders did not contain orders for R15's right arm skin tear or R15's right leg wound prior to 7/30/24.</p> <p>R15's Progress Note dated 7/25/24 shows small spot on shin; spot of blood, applied bordered gauze and antibiotic ointment, will monitor.</p> <p>R15's Progress Note dated 7/28/24 shows right arm, just below elbow outward facing-skin tear, approximately 1 inch long. resident is unaware of origin; skin flap intact. Tegaderm applied. will continue to monitor.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Wound Assessment Policy dated 3/2021 shows It is the policy of the facility to asses each wound initially either at the time of admission or at the time the wound is identified. This policy does not address treatment of wounds.</p> <p>On 7/31/23 at 12:03 PM, V2 said the facility does not have any wound treatment policies.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to ensure pressure prevention treatments were completed as ordered for 1 of 2 residents (R12) reviewed for pressure in the sample of 13.</p> <p>The findings include:</p> <p>On 07/30/24 at 08:55 AM, R12 was sitting up in wheelchair in his room. R12 said the nurse last night said she was going to change the dressings on his bottom but never came back and did them.</p> <p>On 07/30/24 at 09:02 AM, V7 Certified Nursing Assistant assisted R12 to stand and pulled down R12's pants and brief. R12 had a dressing to his right buttock that had yellow drainage, a dressing to his left buttock, and a dressing to his coccyx that all were dated 7/28/24. V7 said the dressings are dated 7/28/24.</p> <p>R12's Physician Orders dated 6/28/24 shows an order treatment to (3) pressure injuries to bilateral buttocks/coccyx areas: Wash gently with mild soap et water. Pat dry. Apply a thin layer of zinc oxide to wound beds. Cover with non-adherent pad . Change daily and PRN every day shift for wound care.</p> <p>On 07/30/24 at 12:18 PM, V2 Director of Nursing said R12's dressings should have been changed per the orders.</p> <p>The facility's Weekly Pressure Ulcer Report dated 7/24/24 shows R12 has a stage 2 pressure to the coccyx, a stage 3 pressure to the right buttocks, and a stage 2 pressure to the left buttocks.</p> <p>The facility's Pressure Ulcer/Pressure Injury Prevention Policy dated 3/22 shows If a pressure ulcer/pressure injury is present, provide treatment to heal it and prevent the development of additional pressure ulcer/injuries.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>35174</p> <p>Based on observation, interview, and record review the facility failed to ensure a residents medications were not expired prior to administering it to the resident which applies to 1 of 13 residents (R3) reviewed for medication administration in a sample of 13.</p> <p>The findings include:</p> <p>R3's physician order sheet printed on 7/30/24 showed R3's Morphine Sulfate (Concentrate) oral solution 20 milligrams (mg) per milliliter (ml) 0.25 mil by mouth every 1 hour as needed for pain/shortness of breath was ordered on 8/27/23.</p> <p>On 7/29/24 at 11:35 AM, R3's Morphine Sulfate bottle had a pharmacy tag expiration date of 5/25/24 with 5 ml left in the bottle. V8 Registered Nurse confirmed the amount of medication in the bottle. V8 stated medications should not be used after expiration date.</p> <p>On 7/29/24 at 12:00 PM, V2 Director of Nursing stated the nurse/pharmacy should be checking for expired medications. Medications should not be administered after the expiration date.</p> <p>R3's Controlled Substance Record sheets (revised January 2023) showed R3 received 39 doses of Morphine sulfate after the expiration date (5/25/24). These doses were given from 5/30/24 through 7/28/24.</p> <p>The facility's Medication Storage Policy dated 2022 showed Morphine Sulfate Oral Solutions should be discarded after manufacturer's expiration date unless otherwise indicated.</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>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>35119</p> <p>Based on interview and record review the facility failed to ensure a residents as needed psychotropic medication had a stop date for 1 of 5 residents (R17) reviewed for psychotropic medications in the sample of 13.</p> <p>The findings include:</p> <p>R17's Physician Orders show and order dated 7/2/24 for clonazepam 0.25 mg Give 1 tablet by mouth every 8 hours as needed for restlessness/agitation. There is no stop date for the order.</p> <p>R17's Pharmacy Consultation Report dated for 7/18/24 shows R17 has a PRN order for an anxiolytic, which has been in place for greater than 14 days without a stop date. Rationale for Recommendation: CMS requires that PRN orders for non-antipsychotropic psychotropic drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN order.</p> <p>On 07/31/24 at 9:40 AM, V2 Director of Nursing said she faxed the pharmacy recommendations to the doctor and then waits for the response. V2 was not sure if she had got a response back on the latest pharmacy recommendations.</p> <p>The facility's Psychotropic Medication Use Policy dated 9/2022 shows The timeframe for PRN psychotropic medications, which are not antipsychotic medications, will be limited to 14 days unless a longer timeframe is deemed appropriate by the attending physician or the prescribing practitioner.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>35174</p> <p>Based on observation, interview, and record review the facility failed to ensure controlled medications were secured by a two locked system which applies to 1 of 13 (R3) reviewed for medication storage in a sample of 13.</p> <p>The findings include:</p> <p>On 7/29/24 at 11:35 AM the medication room door was open. This door opens into the dining room area. The nurse was not in the medication room or the dining room at this time. The medication room refrigerator was unlocked. The medication refrigerator contained R3's Morphine Sulfate Oral Solution.</p> <p>R3's physician order sheet printed on 7/30/24 showed R3's order as Morphine Sulfate (Concentrate) oral solution 20 milligrams (mg) per milliliter (ml) 0.25 mil by mouth every 1 hour as needed for pain/shortness of breath.</p> <p>On 7/29/24 at 11:40 AM, V2 Director of Nursing moved the medication cart into the medication room and closed the door.</p> <p>On 7/29/24 at 11:55 AM, V8 Registered Nurse stated the medication room door and refrigerator should be locked. The refrigerator has narcotics in it.</p> <p>On 7/29/24 at 12:00 PM, V2 stated the medication door and refrigerator is supposed to be locked so no one can get into the medications. Narcotics need to have 2 locks.</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>34506</p> <p>Based on observation, interview, and record review, the facility failed to ensure a pureed diet was served with a smooth consistency for five of five residents (R7, R8, R11, R17, R18) reviewed for pureed diets in the sample of 13.</p> <p>The findings include:</p> <p>The facility's Diet Type Report dated July 29, 2024 shows R7, R8, R11, R17, and R18 are on pureed diets.</p> <p>On July 29, 2024 at 10:15 AM, V5 [NAME] pureed five salisbury steak patties with beef broth. V5 then added thickener powder. V5 then put the pureed salisbury steak into the oven to keep it warm. V5 said the pureed california vegetables were already pureed.</p> <p>On July 29, 2024 at 11:28 AM, lunch was served off of a steam table to all residents.</p> <p>On July 29, 2024 at 11:43 AM, a pureed test tray was sampled. The pureed vegetables had small chunks and casings in it. The pureed vegetables were not smooth in consistency. The pureed salisbury steak had chunks in it and required chewing. The pureed salisbury steak was not smooth in consistency. At 11:50 AM, V4 Dietary Manager sampled the pureed vegetables. V4 said the vegetables were stringy and not appropriate. V4 did not sample the pureed salisbury steak but said it looks gritty. V4 said that the salisbury steak is a processed meat and it is difficult to puree. V4 said pureed food should be a baby food consistency. V4 said pureed food should be smooth and not gritty.</p> <p>The facility's Puree Basics Fact Sheet dated October 31, 2003 shows, The puree diets are residents who cannot chew food or swallow without difficulty. Food is blended to a mash potato or applesauce consistence and requires no-chewing before they are swallowed.</p>		