STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145793	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1675 East Ash Street Canton, IL 61520

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on interview and record review the facility failed to prevent significant medication administration errors for 3 residents (R1, R2, and R5) of 6 residents reviewed for medication administration in the sample of 11. Findings include: The Administration of Medication policy dated 8/14/19, documents To provide licensed personnel with guidelines for proper administration of medications. Residents shall receive their medications on a timely basis in accordance with state and federal guidelines, and within established facility policies. It is the responsibility of the Charge Nurse to sign off Medication Administration Record to indicate that medication was given as ordered. 1. Drugs and biologicals may be administered only by licensed physicians, licensed registered or practical nursing personnel, and must be administered in accordance with the written orders of the attending physician. 2. Medication must be administered by the same person preparing the doses for administration. 4. Medications must be documented on E-Mar immediately follow the administration. The Charge Nurse Job Description (not dated) documents 1. Follows established policies and procedures of the nursing department. 6. Is accountable for administration of medications and treatments as prescribed by the attending physician and recording of such in the health record. The Initial Incident sent to the (State agency) dated 5/7/24 documents On 5/7/2024 day shift nurse called in sick. Because of this situation the night shift nurse (V5/Licensed Practical Nurse) passed some medications to residents on 200 wing. At approximately 7:00 AM a nurse from the 300 wing (V14/Licensed Practical Nurse) came up to the 200 wing and began passing medications. The 100 wing nurse (V19/Registered Nurse) went back to assist (V14) when (V19) was done with her morning medication pass. At 8:30 AM the 300 wing supervisor, (V6) came in and started to assist (V14) with the medication pass. (V6) was signing out (R2's) Lyrica and noted the morning dose had already been signed out by (V5). (V6) stopped passing medication at this time and attempted to call (V5) and left a message. At 9:45 AM (V5) called back and stated that she gave medications to the following residents: (R1), (R2), (R3), (R4), (R5), and (R6). Of these six residents the 8:00 AM medications were given twice to (R1), (R2), and (R5). (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145793	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1675 East Ash Street Canton, IL 61520

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Event Report Form (State) Notification (not dated) documents on 5/7/2024 at approximately 7:00 AM, clinical supervisor (V6) was signing out R1's Lyrica and noted the morning dose had already been signed out by the night shift nurse (V5). V6 stopped passing any further medication until she could speak to V5 to clarify what had been given. After speaking with V5 it was found that V5 had also given morning medications to R1, R2, and R5 without signing them out, resulting in those medications being given again by the oncoming nurse (V14). All residents were immediately assessed with no adverse reaction noted. All physicians and Power of Attorneys were also notified. Orders were given to monitor residents for adverse reactions. Vitals for all three residents were taken at discovery, two hours later, then they will be taken every four hours the first day, than every shift for three days. The pharmacist (V16) was consulted and gave instructions for monitoring for specific adverse reactions, and the advanced practical nurse (V15) completed face to face assessments with each resident. There were no negative outcomes to any resident. Investigation initiated. A full report to follow. The Final Incident Report sent to the (State agency) dated 5/9/24, documents Background: On Tuesday May 7 the 6:00 AM nurse called in sick. The night shift nurse (V5/LPN) stayed over until another nurse could get there. (V5) passed medications on 6 (six) residents but did not sign them out on the MAR (Medication Administration Record). (V14/LPN) from 300 wing floated up to the 200 wing to start the medication pass. (V19/Registered Nurse), the 100 wing nurse came to help (V14) with her med pass after (V19) finished passing medications on 100 wing. At 8:30 AM the 300 wing supervisor (V6) came in and started to assist (V14) with the medication pass. (V6) was signing out (R2's) Lyrica and noted the morning dose had already been signed out by (V5). (V6) and (V14) stopped passing medications at this time and attempted to call (V5) and left a message to call the facility. Account of incident: At 9:45 AM (V5) called back and stated that she gave medications to the following residents: (R1), (R2), (R3), (R4), (R5), and (R6). Of these six residents (V5) had given the medications to, (V5) did not sign the MARS on (R1), (R2), (R5) and (R3). Of these 4 (four) residents 3 (three) of them were given their medications a second time. V5/Licensed Practical Nurse Interview by V6/Nursing Supervisor dated 5/7/24 at 9:00 AM, documents Informed (V5) she did not sign out the MAR (Medication Administration Record) on (R2) but gave morning meds. I was able to tell (V5) gave morning med's because (V5) signed out the narcotics at 7:50 AM. (V5) confirmed she gave (R2) med's this morning. I educated (V5) that I also gave (R2) his morning med's because (V5) did not sign them out as given. I asked (V5) why she did not sign these med's out? (V5) replied she does not know why, that's not her normal behavior. I asked (V5) who else she gave meds to this morning? (V5) states she gave med's to (R1), (R2), (R3), (R4), (R5), and (R6). After talking to (V5), I consulted with (V19/Registered Nurse) who also was assisting with medication pass on 200 wing and (V19) voiced that she also gave med's to (R1) and (R5). The Employee Progressive Disciplinary Form dated 5/22/24 documents that V5/Licensed Practical Nurse was given a written warning for failing to sign out administered medication. On 5/7/24 a call off occurred on day shift. (V5) (night shift nurse) began passing morning medications and failed to sign out medications in the EMAR (Electronic Medication Administration Record) after administering to residents, which then resulted in 3 (three) residents inadvertently receiving a double dose of their 8:00 AM medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145793	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1675 East Ash Street Canton, IL 61520

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/24 at 11:10 AM, V1/Administrator stated that a day shift nurse called off and V5/Licensed Practical Nurse stayed over to pass medication until someone else could come in. V6/Nursing Supervisor went to help with the med pass and V5 left. V6 gave medication to R2 and when V6 went to sign it out V6 found it was already signed out of the narcotic book. V5 was contacted and V5 said she had already given medication to R2. V1 also stated (V5) did not have a reason for not signing out the medication, she just didn't. The nurse is supposed to click on the medication, give the medication, then hit save. There is no excuse why this error happened. On 5/23/24 at 11:32 AM, V3/Assistant Director of Nursing stated The med errors should have never happened. V5 had to use the electronic MAR to issue the medication. I have no idea why she did not click them off. V5 is not new to the system. I believe there were three residents that got their medication twice that morning. On 5/23/24 at 10:20 AM, V4/Director of Resident Services stated that on 5/7/24 a day shift nurse called off. V5/LPN stayed over to help with medication pass. V5 passed medication to six residents but did not record the information on the Medication Administration Record/MAR for four of the residents. V6/Nursing Supervisor took over the med pass. While passing medication when V6 was going to give R2 his narcotic it was already signed out that R6 had gotten the medication that morning. V6 stopped the med pass and called V5. Three of the four residents got duplicate medication. On 5/24/24 at 3:58 AM, V5/Licensed Practical Nurse stated that she works 6:00 PM to 6:00 AM. On 5/7/24 a day shift nurse called in and V5 was asked to stay over to help pass medication. V5 does not usually pass medication on the day shift. There are a lot of meds in the morning, and it is a busy time. V5 started passing the day shift medication. V5 passed medication to several residents before going home. V5 was home and got a call from V6/Nursing Supervisor asking V5 who V5 had passed medication to that morning. V6 told V5 that R2 said he had already got his medicine, but it was not signed off the MAR/Medication Administration Record. V5 went over each resident with V6 that V5 had given med's to and there were at least three that V5 had not signed the meds off the MAR. Of the residents that V5 had not signed the MAR, V6 stated that R1, R2, and R5 were given medication again. V5 also stated I wish I had a better explanation of why I didn't sign the MAR, but I don't. Policies and Procedures are in place for a reason, and I know it. I've been a nurse for [AGE] years and have never made a mistake like this. That is not how I do a med pass. I was so upset. I have gone over the scenario a thousand times and don't know how I made this mistake. All I can figure was I was tired and hurrying too fast. I had worked 14 hours and was trying to get as much done as I could to help whoever was coming in to take over. On 5/23/24 at 11:15 AM, V6/Nursing Supervisor stated that there was a call off and V6 went to help with med pass. V6 went to give R2 his medication and R2 said Didn't I already take those? V6 went back to look at the narcotic book and saw that R2 had been given his Lyrica earlier that morning by V5/LPN. V6 asked R2 if he took those pills and R2 said he did Wasn't I supposed to? V6 stopped the med pass and called V5 to find out what V5 had given. V5 verified who she had given morning medication. There were six residents that V5 had given medication and three of those six had gotten a double dose of medication. V5 was asked why she did not sign the medication as given and V5 stated It was a crazy morning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145793	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1675 East Ash Street Canton, IL 61520

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. R1's current computerized medical record, documents R1 was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus without Complications, Essential (Primary) Hypertension, Hyperlipidemia, Major Depressive Disorder, Polyneuropathy, Chronic Obstructive Pulmonary Disease, Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety, Acute and Chronic Respiratory Failure, and Acute Kidney Failure. R1's Physician Orders documents Amlodipine 10 mg one time a day at 8:00 AM, Aspirin 81 mg one time a day at 8:00 AM , Doxepin 10 mg one time a day at 8:00 AM, Flonase Suspension 50 micrograms/mcg 2 sprays each nostril one time a day at 8:00 AM, Loratadine 10 mg one time a day at 8:00 AM, Protonix 40 mg one time a day at 8:00 AM, Vitamin B Complex one time a day at 8:00 AM, Gabapentin 600 mg twice a day at 8:00 AM and 4:00 PM, Oxybutynin 5 mg twice a day at 8:00 AM and 4:00 PM, Polysaccharide Iron 150 mg twice a day at 8:00 AM and 4:00 PM, Tizanidine 2 mg twice a day at 8:00 AM and 5:00 PM, and Tylenol 325 mg (2 tabs) twice a day at 8:00 AM and 6:00 PM. R1's Medication Administration Record/MAR dated 5/1/24 - 5/31/24 documents that on 5/7/24, twelve 8:00 AM medications were signed as given by V14/Licensed Practical Nurse. (These meds were already given by V5 but V5 did not sign the MAR.) The medications were as follows: Amlodipine 10 mg, Aspirin 81 mg, Doxepin 10 mg, Flonase Suspension 50 mcg 2 sprays each nostril, Loratadine 10 mg, Protonix 40 mg, Vitamin B Complex, Gabapentin 600 mg, Oxybutynin 5 mg, Polysaccharide Iron 150 mg, Tizanidine 2 mg, and Tylenol 325 mg (2 tabs). R1's Nursing Note dated 5/7/24 at 2:58 PM, documents that it was found that R1 received a second dose of morning medication. R1's Medication Error Form dated 5/7/24 at 8:30 AM, documents that V5/LPN did not sign out the medication and it was given twice. V6 discovered the med error. The following medications were given twice: Amlodipine 10 milligrams/mg, Aspirin 81 mg, Doxepin 10 mg, Loratadine 10 mg, Protonix 40 mg, Vitamin B Complex, Gabapentin 600 mg, Oxybutynin 5 mg, Polysaccharide Iron 150 mg, Tizanidine 2 mg, Tylenol 325 mg, and Flonase Suspension 50 microgram/mcg 2 sprays each nostril. The medications were given around 7:00 AM and repeated around 8:00 AM. It was noted on a different resident that a narcotic had already been given and after an interview with the night shift nurse (V5) it was decided (R1) had also received her medications. V5 gave medications and did not sign them out. 2. R2's current computerized medical record, documents R2 was admitted to the facility on [DATE] with a diagnosis of Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure, Type 2 Diabetes Mellitus without Complications, Long Standing Persistent Atrial Fibrillation, Acute Kidney Failure, Hypotension, Chronic Kidney Disease Stage 3, Peripheral Vascular Disease, Essential (Primary) Hypertension, Hyperlipidemia, Acute Embolism and Thrombosis of Deep Veins of Left Upper Extremity, Depression, and Acute and Chronic Respiratory Failure with Hypercapnia. R2's MDS (Minimum Data Set) dated 3/21/24 documents a BIMS (Brief Interview for Mental Status) Score of 13/15, indicating (cognition intact). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145793	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1675 East Ash Street Canton, IL 61520

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Physician Orders documents Fluoxetine 10 mg one time a day at 8:00 AM, Furosemide 40 mg one time a day at 8:00 AM, Omeprazole 40 mg one time a day at 8:00 AM , Apixaban 5 mg twice a day at 8:00 AM and 6:00 PM, Carvedilol 25 mg twice a day at 8:00 AM and 6:00 PM, Polysaccharide iron complex 150 mg twice a day at 8:00 AM and 6:00 PM, Potassium Chloride extended release 10 milliequivalents/MEQ twice a day at 8:00 AM and 5:00 PM, Pregabalin 75 mg twice a day at 8:00 AM and 6:00 PM, and Umeclidinium-Vilanterol Inhalation 1 puff one time a day at 8:00 AM. R2's Medication Administration Record/MAR dated 5/1/24 - 5/31/24 documents that on 5/7/24, nine 8:00 AM medications were signed as given by V14/Licensed Practical Nurse. (These meds were already given by V5 but V5 did not sign the MAR.) The medications were as follows: Fluoxetine 10 mg, Furosemide 40 mg, Omeprazole 40 mg, Apixaban 5 mg, Carvedilol 25 mg, Polysaccharide iron complex 150 mg, Potassium Chloride extended release 10 milliequivalents MEQ, Pregabalin 75 mg, and Umeclidinium-Vilanterol Inhalation 1 puff. R2's Controlled Substance sheet for Pregabalin 75 mg capsule documents Take 1 (one) capsule by mouth twice daily for nerve pain. V5 gave the medication at 7:50 AM on 5/7/24 and V6 gave it again at 9:00 AM on 5/7/24. R2's Nursing Note dated 5/7/24 at 3:01 PM, documents that it was found that R2 received a second dose of morning medication. R2's Medication Error Form dated 5/7/24 at 8:30 AM, documents that V5/LPN did not sign out the medication and it was given twice. V6 discovered the med error. The following medications were given twice: Fluoxetine 10 milligrams/mg, Furosemide 40 mg, Omeprazole 40 mg, Apixaban 5 mg, Carvedilol 25 mg, Polysaccharide Iron Complex, Potassium Chloride 10 MEQ, and Pregabalin 75 mg. The error was noted when (V6) was signing out Pregabalin in the narcotic book. Previous Nurse (V5) did not sign out drugs on the MAR after administering them. On 5/24/24 at 7:56 AM, R2 was asked if he ever got medication he should not have got. R2 stated Yes, once. 3. R5's current computerized medical record, documents R5 was admitted to the facility on [DATE] with a diagnosis of Seizures, Crohn's Disease, Chronic Kidney Disease Stage 4, Poly Osteoarthritis, Essential (Primary) Hypertension, Rheumatoid Arthritis, Vitamin D Deficiency, Hyperlipidemia, Dependence on Renal Dialysis, and End Stage Renal Disease. R5's Physician Orders documents Fluticasone Furoate Vilanterol 1 puff one time a day at 8:00 AM, Fish Oil 1200 mg one time a day at 8:00 AM, Folic Acid 1 mg one time a day at 8:00 AM, Furosemide 10 mg one time a day at 8:00 AM, Lasix 20 mg one time a day every Tuesday, Thursday, Saturday, and Sunday at 8:00 AM, Levothyroxine 50 Micrograms/MCG one time a day at 8:00 AM, Loratadine 10 mg one time a day at 8:00 AM, Myrbetriq Extended Release 25 mg one time a day at 8:00 AM, Omeprazole 20 mg one time a day at 7:30 AM, Primidone 150 mg one time a day at 7:00 AM, Multivitamin with Mineral one time a day at 8:00 AM, Amino Acids Protein Hydrolysate 30 milliliters/ml one time a day at 8:00 AM, Tamsulosin 0.4 mg one time a day at 7:00 AM, Colace 100 mg one time a day at 8:00 AM, Sodium Bicarbonate 650 mg one time a day at 8:00 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145793	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1675 East Ash Street Canton, IL 61520

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Medication Administration Record/MAR dated 5/1/24 - 5/31/24 documents that on 5/7/24, fifteen 8:00 AM medications were signed as given by V14/Licensed Practical Nurse. (These meds were already given by V5 but V5 did not sign the MAR.) The medications were as follows: Fluticasone Furoate Vilanterol 1 puff, Fish Oil 1200 mg, Folic Acid 1 mg, Furosemide 10 mg, Lasix 20 mg, Levothyroxine 50 Micrograms/MCG, Loratadine 10 mg, Myrbetriq Extended Release 25 mg, Omeprazole 20 mg, Primidone 150 mg, Multivitamin with Mineral, Amino Acids Protein Hydrolysate 30 milliliters/ml, Tamsulosin 0.4 mg, Colace 100 mg, and Sodium Bicarbonate 650 mg. R5's Nursing Note dated 5/7/24 at 3:15 PM, documents that it was found that R5 received a second dose of morning medication. R5's Medication Error Form dated 5/7/24 at 8:30 AM, documents that V5/LPN did not sign out the medications and they were given twice. V6 discovered the med error. The following medications were given twice: Fluticasone Furoate Vilanterol 1 puff, Fish Oil 1200 mg, Folic Acid 1 mg, Furosemide 10 mg, and Vibegron 75 mg. (This list of meds is not accurate. Vibegron was not given and there are 11 meds not listed that were given. On 5/25/24 at 10:02 AM, V4 sent an electronic message that documents V6 said V6 printed out the MAR when she filled out the med error form but must have missed a couple pages.) The medications were given around 7:00 AM and repeated around 8:00 AM. It was noted on a different resident that a narcotic had already been given and after an interview with the night shift nurse (V5) it was discovered this resident had also received his medications. V5 gave morning medications and did not sign the MAR. MAR resulting in the day nurse (V6) also giving the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145793	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1675 East Ash Street Canton, IL 61520

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on interview and record review the facility failed to follow procedures when documenting medication for four residents (R1, R2, R3, and R5) of six residents reviewed for medication in the sample of eleven. Findings include: The Administration of Medication policy dated 8/14/19, documents To provide licensed personnel with guidelines for proper administration of medications. Residents shall receive their medications on a timely basis in accordance with state and federal guidelines, and within established facility policies. It is the responsibility of the Charge Nurse to sign off Medication Administration Record to indicate that medication was given as ordered. 1. Drugs and biological's may be administered only by licensed physicians, licensed registered or practical nursing personnel, and must be administered in accordance with the written orders of the attending physician. 2. Medication must be administered by the same person preparing the doses for administration. 4. Medications must be documented on E-Mar (Electronic Medication Administration Record) immediately follow the administration. The Charge Nurse Job Description (not dated) documents 1. Follows established policies and procedures of the nursing department. 6. Is accountable for administration of medications and treatments as prescribed by the attending physician and recording of such in the health record. The Initial Incident sent to the (State agency) dated 5/7/24 documents On 5/7/2024 day shift nurse called in sick. Because of this situation the night shift nurse (V5/Licensed Practical Nurse) passed some medications to residents on 200 wing. At approximately 7:00 AM a nurse from the 300 wing (V14/Licensed Practical Nurse) came up to the 200 wing and began passing medications. The 100 wing nurse (V19/Registered Nurse) went back to assist (V14) when (V19) was done with her morning medication pass. At 8:30 AM the 300 wing supervisor, (V6) came in and started to assist (V14) with the medication pass. (V6) was signing out (R2's) Lyrica and noted the morning dose had already been signed out by (V5). (V6) stopped passing medication at this time and attempted to call (V5) and left a message. At 9:45 AM (V5) called back and stated that she gave medications to the following residents: (R1), (R2), (R3), (R4), (R5), and (R6). Of these six residents the 8:00 AM medications were given twice to (R1), (R2), and (R5). The Event Report Form (State) Notification (not dated) documents on 5/7/2024 at approximately 7:00 AM, clinical supervisor (V6) was signing out R2's Lyrica and noted the morning dose had already been signed out by the night shift nurse (V5). V6 stopped passing any further medication until she could speak to V5 to clarify what had been given. After speaking with V5 it was found that V5 had also given morning medications to R1, R2, and R5 without signing them out, resulting in those medications being given again by the oncoming nurse (V14). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145793	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1675 East Ash Street Canton, IL 61520

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Final Incident Report sent to the (State agency) dated 5/9/24, documents Background: On Tuesday May 7 the 6:00 AM nurse called in sick. The night shift nurse (V5/LPN) stayed over until another nurse could get there. (V5) passed medications on 6 (six) residents but did not sign them out on the MAR (Medication Administration Record). (V14/LPN) from 300 wing floated up to the 200 wing to start the medication pass. (V19/Registered Nurse), the 100 wing nurse came to help (V14) with her med pass after (V19) finished passing medications on 100 wing. At 8:30 AM the 300 wing supervisor (V6) came in and started to assist (V14) with the medication pass. (V6) was signing out (R2's) Lyrica and noted the morning dose had already been signed out by (V5). (V6) and (V14) stopped passing medications at this time and attempted to call (V5) and left a message to call the facility. Account of incident: At 9:45 AM (V5) called back and stated that she gave medications to the following residents: (R1), (R2), (R3), (R4), (R5), and (R6). Of these six residents (V5) had given the medications to, (V5) did not sign the MARS on (R1), (R2), (R3) and (R5). Of these 4 (four) residents 3 (three) of them were given their medications a second time. V5/Licensed Practical Nurse Interview by V6/Nursing Supervisor dated 5/7/24 at 9:00 AM, documents Informed (V5) she did not sign out the MAR (Medication Administration Record) on (R2) but gave morning meds. I was able to tell (V5) gave morning med's because (V5) signed out the narcotics at 7:50 AM. (V5) confirmed she gave (R2) med's this morning. I educated (V5) that I also gave (R2) his morning med's because (V5) did not sign them out as given. I asked (V5) who else she gave meds to this morning? (V5) states she gave med's to (R1), (R2), (R3), (R4), (R5), and (R6). After talking to (V5), I consulted with (V19/Registered Nurse) who also was assisting with medication pass on 200 wing and (V19) voiced that she also gave med's to (R1) and (R5). On 5/23/24 at 11:10 AM, V1/Administrator stated that a day shift nurse called off and V5/Licensed Practical Nurse stayed over to pass medication until someone else could come in. V6/Nursing Supervisor went to help with the med pass and V5 left. V6 gave medication to R2 and when V6 went to sign it out V6 found it was already signed out of the narcotic book. V5 was contacted and V5 said she had already given medication to R2. V1 also stated (V5) did not have a reason for not signing out the medication, she just didn't. The nurse is supposed to click on the medication, give the medication, then hit save. There is no excuse why this error happened. On 5/23/24 at 11:15 AM, V6/Nursing Supervisor stated that there was a call off and V6 went to help with med pass. V6 went to give R2 his medication and R2 said Didn't I already take those? V6 went back to look at the narcotic book and saw that R2 had been given his Lyrica earlier that morning by V5/LPN. V6 asked R2 if he took those pills and R2 said he did Wasn't I supposed to? V6 stopped the med pass and called V5 to find out what V5 had given. V5 verified who she had given morning medication. There were six residents that V5 had given medication and three of those six had gotten a double dose of medication. On 5/23/24 at 10:20 AM, V4/Director of Resident Services stated that on 5/7/24 a day shift nurse called off. V5/LPN stayed over to help with medication pass. V5 passed medication to six residents but did not record the information on the Medication Administration Record/MAR for four of the residents. On 5/23/24 at 11:32 AM, V3/Assistant Director of Nursing stated The med errors should have never happened. V5 had to use the electronic MAR to issue the medication. I have no idea why she did not click them off. V5 is not new to the system. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145793	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1675 East Ash Street Canton, IL 61520

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/23/24 at 3:25 PM, V3/Assistant Director of Nursing stated that the nurse that gets the medication ready is the nurse that should give it to the resident. V3 stated that V6/Nursing Supervisor was the nurse that gave the second dose of medication to R2. V3 was asked why V6 did not sign the Medication Administration Record/MAR for R2. (V14/LPN had signed the MAR for R2.) V3 stated that did not make sense. Maybe one signed for the medication and the other gave it. On 5/24/24 at 3:58 AM, V5/Licensed Practical Nurse stated that she was told she did not sign the MAR for at least three residents and R1, R2, and R5 were given their medication twice. V5 also stated I wish I had a better explanation of why I didn't sign the MAR, but I don't. Policies and Procedures are in place for a reason, and I know it. I've been a nurse for [AGE] years and have never made a mistake like this. That is not how I do a med pass. I was so upset. I have gone over the scenario a thousand times and don't know how I made this mistake. All I can figure was I was tired and hurrying too fast. I had worked 14 hours and was trying to get as much done as I could to help whoever was coming in to take over. On 5/24/24 at 11:55 AM, V14/LPN stated that she did not know R1, R2, and R5 and did not give any medication to them. V14 was asked why her initials were on the MAR as giving their medication. V14 stated I might have signed it. V14 also stated that she was Shadowing V6/Nursing Supervisor and V6 gave the medication to R2. On 5/25/24 at 10:17 AM, V19/Registered Nurse stated that she was helping V14 with the med pass because V14 was not familiar with the residents on the 100-200 Hall. V19 named five residents she helped V14 with. They were R1, R7, R8, R9, and R10. V19 was told that V14 stated V14 did not give any medication to the residents because V14 did not know the residents. V14 specifically said she did not give med's to R1, R2, and R5. V19 stated I might have given (R1) hers. Later V6/Nursing Supervisor was helping V14 with med pass. 1. R1's current computerized medical record, documents R1 was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus without Complications, Essential (Primary) Hypertension, Hyperlipidemia, Major Depressive Disorder, Polyneuropathy, Chronic Obstructive Pulmonary Disease, Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety, Acute and Chronic Respiratory Failure, and Acute Kidney Failure. R1's Medication Administration Record/MAR dated 5/1/24 - 5/31/24 documents that on 5/7/24, twelve 8:00 AM medications were signed as given by V14/Licensed Practical Nurse. (These meds were already given by V5 but V5 did not sign the MAR.) The medications were as follows: Amlodipine 10 mg, Aspirin 81 mg, Doxepin 10 mg, Flonase Suspension 50 mcg 2 sprays each nostril, Loratadine 10 mg, Protonix 40 mg, Vitamin B Complex, Gabapentin 600 mg, Oxybutynin 5 mg, Polysaccharide Iron 150 mg, Tizanidine 2 mg, and Tylenol 325 mg (2 tabs). R1's Nursing Note dated 5/7/24 at 2:58 PM, documents that it was found that R1 received a second dose of morning medications. R1's Medication Error Form dated 5/7/24 at 8:30 AM, documents that V5/LPN did not sign out the 8:00 AM medications and they were given twice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145793	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1675 East Ash Street Canton, IL 61520

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R2's current computerized medical record, documents R2 was admitted to the facility on [DATE] with a diagnosis of Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure, Type 2 Diabetes Mellitus without Complications, Long Standing Persistent Atrial Fibrillation, Acute Kidney Failure, Hypotension, Chronic Kidney Disease Stage 3, Peripheral Vascular Disease, Essential (Primary) Hypertension, Hyperlipidemia, Acute Embolism and Thrombosis of Deep Veins of Left Upper Extremity, Depression, Acute and Chronic Respiratory Failure with Hypercapnia. R2's Medication Administration Record/MAR dated 5/1/24 - 5/31/24 documents that on 5/7/24, nine 8:00 AM medications were signed as given by V14/Licensed Practical Nurse. (These meds were already given by V5 but V5 did not sign the MAR.) The medications were as follows: Fluoxetine 10 mg, Furosemide 40 mg, Omeprazole 40 mg, Apixaban 5 mg, Carvedilol 25 mg, Polysaccharide Iron Complex 150 mg, Potassium Chloride Extended Release 10 milliequivalents/MEQ, Pregabalin 75 mg, and Umeclidinium-Vilanterol Inhalation 1 puff. R2's Nursing Note dated 5/7/24 at 3:01 PM, documents that it was found that R2 received a second dose of morning medications. R2's Medication Error Form dated 5/7/24 at 8:30 AM, documents that V5/LPN did not sign out the 8:00 AM medications and they were given twice. 3. R3's current computerized medical record, documents R3 was admitted to the facility on [DATE] with a diagnosis of Depression, Chronic Obstructive Pulmonary Disease, Respiratory Failure, Unspecified with Hypoxia, and Hyperlipidemia. R3's Medication Administration Record/MAR dated 5/1/24 - 5/31/24 documents that on 5/7/24, four 8:00 AM medications were signed as given by V6/Nursing Supervisor. (These meds were already given by V5 but V5 did not sign the MAR.) The medications were as follows: Duloxetine 20 mg, Prednisone 10 mg, Buspirone 15 mg, and Symbicort Inhalation 160-4.5 mcg 2 puffs. On 5/23/24 at 3:25 PM, V3/Assistant Director of Nursing was asked why V6 had signed off giving R3's med's if V6 did not give them. V3 stated that V6 probably did because V6 knew that V5 had already given the medication to R3 and wanted to show that it had been given. V3 was asked if the MAR should have been coded to read the progress note? V3 replied Yes. On 5/24/24 at 7:25 AM, V3/Assistant Director of Nursing stated that V6 signed R3's med's as being given on the MAR after V6 had talked to V5. V6 should have coded the MAR as a 9 for each medication and entered a Progress Note. The Medication Administration Record Chart Codes document 9=Other/See Nurses Notes (None of R3's 8:00 AM medications were coded as 9) 4. R5's current computerized medical record, documents R5 was admitted to the facility on [DATE] with a diagnosis of Seizures, Crohn's disease, Chronic Kidney Disease Stage 4, Polyosteoarthritis, Essential (Primary) Hypertension, Rheumatoid Arthritis, Vitamin D Deficiency, Hyperlipidemia, Dependence on Renal Dialysis, and End Stage Renal Disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145793	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Care Center	1675 East Ash Street Canton, IL 61520

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's Medication Administration Record/MAR dated 5/1/24 - 5/31/24 documents that on 5/7/24, fifteen 8:00 AM medications were signed as given by V14/Licensed Practical Nurse. (These meds were already given by V5 but V5 did not sign the MAR.) The medications were as follows: Fluticasone Furoate Vilanterol 1 puff, Fish Oil 1200 mg, Folic Acid 1 mg, Furosemide 10 mg, Lasix 20 mg, Levothyroxine 50 Micrograms/MCG, Loratadine 10 mg, Myrbetriq Extended Release 25 mg, Omeprazole 20 mg, Primidone 150 mg, Multivitamin with Mineral, Amino Acids Protein Hydrolysate 30 milliliters/ml, Tamsulosin 0.4 mg, Colace 100 mg, Sodium Bicarbonate 650 mg. R5's Nursing Note dated 5/7/24 at 3:15 PM, documents that it was found that R5 received a second dose of morning medications. R5's Medication Error Form dated 5/7/24 at 8:30 AM, documents that V5/LPN did not sign out the 8:00 AM medications and they were given twice.