

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145825	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER South Elgin Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 746 West Spring Street South Elgin, IL 60177	

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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490</p> <p>Based on interview and record review the facility failed to ensure a nurse was competent to administer medications as ordered and transcribe orders for 4 of 4 residents (R3, R4, R7 and R8) reviewed for nursing services in the sample of 8.</p> <p>Findings include:</p> <p>1. R3's Face Sheet shows that she admitted to the facility on [DATE] with diagnoses of: polyneuropathy, schizoaffective disorder, neuromuscular dysfunction of the bladder, anxiety, hypothyroidism, insomnia and hyperlipidemia. R3's Minimum Data Set (MDS) assessment dated [DATE] shows that her cognition is intact.</p> <p>R3's August Medication Administration Record (MAR) shows that she takes lamotrigine (anticonvulsant) 25 milligrams (mg)-3 tablets once daily at 8:00 AM for mood stabilization, aripiprazole (antipsychotic) 10 mg daily at 8:00 AM for mood and paranoia and gabapentin (anticonvulsant) 300 mg three times a day at 8:00 AM, 12:00 PM and 6:00 PM for anxiety/pain.</p> <p>On 8/13/24 at 10:05 AM, R3 said that V3 (Registered Nurse) gave her her 8:00 AM medication one day and she was missing 2 of the 3 tablets of lamorigine, her aripiprazole and her gabapentin. R3 said that she had to tell V3 that she was missing them and then she corrected it.</p> <p>2. R4's Face Sheet shows that she admitted to the facility on [DATE] with diagnoses of: seizures, diabetes mellitus, hypothyroidism, hypertension, edema, gastro-esophageal reflux, high cholesterol, morbid obesity, depression, schizoaffective disorder and obstructive sleep apnea. R4's MDS dated [DATE] shows that her cognition is intact.</p> <p>R4's August MAR shows that she receives the following medications at 8:00 PM: metformin (antidiabetic) 1000 mg, pravastatin (statin) 10 mg, bumetanide (diuretic) 2 mg, divalproex (anticonvulsant) 500 mg, famotidine (acid reducer) 20 mg, levetiracetam (anticonvulsant) 500 mg and ferrous sulfate (supplement) 325 mg. R4's August MAR shows that she receives the following medications at 9:00 PM: mirtazapine (antidepressant) 7.5 mg and olanzapine (antipsychotic) 15 mg.</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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/13/24 at 9:45 AM, R4 said that V3 came to her room awhile back to give her her evening pills. R4 said that she only had 4 pills in the cup and she usually takes 9 pills at bedtime. R4 said she told V3 that she takes more pills than that and she left the room with the pills and then another nurse brought her the correct amount of pills. R4 said that again last Friday, V3 brought her evening pills in and there was only 8 pills in the cup. R4 said that she showed V3 the list of medications that she takes and she said that she must have forgotten the mirtazapine and went and got her another pill. R4 said that she has told the manager that she does not feel comfortable with V3 giving her her pills any longer.</p> <p>3. R8's MDS dated [DATE] shows that her cognition is intact.</p> <p>R8's August MAR shows that she takes quetiapine (antipsychotic) 25 mg-2 tablets at bedtime for agitation/restlessness and melatonin (supplement) 3 mg- 3 tablets at bedtime.</p> <p>On 8/13/24 at 10:26 AM, R8 said that one evening she was out in the common area when V3 came up to her and gave her one pill in a cup. R8 said that she gave the cup back and told her that it did not look like any of the pills that she takes and she takes more than one pill. R8 said that she then brought me the pills I usually take. R8 said that she has no idea what pill she was about to give her but it was not her pill. R8 said that she does not trust that V3 is giving the right pills. R8 said that she knows her pills so she can tell the nurse when they are wrong but she is really concerned about the residents who can not speak for themselves.</p> <p>4. R7's July Physician's Order Sheet shows an order entered by V3 for: Haldol (antipsychotic) 5 mg po (by mouth) or IM (intramuscular) PRN (as needed) Q6 hours (every 6 hours) for aggitation (sp) To the left of the order in large writing and underlined twice was Haldol Lactate and signed by V4 (Physician) on 7/9/24.</p> <p>On 8/13/24 at 12:43 PM, V4 said that he gave V3 a telephone order for Haldol lactate for a resident and she transcribed it wrong. V4 stated, I was mad.</p> <p>V3's Supervisor Report of Counsel Form dated 7/11/24 shows, On or around 7/11/24 [V3] was found to have administered medication inappropriately. [V3] was advised to ask for help or additional training to prevent this from occurring and failed to do so.</p> <p>V3's Personnel File did not contain any Nurse Competency Checklists.</p> <p>On 8/13/24 at 11:16 AM, V3 said that she started working at the facility in July. V3 said that during one of her medication passes with R4, she had missed a page of medications but it was corrected and the resident received all her ordered medications. V3 said that since then, she brings all of R4's medications into her so she can review them before taking them in pudding. V3 said that the other night while R4 was reviewing her medications, she was short one pill. V3 said that she went back and got the missing pill for R4. V3 said, When its late, your tired and trying to get things done, it can happen so now I have her verify that I am giving the right medications. V3 said that she is unaware of any medication issues with R3 or R8. At 12:11 PM, V3 said that she did transcribe R7's orders for his Haldol wrong but she already apologized to the doctor. At 2:55 PM, this surveyor showed V3 a Nurse Competency Checklist that was provided by the facility and she said that she has never seen the checklist before and has never had any competency evaluations that she is aware of.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/13/24 at 11:55 AM, V2 (Previous Director of Nursing) said that they have had a few issues with V3. V2 said that a good nurse requires good thinking skills and assessment skills and she feels that V3 lacks those skills. V2 said that she has concerns with V3's thoroughness and her competency to provide care.</p> <p>On 8/13/24 at 2:07 PM, V7 (Director of Nursing) said that all nurses should go through an orientation with another nurse for a few days and the nurse should fill out a competency form to ensure the nurse is competent to work with the residents.</p> <p>The facility Resident Council Minutes for July shows, Nurse [V3] needs a little improvement.</p> <p>The facility's undated Job Summary for a Registered Nurse shows, Executes procedures consistent with interdisciplinary nursing care plans, the regulatory manual .consistently demonstrates proficiency in skills applicable to nursing Provides for the safety and security needs of assigned residents .</p> <p>The facility said that they do not have a policy on nurse competencies.</p>		