STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145847	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stearns Nursing & Rehab Center	3900 Stearns Avenue Granite City, IL 62040

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 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** 45947 Based on interview and record review, the Facility failed to administer insulin timely as prescribed by physician for 1 of 3 residents (R2) reviewed for medications in the sample of 4. Findings include: R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including major depressive disorder with psychiatric symptoms, schizoaffective disorder, borderline personality disorder, and type 2 diabetes mellitus. R2's Undated Minimum Data Set (MDS) printed 5/22/24 documented R2 was cognitively intact, had verbal behavioral symptoms directed at others every one to three days, and was independent with activities of daily living and ambulation. R2's May 2024 Physician Orders document order for Basaglar 100 units/mL (milliliter) Kwikpen, inject 30 units subcutaneously twice per day. R2's Medication Administration Record (MAR) for the month of February 2024 documents circled initials around the 8:00 PM dose of Basaglar 100 units/mL Kwikpen, inject 30 units subcutaneously twice per day, along with the documentation, MD (Medical Doctor) aware, no new orders. R2's Progress Notes for the month of February 2024 do not contain documentation regarding any changes to R2's 8:00 PM Basaglar Kwikpen or whether it was given on 2/23/24. On 5/22/24 at 1:21 PM, R2 stated a few months ago her insulin was not given for 24 hours and R2 was told the Facility did not have it in stock. On 5/22/24 at 3:18 PM, V2, Director of Nursing (DON), stated R2 did miss the evening dose of insulin on 2/23/24 because it did not come in from the pharmacy in time. She stated the doctor said to give it when it came in, and they did. On 5/23/24 at 9:25 AM, V12, Pharmacist, stated R2's Basaglar had to be ordered from another pharmacy, but it was received and sent out to the facility on [DATE]. She stated the volume sent for R2 would have lasted until at least 2/29/24. (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: 145847	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stearns Nursing & Rehab Center	3900 Stearns Avenue Granite City, IL 62040

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/24 at 1:50 PM, V13, Licensed Practical Nurse (LPN), stated, (R2) gets her long acting insulin in the morning and at night. The pharmacy usually comes around 7:00-8:00 PM, and (R2) usually gets her medications around that time. That night (2/23/24), I checked (R2)'s blood sugar, and pharmacy had not come yet, so I documented we did not have it. The NP said to just monitor her blood sugar and give it to her when it came in. The medication came later that evening, probably around 8:30 PM at the latest. The medication was given but was not documented in (R2's) MAR (Medication Administration Record) or Progress Notes. I would sometimes document this in the Progress Notes, but often times I will just mention it (to the next nurse) in report. On 5/23/24 at 2:10 PM, V2, DON, stated she would expect staff to document in the resident's medical chart to verify that a medication was given under these circumstances, but it may be written on the 24 Hour Nursing Report. She stated she was here on the evening of 2/23/24 and remembers R2 getting the Basaglar a little later after it came in from pharmacy. The Facility's 2/23/24 24 Hour Nursing Report documents R2's insulin given when received approx (approximately) 9:45 PM. R2's Progress Notes for the month of February 2024 do not document any physician communication regarding late administration of Basaglar Kwikpen on 2/23/24. On 5/23/24 at 3:15 PM, V2, DON, stated she expects staff to follow the Facility's Medication Administration policy, but feels that order to resume insulin when received covers the administration time. She did not feel staff should have charted when the physician was contacted, whether the medication arrived, or whether the medication was administered. The Facility's Undated Medication Administration - General Guidelines Policy documents, Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with written orders of attending physicians, taking into consideration manufacturer's specifications, and professional standards of practice. All current medications and dosage schedules are listed on the resident's medication administration record (MAR) or treatment record and administered timely according to facility policy. Medications are administered within one hour before and one hour after the scheduled time, except for orders relating to before, after, and during meal orders, which are administered as ordered. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g., resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR/TAR for that dosage administration is initialed and circled.