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	06/18/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156 Based on observation, interview, and record review the facility failed to prevent resident to resident abuse for 4 of 6 residents (R3, R5, R35, and R259) reviewed for abuse in the sample of 45. Findings include: 1. R35's Physician Order Sheets (POS) dated June 2024 documents R35's diagnoses of Hyperlipidemia, type 2 diabetes mellitus without complications, hypertension, benign prostatic hyperplasia without lower urinary tract symptom, patient noncompliant with other medical treatment and regimen related unspecified. Muscle weakness, and unspecified dementia. R35's Minimum Data Set, MDS, dated [DATE] documents R35 was severely impaired for cognition for activities of daily living. R35's Care Plan with a Problem Onset date of 10/31/2023 documents, (R35) is at risk for psych-social concerns . on 10/31/2023 in which he was reported to have hit another resident with his walker (upon review this was noted to be unintentional, unfounded abuse). R35's Progress Notes dated 10/31/2023 at 9:20 PM, This shift at 3:45 resident became upset with another resident because she grabbed his walker. He picked his walker up hitting another resident with it on her right hand and wrist. Resident was redirected and separated from others. Resident Incident Report 10/31/2023 at 3:45 PM, Resident reported to have hit (R259) in the hand/wrist with his walker while the two were moving up the hallway. Reported that (R259) pushed at the resident's walker at which time he became upset and hit her with the walker. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R35's Initial Report dated 10/31/2023 at 4:00 PM, Re: allegation of resident-resident physical abuse. On this date 10/31/2023 at 3:45 PM, (R35) 66 y.o. {year old} male) and (R259) {76 y.o. female} were in the common area of the facility memory care unit when due to crowding both residents were attempting to move in the same direction at which time (R259) pushed (R35's) walker out of her way upsetting (R35). (R35) then proceeded to hit (R259) with his walker making contact with the top of her hand. (R259) c/o (complained of) pain to her hand and x-rays are being obtained to rule out fracture. The residents were immediately separated, and assessment completed with no obvious major injuries observed. Notifications to families and MD were completed. Facility DNS and administrator were notified, and an investigation was initiated per protocol. Due to the poor cognitive condition of both residents at this time, approximately 30 minutes after the event occurred, follow-up interviews were completed with neither resident voicing recollection of the event. Upon review of facility camera monitoring, it was observed when (R259) pushed the walker (R35) picked it up quickly and at that time hit (R259) in the hand. No intention to hit or harm (R259) was observed. X-rays were completed precautionary with no injuries noted. No s/s (signs symptoms) of pain or acute distress or injury at this time. No founded abuse. R35's Final Incident Report, incident date 10/31/2023 documents, 'Resident to resident physical contact occurred in the facility memory care unit between (R35), a 66 y.o. male, and (R259), a [AGE] year old female. Due to crowding in the area the residents were attempting to move in the same direction at which time (R259) pushed (R35's) with his walker. The walker made contact with the top of the female resident's hand. (R259) c/o (complained of) pain to her hand following the incident and an x-ray has been ordered to rule out fracture. There are no obvious s/s signs/symptoms of injuries. Approximately 30 min (minutes) after the event this DNS attempted to interview both residents involved with no recollection noted by either individual. All notifications and reporting completed. Final report to following completion of full investigation into the event. R259's Physician Order Sheet (POS) dated June 2024, Alzheimer disease, osteoarthrosis, unspecified psychosis not due to a substance or known physical condition, and restlessness and agitation. R259's MDS dated [DATE] documents she uses a wheelchair. The MDS does not document her cognition level. R259's Care Plan with a problem onset date of 4/27/2022 documents, (R259) needs assistance with ADL's (activities of daily living). She has impaired mobility and impaired cognitive skill. Diagnosis of osteoarthritis, Alzheimer dementia with behavioral disturbances, paranoid schizophrenia, COPD, Bipolar affective disorder, and dyspnea with exertion. (R259) is at risk for abuse neglect related to diagnosis of Alzheimer dementia with behavioral disturbance, paranoid schizophrenia, bipolar affective disorder, has impaired cognitive skills and needs assistance with ADL's, (Activities of daily living). Goal and Target Date: I will be free of abuse and/or neglect at all times. R259's Nurse's Notes dated 10/31/2024 at 9:08 PM, This shift resident was trying to maneuver through the table and chairs in the dining room, grabbing another resident's walker moving it out of the way. Resident who the walker belonged to, picked up the walker slamming it up against her right hand and wrist. Resident yelled out 'it hurt', grabbing her hand. R259's Incident Report Follow Up Report, resident to resident physical on 10/31/2023 at 3:45 PM, Resident was reaching and propelling herself in her wheelchair when she grabbed another resident's walker. The other resident became upset and hit resident on her hand and wrist with his walker. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R259's Post Incident Actions, Resident to resident physical, date 10/31/2024 at 3:45 PM, Resident was reaching and propelling herself in her wheelchair when she grabbed another resident's walker. The other resident became upset and hit resident on her hand and wrist with his walker. On 6/14/2024 at 12:55 PM, V2, Director of Nursing stated, (V22) Licensed Practical Nurse (LPN) no longer works here and we do not have a working number for her. This incident happened so long ago. I did not witness the altercation but was told there was an incident between (R259 and R35). I believe (R35) hit her with the walker and she was going past him. I would not expect any resident to be hitting any other resident. On 6/14/2024 at 1:22 PM, V2 stated, I did the investigation for it and felt both residents were confused and there was no intent to hurt each other, that's why it was not substantiated. 33110 2. R5's Face sheet dated 3/8/24 documents he was admitted to the facility on [DATE]. R5's MDS dated [DATE] documents R5 is severely cognitively impaired. R5's Baseline Care Plan dated 3/9/24 documents Behaviors inpatient Pysch (psychiatric) at (Local Hospital) 1 to 1 upon return. Physical altercation with male resident place stop sign on door. R5's Nurse's note dated 3/9/24 documents resident noted standing outside another resident's door, when the resident tried to enter his own room, the resident began attacking him. R5's Interdisciplinary Progress Note dated 3/9/24 documents resident (R5) noted standing outside another resident's door. When the resident (R3) tried to enter his room. This resident (R5) began attacking him. This resident (R5) banged the residents head on the wall. Staff rushed to both residents and was able to break the two apart. This resident (R5) was sent out for a Psych evaluation. Management advised staff upon return resident will be on one to one. R5's Final Abuse Investigation titled Departmental Note dated 3/9/24 documents on 3/9/24 at 10:30 (AM or PM was not documented) a physical altercation occurred between 2 male residents on the facility memory care unit. Staff intervened and immediately separated the individuals. Both residents suffer from severe cognitive impairment requiring long term care on the facility MCU (Memory Care Unit). Both residents were assessed (at a local hospital) ER (emergency room). The Facility administrator and this DNS (Director of Nursing Services) were notified immediately. Follow-up and interventions were placed immediately, and an investigation initiated. R5 was admitted to inpatient psychiatric services for medication adjustment and stabilization. While R3 returned to the facility, with no needed follow-up, monitoring and care to continue per protocol. V24's Incident Witness Statement dated 3/9/24 documents (R5) noted in doorway. (R3) noted approaching the door and attempting to push past (R5) to enter the room startling (R5) when he swung his hand and hit (R3) in the side of his head. (R3) fell into the door frame hitting his head onto the frame. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V25's Incident Witness Statement undated documents (R5) was standing in the door when (R3) pushed past him. I think he scared him because (R5) swung at him and hit him in the head. Then (R3) hit the door frame. We ran up and got them away from each other. R3's MDS dated [DATE] documents R3 is severely Cognitively impaired. R3's Care Plan dated 3/7/22 with next review date of July 2024 documents (R3) is usually understood and he usually understands others diagnosis of Unspecified Dementia with Behavioral Disturbances. R3's goal is my needs will be anticipated and met by staff through the review date. Intervention Report changes in his ability to communicate to the MD/NP (Medical Doctor/Nurse Practitioner)). (R3) is at risk for abuse and neglect related to impaired cognitive skills and requires assistance with ADL's (Activity of Daily Living). Diagnosis Unspecified Dementia with Behavioral Disturbances I will be free of abuse and neglect through the review date of 7/2024. (R3) intervention Keep him safe from harm at all times. R3's Interdisciplinary Note dated 3/9/24 documents this resident was noted to be attempting to enter his room at which time a second male resident with confusion whom had been admitted less than 24 HR (Hours) prior became aggressive thinking that this resident was entering the wrong room. The second resident swung his fist hitting (R3) in the side of his face at which time R3 fell to the side noted to bouncy his head back and forth between the sides of the door frame in which he fell . Staff heard the commotion immediately and separated them. R3's Interdisciplinary Note dated 3/10/24 documents resident continues on incident follow up for resident to resident altercation incident. Resident right eye remains blackened. Skin tear to right arm remains and bruising to left ear. Resident alert and able to make needs known denies pain/discomfort at present moment. no S/S (signs and symptoms) of distress noted. On 6/18/24 at 1:30PM V2 stated, Based on what we saw (R5) had been in the facility less than 24 hours. We received him from another facility because he continued to elope from that facility. We had no issues with him. (R5) was standing in the doorway to (R3) room. His room (R5) was halfway down the hallway at the other facility he thought that was his room so when (R3) tried to enter the room (R5) hit him. The Abuse Prevention Ploicy with a history date of 10/22 documents, The facility is committed to protecting the resident from abuse by anyone including, but not necessarily limited to facility, staff, other residents, consultant, volunteer, and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Abuse may be resident to resident, staff to resident, family to resident or visitor to resident.

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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	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** 34964 Based on interview and record review, the facility failed to administer medications as ordered for 1 of 5 residents (R46) reviewed for pharmacy services in the sample of 45. Findings include: On 6/12/24 at 10:44 AM, R46 stated he is supposed to get Tylenol 500 milligrams (mg) three times daily (TID) at 6:00 AM, 2:00 PM and 10:00 PM because he has chronic pain. He stated the regular nurses are very good about getting his medications timely but when the agency nurses are here, he doesn't always get his Tylenol as ordered. He stated his pain is pretty well controlled, but he just wished the agency nurses would pay closer attention. R46's Diagnoses/ History dated 11/7/23 documents his diagnoses to include Other Chronic Pain and Wedge Compression Fracture Fourth Lumbar Vertebra, Subsequent for fracture with routine healing. R46's Physician Orders dated May 2024 documents the order dated 3/13/23: Tylenol Extra Strength 500 milligram (mg) caplet-give 2 tabs by mouth (po) TID (three times a day) at 6:00 AM, 2:00 PM and 10:00 PM***Do not change administration times*** diagnosis: pain. R46's Medication Administration Records (MARs) reviewed for April, May and June 2024 were reviewed with missed doses of Tylenol 500 mg 2 tabs noted in April: 4/10 at 2:00 PM, 4/19/24 6:00 AM, and April 30 at 10:00 PM; No missed doses noted in May and missed doses in June 2024 on 6/2 at 10:00 PM and 6/4/24 at 10:00 PM. R46's Minimum Data Set (MDS) dated [DATE] documents he has a BIMS (Brief Interview for Mental Status Score) of 15, indicating he is alert and oriented to person, place, time, and situation. R46's Care Plan, undated, documents, (R46) has the potential for pain related to L-4 compression fracture and my diagnosis of Osteoarthritis. The goal for this care plan documents, I will maintain adequate level of comfort as evidenced by no signs/symptoms of unrelieved pain or distress, verbalizing satisfaction or expressing relief and comfort through next review. Interventions for this care plan include, Observe me for signs and symptoms of pain such as moaning, yelling, crying, favoring a body part, rocking, rubbing a body part, wringing hands, or facial grimacing; Offer non-pharmacological interventions such as relaxation, deep breathing, massages, or repositioning; Use pain scale to identify pain level and intensity; Administer medications as per MD (Medical Doctor). Notify MD/NP (Nurse Practitioner) if pain medication is not effective; Assess location, duration, intensity, and frequency of pain; Evaluate pain using 1-10 pain scale every shift and as needed; Reposition me for comfort. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 10:05 AM, V2, Director of Nursing, stated she specifically changed R46's times for when he receives his Tylenol because when she worked the floor as a nurse and would take his Tylenol to him at 9:00 PM he would refuse to take it before 10:00 PM, so she would have to go back later and give him his Tylenol. V2 stated she changed the times to meet his preferences and would expect any other nurse, agency or not, to follow his physician orders and administer his Tylenol as ordered. V2 acknowledged the missed doses of R46's Tylenol on his April 2024 MAR and June 2024 MAR but stated she could not find the copy of R46's April MAR. She stated she looked at it last week, but it is no longer in his chart, and she is looking for it. The facility's policy, Medication Administration-General Guidelines dated 1/15, documents, Policy: Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Procedures: 2. Medications are administered in accordance with written orders of attending physicians, taking into consideration manufacturer's specifications, and professional standards of practice. The policy documents 11. The resident's MAR/TAR (Treatment Administration Record) is initialed by the person administering a medication, in the space provided under the date, and on the line for that specific medication dose following medication administration. Initials on each MAR/TAR are verified with a full signature in the space provided or on the signature log.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 35156 Based on interview and record review the facility failed to prevent significant medications errors regarding insulin administration for 4 of 6 residents (R16, R41, R42 and R104) reviewed for significant medication errors in the sample of 45. Findings include: 1.R41's Physician's Order Sheet (POS), dated June 2024, documents, diagnoses of long-term use of insulin, other lack of coordination, tremor, cerebral ataxia in disease classified elsewhere, type 1 diabetes mellites with hypoglycemia without coma. R41 has an order for NovoLog 100 unit/ML Flexpen Administer 8 units prior to meals with the correctional scale following 70-200= none, 201-250 = 2 units, 251-300= 3 units, 301-350- 4 units, 351-400= 5 units, 401-450= 6 units, 451 or higher 7 units DO not hold insulin. R41's Care Plan Problem with onset date of 1/26/2020 documents, (R41) is at risk for falls and has a history of actual falls related to balance issues and diagnosis of cerebral ataxia, hypertension which being treated, pain in right knee tremor unspecified, other lack of coordination, pain, insomnia and diabetes with low blood sugar at time, I have a history of unspecified fracture of left patella with routine healing. R41's Minimum Data Set, MDS, documents she is alert and orientated for cognition and activities of daily living. R41's Nurse's Notes dated 5/7/2024 at 4:39 PM, Was alerted by housekeeping that resident fell while walking down the hall. This writer observed resident on the floor sitting on her buttocks with back against the wall. Asked resident what happened, resident stated that her blood sugar was low, and she got dizzy. Blood sugar checked; it was 67. Resident stated she just went down to her buttocks. All extrem (extremities) WNL (within normal limits) for resident. Proper footwear attire worn. Resident assisted off floor and back up onto feet. Resident assisted to room and body assessment performed. No injuries noted. R41's Incident Report dated 5/7/2024 at 2:38 PM, Was alerted by housekeeping that resident fell while walking down the hall. This writer observed resident on the floor sitting on her buttocks with back against the wall. Asked resident what happened resident stated that her blood sugar was low, and she got dizzy. Resident stated she was just went down to her buttocks. BLGL noted 58 upon check. No obvious s/s of hypoglycemia noted. No injuries noted. Body assessment and pain assessments. Provided snack. Slow increase of BLGL (blood glucose level) noted with results at dinner time. No s/s (signs and symptoms) of hypoglycemia are present. Resident states that she feels fine. Immediate Post Incident Action: Encouraged resident to eat snacks when she feels blood sugar was low and to ask for assistance when she is feeling weak. IDT (Interdisciplinary Team) completed, and resident encouraged to use wheelchair when BLGL is low if short acting insulin is given. R41's Medication Administration Record, MAR, dated 5/7/2024 documents 7:30 AM, has initials and three numbers, 3, 4, 6, with the time, 11:30 AM. The MAR does not document the units of insulin given to R41 on 5/7/2024 at 11:30 AM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R41's May 2024 Mar documents on 5/7/24 at 5:30 PM, R41's blood sugar level was 67 (slightly low). A normal blood glucose level of 70-100 mg (milligram per decimeter). R41's MAR does not document how many units of insulin were given at 11:30 AM. R41's May 2024 MAR documents for the 7:30 AM, sliding scale insulin 21 out of 31 days does not document how many units of sliding scale insulin were given. For the 11:30 AM, dose 23 of 32 doses does not document how many units of sliding scale insulin were given. For the 5:30 PM, dose sliding scale insulin only 23 of 32 units were not documented. On 6/13/2024 at 11:34 AM, V2, Director of Nursing stated, Every nurse charts differently. It's hard, because we have a lot of agency nurses and not everyone is charting the same way. Not everyone is charting how many units of insulin were given. I do not have a flow sheet or anything documenting how many units of insulin were given. I would expect the units to be documented of how many were given based on the sliding scale. There is no way to know how many units were given to (R41) on 5/7/2024. 2.R42's POS dated June 2024 documents a diagnosis of type 2 diabetes mellitus with diabetic chronic kidney disease. R42's Care Plan with a problem onset date of 9/15/2024 documents diabetes mellitus: I require healthcare monitoring related to my diagnosis of diabetes mellitus, I receive oral anti-diabetic mediations daily to help manage my symptoms, I am at risk for episodes of hypo/hyperglycemic reactions. On 6/18/2024 at 8:14 AM, R42's June MAR only documents three numbers, initials, but does not document how many units of sliding scale insulin were given on 6/18/2024 at 8:00 AM dosage. R42's MAR for June 2024 for the 8 AM, dose documents 11 out of 18 units were not documented for the 8 AM dose, 7 out 18 units were not documented for the 12:00 PM dose, 8 out of 18 doses for the 4:00 PM, and 9 out of 17 doses for the 8:00 PM. On 6/18/2024 at 8:12 AM, V4, Licensed Practical Nurse (LPN) stated, I work here full time and when I chart in the MAR, I write down the three numbers in each of the blank boxes. I do not see any place to write the number of units given. Different people do it different ways. I did not write down any units. I gave insulin this morning to (R42). 3. R104's POS dated June 2024 documents a diagnosis of type 2 diabetes mellitus without complications. Type 2 diabetes mellitus without complications Humalog 100 unit/ML vial sliding scale AC (before meals) and HS (bedtime). R104's Instant Care Plan dated 4/27/2024 type II, Dietary Mellitus. R104's MAR for June 2024 documents, Humalog 100 unit/ML vial sliding scale AC and HS R104's MAR for June 2024 documents, Humalog 7:30 AM, no amount of insulin units was documented for 16 of 18 doses. For the 11:30 AM, 15 out of 17 units doses were not documented, and for the 4:30 PM, dose 17 out of 17-unit doses were not documented. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/18/2024 at 8:19 AM, V17, LPN stated, I gave insulin this morning to (R104). I normally take the blood sugar and record it in the book. I use each box for the blood glucose levels. There is not a spot for how many units were given. I don't think there is even a spot for it. 50840 4. R16's POS for June 2024 documents a diagnosis of Type 2 Diabetes Mellitus with diabetic neuropathy. R16's Care Plan documents, at risk for hypo/hyperglycemia related to diabetes diagnosis. R16's June 2024 MAR does not document the number of insulins given to R16. The MAR does not document any units given for 9 of 18 doses for the 6:00 AM, dose, for 15 of 17 doses for the 11:00 AM dose, for 11 of 17 doses for the 4:00PM and 13 out of 17 doses for the 9:00 PM dose. The Insulin Injection Policy with a history date of 8/16 documents, Daily insulin injections are given with a physician's order. Injection sites will be rotated. Insulin will be given before meals unless otherwise ordered by the physician. Record type, amount, time and site of injection on the MAR/eMAR (electronic medication administration record).