STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aledo Rehab & Health Care Center	304 S.W. 12th Street Aledo, IL 61231

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 32061 Based on observation, interview and record review, the facility failed to assess, notify the physician and obtain a treatment order for a newly identified pressure wound for one of three residents (R2), reviewed for pressure wounds, in a sample of 3. The facility policy, Decubitus Care/Pressure Area, dated (revised) 1/18 documents, It is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer. Upon notification of skin breakdown, the pressure area will be assessed and documented on the Treatment Administration record or the Wound Documentation Record. Document size, stage, site, depth, drainage, color, odor, and treatment (after obtaining from the physician). Notify the physician for treatment orders. The orders should include: type of treatment, frequency treatment is to be performed, how to cleanse, site of application. R2's (Hospital) After Visit Summary, dated 6/29/24 to 7/5/24 documents that R2 was readmitted to the facility with the following diagnoses: Closed Fracture of Neck of Right Femur and Compression Fracture of T (Thoracic) 12 Vertebra. R2's Nurses Notes, dated 7/5/24 and signed by V11/Agency Licensed Practical Nurse document, (Nurse) called facility to give report regarding (R2) discharge from hospital. (R2) has right hip fracture, superior and inferior pubic (ramus) fracture and T12 compression fracture. Has some shearing to left buttock. R2's Nurses Notes, dated 7/5/24 and signed by V10/Agency Licensed Practical Nurse document, (R2) arrived to this facility at 5:58 P.M. Skin assessment performed. Bruising noted to bilateral forearms. Surgical site noted to right hip. Dressing dry and intact. Opened area noted to upper right (left) buttock. Right and left buttocks red. Bilateral heels boggy. R2's facility Nursing Admission Assessment, dated 7/5/24 and completed by V10/Agency Licensed Practical Nurse documents, Opened area to left buttock. R2's current Treatment Administration Record, dated July 2024 and verified by V4/Agency Registered Nurse, documents, (7/8/24) Right hip surgical incision. No note of the pressure wound to R2's left buttock or a physician's order to treat the wound to R2's left buttock, is noted. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24 at 12:18 P.M., V8/Agency Licensed Practical Nurse removed a heavily feces-soiled, undated bandage from R2's left buttock. An inverted V-shaped, Stage 2 pressure wound, measuring 2.5 CM (Centimeters) X 1.5 CM was present. At that time V8/Agency Licensed Practical Nurse verified she was unaware of the pressure wound and no previous assessment of the wound, physician notification or physician's orders for the treatment of the wound were completed.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32061 Based on interview and record review, the facility failed to implement interventions to reduce a resident's risk of a fall (R2) and failed to provide adequate supervision to prevent falls (R1 and R2), for two of three residents reviewed for falls, in a sample of 3. These failures resulted in R1 sustaining a fall with a hematoma and R2 sustaining a fall with a right hip fracture, pubic rami fracture and a T12 compression fracture. FINDINGS INCLUDE: The facility policy, Fall Prevention dated (revised) 11/10/18 directs staff, To provide for resident safety and to minimize injuries related to falls. All staff must observe residents for safety. If residents with a high risk code are observed up or getting up, help must be summoned, or assistance must be provided to the resident. Appropriate interventions will be implemented for residents determined to be at high risk for falls. 1. R1's New Admission Information form documents that R1 was admitted to the facility on [DATE]. R1's facility Cumulative Diagnosis Log documents R1's diagnoses: Dementia Disorder, Severe Dementia with Agitation, Legally Deaf, Anxiety. R1's Fall Risk Assessment, dated 3/5/24 documents that R1 is a High Risk for Falls, score 14 (10 points or more equals high risk for falls). R1's Care Plan, dated 3/22/24 includes the following Focus Area: (R1) does not understand mobility limits due to cognitive limitations. Also included are the following Interventions: Assist to recliner if restless in bed; Attempt to anticipate needs, Encourage and assist placement of proper non-skid footwear throughout the night and while in bed; Encourage resident to sit in areas well supervised by staff; Monitor in common areas while awake. R1's facility Investigation Report for Falls, dated 3/17/24 documents, 3/17/24 fell in room, unattended while making bed, due to vertigo. No injury. Intervention: Medication review. First (resident) up (in morning). Lab (laboratory) work. R1's facility Investigation Report for Falls, dated 3/18/24 at 3:00 A.M. documents, Got up from bed unassisted. Laceration to back of head, sent to ER (emergency room) for staples. Intervention: Prefers to sleep in recliner in main area, at times. R1's facility Investigation Report for Falls, dated 6/15/24 at 4:40 P.M. documents, Sitting in (high back padded reclining) chair in dining room, unattended. Stood from chair and fell while not wearing non-skid footwear. Intervention: Remind staff to apply non-skid footwear at all times. R1's facility Investigation Report for Falls, dated 6/24/24 at 8:00 P.M. documents, fell in kitchenette area from wheelchair, unattended. Hematoma to left eyebrow. Intervention: Hospice to provide a peddle reclining wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's facility Investigation Report for Falls, dated 7/1/24 documents, Slid from wheelchair, next to nurse. No injuries. On 7/8/24 at 2:18 P.M., V4/Agency Registered Nurse stated, I was the nurse on duty the evening of June fifteenth when (R1) fell in the dining room. It was only me and two CNAs (Certified Nursing Assistants) working at the time. (V7/CNA-former employee) had left the dining room with a resident and (R1) stood from (R1's) wheelchair and fell to the ground. Another resident yelled for help and (V7) returned to the dining room and found (R1). I was down the hall, and the other CNA was down the hallway too. (R1) only had socks on, they weren't non-skid. I wasn't aware that R1 was supposed to be under direct line of vision of staff at all times when (R1) was out of bed and I didn't know (R1) was supposed to have non-skid footwear on, also. On 7/8/24 at 2:31 P.M., V8/Agency Licensed Practical Nurse stated, (R1) was out of (R1's) Alprazolam on June twenty-ninth and July first when I worked. I was under the impression it had been ordered by the hospice nurse and was going to be delivered. I had nothing to give (R1) for her anxiety. I have never seen (R1) so agitated and anxious. (R1) even fell , when I was standing near (R1) because (R1) couldn't sit still. On 7/9/24 at 7:00 A.M., V6/Registered Nurse confirmed that R1 fell in the kitchenette area of the locked unit on 6/24/24 at 8 PM, while unattended by staff. 2. R2's Facility Profile Sheet documents that R2 was admitted to the facility on [DATE] at 10:45 A.M. with a diagnosis of Weakness, Major Depressive Disorder, (recent) Fracture of Left Radius and Left Femur. R2's Progress Notes dated 5/3/24 at 2:20 P.M. document, (R2) had an unwitnessed fall in room. (R2) came out of room and was seen by nurse while (R2) was holding onto the rail and stated she fell . (R2) assessed and sent to emergency room . R2's Baseline Care Plan, dated 5/3/24 documents, high Fall Risk Assessment, Fall History, Gait/Balance Problems, Weakness. R2's emergency room Report, dated 5/3/24 documents, (R2) lost balance and fell at (facility). 2.5 CM (Centimeter) laceration to scalp. 4 staples placed. R2's facility Investigation Report for Falls, dated 5/3/24 documents, fell in room. Interventions: Frequent observation with nursing and CNAs (Certified Nursing Assistants). R2's facility Investigation Report for Falls, dated 6/29/24 at 8:20 A.M., (R2) fell in dining room when no staff were present to supervise. R2 sustained a Fractured Right Hip, Pelvis and T12 Compression Fracture. On 7/9/24 at 11:30 A.M., V8/Agency Licensed practical Nurse stated, I was the nurse the morning (R2) fell in the dining room. It was only me and two CNAs. They both had left the dining room to assist other residents and I was down the hall passing medications. (R2) is very impulsive and needs to be watched all the time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/9/24 at 1:45 P.M., V2/Director of Nursing verified that R2 had been left alone in the facility locked unit dining room and fell and sustained multiple fractures while standing unassisted. At that time V2/DON stated, We have been discussing what to do about this situation. One staff member is supposed to stay with the residents at all times so things like this don't happen.

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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. 32061 Based on interview and record review, the facility failed to obtain and administer physician- ordered medication for one of three residents (R1), reviewed for medications, in a sample of three. The facility policy, Medication Administration, dated (revised) 11/18/17 documents, Drug administration shall be defined as an act in which a single dose of prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. Document any medications not administered for any reason by circling initials and documenting on the back of the MAR (Medication Administration Record) the date, time, medication and dosage, reason for omission and initials. If the medication is not available for a resident, call the pharmacy and notify the physician when the drug is expected to be available. Like medications are not to be borrowed from one resident for another. Notify the physician as soon as practical when a scheduled dose of medication has not been administered for any reason.: R1's (facility) Cumulative Diagnosis Log documents R1's current diagnoses as: Severe Dementia with Agitation and Anxiety. R1's June 2024 Physician's Orders Sheet includes the following medications: Alprazolam (Anti-Anxiety) 1 MG (Milligram) take 1 tablet three times daily for anxiety. R1's current Care Plan, dated 3/22/24 includes the following Focus Area: (R1) has a behavior problem associated with anxiety related to worrisome, restlessness, verbal outburst and paranoia. Also included are the following Interventions: Administer medications as ordered. R1's Nursing Progress Notes, dated 6/25/24 at 5:00 P.M., and signed by V5/Agency Licensed Practical Nurse document, (Hospice Nurse) called in regards to needing Alprazolam (Xanax) script for (R1). Nurse will get it ordered and (Nurse) will be here Friday. R1's June 2024 and July 2024 Physician Order Sheets include the following medications: Alprazolam 1 MG take one tablet three times daily. R1's order dose of Alprazolam is circled as not administered for June 29, June 30, July 1 and July 2, 2024, at 8:00 A.M., 12:00 P.M., and 4:00 P.M. No documentation for the omitted doses is present. On 7/9/24 at 9:43 A.M., V2/Director of Nurses confirmed the omitted doses of R1's scheduled Alprazolam. R1's (facility) Controlled Substances Proof of Use sheet for R1's Alprazolam 1 MG tablets document no Alprazolam was signed out or administered to R1 for June 29, June 30, July 1, 2024. On 7/7/24 at 11:00 AM, V2/Director of Nurses confirmed the missing doses of (R1's Alprazolam) due to unavailability. We couldn't get hospice to get us a script. If a medication isn't available, medications can be pulled from the emergency box or can be delivered from Walmart or CVS. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/8/24 at 2:31 P.M., V8/Agency Licensed Practical Nurse stated, (R1) was out of her Alprazolam on June twenty-ninth and July first when I worked. I was under the impression it had been ordered by the hospice nurse and was going to be delivered. I had nothing to give (R1) for (R1's) anxiety. I have never seen (R1) so agitated and anxious.