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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145897	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lebanon Care Center	1201 North Alton Lebanon, IL 62254

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on interview and record review, the Facility failed to document the discharge in the medical record and communicate necessary information for receiving facility for 1 of 3 residents (R2) reviewed for discharge in the sample of 5. Findings include: R2's Face Sheet documents, R2 was admitted to the facility on [DATE] with diagnoses including hypertension, diabetes, chronic liver disease, anxiety, and chronic depression. R2's Minimum Data Set, (MDS), dated [DATE] documented, R2 was severely cognitively impaired with inattention and disorganized thinking. The MDS documented, R2 had delusions, verbal behavioral symptoms directed toward others, other behavioral symptoms not directed toward others, and was independent with mobility. R2's Care Plan starting [DATE] documents, R2 has behavioral disturbances including stripping clothes in public areas, verbal aggression, and throwing items at staff. R2's Nurse's Note dated, [DATE] at 8:00 PM documents, R2 was sent to the emergency room after exhibiting physically aggressive and sexually inappropriate behaviors. R2's Medical Record does not contain any documentation, after the above incident on [DATE] at 8:00 PM. R2's Medical Record does not contain documentation regarding discharge, basis for discharge, physician documentation, physician contact information, resident representative contact information, advanced directives, care plan or any other important information that would be necessary for R2's care at the receiving facility. On [DATE] at 9:15 AM, V1 (Administrator) stated there is no documentation in R2's Medical Record, because the Facility did not initiate an involuntary discharge. She stated, R2's bed hold expired, and they did not accept her back after that. On [DATE] at 11:50 AM, V7 (Social Services Director), stated, the Facility did not initiate an involuntary discharge for R2, but she was not allowed to return after her bed hold expired. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:48 PM, V2 (Director of Nursing), stated R2 did not have an involuntary discharge, but her bed hold expired, and she did not come back. The Facility's Undated Transfer and Discharge Policy and Procedure documents, .documentation, in the residents clinical record shall be required. The residents attending physician must document in the residents clinical record that the facility cannot provide for the residents welfare, or that the resident no longer requires the facilities services.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on interview and record review, the Facility failed to follow discharge requirements for 1 of 3 residents (R2) reviewed for discharge in the sample of 5. Findings include: R2's Face Sheet documents, R2 was admitted to the facility on [DATE] with diagnoses including hypertension, diabetes, chronic liver disease, anxiety, and chronic depression. R2's Minimum Data Set, (MDS), dated [DATE] documented, R2 was severely cognitively impaired with inattention and disorganized thinking. The MDS documented, R2 had delusions, verbal behavioral symptoms directed toward others, other behavioral symptoms not directed toward others, and was independent with mobility. R2's Care Plan starting [DATE] documents, R2 has behavioral disturbances which include stripping clothes in public areas, verbal aggression, and throwing things at staff. R2's Nurse's Note dated [DATE] at 8:00 PM documents, R2 was sent to the emergency room after exhibiting physical aggression and sexually inappropriate behaviors. R2's Medical Record does not contain any documentation after the above incident on [DATE] at 8:00 PM. R2's Medical Record does not document a plan for discharge, basis for discharge, or advanced notification of discharge to R2 and her representative. On [DATE] at 9:15 AM, V1 (Administrator) stated, R2 was not given an involuntary discharge notice, but her bed hold expired while she was in the hospital, and they chose not to readmit her. On [DATE] at 11:50 AM, V7 (Social Services Director), stated, R2 did not return to the Facility after hospitalization , because her bed hold expired. She stated, R2 was not given an involuntary discharge. On [DATE] at 12:30 PM, V2 (Director of Nursing), stated, R2's bed hold expired, and the Facility did not take her back. She was unaware whether R2's responsible party was notified. The Facility's Bed Hold Guarantee Policy revised [DATE] documents, A Medicaid resident, whose hospitalization or therapeutic leave exceeds the 10-day bed-hold period, may return to their previous room if available or immediately upon the first availability of a bed in a semi-private room. If the facility determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with 42 CFR, Sec 483.15 (c). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Undated Transfer and Discharge Policy and Procedure documents, Except for the case of late payment or nonpayment, the facility shall notify the resident and the residents family member, surrogate or representative of the transfer and the reasons for the transfer as stated in the clinical record. The planned involuntary transfer or discharge shall be discussed with the resident, guardian, residents' representative and/or the person or agency responsible for the resident's placement, maintenance and care in the facility. The discussion shall be carried out by the administrator or his/her designee. The content of the discussion and explanation shall be summarized in writing, including the names of those in attendance. The summary shall be made a part of the residents clinical record. A physicians discharge order shall be obtained in the residents record prior to discharge. Prior to transfer or discharge the Social Services Director shall counsel the resident and summarize the counseling session in the residents record.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on interview and record review, the Facility failed to allow a resident to return to the Facility following hospitalization in 1 of 3 residents (R2) reviewed for transfer/discharge in the sample of 5. Findings include: R2's Face Sheet documents, R2 was admitted to the facility on [DATE] with diagnoses including hypertension, diabetes, chronic liver disease, anxiety, and chronic depression. R2's Minimum Data Set, (MDS), dated [DATE] documented, R2 was severely cognitively impaired with inattention and disorganized thinking. The MDS documented, R2 had delusions, verbal behavioral symptoms directed toward others, other behavioral symptoms not directed toward others, and was independent with mobility. R2's Baseline Care Plan dated [DATE] documents, plan to initiate behavior monitoring and psychiatric medication use. R2's Care Plan starting [DATE] documents, R2 has behavioral disturbances which include stripping clothes in public areas, verbal aggression, and throwing things at staff. R2's related diagnoses included chronic schizophrenia, chronic depression, and anxiety. The interventions added were medication review and order for psychiatric consult. R2's Progress Note dated [DATE] by V5 (Nurse Practitioner/NP), documents R2 has a diagnosis of paranoid schizophrenia and was placed at this Facility after going to the hospital, due to having an altercation with a resident at another facility. R2's Progress Note dated [DATE] at 8:45 PM documents, R2 was yelling out nonsensical sentences, then dropped her pants to the floor, grabbed her vagina, and made several statements about her vagina. R2's Nurse's Note dated [DATE] at 4:30 AM documents, R2 was being inappropriate to staff, attempting to pull staff pants down, and making inappropriate gestures. R2's Nurse's Note dated [DATE] at 12:00 AM documents, R2 went to the nurse's station and started singing as loud as she could, then placed both fists in the air and threatened staff member, then went down the hall, removed clothes, and engaged in sexually inappropriate behavior. R2's Nurse's Note dated [DATE] at 10:00 PM documents, R2 attempted to leave through the exit door at the end of the hallway. R2's Nurse's Note dated [DATE] at 5:45 PM documents, R2 was being inappropriate and speaking inappropriately to other residents, then removed her clothing and threw juice at another resident. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Nurse's Note dated [DATE] at 8:00 PM documents R2 was in another resident's room threatening to kill her, then went down the hall and slapped another resident on the shoulder. R2 then grabbed a pill crusher and attempted to hit a nurse in the head. Staff were able to obtain the pill crusher, but R2 then hit another staff member in the head with her fist. R2's Psychiatrist was notified and gave orders to send R2 to the emergency room . On [DATE] at 7:55 AM, V4 (Business Office Manager) stated, R2 was sent to the hospital, because she was having a lot of sexual behaviors. She stated other residents were afraid of her, and she tried to hit a nurse. On [DATE] at 9:15 AM, V1 (Administrator) stated, R2's bed hold expired while she was in the hospital, and they chose not to accept her again. She was not involuntarily discharged , but they just did not readmit her after her bed hold expired. She stated, R2 was not appropriate for this setting and had episodes of physical aggression and sexually inappropriate behavior. She stated, they were unaware of R2's behaviors when they accepted her, but they would not have accepted her if they had known about them. On [DATE] at 11:50 AM, V7 (Social Services Director), stated, R2 did not come back to the Facility, because her bed hold expired. On [DATE] at 12:30 PM, V2 (Director of Nursing), stated R2 had a bad behavioral episode and had to be sent to the hospital. She stated the hospital called for R2 to return, and the Facility stated her bed hold had expired. On [DATE] at 1:48 PM, V6 (Licensed Practical Nurse), stated he remembers R2 blurting out inappropriate things to him sometimes when he walked past the dining room, but did not have much interaction with her until the night she was hospitalized . He stated, She was acting very inappropriately and was out of control. It was nuts. The Facility's Bed Census dated [DATE] documents Room XXX was not occupied. On [DATE] at 1:15 PM V1 (Administrator) stated, there was a bed available for R2 (Room XXX), but they did not allow her to return. The Facility's Bed Hold Guarantee Policy revised [DATE] documents, This facility strives to insure {sic} that each Medicaid resident, who is discharged to an acute care setting or takes a therapeutic leave, has a bed reserved for his/her return. Beds shall be held for 10 days for hospitalization and therapeutic leave for Medicaid recipients and indefinitely for Private Pay residents who elect to pay the charges. A Medicaid resident, whose hospitalization or therapeutic leave exceeds the 10-day bed-hold period, may return to their previous room if available or immediately upon the first availability of a bed in a semi-private room. If the facility determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with 42 CFR, Sec 483.15 (c).