| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145903 | A. Building<br>B. Wing | 04/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Vandalia Rehab & Health Care C | 1500 West St Louis Avenue<br>Vandalia, IL 62471 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356<br><br>Based on interview and record review, the facility failed to follow physician's orders to administer anti-anxiety medication as ordered for 1of 5 (R4) residents reviewed for physician orders in a sample of 12.<br><br>Finding include:<br><br>R4's Admission record, dated 4/03/24, documents R4 was admitted to the facility on [DATE], with diagnoses of Cerebral infarction, Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominant side, Alzheimer's disease with late onset, unspecified dementia, unspecified severity with agitation, Chronic Kidney Disease, Anemia, Hypertension, Morbid obesity, hyperlipidemia, Major depressive disorder recurrent, anxiety, Gastroesophageal reflux disease, Post Traumatic Stress Disease, Atrial Fibrillation, and pain.<br><br>R4's Minimum Data Set (MDS), dated [DATE], documents in Section C a Brief interview for mental status a score of 13, which indicates R4 is cognitively intact. Section D documents under mood little interest or pleasure in doing things present 2-6 days in a 14-day period, Feeling down, depressed, or hopeless present 7-11 days in 14-day period. Poor appetite or overeating present 2-6 days in a 14-day period. Section GG documents that R4 is dependent with oral hygiene, toileting, and showers. She requires substantial to max assist with dressing.<br><br>R4's Care Plan. revised 02/15/24. documents under problems, resident requires use of Psychotropic meds to manage mood and/or behavior issues. Candidate for Gradual dose reduction needs monitored for drug related complications, class of drugs antipsychotic-with black box warning, antidepressant, sedative/hypnotic, Related diagnosis depression, anxiety, insomnia, behaviors exhibited see mood. Goal: Will respond cooperatively to behavior interventions resulting in maintenance on lowest therapeutic dose of medication thru next 90 days. Interventions include in part: Administer anti-anxiety medication as ordered- See Physician order sheets for current med, dose and schedule and observed for antianxiety side effects: drowsiness, sedation, light headedness, somnolence, difficulty speaking, impaired coordination, memory impairment, fatigue, depression, confusion, anxiety, headache, dizziness, irritability, dry mouth, constipation, diarrhea, nausea. Notify Medical Doctor (MD) of noted side effects to determine if benefits of therapy outweigh side effects.<br><br>R4's Physician orders document Lorazepam (Ativan) 0.5mg give 1 tablet orally three times a day with a start date of 08/01/23.<br><br>(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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145903 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/05/2024 |
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| NAME OF PROVIDER OR SUPPLIER Vandalia Rehab & Health Care C | | STREET ADDRESS, CITY, STATE, ZIP CODE 1500 West St Louis Avenue Vandalia, IL 62471 | |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 04/02/24 at 9:46AM, R4 stated there is one male nurse, V7 (Licensed Practical Nurse/LPN), who has forgot to give her noon medication Ativan. R4 said this has happened on a couple of occasions, but not often. R4 said V7 told her the Ativan was in her medication cup, but R4 said she didn't see it. R4 said V7 told her she couldn't see it because it was hidden under her big pills. R4 said she didn't want to argue with V7, so she didn't say anymore. R4 said she has been at the facility for a long time, and usually doesn't have problems with anyone. R4 said V1 (Administrator) and V2 (Director of Nursing) came to talk to her a couple of weeks ago about R4 telling an outside provider V7 didn't give her noon dose of Ativan on a couple of occasions. R4 said when she was out at the outside provider, she told them V7 didn't give her a couple of doses of her Ativan as it was ordered. R4 said she thinks the outside provider called and talked to either V1 or V2 about it. R4 said she told them the same thing; there have been several times he didn't give her the noon dose of Ativan and V7 said it was in her medication cup and she just didn't see it. R4 said she told V1 and V2 she doesn't think the Ativan was in the cup. R4 said later she wasn't sure when, but V7 came and brought her meds to her. R4 said V7 had the Ativan in a separate cup. R4 said she just wants to make sure her Ativan was in the cup. R4 said now every time V7 brings her Ativan, it's in another cup, and she knows it's there.<br><br>On 04/02/24 at 11:00AM, V1 stated she had a concern form, undated, which documents in part on 03/13/24, call received from outside provider of R4 stating V7 was not giving her Ativan as ordered. V1 and V2 met with R4 and said there were several days at lunch 2-3 within the last 3 weeks. R4 was asked if she ever asked V7 at that time why it wasn't in there and she said It's (V7), I don't question him because everyone knows that I don't like him.<br><br>R4's Controlled Substance Proof of use sheet for Lorazepam (Ativan) 0.5mg 1 tablet orally three times a day, dated 02/12/24, documents on 03/01/24 only one dose of medication was given at 6:00AM signed out by V7 (LPN). No documentation for 12:00PM or 8:00PM dose was noted on R4's Controlled Substance Proof sheet. On 03/06/24, the noon dose and bedtime dose signed out by V2 (DON) are documented as given, and no morning dose was noted on the controlled sheet.<br><br>R4's Medication Administration Record (MAR) for Lorazepam (Ativan) documents on 03/01/24 at 12:00PM, dose was given by V7 (LPN), and on 03/01/24 an 8:00PM, dose was given by V8 (LPN). R4's MAR also documents on 03/06/24 an 8:00AM dose was given by V2 (DON).<br><br>The Facility's Narcotic Count Record documents it was completed on 03/01/24 by V7 (LPN) and V10 (LPN) and then again by V7 (LPN) and V8 (LPN), with no time noted on narcotic count record. The Narcotic Count record has times of 6:00AM and 6:00PM listed, but neither was checked. The shift Narcotic Count record, dated 03/06/24, by V10 (LPN) and V2 (DON) documents the Narcotic count sheet was completed at 6:00AM, then V2 (DON) and V11 (LPN) completed it again at 6:00PM. No discrepancy was noted.<br><br>On 4/04/24 at 1:37PM, V2 (DON) said she did work the floor on 03/06/24. V2 said she doesn't know why on 03/06/24 at 8:00AM that R4's Ativan was not signed out. V2 said R4 went to an outside appointment on 03/06/24 at around 8:30-8:45AM. V2 stated R4 usually goes out every Wednesday. V2 said R4 usually gets back around 11:30AM-12:00PM. V2 said she might have forgotten to give R4 her morning dose of Ativan that day. V2 said she usually goes down R4's hall early, and forgot to go back to give R4 her medication before she left.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 04/04/24 at 2:00PM, V7 (LPN) stated he did work on 03/01/24 from 6AM to 10PM. V7 said he doesn't know if he missed a dose of R4's Ativan. V7 said anything could be possible; it's not in his immediate memory. V7 said he is usually pretty good about remembering all the residents' medications. V7 stated he just doesn't recall not giving it to her, and he doesn't know why it wasn't signed out.<br><br>On 04/04/24 at 2:30PM, V8 (LPN) said she did work on 03/01/24 from 10PM to 6AM. V8 she said she worked the night shift that day. V8 said when she came in to relieve V7 (LPN), everything was a mess. V8 said V7 had written down all the stuff he had done. V8 said she was trying to go through everything, and V7 said all of it was done. V8 said the reason her initials are on R4's MAR for 03/01/24 at 8:00PM, was because it wasn't signed out by V7 on the Medication Administration Record (MAR), and V7 had told her everything was done so she thought he just forgot to sign the MAR. V8 said she never looked in the controlled substance proof of use sheet to see if R4's Ativan was actually given because V7 told her it was all done. V8 said she remembers that night very well because everything was a total mess, and she called the V2 (DON) to let her know how big of a mess it was. V8<br><br>said she did not administer the Ativan to R4 on 03/01/24 at 8:00PM because she thought it was already given by V7.<br><br>The Facility's Medication Administration policy, revised 11/18/17, documents, Definition: Drug administration shall be defined as an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The Complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container) Verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given. Procedure in part documents under 19. Document any medication not administered for any reason by circling initials and documenting on the back of the MAR the date, time, the medication and dosage, reason for omission and initials. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48356<br><br>Based on interview and record review, the facility failed to determine that drug records were in order, and an account of all controlled drugs were maintained and periodically reconciled for 1of 5 (R4) residents reviewed for controlled substances in a sample of 12.<br><br>Findings include:<br><br>R4's Admission record, dated 4/03/24, documents R4 was admitted to the facility on [DATE], with diagnoses of Cerebral infarction, Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominant side, Alzheimer's disease with late onset, unspecified dementia, unspecified severity with agitation, Chronic Kidney Disease, Anemia, Hypertension, Morbid obesity, hyperlipidemia, Major depressive disorder recurrent, anxiety, Gastroesophageal reflux disease, Post Traumatic Stress Disease, Atrial Fibrillation, and pain.<br><br>R4's Minimum Data Set (MDS), dated [DATE], documents in Section C a Brief interview for mental status a score of 13, which indicates R4 is cognitively intact. Section D documents under mood little interest or pleasure in doing things present 2-6 days in a 14-day period, Feeling down, depressed, or hopeless present 7-11 days in 14-day period. Poor appetite or overeating present 2-6 days in a 14-day period.<br><br>R4's Care Plan, revised 02/15/24, documents under problems, resident requires use of Psychotropic meds to manage mood and/or behavior issues. Candidate for Gradual dose reduction needs monitored for drug related complications, class of drugs antipsychotic-with black box warning , antidepressant, sedative/hypnotic, Related diagnosis depression, anxiety, insomnia, behaviors exhibited see mood. Goal: Will respond cooperatively to behavior interventions resulting in maintenance on lowest therapeutic dose of medication thru next 90 days. Interventions include in part: Administer anti-anxiety medication as ordered.<br><br>R4's Physician orders document Lorazepam (Ativan) 0.5mg give 1 tablet orally three times a day with a start date of 08/01/23.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 04/02/24 at 9:46AM, R4 stated there is one male nurse, V7 (Licensed Practical Nurse/LPN), who has forgot to give her noon medication Ativan. R4 said this has happen on a couple of occasions, but not often. R4 said V7 told her the Ativan was in her medication cup, but R4 said she didn't see it. R4 said V7 told her she couldn't see it because it was hidden under her big pills. R4 said she didn't want to argue with V7, so she didn't say anymore. R4 said she has been at the facility for a long time, and usually doesn't have problems with anyone. R4 said V1 (Administrator) and V2 (Director of Nursing) came to talk to her a couple of weeks ago about R4 telling an outside provider V7 didn't give her noon dose of Ativan on a couple of occasions. R4 said when she was out at the outside provider, she told them V7 didn't give her a couple of doses of her Ativan as it was ordered. R4 said she thinks the outside provider called and talked to either V1 or V2 about it. R4 said she told them the same thing that there have been several times he didn't give her the noon dose of Ativan, and V7 said it was in her medication cup and she just didn't see it. R4 said she told V1 and V2 she doesn't think the Ativan was in the cup. R4 said later she wasn't sure when, but V7 came and brought her meds to her. R4 said V7 had the Ativan in a separate cup. R4 said she just wants to make sure her Ativan was in the cup. R4 said now every time V7 brings her Ativan, it's in another cup and she knows it's there.<br><br>R4's Medication Administration Record, dated 2/1/24 to 2/29/24, document R4's Ativan 0.5 mg was to be administered three times daily at 8:00 AM, 12:00 PM, and 8:00 PM.<br><br>R4's Controlled Substance Proof of use sheet for Lorazepam (Ativan) 0.5mg 1 tablet orally three times a day, dated 02/12/24, documents the 2/20/24, 12:00 PM and 2/21/24, 12:00 PM and 8:00 PM doses were not signed out. This same sheet documents on 2/22/24 the 2/20/24, 12:00 PM dose and 2/21/24 12:00 PM and 8:00 PM doses were signed out as being administered on the correct day and time by V7(LPN). R4's Controlled Substance Proof of use for Lorazepam (Ativan) 0.5mg 1 tab orally three times a day, dated 03/15/24, documents 03/19/24, 12:00PM dose was not signed out. This same sheet documents on 03/20/24 the 12:00PM dose for 03/19/24 was signed out using the correct date and time. The same sheet also documents 03/23/24 the 12:00PM dose was not signed out until 03/24/24 with the correct date of 03/23/24 12:00PM by V7.<br><br>The Facility's Narcotic Count Records for 02/20/24, 02/21/24, 02/22/24, 03/19/24, 03/20/24, 03/23/24, and 03/24/24 document Narcotic count was done with a signature from on going and outgoing nurses. No discrepancies noted on the sheet by the nurses.<br><br>On 04/03/24 at 12:30PM, V2 (Director of Nursing/DON) said they have had problems with V7 not signing out his narcotic medications. V7 will give the medication, but doesn't sign the book. V2 said she has educated V7 on making sure he signs the narcotic book. V2 said the some of the nurses used to sign off the narcotic count book as correct, but sometimes it wasn't, because V7 forgot to sign off his dose of medications. V2 said the count is correct if V7 would have signed off his place. V2 said the nurses will just put V7's initials in the box so he knows he needs to sign it off. V2 said no one has reported to her that they are having a problem with V7 not signing off his narcotic sheets again.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 04/03/24 at 1:30PM, V7 (LPN) stated he always makes sure the residents get their medications. V7 said he might forget to sign something off on the controlled substance proof of use sheet or medication administration record because of an emergency or fall that might happened during a medication pass. V7 said he is human and forgets stuff. V7 said he tries to sign and do his narcotic count at the beginning and end of every shift. V7 said if there is something that isn't correct, he and the other nurses try to figure it out. V7 said usually it's a scheduled medication that he forgets to sign out. V7 said they will then sign it out during the count, or if he doesn't get to it then, he will sign it out later. V7 said he does remember getting disciplined for not signing out his Controlled Substance use record sheet and not doing count at the beginning and end of every shift. V7 said it wasn't just him that got talked to about not doing the end of shift counts. V7 said all the staff were not doing the end of the shift counts all the time.<br><br>On 04/03/24 at 6:51PM, V10 (LPN) said they do narcotic count at the beginning and end of every shift. V10 said there have been times when they have forgot about doing the narcotic count. V10 said she has had times when the count isn't correct, but she can usually figure out why it's not correct; its usually because someone forgot to sign out a routine narcotic, and usually, they try to fix it right away. V10 said if they do the narcotic count, they will usually fix it when they do the count. V10 said if they didn't get to the count, and they are missing a medication, they will look on the medication administration record and see if the medication was given, then leave a blank spot for that person to sign it later. V10 said she has followed V7 after many shifts, and there have been times there are things that are missing from the narcotic sheet that haven't been signed off, but she can usually figure out what it was. V10 said, Like when (V7) forgets to sign off a routine medication and it shows administered on the MAR. He will come to work the next day or two and we will tell him about it, and he will sign them off then. V10 said all the nurses have been educated on signing off their narcotics and doing their counts at the beginning and end of every shift. V10 said she feels like it wasn't that long ago that they were in-serviced on this. V10 said, No one has ever refused to do their narcotic counts, we just forget.<br><br>.<br><br>On 04/04/24 at 10:16AM, V11 (LPN) stated they should do narcotic count at the beginning and end of every shift. V11 said, The narcotic count does not get done the way it's supposed to. Everyone just gets busy and forgets about it. V11 said if they don't get to it, she tries to do the count for herself to make sure everything is correct. V11 said she has had times when the count wasn't correct, she said it was because someone forgot to sign out the narcotics they administered. V11 said she will try to figure out where the medication went to, she said usually it's a routine narcotic, so she checks the medication administration record to make sure it was administered, and then writes the time in and puts the initials of the person who forgot to sign in the narcotic record so they can sign it later. V11 said sometimes it's a few days later before they sign. V11 said there is one nurse who forget to sign off often. V11 said V7 forgets to sign off his narcotic sheet often. V11 said, (V7) knows we will let him sign off later and he will tell me that he forgot to sign and he will be here tomorrow or the next day to sign the narcotic book.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Facility's Controlled Substance Policy dated 11/06/2018 documents: It is the policy of the facility that all drugs listed as schedule II are subject to specified handling, storage, disposal, and record keeping. Procedures list in part: 7: The drugs in schedule II (and those in other schedules which have been restricted and stored in the controlled substance cabinet) will be counted and reconciled by the nurse coming on duty with the nurse that is going off duty. These records shall be retained for at least a year. 9: Discrepancies must be reported immediately to the Director of Nursing who shall investigate as described in the missing controlled substance policy. When loss, suspected theft, or an error in the administration of regulated drug occurs, a report will be filled with the Pharmacist and Administrator. |