STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145909	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Nursing & Rehab	400 East Hillview Avenue Greenville, IL 62246

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 40701 Based on observation, interview and record review the Facility failed to prevent pressure ulcer development for 1 of 3 residents (R44) reviewed for skin impairment, in the sample of 33. Findings include: R44's face sheet, dated 8/22/2024, documented R44 has diagnoses of displaced subtrochanteric fracture of left femur, paraplegia, acute infarction of spinal cord, depressive disorder, generalized anxiety disorder, obstructive and reflux uropathy, lymphoma, chronic obstructive pulmonary disease, and cognitive communication deficit disorder. R44's Physician Order Sheet, dated 8/17/2024, documented an order for an indwelling urinary catheter secondary to obstructive and reflux uropathy. R44's Physician Order Sheet dated 8/21/2024 documents, Cleanse wound to sacrum with Normal Saline. Apply Calcium Alginate and cover with dry dressing. R44's Braden Scale (Tool to determine skin breakdown risk) dated 8/17/2024 documents R44 is occasionally moist and at moderate risk for skin for skin breakdown. R44's Care Plan dated 7/1/2024, documents, I have potential for pressure ulcer development related to immobility and that R44 needs monitoring, reminding, and assistance to turn and reposition at least every 2 hours. R44's Progress Note, dated 8/17/24, documented R44 has moisture associated skin damage to coccyx. R44's Progress Note, dated 8/18/24 documented resident was yelling out and complained of buttock pain. On 8/21/24 R44 was observed sitting up in her wheelchair on the C hall from 11:30 am until 12:05 pm. R44 was observed as she was transported to the dining room in her wheelchair at 12:05 pm. R44 was observed sitting in her wheelchair in the dining room from 12:05 pm until 1:22 pm without the benefit of being repositioned. Observed R44 as she was transported to the C hall in her wheelchair at 1:22 pm. R44 was continuously observed sitting in her wheelchair from 11:30 am until 2:15 pm without the benefit of being repositioned or being asked if she would like to be repositioned. (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 Note: The nursing home is disputing this citation.	On 8/21/24 at 3:35 PM, R44 was observed as she was transferred to bed via a mechanical lift by V5, CNA and V15, CNA. V5 and V15 performed urinary catheter care on R44 and then rolled her onto her left side. R44 was observed with an approximate 5 cm (centimeters) by 3 cm by 0.2 cm wound to her coccyx. The wound bed was pink and moist. R44 did not have a dressing covering the wound and a small amount of dried feces was observed in the wound bed. On 8/22/24 at 8:50 AM, V17, Regional Nurse stated she would expect R44 to be repositioned at least every 2 hours while up in her wheelchair and while in bed. The Facility's Prevention of Pressure Ulcers/Injuries policy, dated July 2017, documented it is the purpose of this procedure to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Preparation: Review the resident's care plan and identify the risk factors as well as the well as the interventions designed to reduce or eliminate those considered modifiable. Risk Assessment: 1. Assess the resident on admission (within eight hours) for existing pressure ulcer/injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. It continues, 4. Inspect the skin on a daily basis when performing or assisting with person care or ADLS. A. Identify any signs of developing pressure injuries. B. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) C. Wash the skin after any episodes of incontinence D. Moisturize dry skin daily; and e. Reposition resident as indicated on the care plan. Prevention: Moisture 1. Keep the skin clean and free of exposure to urine and fecal matter. It continues, Mobility/Repositioning: 1. Choose a frequency for repositioning based on the resident's mobility, the support surface in use, skin condition and tolerance, and the resident's stated preferences. 2. At least every two hours as resident allows, reposition residents who are chair-bound or bed bound. 3. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628 Based on record review, observations and staff and resident interview, the facility failed to provide treatment to prevent further decrease in range of motion for 1 of 3 (R9) residents reviewed for range of motion in a sample of 33. Findings include: R9 was admitted to the facility on [DATE] with multiple diagnoses including right knee pain, cerebral infarction, cognitive communication deficit, presence of other heart valve, GERD (gastroesophageal reflux disease), generalized muscle weakness, other abnormal gait and mobility, vitamin D deficiency, HLD, (hyperlipidemia), HTN, (hypertension), chronic congestive heart failure and polyneuropathy. Physician orders from 1/16/2024 included PT (physical therapy) and OT (occupational therapy) to evaluate and treat. On 8/19/24 at 11:23 AM, R9 was noted with decreased movement of right hand. R9 stated that they have done exercises but doesn't remember when this was. R9 stated this wasn't helping so she quit. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that R9 had limitation in range of motion on lower and upper extremities on the right side. R9's care plan dated 02/01/18 was reviewed. One of the care plan problems specified R9 has an ADL (Activities of daily living) Self Care Performance Deficit. The goal is that R9 will maintain current level of function in through the next review date. The interventions include a restorative program - AROM) Active Range of Motion BLE, (bilateral lower extremities) 2 sets 10 reps (repetitions); AROM: BLE hip abduction)/adduction; AROM: hip flex, ankle pumps, knee extension. Transfer: R9 requires mechanical lift assist for transfers. On 8/21/2024 at 10:35 AM, V13, Director of Rehabilitation stated she reviewed the records on (R9's) therapy. She stated her records show that her therapy ended in 4/2024. She is not able to view additional records due to the change in electronic medical systems. She stated the floor CNAs perform the restorative programs. V13 provides a copy of the individual residents' restorative program to the MDS coordinator who places it in the restorative binder. On 8/21/2024 at 10:45 AM, V2, Director of Nursing stated the Certified Nursing Assistants (CNA) on the halls are currently providing restorative care to the residents. On 8/21/2024 at 10:50 AM, V10, MDS coordinator, stated she receives the resident's restorative program (V13) and places it a restorative binder that she keeps in her office. V10 puts these restorative tasks in the care plan which then flows over on the electronic medical record for the CNAs tasks for the day. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/2024 at 11:50 AM, V14, CNA, stated she said she was unsure who performs ROM exercises. V14 checked with V8, LPN for guidance. V8 stated that the CNAs perform the restorative care on residents when getting them out of bed. She stated that this can be done when you stretch her out as you get her out of bed. Surveyor requested to observe R9 returning to bed so restorative care can be performed. On 8/21/24 at 12:35 PM, V20, CNA was asked regarding restorative services for residents. She stated the floor CNAs perform this. They know this by looking at the resident's care plan. This activity is then documented on the check list under the restorative program entry. 8/21/2024 at 12:30 PM, V18, (R9's Daughter) stated that her mother has been here since 1/17/22. She stated R9 has a good appetite. She is limited with her activity - more so than since she first arrived. She stated that at least before R9 could stand and use the walker. Now she can barely stand. She stated she has a stroke in 1/2024 which affected her right hand and right leg. She stated that yesterday she asked the staff if they could do therapy because her mom gets so tired of sitting. Staff had told her they would do that when they put her to bed. On 8/21/24 at 2:10 PM, V9 was observed sitting in chair in room. V14, CNA and V16, CNA performed right leg flexion and extension was performed with leg supported at knee and ankle and leg straight x 10. (1 set) Left leg flexion and extension was performed x10 reps (1 set). Knee and ankle supported but left leg was partially bent. Only one set was performed but not two. Leg Abduction was performed while sitting in wheelchair x10 (1 set). Dorsal flexion/plantar performed x10 on each foot Transferred to bed per mechanical lift using correct technique. At this time bilateral right and lower leg extension performed supporting knee and ankle x 10. (1 set). Legs were not bent toward chest and straightened. Hip abduction or adduction were not performed in bed. Ankle inversion and eversion was not performed. There was only one set of exercises performed, not 2 sets as documented in the care plan. The facility's Resident Mobility and Range of Motion policy documented that the policy statement is that d1) residents will not experience an avoidable reduction in range of motion (ROM), 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM, and 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. The policy interpretation and implementation continue that the care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. The care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts. The care plan will include the type, frequency, and duration of interventions as well as measurable goals and objectives. The resident and representative will be included in determining these goals and objectives. The documentations of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the resident's condition or need.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 40701 Based on observation, interview and record review, the facility failed to ensure resident was supervised to prevent falls and implement effective fall prevention measures for 1 of 3 residents (R60), reviewed for incident/accidents, in the sample of 33. This failure resulted in R60 sustaining a fractured femur (broken leg bone), discomfort and a decline in functional status. Findings include: The Facility's Incident Log documents R60 experienced falls on: 6/4/2024 in the main lobby; 6/6/2024 in her bathroom resulting in a hematoma; two falls on 6/8/2024, both in R60's bedroom, with one resulting in an injury requiring a hospital admission. R60's baseline care plan dated 5/14/2024 documents R60 is at Risk for falls and will not experience any injuries related to falls. R60's Care Plan dated 6/4/2024, Staff to offer help resident safely transfer to one of the chairs or couch in the dining room seating area after breakfast. R60's Care Plan dated 6/6/2024 documents, Offer resident to be laid down after meals. R60's Care Plan dated 6/8/2024 documents, Bed in lowest position while occupied as well as Fall mat to be placed next to resident bed while occupied. 15 minute checks will also be initiated upon return from hospital for 72 hours. R60's Care Plan dated 6/12/2024 documents, Verbally remind resident not to ambulate without assistance. R60's Minimum Data Set (MDS) dated [DATE] documents R60 is cognitively impaired and requires partial/moderate assistance to go from the sitting to standing position as well as ambulating. R60's significant change MDS dated [DATE] documents R60 now dependent for transfers. The Facility's Resident Matrix dated 8/19/2024 documents R60 had a fall, a fall with injury and a fall with major injury. The Facility's Resident Incident Report dated 6/4/2024 documents, Resident alarm sounding from main lobby- resident attempting to self-transfer from w/c (wheel chair) in lobby and noted on left knee trying to get up. Wheels locked to w/c with left leg under and trying to stand back up with right foot on the ground and right knee next to chair. Denied pain or injury. Assisted resident to chair and no injuries assessed. Transferred back to w/c w/ (with) alarm in place. Immediate actions taken: assessed and transferred back to w/c with alarm under resident and taken back to common area. The Facility's Resident Incident Report dated 6/6/2024 documents, Resident transferred self to bed and fell on to knees. Immediate action taken: assisted to w/c and assessed for injuries none noted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Facility's Resident Incident Report dated 6/8/2024 at 10:30 AM documents, CNA responded to alarm and noted resident on the floor in front of nightstand holding onto IV pole. CNA call[ed] for nurse. Resident assessed and assisted back onto the bed. Resident denies hitting head and denies pain at the time. There is no immediate action taken documented. The Facility's Resident Incident Report dated 6/8/2024 at 2:20 PM documents, CNA and nurse responded to loud noise. Resident noted on her back in the doorway of residents room. Resident assessed and not moved d/t (due to) resident screaming in pain to neck head and left hip. No visual injury noted. Resident sent to ER (emergency room) for possible unseen injuries. The Facility's Final Report to Illinois Department of Public Health dated 6/14/2024 documents the date of occurrence was 6/8/2024. The Initial Report documents R60 fell in the doorway of her room, began exhibiting signs of pain, was sent to the local emergency room , and was diagnosed with a fracture of the left femoral neck. It further documents, On 6/8/2024 (R60) attempted to ambulate on her own without assistance from staff. (R60) ambulated to the door of her room and when she got to the doorway she fell , landing on her left side. Nursing staff immediate assessed (R60), called her PCP (Primary Care Provider) and obtained orders to end resident to the ER (emergency room). Later in the evening the facility received a fax from the ER revealing a fracture of the left femoral neck. Resident was transferred to (metropolitan) hospital for further treatment of her injuries. Upon return the IDT (Inter-Disciplinary Team) assessed (R60) and determined that she is not ambulatory at this time due to mental status and physical limitations. IDT determines that based on the resident current state resident bed will be lowered to lowest position while occupied, a fall mat will be next to the bed while occupied, and resident will be placed on 15-minute checks for the first 72 hours following readmission. R60's X-ray report dated 6/8/2024 documents, Indication: fell , left hip pain. Impression: Fracture of the left femoral neck. R60's Progress Notes dated 6/8/2024 at 10:45 AM documents a Certified Nursing Assistant (CAN) responded to R60's personal alarm and noted resident was on the floor in front of nightstand holding onto the Intravenous pole. R60's wheelchair was placed at bedside in the locked position and reminded for her safety to use call light and wheelchair. R60's Progress Notes dated 6/8/2024 at 2:20 PM documents a CNA and nurse heard a loud noise and responded, and resident was noted laying on her back in the door to her room with the wheelchair at her feet. R60 was yelling out in pain related to the back of her head, neck and left hip. R60's PCP was notified of the second fall, possible injuries and gave an order to send to the hospital. R60's Progress Notes dated 6/12/2024 at 6:20 PM documents R60 returned to the Facility and was yelling/moaning out loud upon arrival and continued to moan throughout the shift. R60's Every 15 Minute Check Sheet dated 6/12/2024 checks were implemented and was in bed moaning for several consecutive hours. On 8/20/2024 at 11:36 AM V5, Certified Nursing Assistant (CNA), V10 Registered Nurse (RN) and V15, CNA stated R60 sustained a hip fracture while at the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 8/21/2024 at 8:58 AM, R60 was in bed. R60's bed was not in its lowest position. This observation was verified by a second surveyor. On 8/21/2024 at 11:45 AM, V5 stated R60 is a fall risk and attempts to get out of bed unassisted. V5 stated R60's bed should be in the lowest position. V5 stated R60 is smarter than you think. It's 'iffy' if she would remember directions given. V5 stated she would not consider reminders as an effective intervention and should be 1:1 supervision. V5 stated she has expressed her concerns to nursing staff and the Director of Nursing (DON). V5 stated R60 requires two staff members for assistance with ambulation/transfers. On 8/21/2024 at 11:56 AM, V15 stated R60's bed should be in the lowest position and requires 1-2 staff members for assistance. V15 stated if none of the fall prevention interventions are working, staff must sit with R60. On 8/22/2024 at 9:42 AM, V10, MDS/Care Plan Nurse stated, We usually look at what interventions they have, look at what they already have in place, investigate what happened, look at other interventions in place to come up with more. One of the falls (R60) was using an intervention we already had in place, the wheelchair. We meet every morning, the next morning after it happens, we have an IDT meeting. The immediate intervention on this one was to keep her in a supervised area. Our intervention after that one was to transfer into one of the chairs. She was trying to transfer herself, so we go ahead and transfer her to the chair. (R60) had two falls on 6/8 (2024) one in morning, and one later. The IDT meeting probably wouldn't have been until the next day. That's the one I was just saying, we locked the wheelchair and put it by her, the second fall she was pushing the wheelchair. They had immediately put that intervention into place, they didn't document it on here (the Incident Report). That fall was on the weekend, the IDT meeting wouldn't have been until Monday. They call and notify (V1, Administrator) and (V2, Director of Nursing) of fall, and they ask them what did you do. On 8/22/2024 at 9:43 AM V1 stated, (R60's) (6/4/2024) fell in the common area. That wasn't the immediate intervention. She was in the front lobby. We were all in morning meeting. She tried to self-transfer, and they brought her to the circle/old nurse's station. IDT meetings are held every meeting after morning meeting. (R60's) 6/6 (2024) fall- the root cause was self-transfer. Most of the time she is trying to get herself from wheelchair to softer chair, so we try to transfer her before she does because she is always trying to transfer self into those chairs. She has been offered into one of those chairs but didn't want too today. The first fall (On 6/8/2024)-her wheelchair was not around her bed. She tried to get out of bed, held onto IV pole. The immediate intervention was to put wheelchair with wheels locked next to bed, but that then unfortunately led to next fall. She (R60) held onto wheelchair with breaks locked and used it as a walker. I watch it on video, the CNA had just laid eyes on her. I saw it in video. During this time, she had UTI (urinary tract infection) and was very confused and agitated. (R60's) alarm (position changing alarm) was not sounding on this one (second fall on 6/8/2024). It's care planned she has a history of turning it off. We put her alarm at the head of bed frame, I think she turned it off. Those interventions were the safest thing we could come up with. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Facility's Fall and Fall Risk, Managing Policy dated March 2018, documents, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. It continues to document, If falling recurs, despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. It further documents, Position change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. It further documents, If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously been identified. The staff and or/physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on observation, interview, and record review, the facility failed to monitor resident for behaviors and review as needed (PRN) psychotropic medication for 4 of 4 residents (R7, R20, R24, R56) reviewed for unnecessary medications in a sample of 33. Findings include: 1. R20's Admission Record, with print date of 08/21/24, documented R20 has diagnoses of but not limited to depression and unspecified psychosis not due to a substance or known physiological condition. R20's Minimum Data Set (MDS), dated [DATE], documented R20 is she is moderately cognitively impaired with a Brief Interview of Mental Status (BIMS) of 11 out of 15 and requires some assistance with her activities of daily living (ADLs). R20's Care Plan, with print date of 08/20/24, documented description antidepressant medication and antipsychotic drug use: At risk for side effects and interventions of but not limited to monitor patterns of target behaviors. R20's Physician's Orders, dated 03/25/24, documented R20 was to get the following medications: Sertraline 100 milligrams (mg) 2 tabs by mouth at bedtime related to depression, unspecified, Bupropion 75mg 1 tab by mouth two times a day related to depression, and Quetiapine Fumarate 25mg 1 tab by mouth at bedtime related to depression. R20's Physician's Orders, dated 08/15/24, documented R20's previous Quetiapine Fumarate was discontinued and increased to Quetiapine Fumarate 25mg 2 tabs at bedtime and Quetiapine Fumarate 25mg give half a tab (12.5mg) daily at 5:00 PM. R20's Resident Care Plan Behavior Tracking Record for the month of May 2024 was reviewed and documented, Problem: Resident showing signs of depression, down/tearful and does not have any documentation for the day shift on the following dates: 05/01/24 through 05/18/24, 05/22, 05/23, 05/26 through 05/29/24, and 05/31/24. No documentation on the evening shifts for the dates of 05/01/24 through 05/19/24, 05/22/24 through 05/31/24. Problem: Resident will wander around facility near exits and become lost was reviewed and has no documentation for the day shift for the dates of 05/01/24 through 05/19/24, 05/22, 05/23, 05/26/24 through 05/29/24, and 05/31/24. The evening shift has no documentation from 05/01/24 through 05/19/24 and no documentation from 05/22/24 through 05/31/24. R20's Resident Care Plan Behavior Tracking Record for the month of June 2024 was reviewed and documented Problem: Resident showing signs of depression, down/tearful. Resident will wander around facility near exits and become lost has no documentation for day shift on the following dates: 06/02/24 through 06/06/24, 06/08/24 through 06/14/24, 06/18/24 through 06/22/24, and 06/26/24 through 06/28/24. There was no documentation noted for the evening shift for the following dates: 06/01/24 through 06/18/24 and 06/20/24 through 06/30/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R20's Behavior Tracking Record for the month of July 2024 was reviewed and documented Problem: Resident showing signs of depression, down/tearful and Resident will wander around facility near exits and become lost has no documentation for day shift on the following dates: 07/24/24 through 07/26/24 and 07/30/24. On the evening shift for the problem of resident showing signs of depression, down/tearful has no documentation noted for 07/01/24 through 07/05/24, 07/07/24 through 07/12/24, 07/15, 07/16, 07/19/24 through 07/23/24, 07/25, 07/26, and 07/28/24 through 07/31/24. On the evening shift for the problem of resident will wander around facility near exits and become lost has no documentation for the dates of 07/01/24 through 07/05/24, 07/07/24 through 07/12/24, 07/15, 07/16, 07/19/24 through 07/23/24, 07/26, and 07/28/24 through 07/30/24. 2. R56's Admission Record, with print date of 08/21/24, documented R56 has diagnoses of but not limited to delusional disorder, paranoid personality disorder, major depressive disorder, and dementia. R56's MDS, dated [DATE], documented he is cognitively intact with a BIMS of 13 out of 15 and requires setup/clean up assistance with oral hygiene, shower/bathe, lower body dressing, personal hygiene, supervision or touching assistance with toileting hygiene, independent with upper body dressing, put on/take off footwear, occasionally incontinent of bowel and bladder. R56's Care Plan, with print date of 08/21/24, documented Antidepressant medication use: At risk for side effects and Antipsychotic drug use: At risk for side effects with interventions of but not limited to monitor patterns of target behaviors. R56's Physician's Orders, dated 07/22/24, documented R56 was to get the following medication: Seroquel Oral Tablet 25mg (Quetiapine Fumarate), Give 25mg by mouth at bedtime related to major depressive disorder. R56's Physician's Orders, dated 07/25/23, documented R56 was to receive the following medication: Sertraline HCl Tab 100mg. Give 1.5 tablet by mouth one time a day related to major depressive disorder. R56's Resident Care Plan Behavior Tracking Records for the month of May 2024 were reviewed and documented Inappropriate behavior, comments, and delusions and down, depressed, and tearful. No documentation for day or evening shifts for the following dates 05/01/24 through 05/31/24. R56's Resident Care Plan Behavior Tracking Records for the month of June 2024 were reviewed and documented Inappropriate behavior, comments, and delusions and down, depressed, and tearful. No documentation for day shift on the following dates 06/02/24 through 06/06/24, 06/08/24 through 06/14/24, 06/18/24 through 06/22/24, and 06/26/24 through 06/28/24. On the evening shift there was no documentation for the following dates 06/01/24 through 06/18/24 and 06/20/24 through 06/30/24. R56's Resident Care Plan Behavior Tracing Records for the month of July 2024 were reviewed and documented Inappropriate behavior, comments, and delusions and down, depressed, and tearful. No documentation for day shift on the following dates 07/23/24 through 07/26/24 and 07/30/24. On the evening shift there was no documentation for the following dates 07/01/24 through 07/05/24, 07/07/24 through 07/12/24, 07/15, 07/16, 07/19/24 through 07/23/24, 07/25, 07/26, and 07/28/24 through 07/31/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145909	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenville Nursing & Rehab	400 East Hillview Avenue Greenville, IL 62246

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/24 at 9:42 AM V10, MDS Coordinator stated all the tracking sheets should be filled out on every shift. V10 said they are used to see if medications are working and to see if they need to adjust the medication, so they don't have behaviors. On 08/22/24 at 10:00 AM, V1, Administrator stated she noticed behavior tracking was not being done. V1 said Certified Nursing Assistants (CNAs) and nurses are supposed to fill out behavior tracking. With Point Click Care (PCC) they will be documenting behaviors in PCC. V1 said they are supposed to be charting every day and days and evenings, but they are busy and sometimes the tracking slips their minds. V1 was asked how they are justifying increasing R20's Seroquel medication when there is no documentation on the behavioral tracking record to support the medication being increased. V1 stated she wasn't a nurse, and she would have to check on that. She said she would be curious what her progress notes say because the nurses document on her in the progress notes about every shift and nights are worse for her and they will document on her. 40701 3. R7's Face sheet dated 8/21/2024 documents R7 has diagnoses of Depression and Anxiety. R7's Order Summary Report dated 8/21/2024 documents R7 takes Lorazepam 0.5 milligrams (mg) for Anxiety. R7's Order Summary Report dated 8/21/2024 documents R7 takes Mirtazapine 7.5 mg and Sertraline 100 mg for Depression. R7's Care Plan dated 8/21/2024 document R7 takes antidepressant medication and to monitor for uncontrolled sx (symptoms) for depression and report to PCP (Primary Care Physician) prn (as needed). R7's Care Plan dated 8/21/2024 document R7 has a mood problem. R7's Care Plan dated 5/29/2024 documents R7 takes anti-anxiety medications and was updated 821/2024 to include Monitor for uncontrolled sx and report to PCP prn. R7's Care Plan dated 8/15/2024 documents R7 has anxiety, will have improved mood state, and show decreased episodes of anxiety through the next review date. Monitor/record mood to determine if problems seem to be related to external causes. Resident Care Plan Behavior Tracking Record for June 2024 and July 2024 documents, Problem: Resident showing signs of depression, down/tearful. Goal: Resident will have less than one episode during next review. Psychotropic Medications: Sertraline and Mirtazapine. Diagnosis: Depression. R7 has not experienced any of these symptoms. There are multiple days/shifts there are no entries documented to reflect if R7 experienced symptoms. These dates include: 6/11/2024, 6/12/2024, 6/13/2024, 6/18/2024, 6/21/2024, 6/22/2024, 6/23/2024, 6/24/2024, 6/25/2024, 6/31/2024, 7/2/2024, 7/3/2024, 7/9/2024, 7/23/2024 where there was no documentation for either day or night shift. On 7/6/2024, 7/8/2024, 7/15/2024, 7/16/2024, 7/20/2024, 7/21/2024, 7/22/2024, and 7/23/2024 there was documentation completed for signs or symptoms on dayshift. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Care Plan Behavior Tracking Record for July 2024 documents, Problem: Resident showing signs of anxiety and inappropriate laughter/tearfulness. Goal: Resident will have less than one episode during next review. Psychotropic Medication: Lorazepam. Diagnosis: Anxiety. R7 has not experienced any of these symptoms. There are multiple days/shifts there are no entries documented to reflect if R7 experienced symptoms. These dates include: 6/11/2024, 6/12/2024, 6/13/2024, 6/18/2024, 6/21/2024, 6/22/2024, 6/23/2024, 6/24/2024, 6/25/2024, 6/31/2024, 7/2/2024, 7/3/2024, 7/9/2024, 7/23/2024 where there was no documentation for either day or night shift. On 7/6/2024, 7/8/2024, 7/15/2024, 7/16/2024, 7/20/2024, 7/21/2024, 7/22/2024, and 7/23/2024 there was documentation completed for signs or symptoms on dayshift. On 8/22/2024 at 12:09 PM, V19, Certified Nursing Assistant, stated R7 did have some depression and anxiety back when she had her toe removed and stated it was around June or July of 2024. V19 stated behavior tracking should be done every day on dayshift and night shift. R7's Face sheet dated 8/21/2024 documents R7 had a complete traumatic amputation of her Right Great Toe on 5/29/2024. On 8/22/2024 at 9:46 AM, V1, Administrator stated, I noticed behavior tracking is not being done. CNAs and nurses are supposed to fill out behavior tracking. Every day they are supposed to be charting. They are busy and sometimes the tracking slips their minds. 4. R24's Face Sheet dated 8/21/2024 does not include a diagnosis for anxiety. R24's Order Summary Report dated 8/21/2024 documents Order date 7/16/2024- Ativan 0.5 mg by mouth every 4 hours as needed for Anxiety for osteoarthritis. On 8/22/2024 at 12:34 PM, V2, Director of Nursing stated R24 receives the Ativan for restlessness. R24's Mediation Administration Record (MAR) dated August 2024 documents R24 received doses of Ativan on 8/2/2024, 8/7/2024, 8/10/2024, 8/11/2024, 8/13/2024, 8/16/2024, ad 8/21/2024. The facility's policy, Antipsychotic Medication Use, revised date of 12/2016, documented Policy Statement Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. It further documented Policy Interpretation and Implementation c. Based on assessing the resident's symptoms and overall situation, the Physician will determine whether to continue, adjust, or stop existing antipsychotic medication. It also documented 14. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. 15. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication. 16. The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44556 Based on observation, interview, and record review, the facility failed to label food items in the refrigerator with open dates and use by dates and dispose of outdated food items in the refrigerator. Findings include: On 08/19/24 at 09:15 AM, The initial tour of the kitchen was completed and the walk-in refrigerator with the following items was observed: 1. Open container of milk with no open date on it. 2. A gallon container of dill pickle slices with an open date of 07/10 and a use by date of 08/16/24 was on the lid. 3. A container of chicken noodle soup with a use by date of 08/18/24 on the lid. 4. A gallon container of red French dressing with no open date or use by date observed on it. 5. A gallon container of Caesar dressing with no open date and use by date observed to be on it. 6. A container of vanilla yogurt with no open date or used by date observed on it. On 08/19/24 09:25 AM V3, Dietary Manager stated she would expect staff to label the containers with a received date, open date, and a use by date. She said she would also expect the staff to check the refrigerator daily and remove any outdated items. She said they have a chart located in the kitchen that lists how many days a food is good and how many days a certain food requires to be thawed out. On 08/22/24 at 10:00 AM, V1, Administrator stated she would expect everything in the refrigerator to be labeled with the open date and use by date, and she would expect them to be disposing of the food if the used date has come and gone. The facility's Food Storage (Dry, Refrigerated, and Frozen) policy, not dated, documented Guideline: Food shall be stored on shelves in a clean, dry area, free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. It further documents Procedure: General storage guidelines to be followed: a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. It also documents c. Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration.