STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145910	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calhoun Nursing & Rehab Center	#1 Myrtle Lane Hardin, IL 62047

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42108 Based on interview and record review the facility failed to investigate and provide treatment for bruises and abrasions to one of three residents (R2) reviewed for resident injury on the sample list of 11. Findings include: R2's Care Plan, not dated, documents, Positioning/Bowel and Bladder/Skin Integrity: Please encourage me to turn and reposition myself when in bed and reposition myself when up in my chair. Assist me if needed. I have a pressure re-distribution mattress on my bed and pressure re-distribution cushion in my wheelchair. Please look at my skin during showers and with any care and report any redness, bruising or open areas to my nurse/MD (Medical Doctor) right away. Please observe my skin weekly and notify MD with any decline or change in condition. R2's Minimum Data Set, undated, documents, that R2 was severely cognitively impaired, required assist from staff for activities of daily living, (ADL), does not document any skin concerns. R2's undated Face Sheet, documents diagnoses including Type 2 diabetes mellitus without complications, Sick sinus syndrome, old myocardial infarction, Atherosclerosis heart disease of native coronary artery without angina pectoris, dementia, R2's Weekly Skin Assessment, dated 11/24/2023, at 3:40PM, documents, No skin issues present. R2's Notes, dated 11/25/23, at 11: 23AM, documents, Nursing: Resident left the facility via family vehicle. will be gone until Monday. Resident's meds (medications) were sent with family. R2's Notes, dated 11/26/23 at 5:34PM, documents, Nursing: Resident returned to facility with family per family vehicle. R2's Notes, dated 11/27/23 at 1:32AM, documents, Nursing: Resident was out with family the last few days and arrived back to the facility this evening. Staff noticed bruising to resident's left foot this pm, on top of foot and toes. Resident was unsure what happened. Will continue to observe. R2's Weekly Skin Assessment, completed date 11/29/2024 at 4:11AM, documents, large dark reddish-purple Purpura to right wrist and Reddish colored bruising to left wrist. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Weekly Skin Assessment, completed date 12/06/2023 at 12:55AM, documents, bruise to right wrist-change condition, bruise left wrist resolved, sacrum abrasion still present, left lateral calf purpura still present, left lateral foot bruise still present, right thigh bruise still present, left thigh bruise still present. R2's Weekly Skin Assessment, completed date 12/15/2023 at 1:11AM, documents, bruise to right wrist still present, sacrum abrasion still present- abrasions to the right and left sacrum, left lateral calf purpura still present, left lateral foot bruise still present, right thigh bruise still present, left thigh bruise still present. Scab to the bridge of nose is resolved. R2's Weekly Skin Assessment, completed date 12/20/2023 at 11:33AM, documents, bruise to right wrist still present, sacrum abrasion still present- abrasions to the right and left sacrum, left lateral calf purpura still present, left lateral foot bruise still present, right thigh bruise still present, left thigh bruise still present. On 4/26/24 at 3:15PM V14, R2's family, stated, that he would like to know what happened when R2 fell and broke her pelvis. He stated he has tried to get information from the facility and they tell him he has to wait for a report. V14 stated, that he has some family members who work at the facility and the facility won't give them any information either. V14 stated, that (R2) had a fall back in June and the facility never explained what happened and (R2) had bruises on her face like she fell face first out of the wheelchair. V14 stated, that he did not get informed of any bruises his mother had in November on her legs and thighs. On 5/14/2024 at 11:08AM V2, Director of Nurses, stated, that she believes that the multiple bruises came from an outing with family. V2 stated, that R2 had a wound to her coccyx in the past, but that has healed. When asked about the abrasions to R2's right and left sacrum, V2 responded a shear. V2 stated, that usually they do nothing with it and that the CNA's, (certified nurse's assistant), apply barrier cream. V2 stated, that they don't usually document anything. V2 stated, that this information should be documented in the wound notes and she would get the documentation for me. V2 stated, that outside of the bruising to R2's right foot there is no other documentation of bruising and abrasions. On 4/26/2024 asked for an investigation of the bruises. As of 5/15/2024 the facility was unable to provide any investigation or explanation of these bruises and there were no fall reports around that time for R2. On 5/14/2024 at 1:10PM V8, Registered Nurse, (RN), stated, that when finding or being notified of bruising you go down and assess. V8 stated, that then you try to find out how it happens. V8 stated if you know what happened then good but if not then they fill out an incident report. V8 stated this is the responsibility of the nurse. On 5/14/2024 at 1:13PM V15, Licensed Practical Nurse, (LPN), stated, that she has worked at the facility for years. V15 stated, that she provided care for R2. V15 stated, that R2 was ambulatory. V15 stated, that R2 had poor safety awareness and was forgetful. V15 stated, that R2 had a wound in the past, but was not aware of any prior to discharge. V15 stated, that if there is a skin issue or injury an incident report is completed and they try to find out what happened/cause of the bruise and get treatment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/2024 at 1:15PM V16, RN, stated, that she cared for R2, but it has been a while. V16 stated, that she does not remember any particulars as it relates to her. V16 stated the normal practice is when you are notified of a bruise you assess then you try to find out what happened. V16 stated, that you complete an incident report and if you can't find out what happened then V1 and V2 are notified. The report is given to them for further investigation. On 5/15/2024 at 5:33AM V17, LPN, stated, that she cared for R2. V17 stated, that she received in report that R2 had returned from outing with family and some bruising was found. V17 stated, that she did her own skin check and documented her finding. V17 stated, that she was not aware how R2 got the areas. V17 stated, that she did not complete an incident report because that would have been done by the nurse that found the areas. V17 stated she is aware of an area to R2's buttocks and it was an abrasion. V17 stated, that the area would open up and then it would close and open again. V17 stated, that they had tried barrier but that didn't work and she spoke with the previous Wound Nurse and applied a treatment similar to skin prep. V17 stated it worked but the area would reopen. On 5/15/2024 at 3:02PM V1, Administrator, stated, that he would expect his staff to follow the policy as it relates to incidents and injury. The facility's Accident & Incident Documentation & Investigation Resident Incident, dated 7/18, documents, POLICY: Accidents and/or incidents involving resident care will be investigated and documented on the Resident Incident Report entry form in the LTC system. An incident is defined as an occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident. Accidents and incidents will be analyzed for trends or patterns to enable the facility to enhance preventive measures to reduce the occurrence of incidents. It continues PROCEDURE: 1. General Information: a. The Licensed Nurse assigned at the time of the resident care accident/incident is responsible for conducting an investigation of the circumstances surrounding the accident/incident, and for notifying the Supervisor, Director of Nursing, and/or the Executive Director as appropriate. b. The Licensed Nurse at the time of the incident is responsible for initiating / completing the Resident Incident Report, ensuring that all items identified on the form have been completed as applicable to the accident/incident. c. The Licensed Nurse at the time of the incident is responsible for documenting the incident in the resident's medical record, in accordance with the guidelines below and set forth on the Resident Incident Report. d. If incident/accident is related to a visitor, refer to Accident & Incident Documentation & Investigation-Visitor Incident Policy. 2. Notification and Documentation in the Resident's Medical Record: a. The Licensed Nurse shall place the resident on the 24-Hour Report, document the incident, and notify the supervisor and Director of Nursing for follow through as needed. b. The Licensed Nurse may complete a Nurses' Notes, and update the Resident Care Plan as needed c. The Nurse's Notes could contain the following documentation on Date and time of incident: Clear, objective facts of what occurred; The last time the resident was seen by staff prior to the incident; An evaluation of the resident's condition at the time of the accident/incident could include a description of the resident, vital signs, and any other physical characteristics apparent as a result of the accident/incident; Any treatment provided; Any contacts made or attempted with the resident's physician, family, legal representative, or any other health care professional or person involved with the resident's care; The resident's outcome and any information concerning the incident; and on The Nurse's signature, date, and time of the charting. The Executive Director / Director of Nursing will notify the State Department of Health in accordance with reporting guideline's in the event the accident/incident is reportable. The Attorney General may need notification also. (Mississippi only).