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	07/19/2024

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on interview and record review, the facility failed to ensure residents were free from abuse for 4 of 4 residents (R10, R22, R37, R112) reviewed for abuse in the sample of 45. Findings include: 1. R22's Face Sheet documents R22 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes, morbid, obesity and pain. R22's Minimum Data Set (MDS) dated [DATE] documented R22 was severely cognitively impaired and ambulated via wheelchair. R22's Care Plan dated 6/5/24 does not address abuse. R112's Face Sheet documents R112 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia, auditory hallucinations, and homicidal ideations. R112 was discharged from the Facility on 12/7/23. R112's MDS dated [DATE] documents R112 was severely cognitively impaired and ambulated with wheelchair and walker. R112's Care Plan dated 9/27/23 does not address abuse. The Facility's Initial Incident Description sent to the Illinois Department of Public Health (IDPH) on 12/6/23 documents, On Wednesday December 6th, 2023 at 1:30pm, it was reported that (R112) made contact with (R22)'s arm. Residents were immediately separated and (V1) immediately notified. R22's 12/6/23 Resident Incident Report reported by V6, Certified Nursing Assistant (CNA), and prepared by V12, Registered Nurse (RN), documents, This resident sitting in wheelchair in hallway as staff moving belonging from room [ROOM NUMBER] to new room [ROOM NUMBER]. Another resident going down the hallway passed this resident and hit this resident in the right arm/bicep with closed fist. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R112's 12/6/23 Resident Incident Report reported by V6, CNA, and prepared by V10, Licensed Practical Nurse (LPN), documents, Staff reported that resident was with a staff member on North hall when she came upon a resident in a wheelchair and she reached out and hit her, they were immediately separated and checked for injuries. On 7/18/24 at 9:20 AM, R2 stated she did not recall the 12/6/23 incident and could not remember if another resident has ever hit her in the facility. On 7/18/24 at 10:16 AM, V6, CNA, stated R112 went by R22 in the hallway and punched her. She stated she separated the residents and reported the incident to her nurse. On 7/18/24 at 9:35 AM, V1, Administrator, stated R112 had a behavior and hit R22. The Facility's Final Incident Description sent to IDPH on 12/13/24 documents, On 12/6/2023 at approximately 1:30 PM, (R112) was walking with a staff member down north hall of the facility when they approached (R22) in the hallway and it was reported that (R112) with a closed fist made contact with (R22)'s right arm/bicep. Upon final investigation it found that (R112) did make contact with (R22)'s right arm. 2. R10's Face Sheet documents R10 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes, atrial fibrillation, and chronic kidney disease. R10's 7/18/24 MDS documents R10 was cognitively intact and ambulated via wheelchair and walker. R10's Care Plan dated 7/12/24 does not address abuse. R37's Face Sheet documents R37 was admitted to the facility on [DATE] with diagnoses including unspecified dementia and cerebral infarction. R37's MDS dated [DATE] documented R37 was severely cognitively impaired and ambulated with walker. R37's Undated Care Plan with goal date of 9/6/24 documents R37 was verbally abusive at times, had threatened staff, yelled out, and had hallucinations and delusions. The Facility's Initial Incident Description sent to the State Survey Agency on 1/23/24 documents, On Tuesday January 23, 2024 at 10:45AM, it was reported that (R37) made contact with the back of (R10). Residents were immediately separated and (V1) immediately notified. R10's Resident Incident Report reported by V13, CNA, and prepared by V9, LPN, on 1/23/24 documents, This resident explained that another resident was in his bed. This resident attempting to tell other resident he is in the wrong room, other resident became agitated and began yelling and hit this resident with call light 4 or 5 times across upper back. Writer came to room in response to the call light and did separate residents. On 7/18/24 at 1:20 PM, R10 stated R37 came into his room and thought it was his own. He stated R37 was insistent he was in the right room and did not want to leave, then hit R10 a couple of times with the call light. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/18/24 at 9:27 AM, R37 was unable to respond appropriately to questions or provide any information regarding 1/23/24 incident. On 7/18/24 at 9:35 AM, V1, Administrator, stated R37 was in the wrong bed and hit R10 with the call light. On 7/18/24 at 9:54 AM, V13, CNA, stated R37 went into R10's room, believing it was his own, then yelled at R10 about being in his room and hit him with the call light. V13 stated she entered the room after she heard yelling and separated the residents and helped de-escalate R37. The Facility's Hand-Written Statement by V14, LPN, on 1/23/24 documents, Resident (R10) stated to this nurse that he was sitting in his w/c (wheelchair) with his blankets on. Resident (R37) came into his room and told him he was in the wrong room. (R10) replied that he was mistaken and this is his room. Directed him back to his room next door. (R37) then grabbed the call light cord and raised his arm with it to hit him. (R10) pulled his blankets over his head and leaned forward in his chair. (R37) hit him 4-5 times mid back with the chord {sic}. Staff immediately came in and moved him in his wheelchair out of the way. On skin assessment, resident has two small areas of redness to mid back. Not raised. On 7/18/24 at 10:42 AM, V14, LPN, stated she was called down to R10's room where R37 was in R10's bed. She stated she did not see R10 hit R37, but R10 told her R37 hit him and R37 had the call light balled up in his fist. On 7/18/24 at 2:02 PM, V9, RN, stated V13, CNA, called her down to R10's room where R37 thought R10 was an intruder and was hit him with the call light multiple times. She stated R10 was not seriously injured, but had a red mark on his back. The Facility's Final Incident Description submitted to the State Survey Agency on 1/30/24 documents, On 1/23/2024 at 10:45AM, (R37) had put himself in the bed of (R10). (R10) approached (R37) and told him that he is in the wrong room and bed and (R37) became agitated and started yelling and had contacted (R10) via call light cord lightly striking his back. Upon final investigation, (R37) did contact (R10) via call light. (R37) really believed he was in his own bed and simply reacted. On 7/19/24 at 11:25 AM, V1, Administrator, stated he expects the facility to keep residents free from abuse. The Facility's Abuse Prevention Policy revised 10/2022 documents, The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteer and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Abuse: Will infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse may be resident-to-resident, staff-to-resident, family-to-resident, or visitor-to-resident. Physical Abuse: This includes but is not limited to hitting, slapping, pinching, and kicking.

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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** 34964 Based on observation, interview and record review, the facility failed to implement care plan interventions to prevent falls for 1 of 5 residents (R44) reviewed for falls in the sample of 46. R44 sustained multiple falls while at the facility, including a fall that resulted in a fracture of the left hip. Findings include: R44's Face Sheet, printed 7/19/24, documents she has a diagnosis of Other fracture of lower end of left femur, subsequent encounter for closed fracture with routine healing, Encounter for other orthopedic aftercare, and Fracture of unspecified part of neck of left femur, initial encounter for closed fracture. R44's Minimum Data Set (MDS) dated [DATE] documents R44 is severely cognitively impaired and requires supervision and touch assistance for transfers into chair or bed to chair transfers. R44's undated Care Plan with the goal date of 10/24 documents, Safety Notes: I have a history of falling and am a continued fall risk. I have poor safety awareness. Make sure I have nonskid socks or shoes on before transfers or walking. Keep items that I frequently use within my reach, but keep area free of clutter and safety hazards. Transfer me per (brand name) Transfer Screen. Redirect me and reassure me when I get anxious and wander. I have a high/low bed and bilateral 1/2 rails on my bed, and I have non-skid strips on the left side of my bed because that is the side I get out on. Be sure my bed is in proper position in relation to my non-skid strips. I have a (alarm) to my wheel chair. I have been discontinued from being an elopement risk. If I start to wander, please redirect me or get social services. The goal for this care plan documents, I want to be safe and free of falls. On 7/18/24 at 2:57 PM, R44 was lying in her bed with her wheel chair positioned beside her bed with the brakes unlocked. There were no non-skid strips on the floor on either side of her bed. V16, Certified Nursing Assistant (CNA) came in and pulled R44's blankets back off her feet and R44 had her shoes on in bed. V16 stated (R44) requires assist to transfer safely but will transfer herself at times. V16 stated she had just come down a little while ago to help (R44) lay down in bed and (R44) had already transferred herself into bed without assist. V16 verified there were no non-skid strips on (R44's) floor next to her bed or in her bathroom. R44 woke up and was pleasantly confused. She stated, There is usually someone running around here to help me or I just get up by myself. I do alright. R44's Fall Report dated 10/17/23 documents, Resident was sitting at NS (nurses station) visiting with son. Son left facility and did not tell staff he was leaving and resident stood up, tripped over catheter tubing, and fell , hitting the back of her head. Swelling to back of head. Complaint of head hurting. Sent to (local hospital) for eval. Immediate post-incident action: Bladder training in progress to discontinue foley. Meds reviewed by NP (Nurse Practitioner) 10/17/23. R44's Fall Report dated 10/21/23 documents, Got up from bed unassisted, lost balance and fell . No injury noted. Immediate post-incident action: Ensure gripper socks are on when in bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R44's Fall Report dated 10/29/23 documents, Unit aide walking by resident's room and saw resident sit herself on the floor between her bed and her wheel chair. Stated she was trying to walk to bathroom and that her legs gave out so she sat down. She did not hit her head. Immediate Post-Incident Action: Non-skid strips place on floor beside bed. R44's Fall Report dated 12/18/23 documents, Resident found sitting on floor next to bed. Wheelchair was facing bed with wheels locked, lights off, floor free of clutter and she had gripper socks in place. Resident stated she was trying to get back in bed when her feet just slid on the floor. Stated she fell like a child would and can't believe that she would do that. Resident denies hitting head, states she fell straight to her bottom in a slow manor. She stated the only thing that hurt is her pride. ROM (Range of Motion) and Neuros WNL (within normal limits) for resident. Immediate post-incident action: make sure bed is in proper position with non-skid strips in correct place in correlation to bed at transfer site. R44's Progress Note dated 12/18/23 at 11:20 PM, which was included in the fall investigation, documents, During examination of the room, noted bed was pushed over so non-skid strips on floor were under wheelchair instead near the area her bed was. Bed was moved back into position so non-skid strips in the proper place. R44's Fall Report dated 1/6/24 documents, Staff heard commotion on hall and upon passing room saw resident propped up on elbow on floor. Nurse alerted. Upon entering room resident was sitting on right hip leaning over on right elbow on floor. Resident states she was trying to transfer from wheel chair to stationary chair to read the newspaper on the side table and missed the chair. Shoes on , room lit. Floor did have spilled water from resident falling over as well as table and paper. AROM (active range of motion) WNL. Skin intact. Denies hitting head. Resident has been more confused today. Immediate post-incident action taken: Additional chairs removed from room and request for UA (urinalysis) sent to MD (Medical Doctor). R44's Fall Report dated 4/8/24 documents, Charge nurse heard resident yelling and upon entering resident's room, observed resident lying on the floor on her back at the foot of her bed, between her bed and the BR (bathroom) door. She came and got writer off East hall to eval resident. Resident stated that she got up to use the bathroom and fell . She is screaming and crying in pain, holding left hip and left groin. LLE (left lower extremity) rotated outward and resident will not let writer perform PROM (passive range of motion) to LLE. Sent to (local hospital) for eval. Immediate post-incident action: will re-evaluate when returns to facility. R44's Progress Note dated 4/9/24 at 4:52 AM documents, Call placed to (local hospital) to check on resident. Nurse (hospital staff) stated that resident was being admitted with left hip fracture and that MD had already been consulted and that resident is to have surgery in am. R44's hospital Radiology Report dated 4/8/24 at 9:41 PM documents, Impression: Mildly displaced transverse fracture through the base of the greater trochanter. Mildly displaced lesser tuberosity avulsion fracture. R44's Morse Fall Scale dated 4/8/24 documents her fall risk score of 90. Per the assessment, a score of 46 or more indicates the resident is at a high risk of falls and high-risk fall prevention interventions should be implemented. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R44's (name brand) Screen (for mobility devices) dated 5/24/24 documents R44 requires one person assist for transfers. On 7/19/24 at 10:08 AM V2, Director of Nursing (DON) stated after R44 returned from the hospital, they moved her to a different room because her previous roommate had too much clutter in her room and that was what caused R44 to fall and fracture her hip. She stated the roommate's wheelchair was blocking R44's ability to get into her own w/c and she got off the wrong side of the bed and tried to walk around and fell . She stated the non-skid strips did not have anything to do her fall. V2 stated when R44's room was moved she thinks it was just overlooked that she was supposed to have non-skid strips on the floor to help prevent her from falling. She stated the error has been corrected now. The facility's policy, Accident & Incident Documentation & Investigation Resident Incident revised 7/18, documents, Accidents and/or incidents involving resident care will be investigated and documented on the Resident Incident Report entry form in the (computer) 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 and patterns to enable the facility to enhance preventative measures to reduce the occurrence of incidents.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 45947 Based on interview and record review, the facility failed to implement a Quality Assurance Performance Improvement (QAPI) Program which meets at least quarterly with the required members, including the Medical Director. This failure has the potential to affect all 57 residents who reside in the facility. Findings include: On 7/17/24 at 2:41 PM, V1, Administrator, stated the last QAPI Meeting was in March 2024, and the next meeting has not yet been scheduled. He stated V15, Medical Director, does not regularly attend the meetings, so he sends him a recapulation email after each meeting. On 7/19/24 at 11:25 AM, V1, Administrator, stated a QAPI meeting is set for 7/26/24 with V15, Medical Director, and they will continue on a monthly basis moving forward. He stated he expects all facility policies to be followed. The Facility's Quality Improvement Program revised 10/2022 documents, The Quality Improvement Committee will assess and monitor the quality of services provided to the residents in the facility in order to identify potential problems and/or opportunities for improvement. The committee will implement and systemically evaluate programs and processes to identified problems in order to proactively improve health care delivery. The committee will meet monthly at an established time. Committee team members shall consist of DNS (Director of Nursing Services), Medical Director or designee, and three other staff; at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and the Infection Preventionist.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 42834 Based on interview and record review the facility failed to ensure they had a qualified Infection Preventionist responsible for the facility's Infection Control Program at the facility. This has the potential to affect all 57 residents living in the Facility. Findings include: On 7/16/2024 at 9:00AM, V1, Administrator stated, (V3), Registered Nurse (RN)) was the Infection Control Specialist. On 7/19/2024 at 11:00AM, V3, Registered Nurse, RN, stated I took all the modules, but I did not pass the test. I am not taking it again. Facility job description dated 11/1/2019 states Under the direction of the Director of Nursing Services, the Infection Preventionist serves as a support person within the facility, providing guidance and education; assistance in problem solving related to resident care; monitoring compliance with state and federal regulations and coordinates the Infection Prevention and Control Program as set forth in the Resident Care Policy and Procedure Manual. Essential Duties: Maintains certification in Infection Prevention and Control.