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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>145985 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>05/28/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>University Nsg & Rehab Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1095 University Drive<br>Edwardsville, IL 62025 |  |

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)  |
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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>49494</p> <p>Based on record review and interview the facility failed to provide sufficient staffing on 5/20/24 for 4 of 6 (R1, R2, R3, R4) residents sampled for medications and blood glucose testing.</p> <p>Findings include:</p> <p>The facility daily assignment schedule dated 5/20/24 documented a licensed nurse assigned to A hall and a licensed nurse assigned to C hall. The facility daily assignment schedule dated 5/20/24 did not document a licensed nurse assigned to the B hall.</p> <p>On 5/23/24 at 6:10 AM, V5, CNA (Certified Nurse Assistant) stated the B hall did not have a nurse for the entire day shift on 5/20/24.</p> <p>On 5/23/24 at 6:15 AM, V6, CNA stated she worked on 5/20/24 and that there was no nurse on the B hall that day.</p> <p>On 5/23/24 at 6:30 AM, V7, CNA stated she was assigned to the B hall on 5/20/24 and there was no nurse assigned to the B hall. V7 stated she went to the other two floor nurses on duty to request medications for some of the B hall residents and that the two floor nurses informed her that they were not able to pass the B hall medications and informed her to go to the facility Social Worker for direction. V7 stated the Social Worker went to the Administrator about the B hall not having a nurse but the B hall residents still did not receive any medications all day on 5/20/24. V7 stated that no nurses ever checked on the residents on B hall on 5/20/24 and that the residents were upset, and some were complaining of pain.</p> <p>On 5/23/24 at 6:40 AM, R1 stated that at the beginning of the week the B hall did not have a nurse and that he and the other residents did not receive any medications. R1 stated he went and told V1, Administrator, that he had not received any medications all day. R1 stated that V1 replied to him that the other nurses will pass the meds, or they will get fired. R1 stated he never did receive his morning or noon medications.</p> <p>On 5/23/24 at 6:47 AM, V3, LPN (Licensed Practical Nurse) stated she worked on C hall on 5/20/24 and that the B hall did not have a nurse assigned to it. V3 stated she passed a few medications on the B hall on 5/20/24 but she does not know if anyone checked any of the diabetic residents' blood sugars on the B hall.</p> <p>(continued on next page)</p> |

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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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On 5/23/24 at 7:05 AM, V15, daughter of R4 stated that the facility is very short staffed and that her mom did not receive any medications on 5/20/24 because B hall did not have a nurse.</p> <p>On 5/23/24 at 7:40 AM, R2 stated on Monday, 5/20/24 he did not receive any medications. R2 stated he was very concerned because he is on a lot of medications including medications for high blood pressure and for chronic liver disease. R2 stated he asked one of the nurses on another hall for assistance and she replied that she is not allowed to help him, so he went to the front nurse to ask the Administrator for assistance around 2 PM. R2 stated he informed V1 that he needed someone to give him his morning and noon medications and that she replied okay but no one ever came to administer his morning and noon medications.</p> <p>On 5/23/24 at 8:15 AM, V11, daughter of R3, stated that she received a call on 5/20/24 from her mom around noon time and that her mom stated she had been at the facility all morning and her dad had not received any medications nor had anyone checked his blood sugar. V11 stated her dad (R3) was in pain because he had not received any pain medicine all day.</p> <p>On 5/23/24 at 8:25 AM, V12, wife of R3, stated she was at the facility visiting her husband all day on 5/20/24 and that her husband did not receive any medications on this day. V12 stated her husband has chronic back pain and requires pain pills every 6 hours. V12 stated she went to the Administrator's office after lunch and informed her of her concerns regarding her husband not receiving any medications and that the Administrator, (V1) replied to her the nurses out there can give your husband his medications. V12 stated she informed (V1) that the nurses had already told V12 they can't pass the B hall medications and that (V1) just shrugged her shoulders in response.</p> <p>On 5/23/24 at 9:53 AM, V14, CNA stated she was assigned to the B hall on Monday, 5/20/24 and that they did not have a nurse on the hall all day. V14 stated she did not see any nurses administering medications nor checking blood sugars on the B hall. V14 stated the residents were complaining about not getting their medications and that some of the B hall residents were complaining of pain.</p> <p>On 5/23/24 at 1:45 PM, Administrator, V1 stated she was not made aware of the B hall not having a nurse assigned to it until 10:30 AM on 5/20/24. V1 stated the Interim DON (Director of Nursing) was scheduled to work the floor on 5/20/24 but that she got called in on the evening shift on 5/19/24 so she did not come in on 5/20/24. V1 stated she attempted to call a nurse in but was unsuccessful and that the facility does not have a contract with a staffing agency because the current owner has not paid the bill with the staffing agency. V1 stated on 5/20/24 she called the two floor nurses to her office and told them that this isn't ideal, but she needed them to pass medications to the residents on B hall and that the nurses refused to do so.</p> <p>On 5/28/24 at 10:23 AM, V17, Regional Director stated that she would have expected a licensed nurse to pass the medications to the residents on B hall on 5/20/24.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>The facility's Staffing, Sufficient and Competent Nursing Policy, dated August 2022, documented Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Sufficient staff: 1. Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including: a. assuring resident safety; b. attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident; c. assessing, evaluating, planning and implementing resident care plans; and d. responding to resident needs. It continues, 6. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments and the facility assessment.</p> |  |  |

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| <p>F 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49494</p> <p>Based on interview and record review the facility failed to administer medications as ordered for residents (R1, R2, R3, R12) of 4 residents reviewed in a sample of 12. This failure resulted in R1 and R3 experiencing severe pain.</p> <p>Findings include:</p> <p>R1's face sheet, dated 5/23/24, documented that R1 was admitted on [DATE] with diagnoses of quadriplegia, hypertension, COPD (Chronic Obstructive Pulmonary Disease), spinal stenosis, intervertebral disk degeneration, osteoarthritis, and cirrhosis of the liver. R1's MDS (Minimum Data Set) dated 5/27/24 documented R1 is cognitively intact.</p> <p>On 5/23/24 at 6:40 AM, R1 stated that at the beginning of the week B hall did not have a nurse and that he did not receive any of his morning or noon medications. R1 stated that he went to the facility Administrator around 2 PM on this day and informed her that he had not received any medications all day. R1 stated that (V1) informed him she was aware of that hall not having a nurse and that the other nurses would administer his medication, or they will get fired. R1 stated he never did receive his morning or noon medications on this day. R1 stated he normally takes pain pills every 6 hours and that he had to go from 3:00 AM until 4:00 PM without pain medication. R1 stated that his pain rating was at a level of 10 by the time he finally received the pain medication at 4 PM.</p> <p>R1's MAR (Medication Administration Record) dated 5/23/24 documented that R1 has physician orders to receive the following medications between 7 AM and 10 AM: budesonide-formoterol aerosol inhaler 8-4.5 mcg (micrograms) 2 puffs inhalation, vitamin b-12 250 mcg , fibercon 625 mg (milligrams), finasteride 5mg, baclofen 5mg, arginine-glutamine-calcium 1.5 grams, lidocaine patch 5%, omeprazole 20mg, oxycodone 10 mg every 6 hours as needed, polyethylene glycol 17 grams, senna 8.6 mg, toprol XL 25 mg, venlafaxine 37.5 mg, and vitamin D3 25 mcg. The MAR (Medication Administration Record) does not have a nurse's initials documented for these medications on 5/20/24 indicating they were not administered as ordered by R1's physician.</p> <p>R1's MAR, dated 5/23/24, documented that R1 is to receive gabapentin 600 mg between 11 AM and 1 PM. R1's MAR does not have a nurse's initials documented as administered for this medication on 5/20/24.</p> <p>R1's MAR documented an order for a pain assessment to be completed every shift and as needed. The MAR did not document a pain assessment was completed on the day shift on 5/20/24. R1's MAR did document a pain assessment was completed on the evening shift of 5/20/24 and R1 rated his pain at a level of 10.</p> <p>R2's face sheet, dated 5/28/24, documented R2 was admitted to the facility on [DATE] with diagnoses of chronic kidney disease, COPD, generalized anxiety disorder, depression, anemia, and tachycardia. R2's MDS, dated [DATE], documented that R2 is cognitively intact.</p> <p>(continued on next page)</p> |

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| <p>F 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>  | <p>On 5/23/24 at 7:40 AM, R2 stated that on Monday, 5/20/24 he did not receive any of his medications all day. R2 stated that he was concerned because he is on a lot of medications, and it is essential he receives them for his high blood pressure and chronic liver disease. R2 stated he asked a nurse on another hall for his medications and that she stated she was not allowed to help him. R2 stated he then went to the Administrator's office and informed (V1) Administrator that he needed someone to give him his morning medications and that she replied okay. R2 stated he never did receive any of his morning nor noon medications.</p> <p>R2's MAR dated 5/23/24 documented that R2 has physician orders to receive the following medications between 7 AM and 10 AM: lidocaine adhesive medicated patch 4% and a steroid inhaler. The MAR does not have a nurse's initials documented for these medications on 5/20/24 indicating they were not administered. R2's MAR dated 5/23/24 documented that R2 has physician orders to receive the following medications every day at 11 AM: aspirin 81 mg, folic acid 1 mg, Lasix 20 mg, spironolactone 50 mg, tamsulosin .4 mg, iron 325 mg, and lactulose 20 mg. R2's MAR does not have a nurse's initials documented for these medications on 5/20/24 indicating the medications were not administered as ordered.</p> <p>R3's face sheet, dated 5/23/24, documented R3 was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder, generalized anxiety disorder, neuromuscular dysfunction of bladder, low back pain, chronic kidney disease, major depressive disorder, cerebral infarction, dementia, hyperlipidemia, anemia, diabetes, and chronic pain. R3's MDS, dated [DATE], documented R3 is moderately cognitively impaired.</p> <p>On 5/23/24 at 8:15 AM, V11, daughter of R3, stated that she received a call from her mother, (V12) on 5/20/24 at noon and that (V12) stated (R3) has not had any medications all day and that no one had checked (R3's) blood sugar. V11 stated that her dad, (R3) was in pain because he had not received any pain medication all day on 5/20/24.</p> <p>On 5/23/24 at 8:25 AM, V12, wife of R3, stated that her husband (R3) did not receive any medications on Monday, 5/20/24. V12 stated that (R3) has chronic back pain and has had 3 failed back surgeries. V12 stated her husband needs pain pills every 6 hours to control his pain and that he didn't receive any pain medication all day on 5/20/24. V12 stated that she went to the Administrator's office after lunch and the Administrator, (V1) stated the nurses out there can pass meds. V12 stated she informed (V1) that the nurses said they can't pass the medications on the B hall. V12 stated (V1) just shrugged her shoulders in response.</p> <p>R3's MAR, dated 5/23/24, documented R3 has physician orders for the following medications to be administered every day between 7 AM and 10 AM: ascorbic acid 1000 mg, Dulcolax 5 mg, duloxetine 30 mg, Eliquis 5 mg, finasteride 5 mg, furosemide 40 mg, guaifenesin 600 mg, hydralazine 25 mg, novolog insulin pen 100 unit/ml amount to administer per sliding scale, tamulosin .4 mg, and protonix 20 mg. R3's MAR does not have a nurse's initials documented as administered on 5/20/24 nor is there a blood sugar documented as ordered for the insulin administration.</p> <p>R3's MAR, dated 5/23/24, documented R3 has physician orders for the following medications to be administered every day between 11 AM and 1 PM: Ativan .5 mg, hydralazine 25 mg, hydroxyzine 25 mg, novolog insulin pen 100 unit/ml administer per sliding scale, and oxycodone 5 mg. R3's MAR does not document that these medications were administered on 5/20/24 nor does it document that a blood sugar test was completed as ordered for the insulin administration.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0755</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>  | <p>R3's nurses note dated 5/22/24 at 3:38 PM documented We encountered a staffing challenge 5/20/2024. In this case residents' medications ran later than normal. MD (Medical Director) and POA (Power of Attorney) are aware. Crisis management and Inservice education in place. Additional CNA added to B hall for monitoring, VS (Vital Signs) q4 hrs until 5/24/2024. Additional leadership rounding in place. Staff will continue to mx residents for any concerns. This note was signed by V2, Interim Director of Nursing.</p> <p>R12's face sheet, dated 5/28/24, documented R12 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes, congestive heart failure, history of embolisms, hypertension, anemia and chronic kidney disease. R12's MDS, dated [DATE], documented R12 is cognitively intact.</p> <p>R12's MAR, dated 5/23/24, documented R12 has physician orders for the following medications to be administered everyday between 7 AM and 10 AM: amlodipine 10 mg, entresto 24 mg, famotidine 40 mg ferrous sulfate 324mg, flonase allergy relief spray 50 mcg, folate 1 mg, Humalog insulin 13 units, insulin glargine 60 units, Jardiance 10 mg, Lasix 40 mg, magnesium oxide 400 mg, metformin 50 mg, toprol 100 mg, aspirin 81 mg, and spironolactone 25 mg. R12's MAR does not have these medications documented as administered on 5/20/24. R12's MAR documents an order for blood sugars to be tested every morning between 6 AM and 8 AM. R12's MAR does not document a blood sugar result for 5/20/24 between the times of 6 AM and 8 AM.</p> <p>R12's MAR, dated 5/23/24, documented R12 has an order to receive 13 units of Humalog insulin every day between 11 AM and 12 PM. R12's MAR does not document this insulin was administered on 5/20/24.</p> <p>R12's progress note, dated 5/22/24, documented we encountered a staffing challenge on 5/20/24. In this case residents' medications ran later than normal. MD notified. Resident is own POA and is aware. Crisis management and in-service education in place. Additional CNA added to B hall for monitoring, VS q4 hrs until 5/24/2024. Additional leadership rounding in place. Staff will continue to mx residents for any concerns.</p> <p>On 5/23/24 at 1:45 PM, Administrator, V1 stated she was not made aware of the B hall not having a nurse assigned to it until 10:30 AM on 5/20/24. V1 stated the Interim DON (Director of Nursing) was scheduled to work the floor on 5/20/24 but that she got called in on the evening shift on 5/19/24 so she did not come in on 5/20/24. V1 stated she attempted to call a nurse in but was unsuccessful and that the facility does not have a contract with a staffing agency because the current owner has not paid the bill with the staffing agency. V1 stated on 5/20/24 she called the two floor nurses to her office and told them that this isn't ideal, but she needed them to pass medications to the residents on B hall and that the nurses refused to do so.</p> <p>On 5/28/24 at 10:23 AM, V17, Regional Director stated that she would have expected a licensed nurse to pass the medications to the residents on B hall on 5/20/24.</p> <p>On 5/28/24 at 2:35 PM, V1, Administrator stated that if there are no initials on the MAR then the medications were not administered.</p> <p>(continued on next page)</p> |  |  |

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| F 0755<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some   | The facility's Administering Medications Policy, dated April 2019, documented medications are administered in a safe and timely manner, and as prescribed. 1. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. 2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. 3. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. 4. Medications are administered in accordance with prescriber orders, including any required time from. It continues, 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified. |  |  |