STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146011	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robings Manor Rhc	502 North Main Brighton, IL 62012

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview and record review, the facility failed to conduct the admission/initial comprehensive assessment for 4 of 6 residents (R1, R4, R5, R6) reviewed for comprehensive resident assessments in the sample of 6. Finding include: 1. R1's Admission Record, undated, documents R1 was admitted to the facility on [DATE]. R1's Cumulative Diagnosis Log, undated, documents R1's diagnoses include Vascular Dementia, Alzheimer's, Arthritis, Cerebral Atherosclerosis, Anxiety, Chronic Obstructive Pulmonary Disease (COPD), Hypertension (HTN), and Migraines. There was no Admission/Initial Minimum Data Set (MDS) located in R1's medical record. On 4/24/24, the facility did not provide R1's Admission/Initial MDS to the surveyor. 2. R4's Admission Record, undated, documents R4 was admitted to the facility on [DATE]. R4's Cumulative Diagnoses Log, undated, documents R4's diagnoses include Neoplasm of Brain/Meninges, Parkinson's Disease, Benign Prostatic Hyperplasia (BPH), and Hyperlipidemia. There was no Admission/Initial MDS located in R4's medical record. On 4/24/24, the facility did not provide R4's Admission/Initial MDS to the surveyor. 3. R5's Admission Record, undated, documents R5 was admitted on [DATE]. R5's Cumulative Diagnosis Log, undated, documents R5's diagnoses include Parkinson's Disease, Multiple Fractures, Dementia, Falls, Osteoporosis, Atherosclerotic Heart Disease (ASHD), Sleep Apnea, Polyneuropathy, Hyperlipidemia, Difficulty Walking, Fibromyalgia, Adult Failure to Thrive, and HTN (hypertension). There was no Admission/Initial MDS located in R5's medical record. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/24, the facility did not provide R5's Admission/Initial MDS to the surveyor. 4. R6's Admission Record, undated, documents R6 was admitted to the facility on [DATE]. R6's Hospital Record, dated 11/30/23, documents R6's diagnoses include Bipolar Disorder, Depression, DM (diabetes) Type 2, HTN, Anemia, A-Fib (atrial fibrillation), Sepsis, Urinary Tract Infection (UTI), Cystitis, Coronary Artery Disease (CAD). There was no Admission/Initial MDS located in R6's medical record. On 4/24/24, the facility did not provide R6's Admission/Initial MDS to the surveyor. On 4/24/24 at 10:46 AM, V2, Assistant Director of Nursing (ADON), stated I'm aware there should be Care Plans and MDS in the resident charts. I know they had some issues with printing them out but I'm not sure. On 4/24/24 at 11:15 AM, V3, MDS Nurse, stated I talked to the previous MDS nurse, and she was not able to print any of the Care Plans or MDS to put in the resident charts. On 4/24/24 at 11:20 AM, V5, Registered Nurse (RN)/Previous MDS Nurse, stated I stopped being the MDS nurse about a month ago. I have had to hand write things because I couldn't get the computer to print them out. I told the Regional MDS Coordinator and (V6, Previous Administrator) who told me she put three tickets in to have this issue fixed, and it was never fixed. V5 stated I believe that a Corporate person was planning on printing all Care Plans and MDS out and put them in a hanging file for staff to have access to them. On 4/24/24 at 11:30 AM, V1, Regional Director of Operations/Interim Administrator, stated They should have been printing the Care Plans and MDS and putting them in the resident charts so all staff can have access to them. The Previous Administrator, who reports to me, would have reported this issue to me, and I did not know anything about it. I know that we changed companies and went from (electronic medical record), which got hacked, and now we are moving everything into (new electronic medical record), with hopes by August or September 2024, all staff will have access to (the new electronic medical record). Since I have just been made aware of this issue, we will be doing an audit of all resident charts to ensure there is an updated care plan and MDS in the chart. On 4/25/24 at 1:15 PM, V1, Administrator, stated that she would expect the nursing staff and MDS Coordinator to complete a baseline Care Plan upon the resident's admission, along with the RAI (Resident Assessment Instrument)/MDS assessments, then complete the Comprehensive Care Plan within 7 days. V1 stated that the Care Plan and MDS should be updated with any change in condition and quarterly. V1 stated that she would expect staff to print out both the Care Plan and MDS and place in the resident's medical record for staff to review. V1 stated that she expects all staff to review and follow the resident's Care Plan and MDS to provide proper care to that resident. V1 stated that she has already started auditing resident medical records for updated Care Plans and MDS in every chart. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Comprehensive Assessment/MDS Policy, dated 11/1/17, documents It is the policy of [NAME] Health Care to comprehensively assess and periodically reassess each Resident admitted to this facility. The results of this Resident assessment shall serve as the basis for determining Resident strengths, needs, goals, life history and preferences to develop a comprehensive plan of care for each Resident with the goal of attaining or maintaining the Resident's highest practicable physical, mental, and psychosocial well-being. The Resident Assessment Instrument (RAI) shall be the guide utilized for all comprehensive assessments, care area assessments and care planning. The following procedures shall be utilized in completion of the Minimum Data Set (MDS)/comprehensive assessment. 1. The RAI shall be utilized to comprehensively assess Residents. 2. A Registered Nurse shall coordinate the RAI for each Resident. 3. Each Resident residing in this facility for a full 14 days shall have a MDS initiated by the 13th day after admission, and a RAI completed by the 14th day after admission. Admission applies to: a. First admission to the facility, or b. Subsequent admissions to the facility: i. After the Resident was discharged from this facility with no anticipation of return, or ii. After discharge with no return anticipated but no return within 30 days. 4. The Comprehensive Assessment shall consist of: a. MDS as defined by CMS and state guidelines. 5. The MDS shall be re-evaluated according to the following schedule. a. Quarterly-within 92 of previous ARD/MDS. b. Annually- within 366 days of previous Comprehensive ARD/MDS. c. Significant Change in Status. 7. 15 months of OBRA MDS shall be kept in a Resident ' s active clinical record.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview and record review, the facility failed to complete quarterly assessments for 2 of 6 residents (R2, R3) reviewed for quarterly assessments in the sample of 6. Findings include: 1. R2's Admission Record, undated, documents R2 was admitted to the facility on [DATE]. R2's Minimum Data Set (MDS), dated [DATE], documents R2 has a moderate cognitive impairment and is independent of all Activities of Daily Living (ADLs). R2's MDS documents R2 is always continent of bowel and bladder. There were no other quarterly MDSs to review in R2's medical chart. As of 4/24/24, the facility did not provide R2's quarterly MDSs for the surveyor to review. 2. R3's Admission Record, undated, documents R3 was admitted to the facility on [DATE]. R3's Cumulative Diagnosis Log, undated, documents R3's diagnoses include Alzheimer's Disease, Dementia, HTN, Hypothyroidism, Osteopenia, Major Depressive Disorder, General Anxiety Disorder, and Arthritis. R3's MDS, dated [DATE], documents R3 has a moderate cognitive impairment and requires supervision/touching assistance from staff for all ADLs. R3's MDS documents R3 is occasionally incontinent of both bowel and bladder. R3's MDS has not been updated since 7/13/23. There were no other quarterly MDSs to review in R3's medical chart. As of 4/24/24, the facility did not provide R3's quarterly MDS for the surveyor to review. On 4/24/24 at 10:46 AM, V2, Assistant Director of Nursing (ADON), stated I'm aware there should be Care Plans and MDS in the resident charts. I know they had some issues with printing them out but I'm not sure. On 4/24/24 at 11:15 AM, V3, MDS Nurse, stated I talked to the previous MDS nurse, and she was not able to print any of the Care Plans or MDS to put in the resident charts. On 4/24/24 at 11:20 AM, V5, Registered Nurse (RN)/Previous MDS Nurse, stated I stopped being the MDS nurse about a month ago. I have had to hand write things because I couldn't get the computer to print them out. I told the Regional MDS Coordinator and (V6, Previous Administrator), who told me she put three tickets in to have this issue fixed, and it was never fixed. V5 stated I believe that a Corporate person was planning on printing all Care Plans and MDS out and put them in a hanging file for staff to have access to them. (continued on next page)

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 11:30 AM, V1, Regional Director of Operations/Interim Administrator, stated They should have been printing the Care Plans and MDS and putting them in the resident charts so all staff can have access to them. The Previous Administrator, who reports to me, would have reported this issue to me, and I did not know anything about it. I know that we changed companies and went from (electronic medical record), which got hacked, and now we are moving everything into (new electronic medical record), with hopes by August or September 2024, all staff will have access to (the new electronic medical record). Since I have just been made aware of this issue, we will be doing an audit of all resident charts to ensure there is an updated care plan and MDS in the chart. On 4/25/24 at 1:15 PM, V1, Administrator, stated that she would expect the nursing staff and MDS Coordinator to complete a baseline Care Plan upon the resident's admission, along with the RAI (Resident Assessment Instrument)/MDS assessments, then complete the Comprehensive Care Plan within 7 days. V1 stated that the Care Plan and MDS should be updated with any change in condition and quarterly. V1 stated that she would expect staff to print out both the Care Plan and MDS and place in the resident's medical record for staff to review. V1 stated that she expects all staff to review and follow the resident's Care Plan and MDS to provide proper care to that resident. V1 stated that she has already started auditing resident medical records for updated Care Plans and MDS in every chart. The facility's Comprehensive Assessment/MDS Policy, dated 11/1/17, documents It is the policy of (Corporation of Facility) to comprehensively assess and periodically reassess each Resident admitted to this facility. The results of this Resident assessment shall serve as the basis for determining Resident strengths, needs, goals, life history and preferences to develop a comprehensive plan of care for each Resident with the goal of attaining or maintaining the Resident's highest practicable physical, mental, and psychosocial well-being. The Resident Assessment Instrument (RAI) shall be the guide utilized for all comprehensive assessments, care area assessments and care planning. The following procedures shall be utilized in completion of the Minimum Data Set (MDS)/comprehensive assessment. 1. The RAI shall be utilized to comprehensively assess Residents. 2. A Registered Nurse shall coordinate the RAI for each Resident. 3. Each Resident residing in this facility for a full 14 days shall have a MDS initiated by the 13th day after admission, and a RAI completed by the 14th day after admission. Admission applies to: a. First admission to the facility, or b. Subsequent admissions to the facility: i. After the Resident was discharged from this facility with no anticipation of return, or ii. After discharge with no return anticipated but no return within 30 days. 4. The Comprehensive Assessment shall consist of: a. MDS as defined by CMS and state guidelines. 5. The MDS shall be re-evaluated according to the following schedule. a. Quarterly-within 92 of previous ARD/MDS. b. Annually- within 366 days of previous Comprehensive ARD/MDS. c. Significant Change in Status. 7. 15 months of OBRA MDS shall be kept in a Resident ' s active clinical record.

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F 0639 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Maintain 15 months of resident assessments in the resident's active clinical record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview and record review, the facility failed to keep 15 months of resident assessments in residents' medical records for 6 of 6 residents (R1, R2, R3, R4, R5, R6) reviewed for maintaining 15 months of residents' assessments in the sample of 6. Findings include: 1. R1's Admission Record, undated, documents R1 was admitted to the facility on [DATE]. R1's Cumulative Diagnosis Log, undated, documents R1's diagnoses includes Vascular Dementia, Alzheimer's, Arthritis, Cerebral Atherosclerosis, Anxiety, Chronic Obstructive Pulmonary Disease (COPD), Hypertension (HTN), and Migraines. There is no Minimum Data Set (MDS) completed in R1's Medical Record. On 4/24/24, the facility could not provide any MDS for surveyor to review. 2. R2's Admission Record, undated, documents R2 was admitted to the facility on [DATE]. R2's Hospital Record, dated 4/13/24, documents R2's diagnoses include Anxiety, Depression, HTN (hypertension), Type 2 Diabetes Mellitus (DM), and bipolar disorder. R2's MDS, dated [DATE], documents R2 has a moderate cognitive impairment and is independent of all Activities of Daily Living (ADLs). R2 is always continent of bowel and bladder. R2's MDS has not been updated since 9/7/23. There were no other MDSs completed in R2's medical record. On 4/24/24, the facility could not provide any other MDS for surveyor to review. 3.R3's Admission Record, undated, documents R3 was admitted to the facility on [DATE]. R3's Cumulative Diagnosis Log, undated, documents R3's diagnosis include Alzheimer's Disease, Dementia, HTN, Hypothyroidism, Osteopenia, Major Depressive Disorder, General Anxiety Disorder, and Arthritis. R3's MDS, dated [DATE], documents R3 has a moderate cognitive impairment and requires supervision/touching assistance from staff for all ADLs. R3's MDS has not been updated since 7/13/23. There were no other MDSs in R3's medical record to review. On 4/24/24, the facility did not provide other MDS for surveyor to review. 4. R4's Admission Record, undated, documents R4 was admitted to the facility on [DATE]. (continued on next page)

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F 0639 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's Cumulative Diagnosis Log, undated, documents R4's diagnoses include Neoplasm of Brain/Meninges, Parkinson's Disease, Benign Prostatic Hyperplasia (BPH), and Hyperlipidemia. There was no MDS to review in R4's medical record. As of 4/24/24, the facility did not provide R4's MDS for surveyor to review. 5. R5's Admission Record, undated, documents R5 was admitted on [DATE]. R5's Cumulative Diagnosis Log, undated, documents R5's diagnoses include Parkinson's Disease, Multiple Fractures, Dementia, Falls, Osteoporosis, Atherosclerotic Heart Disease (ASHD), Sleep Apnea, Polyneuropathy, Hyperlipidemia, Difficulty Walking, Fibromyalgia, Adult Failure to Thrive, and HTN. There was no MDS for surveyor to review in R5's medical record. 6. R6's Admission Record, undated, documents R6 was admitted to the facility on [DATE]. R6's Hospital Record, dated 11/30/23, documents R6's diagnoses include Bipolar Disorder, Depression, DM Type 2, HTN, Anemia, A-Fib (atrial fibrillation), Sepsis, Urinary Tract Infection (UTI), Cystitis, Coronary Artery Disease (CAD). There was no MDS in R6's medical record for surveyor to review. On 4/24/24 at 10:46 AM, V2, Assistant Director of Nursing (ADON), stated I'm aware there should be Care Plans and MDS in the resident charts. I know they had some issues with printing them out but I'm not sure. On 4/24/24 at 11:15 AM, V3, MDS Nurse, stated I talked to the previous MDS nurse, and she was not able to print any of the Care Plans or MDS to put in the resident charts. On 4/24/24 at 11:20 AM, V5, Registered Nurse (RN)/Previous MDS Nurse, stated I stopped being the MDS nurse about a month ago. I have had to hand write things because I couldn't get the computer to print them out. I told the Regional MDS Coordinator and (V6, Previous Administrator), who told me she put three tickets in to have this issue fixed, and it was never fixed. V5 stated I believe that a Corporate person was planning on printing all Care Plans and MDS out and put them in a hanging file for staff to have access to them. On 4/24/24 at 11:30 AM, V1, Regional Director of Operations/Interim Administrator, stated They should have been printing the Care Plans and MDS and putting them in the resident charts so all staff can have access to them. The Previous Administrator, who reports to me, would have reported this issue to me, and I did not know anything about it. I know that we changed companies and went from (electronic medical record), which got hacked, and now we are moving everything into (new electronic medical record), with hopes by August or September 2024, all staff will have access to (the new electronic medical record). Since I have just been made aware of this issue, we will be doing an audit of all resident charts to ensure there is an updated care plan and MDS in the chart. (continued on next page)

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	146011	A. Building B. Wing	04/25/2024

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F 0639 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/25/24 at 8:50 AM, when asked how she knows what kind of assistance each resident requires, V9, Certified Nursing Assistant (CNA), stated The nurses let the CNAs know what to do with the residents. I don't look at the resident's Care Plan or MDS for information. On 4/25/24 at 8:55 AM, when asked how she knows what kind of assistance each resident requires, V10, CNA, stated We have an ADL Flow Record for each resident that is filled in by the restorative CNA, and kept in a binder, and that is how we determine what care the resident needs. I never look in the resident's medical record to review their Care Plan or MDS. On 4/25/24 at 9:00 AM, when asked where she gets the information to complete the ADL Flow Record, V11, Restorative CNA, stated I will go and assess the resident myself to determine what needs the resident has and will fill in the ADL Flow Record. The other nurses and CNAs can fill it in as well. I never look at the MDS or Care Plan for resident information, I was told the CNAs are not supposed to look in the resident medical records. On 4/25/24 at 1:15 PM, V1 stated that she would expect the nursing staff and MDS Coordinator to complete a baseline Care Plan upon the resident's admission, along with the RAI (Resident Assessment Instrument)/MDS assessments, then complete the Comprehensive Care Plan within 7 days. V1 stated that the Care Plan and MDS should be updated with any change in condition and quarterly. V1 stated that she would expect staff to print out both the Care Plan and MDS and place in the resident's medical record for staff to review. V1 stated that she expects all staff to review and follow the resident's Care Plan and MDS to provide proper care to that resident. V1 stated that she has already started auditing resident medical records for updated Care Plans and MDS in every chart. The facility's Comprehensive Assessment/MDS Policy, dated 11/1/17, documents It is the policy of (Facility's Corporation) to comprehensively assess and periodically reassess each Resident admitted to this facility. The results of this Resident assessment shall serve as the basis for determining Resident strengths, needs, goals, life history and preferences to develop a comprehensive plan of care for each Resident with the goal of attaining or maintaining the Resident's highest practicable physical, mental, and psychosocial well-being. The Policy documents 15 months of OBRA MDS shall be kept in a Resident's active clinical record.

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	146011	A. Building B. Wing	04/25/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview and record review, the Facility failed to develop a Comprehensive Care Plan for 4 of 6 residents (R1, R4, R5, R6) residents review for comprehensive care plans in the sample of 6. Finding include: 1. R1's Admission Record, undated, documents R1 was admitted to the facility on [DATE]. R1's Cumulative Diagnosis Log, undated, documents R1's diagnoses include Vascular Dementia, Alzheimer's, Arthritis, Cerebral Atherosclerosis, Anxiety, Chronic Obstructive Pulmonary Disease (COPD), Hypertension (HTN), and Migraines. R1's Baseline Care Plan, dated 12/8/23, documents R1 is a High-Risk for Falls due to poor safety awareness, a fall history, R1's Locomotion: wheelchair, R1's Bed Mobility: Assist of one staff member, R1 Transfers: Dependent with assist of one staff member. R1's Cognition: Alert to Self only, Requires segmentation for ADLs. There was no Comprehensive Care Plan based upon a comprehensive assessment completed and placed in R1's Medical Record. 2. R4's Admission Record, undated, documents R4 was admitted to the facility on [DATE]. R4's Cumulative Diagnosis Log, undated, documents R4's diagnoses include Neoplasm of Brain/Meninges, Parkinson's Disease, Benign Prostatic Hyperplasia (BPH), and Hyperlipidemia. R4's Baseline Care Plan, dated 2/15/24, is only partially complete, with page one blank. Page two documents R4 requires assist from one staff member for transfer, and extensive assistance from staff for bathing, grooming, dressing, and toileting. There was no Comprehensive Care Plan done for R4 based upon the comprehensive assessment . 3. R5's Admission Record, undated, documents R5 was admitted on [DATE]. R5's Cumulative Diagnosis Log, undated, documents R5's diagnoses include Parkinson's Disease, Multiple Fractures, Dementia, Falls, Osteoporosis, Atherosclerotic Heart Disease (ASHD), Sleep Apnea, Polyneuropathy, Hyperlipidemia, Difficulty Walking, Fibromyalgia, Adult Failure to Thrive, and HTN. R5's Baseline Care Plan, dated 11/2/23, documents R5 is a High Risk for falls due to poor safety awareness, fall history, psych med use. R5 Baseline Care Plan documents R5 is dependent on use of w/c (wheelchair) and is dependent on two staff for transfers. There was no Comprehensive Care Plan in R5's medical record based upon a comprehensive assessment. 4. R6's Admission Record, undated, documents R6 was admitted to the facility on [DATE]. R6's Hospital Record, dated 11/30/23, documents R6's diagnoses include Bipolar Disorder, Depression, DM Type 2, HTN, Anemia, A-Fib (atrial fibrillation), Sepsis, Urinary Tract Infection (UTI), Cystitis, Coronary Artery Disease (CAD). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There is Comprehensive Care Plan based upon a comprehensive assessment in R6's medical record. On 4/24/24 at 10:46 AM, V2, Assistant Director of Nursing (ADON), stated I'm aware there should be Care Plans and MDS in the resident charts. I know they had some issues with printing them out but I'm not sure. On 4/24/24 at 11:15 AM, V3, MDS Nurse, stated I talked to the previous MDS nurse, and she was not able to print any of the Care Plans or MDS to put in the resident charts. On 4/24/24 at 11:20 AM, V5, Registered Nurse (RN)/Previous MDS Nurse, stated I stopped being the MDS nurse about a month ago. I have had to hand write things because I couldn't get the computer to print them out. I told the Regional MDS Coordinator and (V6, Previous Administrator), who told me she put three tickets in to have this issue fixed, and it was never fixed. I was handwriting only when a resident fell , the date of the fall, a goal, and the interventions. I only did this for the falls and not the ADL or other care. I believe that a Corporate person was planning on printing all Care Plans and MDS out and put them in a hanging file for staff to have access to them. On 4/24/24 at 11:30 AM, V1, Regional Director of Operations/Interim Administrator, stated They should have been printing the Care Plans and MDS and putting them in the resident charts so all staff can have access to them. The Previous Administrator, who reports to me, would have reported this issue to me, and I did not know anything about it. I know that we changed companies and went from (electronic medical record), which got hacked, and now we are moving everything into (new electronic medical record), with hopes by August or September 2024, all staff will have access to (the new electronic medical record). Since I have just been made aware of this issue, we will be doing an audit of all resident charts to ensure there is an updated care plan and MDS in the chart. On 4/25/24 at 9:20 AM, when asked how she knows what kind of assistance each resident requires, V8, Licensed Practical Nurse (LPN), stated I will ask the CNAs, especially about how the resident transfers. I can also look at the resident's Care Plan for information. On 4/25/24 at 1:15 PM, V1 stated that she would expect the nursing staff and MDS Coordinator to complete a baseline Care Plan upon the resident's admission, along with the RAI (Resident Assessment Instrument)/MDS assessments, then complete the Comprehensive Care Plan within 7 days. V1 stated that the Care Plan and MDS should be updated with any change in condition and quarterly. V1 stated that she would expect staff to print out both the Care Plan and MDS and place in the resident's medical record for staff to review. V1 stated that she expects all staff to review and follow the resident's Care Plan and MDS to provide proper care to that resident. V1 stated that she has already started auditing resident medical records for updated Care Plans and MDS in every chart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146011	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robings Manor Rhc	502 North Main Brighton, IL 62012

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Comprehensive Care Planning Policy, dated 7/20/22, documents It is the policy of (Facility's Corporation) to comprehensively assess and periodically reassess each Resident admitted to this facility. The results of this Resident assessment shall serve as the basis for determining each Resident's strengths, needs, goals, life history and preferences to develop a person-centered comprehensive plan of care for each Resident that will describe the services that are to be furnished to attain or maintaining the Resident's highest practicable physical, mental, and psychosocial well-being. The Resident Assessment Instrument (RAI) shall be the guide utilized for all comprehensive assessments, care area assessments and care planning. 1. The Comprehensive Care Plan (CCP) shall be developed within 7 days of the completion of the RAI. a. The CCP shall be reviewed after each Annual, Significant Change and Quarterly MDS and revised as necessary to reflect the resident's current medical, nursing, and mental and psychosocial needs as identified by the IDT. b. The Care Plan shall be revised as necessary when the needs/problems and care and services specified in the plan of care no longer reflect those of the Resident. f. There shall occur times between RAI/MDS completion that ongoing clinical assessment and identification of resident need may warrant update of the CCP. 7. The Care Plan Conference shall be held as necessary to communicate major revisions to the Comprehensive Care Plan and minimally with every Comprehensive MDS completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview and record review, the facility failed to complete revise care plans to address the residents' current needs for 4 of 6 residents (R2, R3, R4, R5) reviewed for revision of Care Plans in the sample of 6. Findings include: 1. R2's Admission Record, undated, documents R2 was admitted to the facility on [DATE]. R2's Hospital Record, dated 4/13/24, documents R2's diagnoses include Anxiety, Depression, HTN, Type 2 Diabetes Mellitus (DM), and bipolar disorder. R2's Care Plan, dated 7/10/23, documents R2 has risk factors that require monitoring and intervention to reduce potential for self-injury. Interventions: Review quarterly and PRN (as needed) residents ADL, mobility, cognitive, behavior and overall medical status, encourage and assist placement of proper non-skid footwear, observe for unsteady/unsafe transfer or ambulation and provide stand by or balance support as needed, Fall Risk quarterly and PRN, call light within reach at all times, Fall: Resident stated to nurse she was wanting to get clothes out of her closet, lost her balance and fell on buttocks, no injury. Interventions added: encourage to ask for help and getting items of clothes out of closet, encourage resident to allow staff to set clothes out for the night/day before. The facility's Fall Log, from February to April 2024, documents R2 has had falls on 2/3/24 and 4/13/24. There were no fall risk assessments, or update to the Care Plan completed after these falls. 2. R3's Admission Record, undated, documents R3 was admitted to the facility on [DATE]. R3's Cumulative Diagnosis Log, undated, documents R3's diagnoses includes Alzheimer's Disease, Dementia, HTN, Hypothyroidism, Osteopenia, Major Depressive Disorder, General Anxiety Disorder, and Arthritis. R3's Care Plan, dated 7/20/23, documents R3 has risk factors that require monitoring and intervention for self-injury. Interventions: (11/19/23) non-skid footwear, fall risk quarterly, utilize w/c versus walker when knees hurt, provided verbal frequent reminders to use call light for staff assist, (1/18/24) keep resident in common areas to observe and provide verbal cues to sit back in w/c, when observed too close to edge, help reposition in w/c, (1/23/24) redirect resident to common areas to be observed, assess for incontinent when fidgety or anxious, assisted with positioning to sit back in w/c, (1/26/24) medication change, neuro checks per protocol, encourage to remain in view of staff in common areas, redirect resident. There are handwritten notes related to R3's falls seen in R3's Care Plan. The Facility's Fall Log, dated from February to April 2024, documents R3 has had falls on 2/13/24, 3/21/24, and 3/25/24. R3's Care Plan was not updated/revised with interventions to address R3's continued falls on 2/13, 3/21 and 3/25/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Comprehensive Care Planning Policy, dated 7/20/22, documents It is the policy of (Facility Corporation) to comprehensively assess and periodically reassess each Resident admitted to this facility. The results of this Resident assessment shall serve as the basis for determining each Resident's strengths, needs, goals, life history and preferences to develop a person-centered comprehensive plan of care for each Resident that will describe the services that are to be furnished to attain or maintaining the Resident's highest practicable physical, mental, and psychosocial well-being. The Policy documents b. The Care Plan shall be revised as necessary when the needs/problems and care and services specified in the plan of care no longer reflect those of the Resident. f. There shall occur times between RAI/MDS completion that ongoing clinical assessment and identification of resident need may warrant update of the CCP. 7. The Care Plan Conference shall be held as necessary to communicate major revisions to the Comprehensive Care Plan and minimally with every Comprehensive MDS completed. The facility's Fall Prevention Policy, dated 11/10/18, documents To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. 1. Conduct fall assessments on the day of admission, quarterly, and with a change in condition. 3. Assessments of Fall Risk will be completed by the admission nurse at the time of admission. Appropriate interventions will be implemented for residents determined to be at high risk at the time of admission for up to 72 hours. The admitting nurse will assign the temporary risk category. 5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident.