STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146071	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place of Belvidere	1701 5th Avenue Belvidere, IL 61008

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed to ensure a resident had an order or care plan for advance directives for 1 of 1 residents (R156) reviewed for advance directives in the sample of 17. The findings include: R156's Facesheet printed 6/13/24 showed he was admitted on [DATE] with diagnoses to include, but no limited to: left arm fracture, atrial fibrillation, stage 4 CKD (chronic kidney disease), diabetes, dementia, CHF (congestive heart failure), dysphagia, and depression. This document showed R1 was admitted for m a local hospital. The Advance Directive portion of this document was blank (no information was entered). R156's Progress Note dated 6/1/24 showed he was R1 was a Full Code. R156's Physician Order Sheets did not contain an order for Advance Directives. R156's EMR (Electronic Medical Record) did not contain a scanned POLST (Practitioner Orders for Life-Sustaining Treatment). R156's Care Plan did not have address Advance Directives prior to 6/13/24 (after surveyor interviewed V4 (SSD - Social Services Director). (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ON 6/13/24 at 9:41 AM, V8 (RN - Registered Nurse) said she had worked at the facility almost 2 years. The surveyor asked V8 what the facility's Advance Directives process was. V8 replied, It's in their chart, on the Face Sheet. When a resident comes from the hospital, the nurse gets report and the resident records from the hospital. The nurse will enter the order for advance directives and it will show up here. V8 opened R156's EMR and stated, Oh, it's not here. Usually it will show up here (V8 pointed near the resident picture and profile information in the upper left area of the computer screen). It may also be on the Facesheet. (V8 opened R156's Facesheet). This is blank. There should be Advance Directives listed in both these places. He doesn't have either. The surveyor asked V8 to check the Physician Order Sheet and she replied, There should be an order, but I don't see one. V8 said V4 (Social Services) also reviews advanced directives with the residents and families and enters the a care plan. V8 said she doesn't know why R156's EMR doesn't have an order for advanced directives, advanced directives entered on the Facesheet, nor a care plan for advanced directives. V8 said it's important to ensure this information is in the EMR to ensure the resident's wishes are being followed in an emergency. On 6/13/24 at 10:08 AM, V4 (SSD) said R156 was admitted to the facility, from the hospital, after falling at home and breaking his left arm. V4 said R156 had dementia and had severe cognitive impairment. V4 said R156's wife visits him frequently, in the evenings. The surveyor asked V4 what the facility's Advanced Directives process was. V4 replied, The nurse gets report from the hospital. The hospital should state if resident is Full code or DNR. The nurses would enter the order (into the EMR). The survey asked V4 to reviewed R156's EMR. V4 said R156 did not have an order for Full code, didn't have a POLST form, and he did not have an Advanced Directive Care Plan. V4 said the nurse should have entered the order and she should have initated the care plan. V4 stated, I take responsibility for the care plan. I don't know why his chart doesn't have this information. I'm usually very on top of things. I'll do it right now. The facility's Advance Directives Policy effective 5/3/22 showed, To ensure that all residents and/or resident representatives are informed concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. Advanced Directives shall not be required as a provision of service or admission. Guidelines: For purposes of this policy and procedure Advanced Directives means instrument, such as a living will or life prolonging procedure declaration, appointment of health care representative and power of attorney for health care purposes. These directives are established under state law and relate to the provision of medical care when the individual is incapacitated. 1. At the time of admission each resident will be asked if they have made advanced directives and provided educational information regarding state and federal law .

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed to ensure a resident was free of restraints for 1 of 1 residents (R156) reviewed for restraints in the sample of 17. The findings include: On 6/11/24 at 9:40 AM, R156 was lying in bed on his right side, curled up. R156 had a blue cast extending from his upper arm down to his hand, in a flexed position. The right side of R156's bed was pushed against the wall and the left side of his bed had a side rail pulled up. The side rail extended from R156's shoulder area to his ankles. R156 was facing the wall. The side rail was only able to be placed in the up and down position from someone outside of the bed. R156 would not be able to remove it himself. On 6/12/24 at 10:42 AM, R156 was lying on his right side in bed with the side rail pulled up. On 6/13/24 8:55 AM, R156 was in bed, lying on back with bent knees, facing the left side rail. R156 was rocking his knees, as if trying to sit up. R156's left arm in a blue cast and he was unable to use it to grab the left side rail. R156 continued to rocked his knees and upper body, but was unable to sit up or move much in the bed. R156 made no attempts to use his right arm to grab the side rail on the left side of the bed. R156 just continued the rocking motion. At 9:34 AM, the surveyor was in the hallway outside R156's room, facing his room during an interview with V7 (CNA - Certified Nursing Assistant). R156 was in the same position and wiggling his legs, like he was trying to wiggle down in bed, to get around the side rail. V7 said R156 had dementia and yells out for his wife most of the day. V7 said he doesn't do a lot of activity. V7 said R156 was admitted with the cast because he fell and broke his arm at home. V7 said R156 can usally roll side to side during care, but can't use his hands to hold on to anything. V7 said R156 wouldn't be able to put the side rail down himself. V7 said R156's side rail was a fall precaution. V7 said R156 is a fall risk, that's why he's close to the nurses' station. V7 said R156 was admitted from the hospital with a Fall Risk band on his arm. During interview, resident continues to have restless legs and attempts to wiggle his body down the bed. R156 finally yelled out, [his wife's name]! V7 looked in the room and told R156 she'd be in a minute. R156 settled. At 9:40 AM, R156 started the rocking and wiggling motion with his legs again. R156 had gotten his feet closer to the edge of the bed, but his legs were resting up against the side rail. R156 yelled, [his wife's name]! V11 (CNA) went into R156's doorway and asked if he needed help. R156 replied, I have to go to the bathroom. V7 and V11 (CNA's) assisted R156 to the bathroom. R156's Facesheet printed 6/13/24 showed he was admitted on [DATE] with diagnoses to include, but no limited to: left arm fracture, atrial fibrillation, stage 4 CKD (chronic kidney disease), diabetes, dementia, CHF (congestive heart failure), dysphagia, and depression. This document showed R156 was admitted for m a local hospital. The Advance Directive portion of this document was blank (no information was entered). R156's Physician Order Sheets did not contain an order side rails for mobility, nor did it contain an order for restraints. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R156's EMR (Electronic Medical Record) was reviewed. The Form tab did not include a Side Rail Assessment for Mobility, Restraint Assessment or a Consent form for Restraint Use. The Misc tab (where scanned documents can be viewed) did not contain either of these assessments. R156's Care Plan did not address side rails usage for mobility or restraint use. R156's Fall Risk completed 6/1/24 showed he was a High Fall Risk. On 6/13/24 at 9:41 AM, V8 (RN - Registered Nurse) said R156 was admitted to the facility after a fall. V8 said R156 broke his arm and came to the facility with the cast on his left arm. V8 said R156 is alert to person only most of the time, but occasionally he's more oriented and can answer appropriately. V8 said R156 is a fall risk. V8 said she thought the side rail on R156's bed was more for repositioning in bed. V8 acknowledged that the side rail was on the same side as R156's coasted arm and he would not be able to use his left arm to grab the side rail, but he might be able to reach over with his right arm. V8 said there should be an assessment for side rails. V8 reviewed R156's chart and said she didn't see a side rail assessment. The surveyor asked V8 if R156's side rail could be considered a restraint. V8 replied, Possibly, he wouldn't be able to get up on his own. The surveyor asked if R156 had a Restraint Assessment. V8 replied, I don't see that either. If the side rail was used as a restraint then there should be be a consent form also. On 6/13/24 at 9:55 AM, V3 (MDS Coordinator/Restorative Nurse) said she had several duties at the facility. V3 said R156 is fairly new at the facility. V3 said R156 was admitted to the facility after some falls at home and a broken arm. V3 said R156 is at the facility for rehab and needs extensive assistance from staff for ADLs (Activities of Daily Living). V3 said R156's abilities fluctuate from being described as dead weight to him trying to get himself up. V3 said she is responsible for completing Side Rail Assessments. V3 said a Side Rail Assessment is found in the Forms tab of the EMR. The surveyor asked V3 if R156 had an assessment. V3 replied, He doesn't have one in here. I have not done an assessment with him. I usually do those with the MDS schedule and I haven't done one on him yet. I'll be doing it this week. The surveyor asked if R156's side rail could be considered a restraint. V3 replied, If it's preventing him for getting out of bed, then it would be a restraint. We try not to use restraints here. If it was a restraint, then we would completed a Restraint Assessment and obtained consent from the family. V3 said R156 did not have a Restraint Assessment or a Restraint Consent in the EMR. V3 said if something restricts a resident's movements, then they would try other things. V3 said there should be a care plan in place for side rails and restraints. V3 said R156's care plan did not address the use of side rails. The facility's undated Side Rail Policy provide on 6/13/24 showed, Side rails may be used for mobility, and or positioning . All residents are assessed for side rail use upon admission. 2. Based on the assessment a determination of how many and which side rails are used is made . (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Restraint Policy revised 8/4/22 showed, To ensure residents are provided a safe environment and the use of restraints is carefully monitored to protect resident rights, personal comfort and safety, assuring the least restrictive means are used. Guidelines: Residents are admitted with a Physician's Order for restraint use shall have a restraint use assessment performed and a physician order obtained for the release of restraints with supervision during the assessment process, as appropriate, or an order to discontinue use. 2. Periodic assessments shall address the resident's status in an effort to reduce or eliminate restraints whenever possible and assure the restrictive method is used which allows the resident to function at their highest practicable level . 4. Restraint assessments are performed at a minimum with the initial application, change in type of restraint and change in the resident's condition which affects how the resident responds to current treatment. 5. Less restrictive measures such as pillows, pads, low beds, removable trays, or behavior plans together with appropriate exercise shall be considered prior to use of more restrictive restraints . 10 . The Care Plan should reflect specific circumstances and medical symptoms for restraint sue. In the event restraint use is altered, the Care Plan will be revised.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review the facility failed to ensure physician orders and interventions were in place for oxygen administration for 1 of 1 resident (R28) reviewed for oxygen in the sample of 17. The findings include: R28's face sheet printed on 6/12/24 showed diagnoses including but not limited to chronic obstructive pulmonary disease, atrial fibrillation, congestive heart failure, and presence of cardiac pacemaker. R28's facility assessment dated [DATE] showed moderate cognitive impairment. On 6/11/24 at 7:56 AM, R28 was asleep in bed. Oxygen was running via a nasal cannula at 1.5 liters per minute. At 10:57 AM, R28 was seated on the edge of his bed and the oxygen tubing was next to him. The oxygen was still running at 1.5 liters per minute. R28 stated he wears the oxygen at night while he is sleeping to help with his breathing. R28 said he occasionally puts it on himself during the day if he is napping. On 6/12/24 at 9:42 AM, R28 was out of his room. The oxygen condenser was still located next to his bed. At 12:50 PM, R28 was out of his room and the oxygen was running at 1.5 liters per minute. R28's order summary report and care plan printed on 6/12/24 did not include any physician orders or care interventions related to the oxygen use. On 6/12/24 at 1:08 PM, V5 (Registered Nurse) stated R28 uses the oxygen when he is sleeping. It is for his COPD (chronic obstructive pulmonary disease). I think it needs to be set at 2 liters per minute. V5 reviewed R28's electronic medical record and said she did not see any orders for it. V5 said he needs physician orders to indicate the rate of flow, when to change the tubing, if humidification is needed, and things like that. He should have a care plan for the use of the oxygen too. The interventions are important to ensure he is being monitored for hypoxia and when to check his oxygen saturation levels. On 6/12/24 at 1:14 PM, V2 (Director of Nurses) stated R28 definitely needs orders for the oxygen administration. Oxygen is a medication and requires a physician order. Incorrect use of oxygen can cause respiratory distress or dependency. V2 reviewed R28's medical record and confirmed there was no physician orders or care interventions for the use of the oxygen. The facility's undated Oxygen Administration policy states: 1. Obtain or review order from the physician for oxygen administration. The order should include flow rate and method of administration. 4. Monitor resident during oxygen administration. 5. Document use of oxygen and response to oxygen administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to ensure monitoring a resident on dialysis treatment, failed to ensure emergency equipment for dialysis was at bedside, and failed to care plan treatment for a dialysis patient for 1 of 1 resident (R3) reviewed for dialysis in the sample of 17. The findings include: On 6/11/24 at 7:01 AM, R3 was in her room lying in her bed. The local medical transportation company was in the hallway preparing to pick R3 up and transport her to dialysis treatment. R3's face sheet showed she was admitted to the facility on [DATE] with diagnoses to include anoxic brain damage, Chronic Kidney Disease (Stage 4), end stage renal disease, hyperkalemia, acute kidney failure and Type 2 Diabetes. R3's facility assessment dated [DATE] showed she has no cognitive impairment and requires dialysis treatments. R3's Physician Order Sheet showed an order started 1/19/2024, Dialysis at [local dialysis treatment center], Tuesday/Thursday/Saturday at 8:30 AM . R3's Current Complete Care Plan showed no care plan related to R3's dialysis treatment. R3's medical profile showed no name or contact information for R3's dialysis treatment center. R3's January 2024 eTAR (electronic Treatment Administration Record) showed no monitoring of R3's dialysis site. On 6/13/24 at 10:47 AM, V5 RN (Registered Nurse) said communication with the dialysis company is done by fax usually. V5 said recently she had to start a phosphorus binder, we can call or fax them. We don't have to weigh her before or after she comes back. I don't know what her port is called its something I haven't heard of before, its not one where you have to listen to a bruit or a thrill. We do have to monitor the site, we look for swelling or bleeding. We monitor that daily. We don't send any kind of communication with her. If they have new orders they will either send them back with her or fax us. At 11:19 AM, V5 said, I've never had to call the dialysis company but I know she goes to [a local dialysis treatment center] so it would be easy enough to look up their phone number, I would just Google the phone number if I needed to call them. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 11:48 AM, V2 DON (Director of Nursing) said, We send them and take care of them when they come back. If there are changes they will either fax them or send them back with the patient. We don't do pre and post treatment weights. They do that there. She had a j graft which clotted so she had a temporary in her chest for a while and then they put one in her left arm. I believe it was going to be a fistula at least that is what they said we were sending her for. I lose track of time as to when she had that done . 3/27/24 is when they did the new access. I don't know if its a fistula because it doesn't specifically say in here (V2 was reviewing R3's medical records.) V2 confirmed the discharge packet from March 2024 showed an AV fistula (arteriovenous fistulas) to the left upper arm. V2 said when R3 comes back from dialysis she should have a dressing in place. V2 said when R3 comes back from dialysis the nursing staff should check that to make sure her site isn't bleeding. V2 said, In general for monitoring the site, they should be checking for redness, warmth, or infection with cares just like everything else. The dialysis center looks at it a lot. It would have a palpable turbulence. In someone who is actively getting dialysis three days a week, its a thought that as an established fistula site, I wouldn't expect them to document monitoring for thrill and bruit every shift. If there was an issue to site, it would be included as a focused assessment. For example, is she was complaining of swelling or pain they would assess for the thrill and bruit as part of that focused assessment. If there were an emergency they would be expected to hold direct pressure over the sit and call for help. There are gloves in all the rooms but no special equipment in her room for an emergency. They would have gowns and gloves on to care for her because she is on enhanced barrier precautions. She should be care planned as being a dialysis patient. The facility's undated policy titled Hemodialysis showed, . To implement processes to promote the comfort, safety, and management of hemodialysis residents . Contractual agreement will include but may not be limited to the following a. Medical and non-medical emergencies. b. Development and implementation of a resident's plan of care. c. Interchange of information useful/necessary for the care of the resident. d. Identifying roles and responsibilities between the facility and the dialysis center Clinical responsibilities might include the following but are determined based on patient needs. a. Assessment and documentation of fistula or graft site. b. Obtaining post dialysis weights as determined by the interdisciplinary team in collaboration with the dialysis center g. Revise and update the resident's care plan as needed.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on interview and record review the facility failed to ensure sufficient Certified Nursing Staffing from October through December of 2023. This has the potential to affect all residents residing in the facility. The findings include: The facility's document CMS form 671 dated 6/11/24 showed 53 residents residing in the facility. The facility's Facility assessment dated [DATE] showed under nursing services that the number of CNAs (Certified Nursing Assistants) on the evening shift should be 4. The facility's October 2023 CNA schedule showed on 10/7/23, 10/14/23, 10/15/23 10/21/23, 10/22/23, 10/28/23 and 10/29/23 there were 2.5 CNAs scheduled on the evening shift. The facility's November 2023 CNA schedule showed on 11/4/23, 11/12/23, 11/18/23, and 11/19/23 there were 2.5 CNAs scheduled on the evening shift and on 11/25/23 and 11/26/23 there were only 2 CNAs scheduled for the evening shift. The facility's December 2023 CNA schedule showed on 12/3/23, 12/9/23, 12/16/23, 12/17/23, ad 12/24/23 there were 2.5 CNAs scheduled on the evening shift and on 12/10/23 and 12/23/23 there were only 2 CNAs scheduled for the second shift. On 6/13/24 at 12:03 PM, V2 DON (Director of Nursing) said, We had a plan of correction in place toward the end of last year for our staffing. We usually have 2 nurses on day shift, 2 on evening shift, and 1-2 on night shift but we only need one. Our CNA staffing goal is 4 aides up plus restorative on days, 3 and a half on evenings, and 3 on night shift as well. Call off's are handled by asking for staff already here to stay over and see if someone can come in early. If we can't find someone then it falls to us administrative staff to cover. If they are short, then we come in and work as CNAs if that is what is needed. Our Activity Director, Receptionist, and Dietary Manager are all CNAs as well so they can all help if needed. On 6/13/24 at 12:07 PM, V1 (Administrator) said at the end of the year last year it would have been some of their evening staffing that caused them to trigger for the pay-roll based journal staffing. V1 said she struggles with keeping people for evening shift. V1 said at the end of the year (2023) it was that they were short staffed and had a call off issue. V1 said she thinks she fixed that when she hired a couple people but only one stayed. V1 said if the administrative staff covered the floor it was reported in the system so if the facility triggered it would have been an actual shortage. V1 said minimum staffing for CNA's is 4 on day shift, 3 on evening shift, and 2 on night shift. The facility's policy reviewed 6/12/24 showed, Staffing Policy . To have appropriate number of staff available to meet the needs of residents . Staffing is based on a formula for determining numbers and levels of staff and on the needs of the residents . Staffing is supplemented as needed by outside agencies .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34891 Based on observation, interview, and record review the facility failed to document the administration of a narcotic on the count sheet and failed to reconcile the count between shifts for 1 of 1 resident (R158) reviewed for pharmacy services outside the sample. The findings include: R158's June 2024 order summary report showed an order start dated 6/7/24 for: Tramadol HCl 50 milligrams oral tablet give 1 tablet by mouth every 6 hours for pain. On 6/12/24 at 7:58 AM, the 300-hall medication cart narcotics box was reviewed with V6 (Registered Nurse-day shift) present. R158's Tramadol card had 19 tablets remaining. The corresponding count sheet showed 20 tablets remaining. V6 stated she caught the miscount this morning when she started her AM shift. V6 said she did the shift change narcotic count with V10 (Registered Nurse-night shift) and realized three doses of the Tramadol had not been signed out on the previous shifts. V6 said V10 corrected the count sheet for the doses she had given. V6 said V9 (Licensed Practical Nurse-PM shift) had given the third dose and that was the one missing tablet on the count sheet. V6 said she did not realize until now that V10 had not given all three doses. V6 said the missed documentation and incorrect count should have been caught between shift change but it was not. R158's electronic medical record did show documentation of the three doses given the day prior. One on the PM shift by V9 and two on the night shift by V10. R158's paper count sheet (already corrected) did show documentation of the two doses given by V10, but nothing documented by V9. R158's shift change sign-out report sheet dated June 2024 was blank for the 6/11 day shift to PM shift change. The report was blank for the 6/11 PM shift to night shift change. The report was blank for the 6/12 night shift to day shift change. On 6/13/24 at 10:49 AM, V2 (Director of Nurses) stated R158's Tramadol was missed on the reconciliation between shifts. Nurses should be signing it out as soon as it is given. That is when the resident received it and the count sheet should be accurately reflecting it. Shift change is a second chance to ensure counts are correct. Two nurses are required to count the remaining doses. Any mistakes should be caught and reported immediately. The facility's undated Narcotic Policy states: 5. Individual Narcotic Sign Out record should include date give(n), time given, dosage, signature of nurse administering medications and number remaining. 7. Two nurses must count narcotics at the beginning and end of each shift, initialing the narcotic count record. The two nurses should be the incoming and outgoing nurse. 8. If there is a discrepancy in the narcotic count, the DON should be notified immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146071	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place of Belvidere	1701 5th Avenue Belvidere, IL 61008

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34891 Based on observation, interview, and record review the facility failed to ensure multi-dose insulin pens were dated when opened and failed to dispose of an expired medication for 3 of 5 residents (R9, R22, R156) in the sample of 17 and 2 residents (R13, R33) out of the sample. The findings include: 1. R9's June 2024 order summary report showed an order start dated 4/16/24 for Basaglar Kwikpen (insulin) 30 units one time daily. R22's June 2024 order summary report showed an order start dated 3/25/24 for Fiasp Pen-Injector (insulin) four times a day per sliding scale. R156's June 2024 order summary report showed an order start dated 6/8/24 for Glargine Pen-Injector (insulin) 15 units in the morning. R13's June 2024 order summary report showed an order start dated 3/11/24 for Toujeo Pen-Injector (insulin) 15 units every 12 hours. R33's June 2024 order summary report showed an order start dated 3/2/23 for Lantus Pen-Injector (insulin) 40 units every 12 hours. On 6/12/24 at 7:53 AM, the 300-hall medication cart had five insulin pens in the top drawer. The pens were labeled with the names of R9, R22, R156, R13 and R33. All five pens had a white sticker on the side that stated to discard after 28 days. Every pen was missing the date to indicate when it had been opened. V6 (RN-Registered Nurse) was present and stated the pens should have been dated as soon as they were opened. They are only good for 28 days. Without the dates there is no way of knowing when to discard them. Outdated insulin has the potential to be less effective. The facility's Vials and Ampules of Injectable Medications policy dated 1/2018 states: 2 .The date opened and this triggered expiration date are both important to be recorded on multidose vials (on the vial label or an accessory label affixed for that purpose). At a minimum, the date opened must be recorded. 2. On 6/12/24 at 7:53 AM, the 300-hall medication cart had a multi-dose vial of Fiasp insulin labeled with R22's name. The vial was dated with an open date of 4/4/24. V6 (RN) said the medication was no longer any good. It is expired and should have been disposed after the 28 days. On 6/13/24 at 10:49 AM, V2 (Director of Nurses) stated expired medications need to be disposed to prevent accidental use. There is the potential of less effectiveness and a change in how it works. Staff can accidentally use it if it is still left in the medication cart. Insulin pens should be dated as soon as they are opened. If it is used beyond the expiration date it can lose its potency. That is the standard procedure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146071	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place of Belvidere	1701 5th Avenue Belvidere, IL 61008

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Storage of Medication policy dated 9/2003 states: 3. No discontinued, outdated, or deteriorated medications are available for use in the facility. All such medications are destroyed.