STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146075	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granite Nursing & Rehabilitation	3500 Century Drive Granite City, IL 62040

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on observation, interview, and record review, the facility staff failed to notify the nurse of a resident having a change in condition to ensure timely assessment for 1 of 4 residents (R3) reviewed for quality of care in the sample of 5. This failure resulted in R3 not having timely assessment and subsequently having a Hypoxic/Unresponsive episode, with Cardiopulmonary Resuscitation (CPR) started, and was hospitalized . The Findings Include: R3's Admission Record, dated [DATE], documents R3 was admitted to the facility on [DATE] and was discharged to the hospital on [DATE]. R3's diagnoses includes Chronic Obstructive Pulmonary Disease (COPD), Arteriosclerotic Heart Disease (ASHD), Cardiomyopathy, Myocardial Infarction (MI), Morbid Obesity, Hyperlipidemia, Anemia, Sleep Apnea, Hypertension (HTN), and a Coronary Artery Bypass Graft (CABG). R3's Baseline Care Plan, dated [DATE], documents R3 was alert cognitively, is a fall risk, and the receives special treatment: Oxygen. R3's Minimum Date Set (MDS), dated [DATE], documents R3 was cognitively intact and dependent on staff for toileting, dressing, and transfers, substantial/moderate assistance with showers and partial/moderate assistance for all other Activities of Daily Living (ADLs). R3's Physician Order, dated [DATE], documents, Oxygen: Oxygen at 2 L (liters) per NC (nasal cannula), as needed for SOB (shortness of breath). On [DATE] at 1:46 PM, V4, Licensed Practical Nurse (LPN), stated, I took care of (R3), and she was always on O2 (oxygen). Even though she had an order for PRN (as needed) oxygen, if you tried to lower her dose, or take it off, she would have a hard time breathing and her sats would drop, so I kept her on 3 L/NC. If I would find her with her Oxygen off, she would always look pale and be slightly lethargic and would have to put her Oxygen back on her. (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 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:33 AM, R3 stated, That morning ([DATE]) I was assisted up to my wheelchair and then to breakfast. After breakfast, I had to go to therapy and then I asked the CNA (Certified Nursing Assistant/V6) to put me back to bed because I was tired and didn't feel good but wanted to get up later for activities. When (V6) came back and got me up to my wheelchair, I told her I wasn't feeling good and she put the nasal cannula in my nose and pushed me to the nurse's desk and told me to wait there because my oxygen tank was empty, and the nurse had to fill it. When I told her I did not feel anything coming out of my cannula, she told me I told you it was empty and needed to be filled. When I got to the desk, there was no one around and (V6) left. I started to feel funny and the next thing I know, I woke up with people doing CPR on me. Then the ambulance guys came and took me to the hospital. On [DATE] at 2:15 PM during revisit interview, R3 stated, I was assisted to my wheelchair by the CNA, and she put the cannula in my nose and hooked it up to a portable oxygen tank. I told her I was not feeling good. I just didn't feel right and felt tired. I told her that I did not feel any oxygen coming out of the cannula and she told me it was because the oxygen tank is empty. She told me to go to the nurse's desk and sit there until I see a nurse and tell her that I didn't feel good and that I needed oxygen. It seemed to be around 30 minutes without seeing the nurse. The next thing I knew, I woke up with someone doing CPR on me and the EMTs taking me away. I did have my caregiver come visit me that morning, but she did not bring me lunch or give me anything for pain. I was not in any pain and did not receive anything for pain that day. On [DATE] at 1:13 PM, V6, CNA, stated, I had already gotten (R3) up for breakfast and after breakfast, she said she wasn't feeling well and wanted to go back to bed, so we helped her back to bed to rest. She wanted back up before bingo, so later I asked a therapist (V5) for help in getting her up, but the therapist was busy, so I just grabbed someone else, and we got her up to her wheelchair. I put her oxygen on the portable tank and pushed her to the nurse's desk because she wanted to talk to the nurse because she was not feeling well. I couldn't see the nurse so had (R3) sit there while I went and answered another resident's call light. (R3) was awake and talking when I left her at the desk. When asked why she did not tell the nurse that R3 was not feeling well, V6 stated, I hadn't seen the nurse around to let her know, so just went and answered the call light. On [DATE] at 10:08 AM during revisit interview, V6 stated, (R3) was not feeling well and wanted back to bed, so I put her back to bed. Shortly after that, she had two visitors, a male and a female who brought her lunch. When they were visiting, (R3) seemed very happy, perky, smiling, and cheery while she at lunch with them. (R3) was complaining that her head and stomach was hurting that morning. I told the nurse (V7, Licensed Practical Nurse/LPN) that morning that (R3) needed her oxygen tank filled because she went to therapy and used most of it. That is why I parked her at the nurse's desk, so she could tell the nurse she wasn't feeling good and to get more oxygen. I went and answered another resident's call light down the hall from (R3's) room and he is hard to get out what he needs, so I was in there for a while, I'm guessing around 10 minutes but less than 30 minutes. When I came out of his room, that's when they were all over (R3). On [DATE] at 11:53 AM, V6 stated, I did tell the nurse that (R3's) O2 was running empty. It was not in the red yet but was low. I put (R3) on that portable tank to take her to the desk because when I hooked her up, it hissed like it still had air in it. I do regret not looking at the tank to make sure it had oxygen. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:30 PM, V5, Director of Therapy Service (DTS), stated, I had a CNA (V3) come ask me for help getting (R3) out of bed and I told her I would be there as soon as I could. When I was on my way, I noticed that (R3) was already up and sitting by the nurse's desk. I said Good Morning (R3) and she did not answer me, which was unusual, so I started talking to her and she was not responding. The Nurse, who was on the floor, must have been with another resident, so I went to the DON's (Director of Nursing) office and got her to come help. On [DATE] at 11:25 AM during revisit interview, V5 stated, (V6, CNA) asked me to help get (R3) out of bed to go to bingo, and when I went to (R3's) room, (V6) told me that (R3) had to get cleaned up first because she was soiled. I left and went back to therapy department and waited for maybe 30 minutes to an hour, and when heading back to help out, that is when I found (R3) at the desk. On [DATE] at 1:24 PM, V7, LPN, stated, I was at lunch and when I came back from lunch, the DON was doing CPR on (R3). I assessed (R3) in the morning when I gave her medications, and she did not have any complaints at that time. When I am at lunch, the other nurse covers for me. I told everyone that day that I was going to lunch. (R3) was always on an oxygen concentrator while in her room and a portable tank when she was up in her wheelchair. On [DATE] at 10:59 AM during revisit interview, V7 stated, I don't remember what time I went to lunch that day. I do know that I let the CNAs know I was going to lunch, and I reported off to the DON. I was probably gone around 30 to 35 minutes. (R3) had no complaints of feeling bad that day. I don't recall seeing any visitors with (R3) that day. The CNA on the floor did not tell me anything about (R3's) oxygen tank needing filled. On [DATE] at 12:20 PM, V2 stated, I was in my office when (V5), came in and got me and said that (R3) needed checked out because she doesn't look good. I immediately went to check on her and she was unresponsive, gray, and was not breathing. I do recall seeing an oxygen tank on her wheelchair but could not tell you how much O2 was in there. (R3) did have a nasal cannula on as well. We then got about four of us and took her to her room and laid her on the floor and could not feel a pulse, so I started CPR. After about three compressions, (R3) began to move and CPR was stopped. We had the Ambu-bag attached to the O2 concentrator and was assisting her breathing. When the EMTs (Emergency Medical Technicians) arrived, (R3) was talking to them before she left the facility. (R3) had an oxygen concentrator in her room and if she felt short of breath, she should have been put on that and the nurse notified instead of taken to the nurse's desk. On [DATE] at 1:55 PM, V2 stated, I would expect the CNAs to get a nurse anytime a resident state they don't feel good and not to leave them alone at the nurse's desk while waiting on the nurse. I would expect anyone putting a resident on O2 to check the tank to make sure there is Oxygen in it. On [DATE] at 11:22 AM during revisit interview, V2, Director of Nursing, DON, stated, EMS (Emergency Medical Service) was called at 2:23 PM, and (V7), was at lunch and returned when the EMS was already here and taking care of (R3). When one nurse goes to lunch, the other nurse covers, or the nurse manager will cover. (V7) did tell me she was going to lunch that day, and she usually takes her lunch after the resident's lunch is over. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 8:30 AM, V10, CNA, stated, If a resident tells me they are not feeling well and wants to see the nurse, I will tell the nurse immediately, and the nurse will go check that resident out and do vital signs. I would not park the resident by the nurse's station to wait for the nurse, I would leave that resident in their room and go get the nurse to go to the resident. On [DATE] at 1:00 PM, V12, Physician, stated, I was not made aware of the incident until last evening ([DATE]) when the facility called me and was asking me about a resident who was sent to the hospital and was found to have Fentanyl in her system. I was not even sure who the resident was. I can tell you that this has happened to other residents at different facilities before with the hospital finding Fentanyl in a resident's urine when they were not on Fentanyl. The facility does not even use Fentanyl. I would expect the CNA to go get a nurse right away anytime a resident states they are not feeling well and needs assistance. On [DATE] at 10:32 AM, V14, Lab Supervisor at (Local Hospital), stated, Our Fentanyl cut off limit is 1 NG (nanogram)/ML (milliliter) and usually once it's positive, it's rare to have a false positive. There are proteins and mouse antibodies that can be found in urine that have been known to give a false positive, however, they usually trigger several false positives and not just one. I remember we had one nursing home resident who tested positive for several things and that was her reason. If the ER (emergency room) would have called us, we could have double checked it, but we got rid of that urine and no longer have it to do anything with it. I don't see very many false positives with Fentanyl. We do a QC (quality control) every day and it was done on that day as well. On [DATE] at 11:20 AM, V1 stated, We went and talked to (R3), and she has no idea if or how she may have received Fentanyl. The physician ordered for a hair sample from (R3) to be tested for Fentanyl and that was done and sent off and we are waiting for the results. On [DATE] at 11:29 AM, V15, Lab Employee, stated, We did receive about six hairs from (R3) to run a Fentanyl test, but we could not run the test because it takes 120 hairs to get the results. The facility only collected six hairs and put them in a urine cup, and it was not packaged properly. I spoke to the facility and gave them the correct way to collect the sample, and they are supposed to be resending them the correct way. It normally takes between five to seven days, once they receive the sample, to get the results. R3's Nursing Note, dated [DATE] at 8:23 AM, documents, Resident up in wheelchair in the dining room at this time. Resident receives skilled therapy r/t (related to) generalized weakness. VS (vital signs) ,d+[DATE], 69, 99.7, 95% @ (at) 3LNC (liters per nasal cannula). When O2 placed at 2 L (liters), resident's O2 sats drop to 90%. Lung sounds clear to auscultation. Bowel sounds present in all 4 quadrants. Skin warm, dry, and intact. Able to make needs known. Plan of care continues. Monitoring ongoing. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R3's Nursing Note, dated [DATE] at 2:49 PM, documents, 2:26 PM (V5) came to DON office asking for help. DON followed (V5) to [NAME] nurse's station to find resident (R3) up in wc (wheelchair). (R3) was nonresponsive to verbal and tactile stimuli, eyes rolled back, skin grey in pallor, no respirations noted, faint pulse noted. 911 called. Crash cart obtained. Res (Resident) pushed to her room, transferred to floor via 4-person lift. CPR initiated. 3 rounds of CPR compressions and ventilation via Ambu bag provided. 4th round of CPR initiated when res became responsive, res squeezed finger of nurse providing compressions. Rising and falling of chest noted. Res verbally responded by moaning. O2 94% on 2L /NC (nasal cannula), P-65. EMTs arrived at this time. Res began verbalizing to EMT's at this time. EMT's exited facility at approximately 2:45 pm transport to (local hospital). R3's Hospital Record/Discharge Summary, dated [DATE], documents in part: Date of Discharge [DATE]. C-Diff (Clostridium Difficile) Positive. She refused to go back to the same nursing home. Patient accepted to (another local facility). Plan: Syncopal episode probably multifactorial in origin, including possibly Fentanyl, she tested positive for Fentanyl in the urine which is not a nursing home medication. She also said that her oxygen tank was empty, and she could have passed because of hypoxia. Acute hypoxic respiratory failure present on admission she was saturating at 81% on room air, blood pressure was 80 she had hypovolemic shock on admission both resolved. Fentanyl in her urine - I spoke with the nursing home and that was not a nursing home medication. Patient was transferred to (current facility) from this facility on [DATE]. She was noted to get some Morphine while she was here, but no Fentanyl was given. Had a Cardiac Cath on [DATE] at (local hospital). R3's Cardiac Cath Hospital Records, page 27, dated [DATE], documents R3 had a Left Heart Catheterization on [DATE] with 2 MG (milligram) of Versed and 75 MCG (microgram) of Fentanyl for the procedure. R3 also had another Cardiac Catheterization from a different hospital on [DATE]. Those hospital records were not available for review. The Facility's Notification of a Change in a Resident's Status, dated ,d+[DATE], documents, The attending physician/physician extender (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) and the resident representative will be notified of a change in a resident's condition, per standards of practice and Federal and/or State regulations. 1. Guideline for notification of physician/responsible party (not all inclusive): a. Significant change in/or unstable vital signs (temperature, BP (blood pressure), Pulse, Respiration). d. Any accident or incident (per Federal and State Regulations). f. Abnormal lab findings. i. Change in level of consciousness.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview and record review, the facility allowed Certified Nursing Assistants (CNA) to administer Oxygen to residents for 1 of 4 residents (R3) reviewed for administration of Oxygen (O2) in the sample of 5. The Findings Include: R3's Admission Record, dated 3/18/25, documents R3 was admitted to the facility on [DATE] and was discharged to the hospital on 3/7/25. R3's diagnoses includes Chronic Obstructive Pulmonary Disease (COPD), Arteriosclerotic Heart Disease (ASHD), Cardiomyopathy, Myocardial Infarction (MI), Morbid Obesity, Hyperlipidemia, Anemia, Sleep Apnea, Hypertension (HTN), and a Coronary Artery Bypass Graft (CABG). R3's Baseline Care Plan, dated 2/27/25, documents R3 was alert cognitively, is a fall risk, and receives special treatment: Oxygen. R3's Minimum Date Set (MDS), dated [DATE], documents R3 was cognitively intact and dependent on staff for toileting, dressing, and transfers, substantial/moderate assistance with showers and partial/moderate assistance for all other Activities of Daily Living (ADLs). R3's Physician Order, dated 2/27/25, documents, Oxygen: Oxygen at 2 L (liters) per nasal cannula, as needed for SOB (shortness of breath). On 3/18/25 at 9:33 AM, R3 stated, After breakfast, I asked the CNA (Certified Nursing Assistant/V6) to get me up for activities. (V6) got me up to my wheelchair and put the nasal cannula in my nose and pushed me to the nurse's desk and told me to wait there, because my oxygen tank was empty, and the nurse had to fill it. When I told her I did not feel anything coming out of my cannula, she told me, I told you it was empty and needed to be filled. When asked about who usually puts her oxygen on her, R3 stated, Either the CNA or the Nurse will put it on me. They kept me on the oxygen all the time, 24/7. On 3/17/25 at 1:13 PM, V6, CNA, stated, I put (R3) on oxygen on the portable tank and pushed her to the nurse's desk. When asked if she is supposed to put residents on oxygen, V6 stated You would have to ask my supervisor. I have been an aide for a while and have always put the resident on oxygen and have never had a problem. On 3/17/25 at 1:24 PM, V7, LPN, stated, (R3) was on an oxygen concentrator while in her room and a portable tank when she is up in her wheelchair. The CNAs usually tell me when a resident needs another oxygen tank. When asked who is responsible for putting O2 on a resident, V7 stated, The CNAs are not supposed to put the resident on oxygen, they are supposed to come tell us and we put it on. On 3/17/25 at 1:30 PM, V8, CNA, stated, I'm not sure if we are allowed to put the oxygen on residents, you would have to ask my managers. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 1:45 PM, V1, Administrator stated, I'm not sure if the CNAs are allowed to put oxygen on residents. I will have to find out for you. On 3/18/25 at 8:05 AM, V9, CNA, stated, When I get a resident out of bed to their wheelchair and they are on oxygen via concentrator, I will place the oxygen on the portable tank to what they were on the concentrator, then I will have the nurse recheck it to make sure it was correct. I am not sure if the CNAs are supposed to be putting oxygen on the residents, but I do it and then have the nurse check it afterwards. On 3/18/25 at 8:30 AM, V10, CNA, stated, When I get a resident out of bed and that resident is on Oxygen via concentrator, I would go tell the nurse the resident needs to be put on a portable tank and the nurse will go and put it on the resident. The CNAs are not supposed to be putting the oxygen on the residents. On 3/18/25 at 8:35 AM, V11, LPN, stated, The nurses are the ones who are responsible for the portable oxygen tanks. If a resident is going from a concentrator to a portable tank, usually it's the CNAs who do it. I am not sure if they are allowed to do so, but they do it, and I will check afterwards to see if they are on the correct amount of oxygen. On 3/17/25 at 2:10 PM, V2, DON, stated, Our CNAs are not allowed to adjust the oxygen on residents, but I believe they are allowed to put them on a portable tank and turn it on to what they are supposed to be on. I see it all the time. The Facility's Oxygen Therapy Policy, dated 8/2014, documents Oxygen is administered to promote adequate oxygenation and provide relief of symptoms of respiratory distress. Responsibility: Nursing Personnel/Respiratory Therapist. Procedure: 1. Oxygen therapy is to be provided under the direction of a written physician's order for O2 therapy is to contain liter flow per minute via mask or cannula/timeframe. On an emergency basis, O2 may be used at 2L/minute until the physician is notified. 2. Explain the procedure to the resident. 3. Assemble the equipment and place appropriate device on resident. 4. Adjust delivery rate as ordered. 5. Check that equipment is functioning properly and assure that mask or cannula is securely and comfortably in place. The Facility's Medication Administration - General Guidelines Policy, dated 8/2016, documents Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Responsibility: All Licensed Nursing Personnel. Procedure: 1. Medications are prepared, administered, and recorded only by licensed nursing, medical, or other personnel authorized by state laws and regulations to administer medications. 2. Medications are administered in accordance with written orders of attending physicians, taking into consideration manufacturer's specifications and professional standards of practice.