

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER Granite Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156</p> <p>Based on interview and record review the facility failed to prevent resident to resident abuse for 2 of 7 residents (R29 and R42) reviewed for abuse in the sample of 31.</p> <p>Findings include:</p> <p>1. R42's Physician Order Sheet for October 2024 documents, Unspecified dementia, severity with behavior disturbances, unspecified dementia, unspecified severity, with agitation, unspecified psychosis not due to a substance or known physical condition, bipolar disorder, major depression, anxiety disorder, Alzheimer disease, insomnia, essential hypertension, allergic rhinitis, GERD, cognitive communication deficit, and adult failure to thrive.</p> <p>R42's Minimum Data Set, dated dated dated [DATE] documents R42 was cognitively intact for decision making for activities of daily living.</p> <p>R42's Care Plan with problem onset date of 2/9/2024 Diagnosis of bipolar, MDD (major depressive disorder), anxiety, and benefit from the use of psychotropic medication. I exhibit attention seeking behaviors/inappropriate behaviors such as pacing up and down halls, daily verbal outburst of cussing at staff and other residents, racial slurs. Abuse was not addressed in R42's Care Plan.</p> <p>R42's Incident Report documents, On the evening of 2/12/2024 at approximately 8:00 PM, Certified Nursing Assistant CNA, V11 stated, I was working on the East Hall. Resident (R29) ambulated out of her room with her walker. (R29) approached CNA and stated, that lady slapped me when I was in bed and pointed to (R42) just as (R42) was walking past them. (R42) reacted to hearing (R29) and seeing her point at her by hitting her face. CNA (V11) immediately intervened and separated the two residents. (R29) went down the hall to the common area and (R42) went into her room. (V11) called for nurses (V8), Registered Nurse (RN) attended to (R29). (V8) completed a head-to-toe assessment. Assessed (R29) for pain and injury, (R29) noted to have a 0.5 cm in length abrasion to her left cheek.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R42's Social Service Note dated 2/13/2024 at 2:55 PM, documents, (V10, Social Service Director) was asked to reach out to (R42's) family and (V9, Adult Protection Service) worker in order to help (R42). Once good phone numbers were obtained, (V10) called (R42's) family member. (R42's) family member answered and (V10) explained that (R42) had attacked not only a staff member but another resident unprovoked. (V10) explained that they were wanting to send (R42) back to the hospital for inpatient psych evaluation and treatment and asked that (R42's) family member come to the facility in order to assist with this. (R42's) family member stated that he would be on his way. (V10) asked (R42's) family member that he bring the guardianship paperwork with him. (R42's) family member stated that the paperwork was not yet completed but that he would bring it. (V10) also reached out to (V9) and explained the situation to her. (V9) agreed to come to the facility in order to assist. (V10), (V2), and (V9) along with (R42's) family member talked with (R42) regarding her actions. (R42) denied hitting anyone or cussing anyone out. (R42) stated that she wasn't listening to anything they had to say and was going back to her room. After talking, (R42's) family member and (V9) determined that it would be best for (R42) to be sent out. (R42) was brought back into the office and explained everything. (R42) then agreed to go to the hospital. (V2) called (Local Hospital). (R42) signed all the paperwork requested by the hospital in order to be admitted. (Hospital) explained that they would send the ambulance once they received the ok from their doctor. When the ambulance arrived (R42) began cussing and fighting with the paramedics and did not want to initially get onto the stretcher. After (R42's) family member talked with her, (R42) was placed on the stretcher with staff assistance and she left the facility. (V9) stated that she feels that (R42) needs more inpatient psychiatric care and treatment at this time and that she will be looking for possibly a locked facility upon discharge from the hospital in the future.</p> <p>2. R29's POS for October 2024 documents a diagnosis of hyperlipidemia, anxiety disorder, anemia, unspecified psychosis not due to a substance or known physical condition, major depressive disorder, insomnia, and hypertension, and cognitive communication deficit.</p> <p>R29's MDS dated [DATE] documents R29 was severely impaired for cognition of activities of daily living. R29 uses a wheelchair.</p> <p>R29's Care Plan, with a problem onset of 8/12/2021 documents, I have a diagnosis of anxiety, psychotic disorder, and benefit from the use of psychotropic medication. I can become angry and confrontational when I am confused. I have had no history of hitting at staff during these episodes. 2/12/2024 Resident immediate separates. Resident assessed for pain/injury. MD (Medical Doctor) family notified. 15-minute checks for rest of night. (Abuse was not addressed in R29's Care Plan.</p> <p>R29's Incident Report dated 2/12/2024 at 8:00 PM, At approximately 8:00 PM, Resident ambulated out of her room. (R29) spoke with CNA (V11), stating, that lady slapped me in the face when I was in bed, and pointed at another resident (R42). (R42) was walking past and heard (R29) and saw her point at her. (R42) responded by hitting (R29) in the face. (R29) yelled out. CNA (V11) intervened and separated residents. (V11) called for nurse (V8). (V8) performed head to toe assessment for pain/injury/skin. Noted a 0.5-centimeter abrasion to (R29)/ left cheek. No complaints of pain. MD (Medical Director) and family notified. DON notified. Resident placed in new room for her safety. IDPH notified. Area cleansed and left OTA (open to air) per order.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R29's Post Incident Action dated 2/12/2024 at 8:00 PM, At approximately 8:00 PM, resident ambulated out of her room. (R29) spoke to CNA (V7), that lady slapped me in the face when I was in bed and pointed at another resident (R42). (R42) was walking past and heard (R29) and saw her point at her. (R42) responded by hitting (R29) in the face. (R29) yelled out. CNA (V11) interviewed and separated residents. Immediate Post Incident Action Care Plan update, resident separated from other resident involved. Resident placed in new room for her safety, medication reviewed, next treatment order, Resident placed on 15-minute checks.</p> <p>On 10/16/2024 at 4:02 PM, V2, Director of Nursing stated, If we can avoid a resident-to-resident altercations at all costs, I would not expect another resident to slap another resident. Hopefully, staff can step in before it escalates to that point. (R42) did wear a lot of rings.</p> <p>The Facility Abuse Policy with a revision date of 11/2/2022 documents, The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteer and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Physical Abuse: This includes but is not limited to hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156</p> <p>Based on observation, interview, and record review the facility failed to ensure a safe transfer for 1 of 5 residents (R64) reviewed for transfers in the sample of 31.</p> <p>Findings include:</p> <p>R64's Physician Order Sheet (POS) dated October 2024 documents a diagnosis of Down's syndrome, hypothyroidism, major depressive disorder, dysphagia, oral phase, other symptoms and signs with cognitive functions and awareness.</p> <p>R64's Care Plan, with a problem onset date of 11/1/2023, documents, I have a diagnosis of MDD (mental depressive disorder) and benefit from the use of psychotropic medication. I have diagnosis of Down's syndrome, Alzheimer/dementia, I am nonverbal and unable to communicate my needs.</p> <p>R64's Minimum Data Set (MDS) dated [DATE] documents R64 was severely impaired for cognition for activities of daily living. Dependent on staff, helper does all of the effort for most activities.</p> <p>On 10/16/2024 at 4:14 PM, V13, Certified Nursing Assistant (CNA) was pushing a mechanical lift down the hallway. She entered R64's room and closed the door.</p> <p>On 10/16/2024 at 4:20 PM, R64's door was opened and R64 was up in the air in a sling and was being transferred to her wheelchair. R64 was hanging in the air and V13 was by herself. No other staff member was in the room.</p> <p>On 10/16/2024 at 4:21 PM, V13 stated, (R64) was a two person assist and there should always be two people in the room while transferring with a mechanical lift and I have no good reason why I did not have another staff member in the room with me. I have two other aides working on this side of the building now.</p> <p>On 10/16/2024 at 4:33 PM, V2, Director of Nursing stated, I expect there to always be at least two staff present when transferring residents with a mechanical lift and there are no circumstances where a safe transfer can be done with only one staff member.</p> <p>R64's EZ Move Screen Transfer Form documents she is a 2 person assist with lift, patient is unresponsive or non-weight bearing. Patient requires assistance with lateral transfers.</p> <p>The (Brand name) Total Lift Policy dated 8/16/2024 documents, The Invacare Total Lift is to be used for total lifts and/or to obtain a resident's weight from bed to chair, chair to bed, or from the floor (maximum lifting per manufacture guidelines). (Brand name) 450 capacity is less than 450 lbs. (Brand name) 600 weight capacity is less than 600 lbs.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>35156</p> <p>Based on observation, interview, and record review the facility failed to ensure food was stored and prepared in a manner which prevents potential contamination. This has the potential to affect all 76 residents living in the facility.</p> <p>Findings include:</p> <p>On 10/15/24 at 8:30 AM, tour of the kitchen was conducted. In the walk-in refrigerator was a roll out cart and on the tray were clear drinks, and pink colored drinks. There were 24 (4 ounce) plastic glasses that had no date and/or label on them.</p> <p>On 10/15/2024 at 8:32 AM, V12, Dietary Manager stated, We just made those drinks today. They should have dated and labeled them. I would expect everything to have a date and label so there is no guessing of when it was made.</p> <p>On 10/15/2024 at 8:33 AM, in the dry storage area is a large, industrial, 72-quart clear container of a whitish brown colored medium grain substance. It is not dated and/or labeled.</p> <p>On 10/15/2024 at 8:34 AM, V12 stated the container contained rice and it should have been dated and labeled.</p> <p>On 10/15/2024 at 8:35 AM, was another 72-quart container, halfway full, containing oblong shaped crumbs. The container was not dated and/or labeled.</p> <p>On 10/15/2024 at 8:36 AM, V12 stated, Those are Panko breadcrumbs. They should have been labeled.</p> <p>On 10/15/2024 at 8:37 AM, There was a clear 72-quart container 1/4 full of what appeared to be some type of dried beans.</p> <p>On 10/15/2024 at 8:38 AM, was a four-quart container of yellowish powder like substance. The container was full. There was no date and/or label.</p> <p>On 10/15/2024 at 8:39 AM, V12 stated the large container was beans and the yellowish substance was cornmeal and they both should have been dated and labeled.</p> <p>On 10/15/2024 at 8:40 AM, the steam table contained scrambled eggs, and boiled eggs.</p> <p>On 10/15/2204 at 8:44 AM, during the breakfast service V11, [NAME] was serving food from the steam table and was wearing kitchen gloves.</p> <p>On 10/15/2024 at 8:47 AM, V11, left the steam table went over to the dirty side of the kitchen, picked up a dirty bowl, sprayed it with an industrial spray hose, cleaned out the bowl took it back to the steam table and continued serving. V11 did not remove her gloves and/or wash her hands and continued serving with the same gloves.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 10/15/2024 at 8:48 AM, V11, was touching the brims of the bowls with her dirty gloved hands and was serving oatmeal.</p> <p>On 10/15/2024 at 8:54 AM, temperatures were taken after the last breakfast tray had been served and were taken with a metal calibrated thermometer and the scrambled eggs were at 117 degrees Fahrenheit (F), and the boiled eggs were at 122.0 degrees F.</p> <p>On 10/15/2024 at 8:57 AM, V12, stated, I would expect all of the food on the steam table to be at least 135 degrees or higher.</p> <p>On 10/18/2024 at 9:54 AM, V15, Dietician stated, I would expect all food to be dated and labeled. All hot food on the steam table should be at least 135 degrees Fahrenheit or higher. If the temperature is lower than 135 degrees, this could be harmful because the temperatures can get in the danger zone and bacteria can grow and thrive at this temperate and could cause foodborne illness to residents.</p> <p>The Monitoring Food Temperatures for Meal Service policy 2016 edition documents, Food temperature will be monitored daily to prevent food borne illness and ensure foods are served at palatable temperatures. Prior to serving a meal. Food temperatures will be taken and documented for cold and hot foods to ensure proper serving temperatures. Any food item not found at the correct holding/serving temperature will not be served but will undergo the appropriate corrective action listed below. If the serving/holding temperate of a hot food is not at least 135 F or higher when checked, they will be reheated to at least 165 F, for a minimum of 15 seconds, only once and discarded or consumed within two hours.</p> <p>The Food Storage (Dry, Refrigerated, and Frozen) Policy 2016 edition documents, Food shall be stored on shelves in a clean, dry area, free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. Label food item held no longer than 24 hours. The label should include the name of the food if not in original packaging, the date by which it should be sold, consumed, or discarded.</p> <p>The CMS 671 Long Term Care Facility Application for Medicare and Medicaid form dated 1016/2024 documents the facility has 76 residents.</p>		