STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146133	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandwich Rehab & Hcc	902 East Arnold Street Sandwich, IL 60548

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on interview and record review the facility failed to prevent the diversion of Schedule II medication. This applies to 2 of 6 (R2, R7) residents reviewed for misappropriation of resident medications in the sample of 14. The findings include: 1. R2's June 2024 Medication Administration Record (MAR) showed an order for Hydrocodone/Acetaminophen 5/325 milligrams (mg) (Commonly referred to as Norco. A combination Schedule II narcotic and over-the-counter pain reliever.) The order shows it is to be given three times a day at 7:00 AM, 1:00 PM, and 8:00 PM. The MAR shows the medications for Saturday 6/22/24, Sunday 6/23/24, and Monday 6/24/24 doses were documented as being given. R2's Controlled Substance Proof of Use records (Narcotic Count Sheets or Count Sheets) showed the facility received three cards of Norco 5/325 mg, each containing 30 tablets. The cards were received by the facility on 5/9/24 and are identified by 1 of 3, 2 of 3, and 3 of 3. Card 2 of 3's initial dose was administered on 6/14/24 at 7:00 AM and the final dose was administered on 6/24/24 at 9:30 PM. Card 3 of 3's first dose was given on 6/22/24 at 8:00 AM and the card had 14 tablets remaining on 6/27/24 at 7:00 AM. (Showing card 2 of 3 and 3 of 3 had overlapping dates.) The narcotic count sheets showed from 6/22/24 at 7:00 AM through 6/24/24 at 8:00 PM, 15 tablets of Norco were dispensed when only 9 tablets should have been administered. R2's 5/9/24 2 of 3 Norco Count Sheet showed the remaining 6 tablets of Norco were documented as being administered on: 1) 6/22/24 at 7:00 AM by V2 (Director of Nursing/DON), 2) 6/22/24 at 1:00 PM by V2, 3) 6/22/24 at 9:00 PM by V27 (Licensed Practical Nurse/LPN), 4) 6/23/24 at 7:00 AM by V8 (Registered Nurse/RN), 5) 6/24/24 (an overwritten date that appears to be 6/24/24) at 1:00 PM by V8, and 6) 6/24/24 at 9:30 PM by V28 (RN). R2's 5/9/24 Norco Count Sheet showed the first 9 tablets were documented as being administered on: 1) 6/22/24 at 8:00 AM by V2, 2)6/22/24 at 1:00 PM by V29 (RN) (V29 was in training at this time and she was working with V2), 3) 6/22/24 at 8:00 PM by V2, 4) 6/23/24 at 8:00 AM by V29, 5) 6/23/24 at 1:00 PM by V29, 6) 6/23/24 at 8:00 PM by V19 (Regional Director of Clinical Operations), 7) 6/24/24 at 8:00 AM by V29, 8) 6/24/24 at 12:45 PM by V29, and 9) 6/24/24 at 8:00 PM by V27. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's June 2024 MAR showed V2 documented as giving the 7:00 AM and 1:00 PM doses on 6/22/24, 6/23/24, and 6/24/24. The 8:00 PM dose on 6/22/24 was documented as being given by V2. The 8:00 PM dose on 6/23/24 was documented as being given by V19. The 8:00 PM dose on 6/24/24 was documented as being given by V27 (not V28 who's alleged signature is documented in the 2 of 3 Count Sheet for this dose.) On 7/1/24 at 9:29 AM, V8 (RN) stated she was originally scheduled to work the 12-hour day shift the weekend of 6/22/24 and 6/23/24. V8 stated she was fired from the facility a few days prior to that weekend due to her refusal to work regarding the count sheets. V8 stated the signatures on R2's 2 of 3 Norco Count Sheet for 6/23/24 at 7:00 AM and 6/24/24 at 1:00 PM are not her signatures. V8 said, Someone very poorly try to copy my name, but it does look like someone tried to copy my signature. I was already fired before that weekend . It looks like the same person signed out all of those medications because the penmanship looks the same for all the dates, times, and signatures. V8 said it appears that a person signed out at least the last six Norco and most likely took them. V8 said, if a nurse signed out the last medication in a card, the policy was to dispose of the card, no witnesses needed to dispose of an empty card, and then file the count sheet. V8 said if a nurse signed out the last 6 narcotic medications in advance, kept them for himself or herself, threw away the empty card, and filed the count sheet; they would most likely not be caught. On 7/1/24 at 11:15 AM, V29 stated she worked the weekend of 6/22/24 with V2 (DON) while she was in training. V29 stated there was an issue with night staff so V2 worked the night shift on 6/22/24 and V19 worked the night shift on 6/23/24. V29 stated if both of R2's Norco cards (2 of 3 and 3 of 3) were in the drawer and in use, the issue with both being in use and the overlapping documentation would have been caught. V29 stated she absolutely did narcotic count at the beginning and end of her shifts. V29 stated because the issue was not found at shift change leads her to believe the 2 of 3 card was not in the drawer on 6/22/24. On 7/1/24 at 1:58 PM, V2 (DON) stated the signatures on R2's 2 of 3 Norco Count sheet for 6/22/24 at 7:00 AM and 1:00 PM were not her signatures. V2 said she is the person in charge of the controlled substance program. V2 stated the medications in the cart belong to the residents and are their property. V2 stated the most likely explanation given the forged signatures, overlapping documentation, and Norco signed out by staff who were not in the building; is the remaining 6 Norco in card 2 of 3 were taken by a nurse. V2 said she was not checking the controlled substance count sheets for overlapping documentation between cards and an issue like this would have gone undetected. On 7/1/24 at 1:58 PM, V19 (Regional Director of Clinical Operations) stated it appeared the last six signatures on R2's 2 of 3 Norco card appeared to be signed by the same person and the dates and times appeared to be similar handwriting as well. V19 stated the only reasonable explanation is the medications were diverted by a nurse. The facility's Abuse Prevention Program policy (Revised 11/28/16) showed residents have the right to be free from misappropriation of their property. The policy showed, Misappropriation of resident property means the deliberated misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. 2. On 6/29/24 and 6/30/24 R2's Norco sheets from 4/2/24 through June 2024 were requested. On 6/30/24 at 10:15 AM, V1 stated all of R2's controlled substance count sheets the facility has available, have been provided. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's April and May 2024 Medication Administration Record (MAR) showed an order for Hydrocodone/Acetaminophen 5/325 milligrams (mg) (Commonly referred to as Norco. A combination Schedule II narcotic and over-the-counter pain reliever.) The order shows it is to be given three times a day at 7:00 AM, 1:00 PM, and 8:00 PM. A list of Norco shipments provided by the facility's pharmacy showed the pharmacy shipped 12 Norco for R2 on 4/15/24. R2's count sheet showed these 12 Norco shipped on 4/15/24 the last dose of 12 tablets was administered on 4/19/24 at 8:00 PM The list of Norco shipments showed R2's next shipment was on 4/19/24 and 90 tablets were delivered. Of the 90 tablets of Norco delivered on 4/19/24, the facility was only able to provide one Count Sheet which ran from 5/4/24 12:30 PM through the final dose on 5/14/24 at 8:00 AM. R2's list of Norco shipments showed 60 tablets were shipped on 4/22/24. R2's Norco count sheet showed the card of 60 was started on 5/14/24 at 8:00 AM (this dose also overlapped a documented dose on the previous card.) R2's MAR showed from 4/20/24 at 8:00 AM through 5/14/24 at 8:00 AM (This is the time frame from when the 90 tablets were administered considering the 12 Norco shipped on 4/15/24 were completed on 4/19/24 at 8:00 PM and the start of the 60 Norco on 5/14/24 at 8:00 AM which were delivered on 4/22/24.) showed 73 doses of Norco were administered (The MAR showed the 5/24/24 1:00 PM dose was not documented; however, this dose was included in the count of 73.) (17 doses of Norco are not accounted for) On 7/2/24 at 1:00 PM, V2 (Director of Nursing/DON) stated 90 tablet supply of medication should last 30 days for a person who takes the medication three times a day. V2 said, if R2's Norco was exhausted on 4/19/24 and he started a 90-tablet supply on 4/20/24 the supply should have lasted until approximately 5/19/24 or 5/20/24, depending on the month. V2 said, given the missing count sheets, the only explanation for R2's missing Norco is they were diverted. R2's April 2024 MAR showed R2's next dose, following the 4/19/24 at 8:00 PM, was on 4/20/24 at 7:00 AM. On 7/2/24 at 1:00 PM, V2 Director of Nursing (DON) stated a supply of 90 tablets that is to be given three times a day should last 30 days. 3. R7's December 2023 Medication Administration Record (MAR) showed an order for Hydrocodone/Acetaminophen 10/325 milligrams (mg) (Commonly referred to as Norco. A combination Schedule II narcotic and over-the-counter pain reliever.) The order shows it is to be given four times a day at 6:00 AM, 11:00 AM, 4:00 PM, and 9:00 PM. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's Controlled Substance Proof of Use records (Narcotic Count Sheets or Count Sheets) showed the facility received four cards of Norco 10/325 mg, each containing 30 tablets (total of 120 tablets). The cards were received by the facility on 12/6/23 and the cards are identified by 1 of 4, 2 of 4, etc . Card 1 of 4's initial dose was administered on 12/7/23 at 4:45 AM and the final dose was documented as being administered on 12/15/23 at 4:00 PM. Card 2 of 4's initial dose as documented as being wasted at 1:115 PM (unknown what time was intended) and the final dose was administered at 4:30 PM on 12/21/23. R7's 1 of 4 Norco Count Sheet showed V8 (Registered Nurse/RN) administered the final six doses in this Norco card. The doses were documented as being given on: 12/14/23 at 6:00 AM, 11:00 AM, and 4:00 PM: then on 6/15/24 at 6:00 AM, 11:00 AM, and 4:00 PM. (The 9:00 PM doses for these days were not signed out on this count sheet. V8 stated the signatures associated with these 6 Norco was her handwriting.) R7's 2 of 4 Norco Count sheet showed the first six doses were administered by: 1) V27 (Licensed Practical Nurse/LPN) on 12/14/23 at 1:115 PM and the medication was wasted by V8 2) V8 on 12/14/23 at 5:00 PM 3) V33 LPN on 12/14/23 at 9:20 PM 4) V33 on 12/15/23 at 5:45 AM 5) V8 on 12/15/23 at 11:00 AM 6) V8 on 12/15/23 at 5:30 PM. (These are duplicate administrations or similar administrations to card 1 of 4.) On 7/1/24 at 1:20 PM, V8 stated regarding R7's Norco count sheet 2 of 4 (received on 12/6/23) Not only are those not my signatures on 12/15 and 12/14, but it's also not how I write my dates and times. I almost always write in military time and the handwriting does not match mine. Also, the signature at the top next to wasted looks like they tried to [NAME] my signature as well and they didn't do a good job of it. It looks like the person who wrote all the times on 12/14 and 12/15 was the same person. (In regard to the signatures on count sheet 1 of 4 on 12/14/23 and 12/15/23) Those are definitely my signatures. See how it's military time and my signatures are very consistent. I did initial one of them but that is my initial. Two of the medications were given on 12/15/23 at 11:00 AM, I do not have memory issues and I would not have dispensed that to her twice and would not have dispensed her medication to another resident. I think a nurse stole the medications from the start of that card (card 2 of 4) and filled in the dates and times. On 7/1/24 at 1:58 PM, V19 (Regional Director of Clinical Operations) stated, regarding R7's 2 of 4 count sheet, the first six signatures appeared to be signed by the same person. V19 said the dates and times also appear to be filled out by the same person. V19 said the most likely explanation is someone filled in, at least the first six doses, dispensed them, and diverted them.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 39543 Based on interview and record review the facility failed to investigate an allegation of drug diversion. This applies to 5 of 6 (R2, R7, R8, R9, R14) residents reviewed for misappropriation of resident property in the sample of 14. The findings include: On 6/28/24 at 10:00 AM, V18 stated herself and V8 reported, over speaker phone, a missing narcotic card to V19. V18 said it was reported sometime in February. V18 said she could not recall exactly which resident was reported. V18 said the incident was never investigated and she was told not to report drug diversion allegations if she did not have proof of who was taking the medication. On 6/28/24 at 11:40 AM, V8 (Registered Nurse/RN) stated I went to [V18 (Minimum Data Set nurse)], I think around February, that we had a missing card of narcotics then [V18] and I reported it to [V19 (Regional Director of Clinical Operations)] over the phone. [V19] swept it under the rug and blew us off. [V19] did not want to believe it and then she blamed it on a night agency nurse, and she never looked into it. We had the pink sheet but not the card. V8 stated it was a partial card of Norco tablets that were missing. (A schedule two narcotic pain medication.) V8 stated, due to the amount of time that had passed, she could not recall which resident had the missing norco. On 6/30/24 at 10:15 AM, V1 (Administrator) stated he did not have any allegations of misappropriation of resident property for February or March 2024. On 7/1/24 at 1:58 PM, V19 denied being aware of any allegations of drug diversion. On 7/1/24 at 1:58 PM, V2 (Director of Nursing) stated she was responsible for the controlled substance program. V2 stated the medications belong to the residents. V2 said controlled substances are more likely to be diverted than other medications. V2 said the purpose of investigating allegations of misappropriation is to attempt to identify if the allegation occurred then to determine the guilty party so the theft does not continue. On 7/2/24 at 2:15 PM, V7 (Licensed Practical Nurse) stated she was not present when V8 and V18 reported the missing card of controlled substances; however, V7 stated both V8 and V18 told her they had reported the missing narcotic card to V19. V7 said, I think it was January of February. V7 said, she could not recall which resident was missing the card of controlled substances. V7 said she did recall looking for the card as well as the count sheet and she was not able to locate either. V7 said the incident was not investigated by administration. R2, R7, R8, R9, R14's Controlled Substances Proof of Use sheets (narcotic count sheets or count sheets) showed these residents were on Schedule II narcotics in February 2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Abuse Prevention Policy (Revised 11/16/18) It is the policy of this facility to prevent the loss of controlled substances and vigorously investigate incorrect inventory of controlled drugs, medications or pharmaceuticals reported by pharmacists, physicians or licensed nurses . 4. Should the count prove to be incorrect compared to actual inventory at any time, report will be made to the Director of Nursing immediately. 5. An immediate inventory of controlled substances will be taken by the Director of Nursing and Administrator. 6. The Director of Nursing will report the discrepancy to the Pharmaceutical Consultant upon verification that the count is inaccurate. 7. The Director of Nursing will investigate the use and disposition of controlled medication to determine the nature of the discrepancy .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39543 Based on interview and record review the facility failed to have policies in place to show accurate reconciliation of controlled substances, failed to implement current policies for the accurate reconciliation of controlled substances, failed to ensure controlled substance records are maintained, and failed to ensure controlled substances are periodically reconciled. This applies to 6 of 6 residents (R2, R7, R8, R9, R12, and R14) reviewed for controlled substances in the sample of 14. The findings include: 1. R12's Controlled Substances Proof of Use sheets (aka Count Sheets or Narcotic Count sheets) showed she had two medication cards for Hydrocodone/Acetaminophen 5/325 milligrams (mg) (Commonly referred to as Norco. A combination Schedule II narcotic and over-the-counter pain reliever.) One card of 30 tablets was delivered on 12/7/23 and had 11 tablets remaining. The second card was delivered on 12/21/23 and had not been used. (30 tablets remained. The card showed V27 (Licensed Practical Nurse/LPN) wasted all 41 tablets of Norco and there was no second nurse who signed as witnessing the Norco being wasted. On 7/2/24 at 1:30 PM, V27 (LPN) stated a second nurse is supposed to witness medications being wasted. V27 said she wasted all 41 tablets of R12's Norco with V7 (LPN) and forgot to have V7 cosign. On 7/1/24 at 1:58 PM, V2 (Director of Nursing) stated narcotic medications are controlled if count sheets due to their high susceptibility to diversion and abuse. V2 said when a nurse wastes a controlled substance, like Norco, the nurse is supposed to waste this medication with another nurse to ensure the medication is wasted and to protect the nursing staff from accusations. On 7/2/24 at 2:15 PM, V7 said she typically signs the controlled substance sheet first, once the medication is verified, then she will dispose of the medication with the other nurse. V7 said she does not recall wasting R12's medication with V27; however, V7 said there were concerns about nursing staff diverting narcotics at the time this medication was wasted and she was especially careful with narcotics at that time. V7 stated V27 was dropping and wasting an excessive number of narcotics and V7 stated she believed V27 was the nurse diverting narcotics. The facility's Controlled Substances policy showed 5. If a resident refuses a dose of a controlled drug, or it is not given for any reason, the medication dose must be destroyed. The dose must be destroyed in the presence of two (2) Licensed Nurses and documented on the disposition sheet as destroyed .9. Discrepancies must be reported immediately to the Director of Nursing who shall investigate as described in the Missing Controlled Substance Policy. When loss, suspected theft or an error in the administration of regulated drug occurs, a report will be filed with the Pharmacist and the Administrator .11. Scheduled drugs may not be returned to the pharmacy upon a resident's discharge/transfer/death. If the return of a resident is expected, scheduled drugs may be kept and counted for a period of up to 7 days. Upon discontinuation of the medication or non-return of the resident within 7 days, the scheduled drug may be destroyed by the Director of Nursing and a Licensed Nurse, two (2) Licensed Nurses with documentation and signature of both on the drug disposition record. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R2's Controlled Substances Proof of Use sheets (aka Count Sheets or Narcotic Count sheets) showed he had 11 count sheets for Hydrocodone/Acetaminophen 5/325 milligrams (mg) (Commonly referred to as Norco. A combination Schedule II narcotic and over-the-counter pain reliever.) from 3/29/24 to 6/27/24. The count sheets showed V27 wasted a Norco on 4/5/24 and there was no second nurse witnessing the waste. The count sheets showed two doses of Norco were signed out on 5/14/24 at 8:00 AM; and the count sheets showed at least 6 Norco were diverted from 6/22/24 through 6/24/24, which the facility failed to identify. On 6/29/24 and 6/30/24 R2's Norco sheets from 4/2/24 through June 2024 were requested. On 6/30/24 at 10:15 AM, V1 (Administrator) stated all R2's controlled substance count sheets the facility has available have been provided. The facility's pharmacy provided list of narcotic delivery showed 90 tablets of Norco were shipped on 4/19/24. The facility was not able to produce one count sheet for 30 tablets out of the 90 tablets delivered. On 7/1/24 at 1:58 PM, V2 stated if the nursing staff were following policy and procedures for counting narcotics and counting narcotic cards, the diversion on 6/22/24 through 6/24/24 may have been identified. V2 said nursing staff were supposed to have a witness for wasting exhausted narcotic cards, which nursing staff were not doing. 3. R7's count sheets for Hydrocodone/Acetaminophen 10/325 milligrams (mg) (Commonly referred to as Norco. A combination Schedule II narcotic and over-the-counter pain reliever.) showed R7 received 4 cards of Norco totaling 120 tablets. R7 count sheet 3 of 4 and 4 of 4 showed overlapping/duplicate documentation: 12/29/23 at 11:10 AM and 12/29/23 at 12:00 PM, then 12/29/23 at 3:28 PM. The count sheet showed the order was one tablet of Norco every 6 hours. On 7/1/24 at 1:58 PM, V2 stated she had no policies or procedures in place to verify duplicate documentations from one count sheet to the next. 4. R8's Morphine 15 milligram tablet (narcotic pain medication) Count sheet (received by facility on 8/17/23) showed on 8/27/23 a tablet of morphine dropped in garbage and no nurse cosigned the waste. R8's Morphine count sheet (received on 8/30/23) showed the following medications were dispensed in the following order: 9/6/23 at 8:00 PM then 9/6/23 at 8:00 AM then 9/7/23 at 10:00 (unknown AM or PM) then 9/7/23 at 8:00 AM. R8's Morphine count sheet (received on 1/11/24) showed the tablets were dispensed in the following order: 1/24/24 at 7:04 AM then 1/24/24 at 8:00 PM then 1/25/24 at 7:30 AM then 1/24/24 at 8:00 PM then 1/25/24 at 7:15 AM then 1/25/24 at 8:00 PM. The count sheet shows the order is to be given every 12 hours. The count sheet shows from 1/24/24 at 7:04 AM through 1/25/24 at 8:00 PM six doses of morphine were dispensed when only 4 should have been dispensed. V27 (LPN) signed as having dispensed 5 out of the 6 doses morphine. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's Morphine count sheet (received on 1/11/24) showed on 2/9/24 at 6:48 AM V27 documented a tablet of morphine was dropped. No second nurse signed as witnessing this waste. R8's Morphine count sheet (received on 3/6/24) showed V27 wasted a morphine tablet on 3/14/24 at 7:15 AM and there was no second nurse cosign. The same count sheet showed the morphine tablets were removed in the following order: 3/17/24 at 8:00 AM then 3/18/24 at 8:00 AM then 3/17/24 at 8:00 PM then 3/18/24 at 8:00 PM. R8's Morphine count sheet (received on 4/29/24 showed V27 wasted a tablet of morphine with no second nurse signing as a witness. R8's count sheets for Oxycodone/Acetaminophen 10/325 milligrams (mg) (Commonly referred to as Percocet or Oxy. A combination Schedule II narcotic and over-the-counter pain reliever.) showed the facility received 60 Percocet on 10/28/23 and another 60 tablets 11/16/23. The count sheets showed R8 could have 1 to 2 tablets every 4 hours as needed for severe pain. V27 (LPN) documented the following withdrawals across the two Percocet count sheets, 11/18/23 at 10:45 AM and 11/18/23 at 4:04 PM on the card received on 10/28/23. V27 then documented on the 11/16/23 Percocet count sheet the following withdrawals: 11/18/23 at 11:45 AM and 11/18/23 at 5:10 PM. V27 dispensed 4 more tablets than allowed by the physician order. R8's Percocet count sheet (received on 2/15/24) showed V27 documented a tablet was dropped and no second nurse signed as having witnessed the waste. R8's Percocet count sheets showed she had two cards of 30, one received on 4/8/24 and the other on 4/25/24. The count sheets showed she could have one tablet every 6 hours as needed for pain. V27 documented on the 4/8/24 sheet that she dispensed a Norco on 4/26/24 at 3:30 PM and 1:10 PM. V27 then documented on the 4/25/24 sheet that she dispensed Percocet on 4/26/24 at 5:30 PM, 4/27/24 at 11:16 AM, and 4/2724 at 4:45 PM. R8's Percocet count sheet showed V27 documented two tablets of Percocet were dropped on 4/27/24 at 11:15 AM and 5/4/24 at 7:15 AM. The 4/27/24 dose was witnessed by an unknown nurse and the 5/4/24 dose was witnessed by V2 (DON). On 6/27/24 at 2:15 PM, V7 (Licensed Practical Nurse) stated R8's dropped Percocet's from 4/27/24 and 5/4/24 were not cosigned as having been witnessed. V7 provided copies of the count sheets, without resident identification, which she copied on or about 6/10/24. V7 provided her copy of R8's Percocet count sheet, (V7's copy had the resident identification removed) showing the 4/27/24 and 5/4/24 dropped Percocet were not cosigned. On 7/1/24 at 8:55 AM V17 (Pharmacist), said she reviewed the resident's controlled substance count sheets on 6/18/24. V17 stated there were numerous controlled substances, across several residents, where medications were dropped or wasted, and no nurse had documented as having witnessed the waste. V17 stated she could not remember which residents had the documented dropped or wasted controlled substances and she did not recall any specific dates. V17 said, when she discussed the issues with the count sheets, the nurse at the time had a high level of discomfort discussing the controlled substances, I could tell she was uncomfortable and she was concerned, which was enough for me to escalate the situation to the administrator that they needed to look into it. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's Percocet count sheet (received on 5/10/24) showed V27 documented a Percocet as wasted and no nurse signed as having witnessed. On 7/1/24 at 1:58 PM, V2 stated she was not aware of the concerns above and the purpose of nurses witnessing wasted medication is to prevent diversion of controlled substances. V2 stated the Percocet cosign for R8's dropped Percocet was not her signature. V2 said V27 did work on 5/4/24 and stated V27 documented notes for residents the day of 5/4/24. On 7/2/24 at 1:30 PM, V27 stated she drops and wastes so many medications because she works a lot and residents drop pills. V27 had no explanation for the lack of witness signatures for her documented dropped and wasted medications other than she forgot. V27 denied any knowledge of duplicate medications. V27 denied working on 5/4/24. 5. R9's Norco Count Sheet (received on 3/19/24) showed V27 (LPN) wasted a tablet of Norco and no nurse signed as having witnessed. 6. R14's Norco count sheet (received on 3/19/24) showed an order for 1 to 2 tablets every 6 hours. V27 signed out two tablets on 4/11/24 at 10:30 AM and one tablet at 5:10 PM. R14's second Norco count sheet (received on 4/7/24) showed V27 dispensed one table at 7:00 AM, then two tablets 2:30 PM, (one tablet was also wasted by V27 at 2:30 PM), then two tablets at 6:15 PM. (From the first two tablets on 4/11/24 at 10:30 AM until the two tablets at 6:15 PM, V27 dispensed 8 tablets of Norco when only 4 tablets could have been dispensed. This does not include the wasted tablet of Norco.) 7. V27 documented, between R2's Norco count sheets from 4/5/24 through 6/28/24; R7's Norco count sheets from 12/7/23 through 3/10/24; R8's Morphine count sheets from 12/29/23 through 5/4/24; R8's Percocet count sheets from 1/24/24 through 6/26/24; R9's Norco count sheet from 3/1/24 through 6/1/24; and R14's Norco count sheets from 4/11/24 through 4/25/24; showed V27 dropped or wasted 21 individual tablets of controlled substances. The count sheets showed V27 failed to have a nurse witness the wasting of 9 of these tablets of controlled substances, not including the 41 tablets of Norco for R12 which were not signed as having been witnessed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38488 Based on observation, interview, and record review the facility failed to ensure menus were reviewed by a dietitian. This applies to all 28 residents residing in the facility. The findings include: On 6/25/24 at 1:45 PM, V12 (Dietary Manager) said since the cooler has been down and the County Health Department had been in for an inspection she has been rewriting the facility's dining menus. V12 said she has not been having the Registered Dietitian review the menus to ensure they are appropriate because she has not had time. On 6/25/24 at 1:45 PM, V12 provided a handwritten menu from June 19th through June 30th. The menu included no serving sizes or recipes. The surveyor attempted to call V30 (Registered Dietitian) multiple times with no response. The facility's policy and procedure with revision date of April 2016 showed, Regional Dietitian; Job Summary: Provide dietitian consultation to the facility to help meet the needs of the residents . Responsibilities: . 7. Assist in development of menus . The facility's policy and procedure with revision date of April 2006 showed, Substitutions; It is the policy of [the facility] that substitutions shall be made to the menu only for reasons of food storage, delivery problems, equipment malfunctions, staff shortages . This is done to assure that foods of adequate nutrient value are served. Procedure: . 2. When a menu item must be substituted, these substitutions will be made after reviewing menu taking into account the menu for the days prior to and after the meal requiring substitution . 7. The Dietitian must sign off on all substitutions made verifying that an appropriate substitution has been made .

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to provide an altered diet for a resident with dysphagia for 1 of 3 residents (R6) reviewed for therapeutic diets in the sample of 22. This failure resulted in R6 experiencing a choking episode requiring the Heimlich Maneuver and abdominal thrusts to dislodge. The Immediate Jeopardy began on 4/26/24 when an order was received to downgrade R6's diet from regular consistency to a mechanical soft consistency and R6 continued to be served a regular diet. V18 (Registered Nurse) was notified of the Immediate Jeopardy on 6/28/24 at 11:10 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 6/28/24 at 3:47 PM, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The findings include: R6's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include sepsis, Type 2 Diabetes, Acquired Absence of right leg below knee, hyperlipidemia, arteriosclerotic heart disease of native coronary artery, ischemic cardiomyopathy, cognitive communication deficit, abnormal posture, oropharyngeal phase dysphagia, and vascular dementia. R6's most recent quarterly dietary assessment was completed on 10/2/23 (approx. 8 months prior). R6's care plan initiated 11/6/23 showed, The resident has nutritional problem or potential nutritional problem related to Type 2 Diabetes . Provide, serve diet as ordered . Another care plan initiated for R6 on 11/6/23 showed, The resident has a need for oral/dental health maintenance . Diet as ordered. Consult with dietitian and change if chewing/swallowing problems are noted . R6's facility assessment dated [DATE] showed he has severe cognitive deficits and no swallowing deficits. R6's Physician Order Sheet showed an order dated 4/26/24, Diet Downgrade to Mechanical Soft/TL (thin liquid) per ST (Speech Therapy). R6's Speech Therapy Discharge notes showed he participated in Speech Therapy from 4/15/24 through 5/10/24. The same Speech Therapy discharge note showed recommendation for oral intake to be Mechanical Soft/Chopped Textures . The facility's Diet Type Report dated 5/8/24 showed R6 was a regular diet and it was crossed off and mechanical was written next to it. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's 6/16/24 Nursing Note entered at 5:50 PM showed, Resident eating in dining room with several residents and a staff member (V10) (Certified Nursing Assistant/CNA). Resident took a bite of bread and meat, an Italian beef sandwich. Resident began to have signs and symptoms of choking. (V10) reports she did the Heimlich, as resident sitting in his chair. Staff member called for additional help, I approached, resident not responding, color poor, we laid him on the floor, [V10] did abdominal thrusts, turned him on his side, still choking, did another set of abdominal thrusts, turned him on his side, object/food expelled resident breathing, alert . R6's Acute Care Hospital Emergency Department documents dated 6/16/24 showed, Todays Visit Reason for Visit: Choking . R6's Physician Order Sheet showed an order dated 6/19/24, Meals: Cut food into bite size pieces, offer drink every 2-3 bites with meals to prevent choking. On 6/25/24 at 1:07 PM, V14 RN (Registered Nurse) said, . It was supper time. Everyone was in the dining room. [R6] sits in the back corner. I was across the hall in the TV room assisting a resident into a chair. I saw the aide, [V11] running. I saw action in the dining room so I went in and saw [V10] and she said [R6] was choking. [R6] could not speak or breathe. He does not stand so we put him on the floor and did abdominal thrusts. A chunk of food came out, it was a bread ball with beef. It looked like he did not chew it . His diet was regular at the time. It is mechanical soft now. He had a regular tray . On 6/25/24 at 1:45 PM, V12 (Dietary Manager) said the nurse is supposed to send diet changes to the kitchen in paper form. V12 said they do not make changes until the order comes from the nurse and that is when the dietary card would be changed. V12 said she does not have a way to track when the dietary card was actually changed because she does not have R6's old cards. On 6/25/24 at 2:34 PM, V11 (CNA) said, [V10] was feeding [R6] and I was feeding another resident. [V10] started doing the Heimlich and I went to get the nurse. Me and [V10] picked him up and put him on the floor. The nurse just stood there while we were doing the Heimlich. [R6] was completely blue before the food came up a little. When the food came up the nurse put her finger in his mouth and pulled it out. He went to the hospital . his diet was regular at that time but they changed it after that to mechanical soft. On 6/26/24 at 9:40 AM, V10 (CNA) said, I was the one that was feeding him. He was eating regular food. He started choking. I went behind his wheelchair and had another aide go get the nurse. My arms wouldn't go around him. We pulled him to the floor. The kitchen asked if we needed 911. I did stomach thrusts . He was not breathing, his lips turned purple His whole face was purple . His diet got changed now to pureed . On 6/27/24 at 12:34 PM, R6 was in the dining room. R6 was served tomato soup, pasta salad, and a grilled ham and cheese sandwich (not mechanically altered) and cut into halves. V23 (CNA) was sitting near R6 while he was eating. R6 took a large bite of his ham and cheese sandwich and began coughing. V23 said to R6, That was a pretty big bite, better slow down. On 6/27/24 at 1:36 PM, V12 (Dietary Manager) said, [R6] was not seen by the dietitian after his choking episode. [R6] was a regular diet but there was a change around the beginning of May. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/2/24 at 1:10 PM, V2 (Director of Nursing) said, Diet changes are entered as an order in the computer by the nurse. They print out a copy and give it to the kitchen. If they don't give it to [V12] and they just put it in the kitchen sometimes things disappear. It is important to ensure the correct diet is entered and changed right away to avoid choking. I don't know where the breakdown happened. I don't know if the dietary card did not get changed or they just didn't read it. The surveyor attempted to call V30 (Registered Dietitian) multiple times with no response. The facility's policy and procedure with review date of April 2006 showed, Therapeutic & Mechanically Altered Diets; It is the policy of [the facility] that therapeutic and mechanically altered diets are ordered by the physician and planned by the dietitian. A therapeutic diet is ordered to manage problematic health conditions . A mechanically altered diet is a diet specifically prepared to alter the consistency of food in order to facilitate oral intake . A physician's order is written for all diets including therapeutic and mechanically altered diets . The dietitian approves, signs and dates all menus . The facility prepares and serves all therapeutic and mechanically altered diets as planned . The facility's policy and procedure with revision date of April 2015 showed, Diet Orders; Policy: It is the policy of [the facility] to establish procedures for writing and communicating diet orders . The Food Service Manager, upon receiving the diet order, shall check the order against the medical record, making sure that the written order exists and that it agrees with the diet order. Any discrepancies in the Diet Order Form and diet order in the chart are discussed with the Director of Nurses or the nurse in charge . The Diet Order Form is to be kept on file in the Dietary Department for reference. The facility's policy and procedure with revision date of April 2016 showed, Regional Dietitian . Provide dietitian consultation to the facility to help meet the needs of the residents . 1. Collects, analyzes and summarizes relevant data from the resident and/or medical record, including anthopometic and laboratory information, appetite, diet orders, nutrition history, medications, and medical concerns . Evaluates the diet prescription relative to diagnosis and recommends changes as appropriate . Assist in development of menus . The facility's policy and procedure with revision date of October 2013 showed, Quarterly Assessments; It is the policy of [the facility] that all residents will be evaluated at least quarterly to ensure periodic monitoring of the nutritional status of the resident and prevent deterioration of nutritional status . 1. The Food Service Manager or designee re-evaluates and documents each resident's nutritional problems or needs at least quarterly. The Food Service Manager or designee writes the progress note on the Dietary Notes form or the Quarterly Assessment form . 2. Quarterly notes by the Food Service Manager or designee shall include at least the following: A. Current diet order . E. Appropriateness of diet order . The Immediate Jeopardy that began on 4/26/24 was removed on 6/28/24 when the facility took the following actions to remove the immediacy. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. On 6/28/24 the following was initiated: A. In house audit of all diet orders to ensure accurate reconciled with dietary cards completed 6/28/24. B. IDT will review Speech Therapy recommendations daily in morning meeting. C. Regional Director in-serviced Dietary Supervisor on quarterly and annual dietary assessments. D. Staff in-serviced on appropriate diets by Regional Director and Administrator on 6/28/24. 2. Compliance will be monitored through the QA process. A. Speech orders will be reviewed daily during morning meeting by the IDT. DON/Designee will ensure all new diet orders are communicated to dietary. B. DON/Designee will in-service on diet orders once a month for the next 3 months.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to ensure food was stored in a safe and sanitary manner. This has the potential to affect all residents residing in the facility. The findings include: The facility's census report provided on 6/25/24 showed 28 residents were residing in the facility. The County Health Department documentation from 6/18/24 showed an onsite visit in response to a complaint regarding refrigeration being down. On 6/18/24 at the time of the inspection the walk in cooler was at 55 degrees and the walk in freezer was at 73 degrees. The same documentaiton showed the County Health Departments directive, . Facility is using domestic refrigerators that were brought in, plus 2 domestic units from next door at [the assisted living building]. Food in both walk in units discarded. Lunch & dinner will be ordered out from local restaurants, or purchase food locally per meal, and discard any leftovers. On 6/25/24 at 1:45 PM, V12 (Dietary Manager) said the facilities walk in cooler had been down for 6-7 weeks now. V12 said she has never worked for a company that would sit on something like having their cooler in the kitchen down. V12 said corporate was bringing a check to get the cooler worked on when they started having issues with the freezer. V12 said the freezer was usable because it was holding at the temperature of a cooler so they had to start using everything fast. V12 said over the weekend the freezer was getting warmer and someone came in on Friday and gave them a quote for fixing it. On 6/25/24 at 1:55 PM, V12 (Dietary Manager) conducted a tour of the refrigerators and kitchen with the surveyor. The refrigerator in the employee break room was being used as storage for the kitchen as well as employee's personal food. The walk in cooler in the kitchen was at 65 degrees and had watermelon, tomatoes, and loaves of bread stored in it. In the room in the back of the kitchen there were two additional domestic refrigerators. There was no thermometer located in either of the refrigerators. There was another refrigerator that the facility was using that was in the assisted living building next door. There was no thermometer in that refrigerator. On 6/25/24 at 1:55 PM, V12 said she has been trying to get a set up together since the cooler and the freezer had been down while she was waiting for a fix that included the domestic refrigerators being brought into the kitchen. V12 said she has been short staffed since March and has been doing a lot of the cooking and other kitchen tasks to cover while they are short. V12 said she was not informed that the freezer was failing until Monday, June 17th when the health department came in and watched her throw all the food away from in the freezer. (The June 2024 Freezer temperature log showed on 6/13/24, V12 documented the temperature in the freezer was 40 degrees.) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's June 2024 walk in freezer temperature monitoring log showed on 6/13/24 the temperature in the freezer was 47 degrees, 6/14/24 the temperature was 41 degrees on morning shift and 45 degrees on evening shift; on 6/15/24 the temperatuer was 40 degrees; 6/16/24 there was no temperature documented; 6/17/24 the temperature was 60 degrees; 6/18/24 the temperature was 80 degrees. (On 6/18/24 when the County Health Department entered the facility to investigate a complaint regarding the walk in cooler being down, the freezer had been down for 5 days and food was still in the freezer.) The facility's May 2024 walk in cooler temperature log showed the temperature logged on 5/21/24 to be 57 degrees. No further temperatures were logged for the month of May. The facility's June 2024 showed several temperatures logged for other refrigerators that were in use. On 6/7/24 the temperature was logged as 60 degrees and showed broken. On 6/27/24 at 10:13 AM, V20 ([NAME] County Sanitarian) said she was in the facility responding to a complaint on 6/18/24. V20 said the coolers were not working. V20 said when she was at the facility the walk in freezer was at 73 degrees and there was food in it. V20 said she instructed the facility to throw away all the food in the freezer at that time and that all meals would need to be purchased from a local restaurant or all groceries purchased per meal, served, and all leftovers discarded. V20 said the facility had started using Domestic refrigeration units. V20 said these Domestic units are not appropriate for using in a facility because they don't have the same compressor and fan system as a commerical unit and cannot cool food quickly enough. V20 said they informed the facility that the domestic units were only to be used for a short time and is a very temporary fix. The facility's policy and procedure with revision date of April 2012 showed, Hazard Analysis Critical Control Point; It is the policy of [the facility] to use a procedure to prevent the outbreak of any food borne illness. Procedure: . A. Frozen foods will be at 0 degrees or lower B. Refrigerated foods will be at 41 degrees or lower .

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to maintain the building to provide a safe and comfortable environment. This applies to 12 of 12 residents (R2, R3, R4, R8, R10, R12, R15, R18, R19, R20, R21, R22) reviewed for functional and safe environment. The findings include: The facility's resident roster provided 6/25/24 showed 12 residents residing on the north wing. The residents residing on the north wing include R2, R3, R4, R8, R10, R12, R15, R18, R19, R20, R21, R22. On 6/25/24 at 10:30 AM the ceiling of the South shower room was observed with insulation and debris from the ceiling on the floor and hanging from the ceiling. There was an area measuring approximately 10-12 feet x 3-4 feet directly above the shower and approximately 12 inches from a nearby light fixture. On 6/25/24 at 11:05 AM, a resident room that was not in service (room [ROOM NUMBER]) had an area measuring approximately 4 feet x 3 feet that had fallen down. There was wallpaper peeling off the wall with what appeared to be mildew/mold on it and around the top of the wall where the wall meets the ceiling. On 6/25/24 at 10:30 AM, V3 (Maintenance Director) said there has been an ongoing leak in the South shower room and in another area of the facility for the last 3 years. V3 said he recently submitted another bid from a roofing contractor to have the deficiency in the roof fixed. V3 said the roof that the facility has is made of fabric layers that are drawn together. There has been a leak at one of the seams in the layers that gets particularly bad with heavy rain. V3 said he was told bids had been submitted prior to him beginning work at the facility approximately 3 years ago and said he has submitted multiple bids himself for the same roofing issue over the last 3 years while he has been the maintenance director. V3 said the last bid he submitted was on June 5, 2024 and he has not heard anything back from corporate since he submitted the bid. V3 said he has been asked to repair the ceiling in the shower room multiple times and has done so but it is a band aid for the situation and not a fix. V3 said there is also a resident room on the south hall with a similar issue which has now had to be taken out of service. V3 said he fixed the ceiling in the resident room [ROOM NUMBER] or 8 times before it was taken out of service. The facility's most recent quote for fixing the facility roof received from [the construction company] was dated 6/5/24. On 6/25/24 at 11:03 AM, V15 (CNA) said, The ceiling has been like that forever. [V3] has given them a lot of quotes to fix it. It looked like it was literally about to fall. It looked moldy and squishy. The ceiling was cracked, chipped, had dark colors on it, and it was sagging. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146133	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandwich Rehab & Hcc	902 East Arnold Street Sandwich, IL 60548

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 at 11:10 AM, V4 (Certified Nursing Assistant/CNA) said she has only been a CNA at the facility for about 2 weeks. V4 said when she started at the facility she could see it was going to fall in. V4 said the ceiling in the shower room appeared black, was cracking, and she could see it was going to cave in. V4 said they use that shower room (South shower room) instead of the North shower room because it is bigger. On 6/25/24 at 11:13 AM, V6 (CNA) said, The ceiling collapsed on Saturday. Before the collapse it looked like it had been patched up a lot before. On 7/2/24 at 9:49 AM, V1 (Administrator) said the facility is waiting on the contractor to present a bid for fixing the roof at this time. V1 said the previous bid received was prior to the roof collapse so the contractor is going to come back and look at it again. V1 said the previous quote had been submitted to corporate but they had not heard anything back from corporate regarding that quote. V1 said the Maintenance Director knows more about the situation with the contractor for the roof and the plan for fixing it. On 7/2/24 at 1:10 PM, V2 (Director of Nursing) said they have 2 shower rooms, the north and south. V2 said typically the residents residing on each hall use their respective showers. V2 said some residents who are on the south hall and are more independent will choose to use the South shower because it is bigger. The facility's undated policy and procedure titled Physical Plant and Environmental Policy and Guidelines showed, Policy Statement: It is of the utmost importance to provide a safe, hospitable, clean, and organized facility and grounds to ensure an environment that is conducive to providing the best care, comfort, and home-like surroundings for residents. A well maintained building and environment is also important for creating safe work surroundings across all departmental staffing and their ability to effectively and efficiently provide care and great living environment to all residents and all necessary resources to do so. The building and grounds must be maintained in the best presentable state and must be done so through routine maintenance and upkeep, housekeeping, and ensuring compliance with current federal, state, local, and NFPA codes . Policy Implementation: The facility Administrator must ensure that the overall scope and effective procedures are followed by each departments supervisors and staff or request of approved contractors for creating and maintaining a safe and comfortable environment for the residents, visitors, and staff. Ensure maintenance work orders are completed in a timely manner and ensure items necessary for repairs are ordered to complete repairs .