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	07/10/2024

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 0684 Level of Harm - Minimal harm or potential for 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** 31615 Based on observation, interview and record review the facility failed to assess and document a residents change of condition and failed to obtain daily weights as ordered for 2 of 3 residents (R1, R2) reviewed for nursing care and assessments in the sample of 3. The findings include: 1. R1's admission record shows he was admitted to the facility 3/16/23 with multiple diagnoses including sepsis, cognitive communication deficit, dysphagia, and aphasia. On 7/10/24 at 12:15 PM, R1 was observed sitting up in his wheelchair at the dining room table. He was dressed and well groomed. He did not verbally respond to any questions. Staff were assisting him with his meal. R1's progress notes for 7/4/24 at 6:47 PM show V2 (RN/DON - Registered Nurse/Director of Nursing) received a physician order to send R1 to the ER (emergency room). The note does not include any assessment, vital signs or reason for the transfer. No previous notes or assessments were documented for 7/4/24. On 7/10/24 at 10:00 AM, V3 (R1's guardian) said V2 (RN/DON) called her on 7/4/24 to tell her R1 was being sent out to the ER, but could only tell her it was because his breathing was really bad. She had no vital signs to report to her. V2 said as a nurse herself, she would have expected V2 to give her details of some assessment and vital signs or what his oxygen saturation levels were at the time. On 7/10/24 at 10:38 AM, V2 (RN/DON) said on 7/4/24 she sent R1 out to the hospital due to a change in his condition. His respirations and blood pressure were both elevated. She said his oxygen saturation was 95%, but at one point it was down to 88% and applied oxygen. She could not recall what time this occurred, and did not document it in the record. V2 said R1's lungs sounded terrible. She said during the day she was monitoring R1 and assessing his vital signs and it should have been documented. V2 said it is important to document everything to paint a picture of the resident and their condition. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Sandwich Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 12:40 PM, V4 (RN) said if a resident is having a change of condition the nurse should get vital signs including oxygen saturation level, a blood sugar to see if they are high or low, lung sounds, and an overall assessment. All of this information should be documented in the progress notes to cover yourself and show what you did, and it paints a picture for the next person so they know what happened. The 12/7/17 policy for notification for change in resident condition or status shows 5. The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 2. R2's admission record shows he was admitted to the facility on [DATE] with multiple diagnoses including alcoholic cirrhosis of liver with ascites (excess abdominal fluid). The order summary sheet of 7/10/24 shows an order a daily weight related to ascites. R2's July 2024 TAR (Treatment Administration Record) shows on 7/4/24 he was 197 pounds, then 7/5/24 he was up to 204 pounds, and 7/7/24 he was 205 pounds. No weights were documented for 7/8/24 or 7/9/24. R2 had no care plan for his cirrhosis or the monitoring of his weights. R2's progress notes on 7/5/24 at 4:42 PM, state he approached the nurses station to report he was going to the ER. He needed a paracentesis (draining of the abdominal fluid) and does not want to wait until his appointment because he was uncomfortable. On 7/10/24 at 10:38 AM, V2 (RN/DON) said R2 has ascites and has scheduled paracentesis. The ascites is caused from his liver failure and it causes him to retain fluids in his abdomen. For this reason he is a daily weight to monitor for any sudden increase in fluid retention. The daily weight is an order on the TAR and is comes up for the nurse on duty. He has no parameters from the physician, but the nurse should call if there is a sudden increase. On 7/10/24 at 12:15 PM, V4 (RN) said the aides do the daily weights and it is recorded on the TAR. She said R2 has an order for daily weights to monitor for any sudden increase in weight. She said this would indicate a fluid overload and would be hard on his heart. On 7/10/24 at 12:30 PM, V6 CNA (Certified Nursing Assistant) said R2 is scheduled for a daily weight and the aides do the weight and report it back to the nurse to put in the computer. She said she did not weigh him yesterday. V6 said R2 had already left the facility for today and would not be back until this afternoon. On 7/10/24 at 1:00 PM, V1 (Administrator) said the facility did not have a policy for daily weights.