

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 07/24/2024
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615</p> <p>Based on interview and record review the facility failed to document a change of condition and death for 1 of 3 residents (R1) reviewed for death in the sample of 6.</p> <p>The findings include:</p> <p>R1's admission record shows he was admitted to the facility on [DATE], and discharged on [DATE]. The [DATE] order summary sheet shows he was admitted to hospice on [DATE].</p> <p>R1's [DATE] at 11:50 PM nursing progress notes show, R1 was noted to be lying in bed, unresponsive. Receiving morphine and ativan every 2 hours as ordered by hospice. Vital signs and oxygen saturation levels were assessed. He had periods of apnea lasting ,d+[DATE] seconds. He was not swallowing and had no urine output.</p> <p>R1's hospice visit note of [DATE] shows the hospice nurse assessed him at 11:30 AM, and completed his vital signs, and he was unresponsive at the time with mottling (blotchy red/purple marbling of skin), and poor skin turgor. He had decreased urine output over the past 24 hours. His respirations were labored or had short periods of hyperventilation. Coarse breath sounds on expiration with periods of apnea (not breathing). He was unable to report pain but appeared to be in no pain according to the nurse assessment. The nurse notes an overall decline in his condition. She noted the facility staff had administered pain medications for comfort.</p> <p>R1's nursing progress notes for [DATE] show no nursing assessments. The notes have no time of death, or when and where his body was released.</p> <p>R1's hospice note of [DATE] documents the date and time of death as [DATE] at 3:18 PM. This information was confirmed by hospice with V7 LPN (Licensed Practical Nurse).</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:26 PM, V7 said on [DATE], R1 had been in and out of it throughout the day, he had scheduled morphine to keep him comfortable. He was definitely end of life, his mouth was open and his breaths were getting slower and he was mottling from the knees down and into his thighs. She recalls the time of death to be around 3:15 PM. V7 stated she called V3 (R1's guardian) a couple of times throughout the day with updates. She sent a fax to the physician to notify him of R1's death. She said staff was present in the room with R1 when he passed, and they cleaned him up after he died . V7 said the coroner came to get him, but could not recall what time. V7 said she was not aware, and could not recall if any documentation was completed, and said her assessments and notifications should have been documented in the progress notes. She said it was an overwhelming day, and must have forgotten.</p> <p>On [DATE] at 11:00 AM, V2 DON (Director of Nursing) said V7 was an agency nurse but did have access to the electronic record and should have been documenting in the progress notes. She said R1's change of condition should have been noted along with all of the notifications to the family, and hospice. The assessments should have included any vital signs, his respirations, and overall condition. The notes should also include the time of death and where his body was released.</p> <p>The [DATE] facility policy for notification for change in resident condition or status documents 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.</p>		