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	09/24/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on interview and record review the facility failed to notify a resident's Healthcare Power of Attorney (HPOA) regarding medication and weight changes. This applies to 1 of 3 resident (R4) reviewed for notification in the sample of 6. The findings include: R4's Admission Record (Face Sheet) showed he was admitted to the facility on [DATE] with diagnoses to include but not limited to dementia with behaviors, seizures, and depression. R4's 8/6/24 Annual Minimum Data Set (MDS) showed he had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 7 out of 15. R1's Physician Orders showed he was on Lasix (a diuretic/water pill) 40 milligrams (mg) once a day which was ordered on 9/12/24 and started 9/13/24. R1's orders showed the 40 mg Lasix was discontinued on 9/16/24 and a new order for 80 mg Lasix was started with the first dose given on 9/17/24. R1's weights showed on 6/5/24 he weighed 187 pounds, then on 7/2/24 he weighed 175 pounds (a month-to-month weight loss of 6.4 percent), and finally on 8/5/24 he weighed 195 pounds (a weight gain of 11.4 percent). R1's progress notes showed no documented re-weights on or about 7/2/24 and 8/5/24. R1's progress notes showed no documented HPOA notifications on or about 7/2/24 and 8/5/24. R1's 7/29/24 Nutrition Note showed he had lost 6.4 percent body weight from 6/5/24 to 7/2/24. R1's 8/28/24 Nutrition Note showed he gained 11.4 percent body weight from 7/2/24 to 8/5/24. On 9/18/24 at 11:50, V12 R4's HPOA stated she was not notified of R4's weight loss, weight gain, or the Lasix dosage increase. V12 stated she learned about the weight loss from the hospice nurse weeks after the weight loss had happened. V12 said she should have been notified of the weight loss once it was identified. V12 said, Nurse said he (doctor) ordered 80 mg of Lasix and no one from facility called me to let me know. The nurse said I thought you and your Dad were not talking but I told her you are still supposed to call me if there were any changes. (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 09/24/2024

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 at 11:20 AM, V11 Registered Nurse stated she received the order from R4's physician and increased R4's Lasix from 40 mg to 80 mg. V11 stated she did not notify R4's HPOA of the Lasix increase and she should have. On 9/19/24 at 12:30 PM, V2 Director of Nursing (DON) stated V12 should have been notified of R4's weight loss and change in Lasix. V2 said V12 should be notified so she is aware of his health condition, and it allows her to make informed decisions about his health care. The facility's Notification for Change in Resident Condition or Status (Revision December 2017) showed, the facility and/or facility staff shall promptly notify appropriate individuals of changes in the resident's medical/mental condition and/or status .a need to alter the resident's medical treatment significantly .5 percent weight gain or loss in 30 days .

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38488

Based on observation, interview, and record review the facility failed to ensure a resident was free of physical abuse for 1 of 3 residents (R1) reviewed for abuse in the sample of 7. This failure resulted in R1 being punched in the face by R2.

The findings include:

R1's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include Type 2 Diabetes, repeated falls, essential hypertension, generalized anxiety disorder, chronic obstructive pulmonary disease, psychoactive substance abuse, muscle spasm, hypokalemia, unsteadiness on feet, and abnormalities of gait and mobility.

R1's facility assessment dated [DATE] showed he has no cognitive deficits and verbal behavioral symptoms directed toward others.

R1's care plan initiated 4/22/24 showed, Resident is known to display/has history of paranoid thoughts/behaviors and or open conflict/criticism with others including false accusations. Specific behavior exhibited: verbal aggression towards staff, false accusations, inappropriate gestures and facial expressions, name calling. Related diagnoses/condition: bipolar disorder Noncompliant with facility policies, makes accusations against others to deflect responsibility for breaking rules . Administer psychotropic medication as ordered by physician . Encourage psychotherapy and/or psychiatric consultation as indicated/tolerated by resident . Help resident understand why behavior is inappropriate/disruptive and the impact it has on personal well being and well being of others. Initiate Behavior Monitoring program to attempt to identify patterns, precursors, and causes of behavior and to attempt to understand the meaning of the behavior.

On 9/18/24 at 1:20 PM, R1 was in his room sitting in his wheelchair. R1 had a bruise to the right side of his face along his nose line. R1 said, [R2] punched me in the face and made my nose bleed.

R1's care plan initiated 5/2/24 showed, The resident is/has potential to be verbally aggressive related to ineffective coping skills, mental/emotional illness, poor impulse control . Analyze key times, places, circumstances, triggers, and what de-escalates behavior and document .

R1's care plan initiated 5/21/24 showed, Resident has risk factors that require monitoring and intervention to reduce potential for self injury. Deafness/profound hearing loss, unsteady gait, weakness . psychiatric disorders becomes easily agitated and animated, use of assistive devices/wheelchair/walker . Risk factors include injury, pain as evidenced by resident being witnessed waving his arms, stomping his feet and throwing himself backwards and sideways in his wheelchair when he is angry

R1's care plan initiated 4/22/24 showed, The resident may be prone to adjustment disorder issues. As evidenced by: outburst towards staff, refusing to comply by policies, exit seeking .

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sandwich Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	R1's 9/11/24 Behavior Note entered at 8:59 AM showed, Resident out in parking lot, yelling to another resident and motioning him (R2) to go back in the building. [R2] was angry, attempting to hit [R1] with his walker but he ended up slamming his walker into the housekeeping manager who was attempting to get [R2] back into the building. Staff member stated her right arm is tender to touch. R2's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include dementia without behavioral disturbance, Chronic Obstructive Pulmonary Disease, Hypertension, mood disorder, and psychotic disorder. R2's care plan initiated 2/14/24 showed, Per documentation received to date, resident has prior criminal record including but not limited to, multiple accounts of aggravated assault and battery from 1976-1978 . Continue to monitor resident's behavior. Follow plan of care, medications and behavior interventions as needed to maintain resident and milieu safety. R2's care plan initiated 10/24/23 showed, Behavior Management potential for verbal and physical aggression towards others . Ensure the safety of resident and others . Monitor for environmental factors that may contribute to new behaviors(s). R2's Behavior Note entered 9/11/24 at 9:05 Am showed, Resident went in to the parking lot unattended. The housekeeping manager was attempting to convince him to come back in to the building. Another resident, [R1] was yelling and motioning to [R2] to get back in the building. [R2] became angry and attempted to hit [R1] with his walker but ended up slamming the walker into the housekeeping manager. No injuries occurred. [R2] was eventually convinced to come back in the building. The facility's abuse investigation showed, Incident: Alleged Physical Abuse; Time: 3:43 PM; Date: 9/11/24 . It was reported to the administrator that R2 allegedly struck R1 in the face . After investigation and interviews, it was ascertained that R2 did strike R1. R2 who suffers from dementia, was walking with a CNA in front of the facility. R1 was reported to have been aggressively addressing R2 from across the parking lot. R2 started approaching R1. The CNA that was walking with him attempted to redirect R2 to no avail. The CNA attempted to obstruct the patch of R2 and was struck by R2. R2 then struck R1 and the two were quickly separated . On 9/18/24 at 2:20 PM, V7 CNA (Certified Nursing Assistant) said, On 9/11/24 R2 went out the door. I followed him and we walked to the dumpster and back. [R1] was over by the handicap parking and he was yelling F%*k you and flipping [R2] off. I told him to stop. [R1] has been picking on [R2] for a long time and I don't know why. [R2] was a nice guy and he just couldn't take it anymore [R2] turned around and headed to [R1]. [R2] drew his fist back and hit me accidentally and then punched [R1] in the face. Gave [R1] a bloody nose. I felt sorry for [R2] no one was doing anything to stop it. On 9/19/24 at 11:03 AM, V6 CNA (Certified Nursing Assistant) said R1 antagonizes R2 every day. V6 said R1 would scream at R2 and tell him and say he was going to kick his ass, kill him, or tell him to get back here you motherf*&ker. V6 said R2 never instigated R1, it was always R1 and she feels bad for R2 being transferred to another facility because he was not the problem. V6 said V1 was aware of the behaviors R1 was having toward R2. On 9/18/24 at 10:18 AM, V9 CNA said, [R1] is an instigator. A couple of weeks ago he went up to [R2] who was sleeping in the recliner and kicked him in his shin to wake him up and tell him he couldn't go outside. I reported it to the nurse. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	The facilities policy and procedure titled Abuse Prevention Program with revision date 11/28/2016 showed, Policy: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below . This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect, or abuse of our residents . Physical Abuse includes hitting, slapping, pinching, kicking .

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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 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** 39543 Based on observation, interview, and record review the facility failed to assess and notify the physician of a new wound. This applies to 1 of 3 residents (R4) reviewed for wound care in the sample of 6. The findings include: R4's Admission Record (Face Sheet) showed he was admitted to the facility on [DATE] with diagnoses to include but not limited to dementia with behaviors, seizures, and depression. R4's 8/6/24 Annual Minimum Data Set (MDS) showed he had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 7 out of 15. On 9/18/24 at 11:50 AM, V12 R4's Healthcare Power of Attorney (HPOA) stated she visited R4 on Monday, 9/16/24. V12 stated, when she visited R4 on Monday, R4's right leg was wrapped in a gauze dressing. V12 stated she is a nurse, and she removed the gauze dressing. V12 stated under the gauze wrap was an absorbent pad covering a 1.5 round wound to R4's shin. V12 said the wound had a white/yellow slough wound bed and yellow drainage. V12 stated she spoke to V11 Registered Nurse (RN) and V11 said the wound had been there since at least the Friday prior. V12 stated she was not notified of the wound. V12 stated R4's doctor had visited him earlier in the day; however, she did not believe he saw the wound because there were no treatment orders for the wound. V12 stated 9/16/24 was the last time she visited her father. On 9/19/24 at 10:35 AM, R4 had gauze wrap to his right leg from the ankle to below the knee. R4 had a gauze wrap to his left leg that had fallen and collected around his ankle. V3 Registered Nurse (RN) removed the gauze wrap to both legs. Underneath the gauze wrap to his right shin was a petroleum gauze dressing. V3 removed the petroleum dressing which exposed a 1.5-inch round non-draining wound. The wound was open, and the center of the wound had slough (a yellow/white substance comprising dead cells and other body matter) which comprised approximately 50 percent of the wound bed. The wound bed was moist. V3 stated she was the nurse who applied the petroleum dressing on R4's right shin the day prior (9/18/24). V3 said the wound was not open and it was a slit the day prior (despite the wound matching the exact description provided by V12 who last visited R4 on 9/16/24.) On 9/19/24 at 11:20 AM, V11 stated she did work Monday 9/16/24. V11 said the wound had just started developing over the last few days prior to 9/16/24 and it initially presented as a blister. V11 said she did not go in the room with R4's physician on 9/16/24 and she does not know if he saw the wound. V11 said, I don't think there are any treatments in place for his shin, not unless there are new orders since I worked last. V11 said the nurse that identifies the wound should be the one to do the initial assessment, provide an initial treatment, and then notify the physician. On 9/19/24 at 3:30 PM, The first and most recent assessment was requested for R4's right shin wound. The facility provided a skin note from 9/19/24 (3 days after V12 first saw wound). The note showed, .wound on right shin, 3 x 3.5 cm (centimeter) . The note did not describe the wound bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 at 12:30 PM, V2 Director of Nursing (DON) stated an assessment is done upon first identifying and then weekly. V2 said an assessment would include measurements and description of the wound bed and drainage. V2 said the purpose of the assessment is to ensure the correct treatments are applied and to track the progress of the wound. V2 said she is also supposed to be notified of new wounds and she was not aware of R4's wound to his shin. V2 said R4's shin wound should have been assessed when it was first identified, even if it was a blister. R4's Care Plan showed, The resident has wounds on the 2nd toe of each foot and on great toe and shin of RLE/foot (Right lower extremity). Possibly r/t (related to) edema, MASD (moisture associated skin damage), or pressure. or potential for pressure ulcer development r/t disease process. The Focus Area was revised on 9/17/24. (Two days before the initial assessment.) R4's Physician Orders on 9/19/24 at 9:50 AM showed no order for petroleum-based dressing or any dressing specific to R4's right shin. (Although one had been applied by V3 on 9/18/24.) The facility's Skin Condition Monitoring policy (Rev January 2018) showed Upon notification of a skin lesion, wound, or other skin abnormality, the Nurse will assess and document the findings in the nurses' notes .Any skin abnormality will have a specific treatment order until area is resolved Documentation of the area must include the following: Characteristic: 1. Size 2. Shape 3. Depth 4. Odor 5. Color 6. Presence of granulation or necrotic tissue .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 39543 Based on observation, interview, and record review the facility failed to perform weekly assessments for pressure wounds. This applies to 2 of 3 residents (R5, R6) reviewed for wounds in the sample of 6. The findings include: 1. On 9/19/24 at 12:30 PM, V2 Director of Nursing stated the wound care physician assesses wounds every other Friday. V2 said the opposite week wound assessments are completed by the evening shift nurse. R5's 9/6/24 Wound Physician note showed she had a stage III pressure injury to her right shin that has not resolved. On 9/19/24 at 1:00 PM, the facility was unable to locate R5's 9/13/24 wound assessment. On 9/19/24 at 1:00 PM, R5 had an intact dressing to the right shin. On 9/19/24 at 12:30 PM, V2 stated she was not working the week on 9/13/24. V2 stated the facility does not have any electronic charting reminders/treatment interventions to que the nurse to complete the wound assessment. V2 said there are signs at the nurses' station to remind the nurses to complete the assessments. V2 stated the assessments should have been documented in the residents' electronic charting. V2 stated R5's wound should have been assessed on 9/13/24 and she does not know why the assessment was not completed. V2 said the assessments are important to ensure the correct treatments are in place and for the tracking of wound progression. 2. On 9/19/24 at 12:30 PM, V2 Director of Nursing stated the wound care physician assesses wounds every other Friday. V2 said the opposite week wound assessments are completed by the evening shift nurse. R6's most recent available physician wound note showed he had an open pressure injury to his right heel measuring 0.6 centimeter (cm) by 1.5 cm by 0.1 cm deep. On 9/19/24 at 1:00 PM The facility was unable to produce a wound care physician note for 9/6/24 and they were unable to produce a facility assessment from 9/13/24. On 9/19/24 at 12:30 PM, V2 stated she was not working the week on 9/13/24. V2 stated the facility does not have any electronic charting reminders/treatment interventions to que the nurse to complete the wound assessment. V2 said there are signs at the nurses' station to remind the nurses to complete the assessments. V2 stated the assessments should have been documented in the residents' electronic charting. V2 stated R6's wound should have been assessed by the wound physician on 9/6/24 and by the facility on 9/13/24. V2 stated she does not know why the assessments were not completed. V2 said the assessments are important to ensure the correct treatments are in place and for the tracking of wound progression. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Decubitus Care/Pressure Areas policy (Revision January 2018) showed, .Documentation of the pressure area must occur upon identification and at least once each week on the TAR (Treatment Administration Record) or Wound Documentation From .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488 Based on observation, interview, and record review the facility failed to prevent residents from smoking in the facility and failed to ensure residents at risk for elopement do not exit the facility for 3 of 3 residents reviewed (R1, R2, R3) reviewed for safety in the sample of 7. The findings include: 1. R1's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include Type 2 Diabetes, repeated falls, essential hypertension, generalized anxiety disorder, chronic obstructive pulmonary disease, psychoactive substance abuse, muscle spasm, hypokalemia, unsteadiness on feet, and abnormalities of gait and mobility. R1's facility assessment dated [DATE] showed he has no cognitive deficits and verbal behavioral symptoms directed toward others. On 9/18/24 at 1:20 PM, R1 was in his room sitting in his wheelchair. R1 showed the surveyor he had a pack of cigarettes and an electronic vaping device tucked in the waist band of his pants. R1's care plan initiated 4/22/24 showed, The resident uses smoking tobacco, vaping device . Resident displays inappropriate smoking behaviors and refuses to follow facility smoking policy as evidenced by having smoking materials on his person in his room and witnessed with lit smoking materials on his person in the facility . Instruct resident about the facility policy on smoking: locations, times, safety concerns Notify charge nurse immediately if it is suspected resident has violated facility smoking policy . The resident's smoking supplies are stored in a locked facility smoke box. R1's 7/8/24 Smoking/Vaping Safety Screen showed, . Demonstrates safety measures for handling cigarette/vaping device . Demonstrates safe storage of materials when not in use. Resident exhibits a clear understanding of the smoking/vaping policy as evidenced by accurately answering questions related to designated smoking/vaping areas, storage and use of smoking materials/vaping device, consequences of non-compliance, and responsibilities of the resident to prevent other residents from obtaining smoking/vaping materials . Resident agrees to abide by the smoking/vaping policy, understands that a change in condition may necessitate additional screening, impact the status of participating in the smoking/vaping procedures and result in discontinuance or modification of smoking/vaping procedures. Resident agrees to smoke/vape only in attendance of staff, approved family member or volunteer The Interdisciplinary Team determines the above named resident may smoke/vape under the following conditions: Resident must sign self out, have staff let him out, and dispose of cigarette butts appropriately if he is to smoke outside of facility smoking times. R1's Health Status Note dated 9/1/24 at 4:32 PM showed, Resident has been argumentative and confrontational with other residents today. This upsets the female residents to the point that they go back into their rooms. He does not heed, in any way, the posted smoking times and continuously goes in and out the front door, causing it to alarm which, in turn, interrupts the nurse and CNA's (Certified Nursing Assistants). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 10:18 AM, V9 CNA (Certified Nursing Assistant) said, [V1] told us [R1] is like a child and we have to overlook what he does. Residents are smoking dab pens (marijuana) inside the facility. [R1] is smoking it all the time. We are told they can do what they want but I don't think they are supposed to be smoking marijuana here. On 9/18/24 at 2:20 PM, V7 CNA (Certified Nursing Assistant) said residents are smoking marijuana right outside the front door. V7 said V1 (Administrator) told them the residents are adults and they can do what they want. V7 said, I guess we are just supposed to leave them alone but you can clearly smell it is marijuana. On 9/19/24 at 11:03 AM, V6 CNA (Certified Nursing Assistant) said residents are smoking marijuana everyday either inside or outside the facility. V6 said R1 smokes cigarettes and marijuana vapes both inside and outside the building. V6 said she knows it is marijuana because of the distinct smell. V6 said it is obvious that it is marijuana. V6 said it has been reported to V1 (Administrator) and he tells us it is not weed we are smelling. On 9/18/24 at 11:30 AM, V3 RN (Registered Nurse) said, [R1] and [R7] have marijuana pens. I know they are marijuana pens because they smell like marijuana. I think [R1] is the main one who is smoking it in the building though. My understanding is we can't do much about it other than confiscate it. The administrator said if we can safely confiscate them we should do that. On 9/19/24 at 1:00 PM, V2 DON (Director of Nursing) said, [R1] likes to get marijuana vapes and share them with other residents. All we can do is confiscate them if we see him with them. [R1] has community pass so he will go to the gas station and get them. [R1] is not allowed to smoke or vape in his room but he has no regard for the rules. On 9/19/24 at 10:27 AM, V1 (Administrator) said residents have been found to have marijuana vapes. V1 said he does not allow smoking either cigarettes or vapes within 50 feet of the building. V1 said R1 does not adhere to the 50 foot rule. V1 said the facility does not allow vaping inside the building of either marijuana pens or regular vapes and if they are found to have them they are confiscated and locked in a drawer. If they have a POA (Power of Attorney) we give it to them when they leave. They have all been educated. V1 said everyone understands it is not allowed and obviously no smoking in the building. V1 said what they do on their own time is their business. V1 said if the residents sign themselves out and go to the park and smoke marijuana it is their right as citizens to do that. V1 said he concerns himself with the rules of the facility. V1 said everyone is allowed to keep their smoking materials with them and in their room. V1 said they had gone back and forth on that decision to allow them to keep their smoking materials but they were educated if they are caught to be smoking inside that they could be restricted. V1 said if they are caught vaping in the facility they are educated. V1 said residents are assessed as to whether or not they are smokers but not whether or not they are safe smokers. V1 said if there were an allegation brought to him regarding a resident smoking in their room or possessing marijuana within the facility he would ask the resident about it. V1 said there would have to be significant proof before they would search a resident's room. (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	09/24/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy with revision date of 10/27/22 showed, Safe Smoking and Vaping Policy, Policy: The facility works to provide appropriate care for residents keeping safety and comfort in mind. Residents may have the desire to smoke/vape and accommodations will be provided as the facility deems appropriate. The electronic cigarette is a non-flammable electronic device with similar functions to those of a common cigarette and can be used as a substitute for the cigarette. Those choosing to vape must follow all expectations of the Safe Smoking and Vaping Policy. Procedure: . A. Smoking is allowed in the resident smoking area only . E. No negative behaviors related to smoking . Breaking of these smoking rules results in: A. 1st offense - loss of ability to carry smoking materials for at least 30 days. 2nd Offense - loss of ability to carry smoking materials for at least 30 days; 3rd Offense - loss of ability to carry smoking materials for at least 30 days; After the 3rd offense, must be re-evaluated for the smoking program 5. Discovery of any prohibited drug as described in the Prohibited Drug Policy found in the facility or used within the facility will lead to immediate discharge from the facility. The facility's policy issue date of 10/10/22 showed, Prohibited Drug/Alcohol Policy; Policy: [the facility] has a responsibility for all resident's safety. Drugs and other substances not prescribed by a resident's treating physician can cause dangerous and life threatening conditions. [The facility prohibits the presence or use of illegal or non prescribed drugs in the facility or anywhere on the premises . As used herein the term Prohibited Drugs shall mean any prescription medication not prescribed to the user and/or controlled substances, including without limitation: marijuana . [The facility] recognizes marijuana is classified as a schedule 1 drug under the federal Controlled Substances Act. This means that there is no currently accepted medical use of marijuana under federal law . Violation of this policy may result in involuntary discharge and a report of criminal action to the authorities. 2. R2's face sheet showed he was admitted to the facility on [DATE] with diagnoses to include dementia without behavioral disturbance, Chronic Obstructive Pulmonary Disease, Hypertension, mood disorder, and psychotic disorder. R2's facility assessment dated [DATE] showed he has severe cognitive impairment and has wandering behaviors. R2's 7/5/24 Wandering-Elopement Evaluation showed he is a High Risk to Wander/Exit Seek. R2's care plan initiated 11/30/23 showed, Resident exhibits/has exhibited in past a tendency to seek to leave facility or wander near exits Frequent visual monitoring and redirection from exits . Intervene as needed to ensure residents/others safety . R2's Health Status Note entered 9/16/24 at 11:56 PM showed, This nurse observed resident irritated and very aggressive verbalizing he was getting out of this place to a CNA (Certified Nursing Assistant). Resident seemed to be redirected with a sandwich and began heading back in the direction of his room. Alarm sounded and it was made apparent resident was attempting to elope. Resident began walking towards street. Resident was finally able to be redirected and brought back in to facility . R2's Behavior Note entered on 9/15/24 at 9:24 AM showed, Resident again outside alone, half way down the parking lot. He is argumentative and difficult to redirect back in to the building. (continued on next page)

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 09/24/2024
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Behavior Note entered 9/15/24 at 8:56 AM showed, Continues to leave the facility unattended at least 3x so far this morning. He becomes angry when we try to redirect and goes right back out the door again. Difficult to have someone constantly sitting with him or walking with him outside. R2's Behavior Note entered 9/11/24 at 9:05 Am showed, Resident went in to the parking lot unattended. The housekeeping manager was attempting to convince him to come back in to the building. Another resident, [R1] was yelling and motioning to [R2] to get back in the building. [R2] became angry and attempted to hit [R1] with his walker but ended up slamming the walker into the housekeeping manager. No injuries occurred. [R2] was eventually convinced to come back in the building. R2's Health Status Note entered 9/9/24 at 2:00 PM showed, Resident continues to walk out the front door without assistance greater than 12 times today. He becomes angry and argumentative when attempts to redirect him are made . R2's Health Status Note entered 9/6/24 at 5:52 PM showed, Resident continues to leave the building without assistance, without supervision. We have addressed this with him multiple times but he continues this behavior. At times he can become angry and combative with staff. On 9/18/24 at 11:30 AM, V3 RN (Registered Nurse) said, [R2] had exit seeking behaviors. Over the weekend I ran out and tracked him down in the parking lot over 13 times. It was terrible. You could get him back in and he would turn around and go right back out. It was Monday night when he got down to the stop sign . On 9/18/24 at 10:18 AM, V9 CNA said, [R2] was exit seeking. Yesterday we got in report that he had taken off and was down at the stop sign. We don't have the staff to make sure he does not get out . On 9/18/24 at 2:20 PM, V7 CNA said, [R2] left on third shift the day before he was discharged from here. They found him down by the stop sign. It was an agency nurse I believe that was here. We only have one nurse and one CNA on night shift so if they are taking care of someone who requires 2 staff for assist there isn't anyone else watching. On 9/19/24 at 1:00 PM, V2 DON (Director of Nursing) said, [R2] would mostly try and walk out of the front door He didn't like that he had to be supervised. I wasn't aware of him making it to the stop sign. [R1] had gotten in trouble for letting [R2] out of the building. [R1] would be outside and he would push the button to turn the alarm off when [R2] went out. To prevent elopement we have the door alarm. When it goes off we run to see who it is and redirect them back into the building . (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedure with revision date of 10/06 showed, Elopement Prevention Policy; Policy: It is the policy of [the facility] to provide a safe and secure environment for all residents. To ensure this process, the staff will assess all residents for the potential for elopement. Determination of risk will be assigned for each individual resident and interventions for prevention be established in the plan of care to minimize the risk for elopement. Procedure: . The Interdisciplinary Team will initiate a plan of care for any resident determined high risk for elopement. Facility specific measures as well as resident specific measures will be included in each high risk resident's plan of care to minimize risk factors. Communication of these interventions will be made to direct care staff through exposure to the resident's plan of care . Interventions of personal door alarm devices and monitoring will be initiated as deemed necessary by the IDT and documented in the individual resident's plan of care . Any high risk residents will be promptly and courteously escorted back to the appropriate nursing unit, activity room, dining area or resident room when noted to be near an exit door . 3. R3's face sheet showed he was admitted to the facility 10/12/23 with diagnoses to include Type 2 Diabetes, dementia with agitation, atherosclerotic heart disease, Bipolar Disorder, Hypertension, Schizoaffective Disorder, and Insomnia due to other mental disorder. R3's facility assessment dated [DATE] showed he has moderate cognitive impairment. R3's Behavior Note dated 8/5/24 at 2:07 AM showed, Resident has been anxious this evening but went to bed without difficulty. At approximately 1:00 AM he was found wandering down the hallway, attempting to push on the Southwest door stating, I've got to get to my trailer. I initially felt he was dreaming and he was reoriented to time and place. he seemed to accept that and went back to bed. He was given Ativan 0.5 per his PRN (as needed) orders. At approximately 1:30 AM we heard the door alarm sound and found he had eloped out the southeast door. We ran outside and found him a good way down the sidewalk . He became somewhat angry stating I want out of here, I'm not staying here. We finally got him back in the building and seated him in the dining room. CNA got him a sandwich, chips, and pop. I went to the nursing office to start this report. CNA stepped inside the door of the office to tell me something and a door alarm went off. This time it was the North east door. We ran outside and resident was a good ways down the sidewalk once again. He was not agreeable to coming inside but we finally persuade him to stay just for tonight . On 9/18/24 at 11:30 AM, V3 RN said, [R3] left the facility. It was myself and a CNA. The alarm went off on the Southeast door and was out the door. We ran outside and found him right away a little ways down the sidewalk. He was hard to redirect. Then 20 minutes later he did it again . No one wears wanderguards or anything, we just respond when we hear the door alarm going off.