STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146175	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinckneyville Nursing & Rehab	708 Virginia Court Pinckneyville, IL 62274

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to initiate the process to timely obtain a prescription medication for 1 of 3 residents (R1) reviewed for medications in the sample of 7.This past noncompliance occurred from 7/27/25 and 7/28/25.Findings include:R1's admission Record documents an admission date of 6/20/25, a discharge date of 7/28/25, and listed diagnoses including hypertension, chronic obstructive pulmonary disease (COPD), unspecified, other cerebral infarction due to occlusion or stenosis of small artery, other specified symptoms and signs involving the circulatory and respiratory systems, bradycardia, unspecified, cerebral infarction, unspecified, and peripheral vascular disease.R1's Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 4, indicating that R1 had severe cognitive impairment.R1's Care Plan documented R1 had COPD and a history of a recent Cerebral Vascular Accident (Stroke). Both focus areas have interventions including giving medications as ordered by the physician.R1's Physician's Order Sheet documented an order for Diltiazem HCl (hydrochloride) Oral Tablet 120 MG (Diltiazem HCl) Give 3 tablets by mouth one time a day for a fib (Atrial fibrillation), hold if pulse under 70. This order documented a start date of 7/27/26.R1's Medication Administration Record (MAR) for July 2025 documented on 7/27/25, R1 was administered Diltiazem HCl Oral Tablet 360mg by V4 (Licensed Practical Nurse/LPN), the area where the pulse is to be recorded is marked n/a. On 7/28/25, this MAR further documents that R1 was not administered her dose of Diltiazem because she was hospitalized .R1's Progress Notes document on 7/28/25 at 9:13am, CNAs (Certified Nursing Assistants) alerted this nurse that resident is SOB (Short of Breath). Upon entering room, resident appears to have labored breathing. O2 (oxygen) at 87% on 3L (Liters) via nasal cannula. Pulse irregular, jumping from 50/60 to 160/170. (Name of Medical Doctor/V5) called at 0834 and gave orders for resident to be sent to ED (Emergency Department) for further evaluation.R1's medical records from the local hospital emergency room dated 7/28/25 at 9:35am, documents the following: .Patient complains of palpitations and shortness of breath that started this morning. Patient was admitted to this hospital Friday for pneumonia and apparently while on the floor she developed atrial fibrillation with rapid ventricular response. She was discharged on Saturday with Cardizem ordered for rate control. Apparently, she did not receive it because the nursing home did not have it available over the weekend. Patient was given Cardizem 15 mg IV (intravenously) push en route by EMS without the accompanying infusion. She had a normal heart rate upon arrival however prior to initiation of the Cardizem infusion her ventricular rate increased to the 120s. She denies any chest pain or fevers .On 8/7/25 at 7:57am, V3 (Licensed Practical Nurse/LPN) stated she was the nurse that sent R1 to the Emergency Room. She stated she was in the middle of medication pass when the aides alerted her that R1 was short of breath and her pulse was all over the place. V3 stated she had not yet administered R1's medications so she went to pull them from the emergency kit and there was only one pill, and it was 180mg. V3 stated R1's dose was 360mg. V3 stated she went to assess R1 and immediately contacted the doctor and sent her to the emergency room. V3 stated she was not sure if the emergency kit had been accessed the day before.On 8/7/25 at 8:30am, V4 (LPN) stated she could not recall how she obtained the medication to administer R1's dose of Diltiazem on 7/27/25 or if she administered it. V4 stated she would not mark that the medication was administered on 7/27/25 unless she gave it. V4 stated if the patient's card was not yet delivered, she would access the emergency kit. V4 stated if she was not able to obtain a resident's medication, she would contact the Physician for further instructions or orders.On 8/7/25 at 9:37am, V5 (Physician) stated missing one dose of Diltiazem can be critical for a patient. V5 stated this medication does not work as effectively as other drugs of the same class. V5 stated he could not say for sure that it directly caused R1's hospitalization because R1 was already in bad shape, but this is not a medication that should ever be missed. V5 stated he wasn't contacted by anyone from the facility about R1 until she was sent to the emergency room on 7/28/25.On 8/7/25 at 10:19am, V8 (Family Member) stated R1 was discharged from the hospital (to the facility) on Saturday 7/26/25. V8 stated R1 was released while still in A-fib (atrial fibrillation), that was the reason that her dose was so high. V8 stated when she met R1 at the emergency room (on 7/28/25), the ambulance driver and the nurse both told her that she had not received the medication since she was previously discharged . V8 stated they (paramedics) gave her the medication she missed intravenously in the ambulance and then they gave her another medication. V8 stated when V9 (family member) went to collect R1's things, two staff members, V1 (Administrator) and V2 (Director of Nursing) both stopped her and