STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146039	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTVIEW TERRACE	100 EASTVIEW PLACE SULLIVAN, IL 61951

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey An extended survey was conducted.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow it's Abuse Prevention policy by failing to report an injury of unknown origin immediately to the Administrator, investigate an injury of unknown origin and report to the state agency for one of one residents (R4) reviewed for bruises on the sample list of 27. Findings include: The facility's Abuse Prevention Program policy dated 2/2018 documents, "Supervisors shall immediately inform the Administrator or his/her designated representative of all reports of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property. Upon	F 607	F607 CFR(s): 483.12 (b)(1)-(3) 483.95 1. The following corrective actions have or will be accomplished for the resident found to have been affected by the alleged deficient practice: A. An investigation was completed for R4, on 2/11/21, regarding the bruise to the right bicep. B. Staff was in-serviced on 5/10/2021 on the Abuse Prevention Policy and Procedures and the policy for Injuries of Unknown Origin. (Attachment A) C. Administrator and Department Managers were in-serviced on implementation of the Abuse Prevention	5/19/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/21/2021

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F 607	Continued From page 1 learning of the report, the administrator of designee shall imitate an investigation." This policy states "The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, laceration, other abnormalities, or injuries of unknown origin as they occur. Upon report of such occupancies the nursing supervisor is responsible for assessing the resident, reviewing the documentation, and reporting to the Administrator or designee." This policy also documents, "Initial Reporting of Allegations. The facility must ensure that all alleged violations of mistreatments, exploitation, neglect, or abuse including injuries or unknown source and misappropriation of resident property, and reasonable suspicion of a crime, are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures. If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report will be made to at least one law enforcement agency of jurisdiction and IDPH (Illinois Department of Public Health) immediately after forming the suspicion (but not later than two hours after forming the suspicion), Otherwise the report must be made not later than 24 hours after forming the suspicion. R4's Nurse's note dated 2/11/21 at 2:40 PM documents, "Bruise to (left) bicep (4.5 centimeters by 2.5 centimeters) noted during shower, reported to administrator for investigation." On 4/28/21 at 9:02 AM, V8 Registered Nurse stated, "The bruise on (R4's) arm was found on the third shift. The CNA's (unknown Certified	F 607	Policy and Procedures and Injuries of Unknown Origin. (Attachment B) 2. All residents had the potential for being affected by the alleged deficient practice. However, with the implementation of 1A-C, the alleged deficient practice will not recur. 3. No systematic changes are required at this time: A. Facility Abuse Prevention Policy was reviewed and was found to be in compliance with federal regulations. 4. The following Quality Assurance plans have been put into effect to ensure continued compliance of the alleged deficient practice. A. All allegations of suspected abuse are to be reported to the Regional Clinical Director to ensure that the Facility Abuse Prevention Policy and Procedures are being executed and that appropriate interventions are implemented to prevent reoccurrence. B. Facility will monitor compliance through the internal QA process. 5. Completion date: 5/19/2021	

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F 607	Continued From page 2 Nursing Assistants) working third shift told my CNAs that they reported it to V13 Licensed Practical Nurse on the third shift but no one had called the Administrator. So, I called V14 (Former Administrator) and V15 (Former Director of Nursing) to report it because it was an injury of unknown origin and that is what our abuse policy says to do. V15 made the note in the chart and I measured the bruise. I didn't know how R4 got the bruise on (R4's) arm." On 4/28/21 at 10:31 AM, V2 Interim Director of Nursing/Corporate Nurse stated that an investigation was not completed and the bruise was not reported to public health.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		5/19/21

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F 609	Continued From page 3 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report an injury of unknown origin to the state agency for one of one residents (R4) reviewed for bruises on the sample list of 27. Findings include: R4's Nurse's note dated 2/11/21 at 2:40 PM documents, "Bruise to (left) bicep (4.5 centimeters by 2.5 centimeters) noted during shower, reported to administrator for investigation." On 4/28/21 at 9:02 AM, V8 Registered Nurse stated, V8 reported the bruise found on 2/11/21 to the Administrator. On 4/28/21 at 10:31 AM, V2 Interim Director of Nursing/Corporate Nurse stated that an investigation was not completed and the bruise was not reported to public health.	F 609	F609 – Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) 1. The following corrective actions have or will be accomplished for the resident found to have been affected (R4), by the alleged deficient practice: A. An investigation in regard to R4's bruise to bicep was completed. B. Administrator was in-serviced on the Abuse Prevention Policy which includes types of abuse, immediate supervision of a resident if alleged perpetrator, investigative procedures, reporting requirements and that any allegation of abuse is to be acted on immediately. (Attachment A) C. Staff in-service was conducted on facility Abuse Prevention Policy and Procedures. (Attachment B) 2. All residents had the potential for being affected by the alleged deficient practice. However, with the implementation of 1A-C, the alleged deficient practice will not recur. 3. No systematic changes are required at this time:	

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F 609	Continued From page 4	F 609	A. Facility Abuse Prevention Policy was reviewed and was found to be in compliance with federal regulations. 4. The following Quality Assurance plans have been put into effect to ensure continued compliance of the alleged deficient practice. A. All allegations of suspected abuse are to be reported to the Regional Clinical Director to ensure that the Facility Abuse Prevention Policy and Procedures are being executed. B. Facility will monitor compliance through the internal QA process. 5. Completion date: 5/19/2021	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610		5/19/21

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F 610	Continued From page 5 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to investigate an injury of unknown origin and report to the state agency potentially preventing further injury to a resident. This failure affects one of one residents (R4) reviewed for bruises on the sample list of 27. Findings include: R4's Nurse's note dated 2/11/21 at 2:40 PM documents, "Bruise to (left) bicep (4.5 centimeters by 2.5 centimeters) noted during shower, reported to administrator for investigation." On 4/28/21 at 9:02 AM, V8 Registered Nurse stated, "The bruise on (R4's) arm was found on the third shift. The CNA's (unknown Certified Nursing Assistants) working third shift told my CNAs that they reported it to V13 Licensed Practical Nurse on the third shift but no one had called the Administrator. So I called V14 (Former Administrator) and V15 (Former Director of Nursing) to report it because it was an injury of unknown origin and that is what our abuse policy says to do. V15 made the note in the chart and I measured the bruise. I didn't know how R4 got the bruise on (R4's) arm." On 4/28/21 at 10:36 AM, V16 Certified Nurse's Assistant (CNA) stated, "I don't remember what third shift said but me and another CNA had toileted (R4) and seen the bruise to (R4's) arm and so I reported it to (V8) because it looked like someone had grabbed (R4) by the arm."	F 610	F610 – Investigate/Prevent/Correct Alleged Violations CFR(s): 483.12(c)(2)-(4) 1. The following corrective actions have or will be accomplished for the resident found to have been affected by the alleged deficient practice (R4): A. Administrator was in-serviced on what would be considered a grievance and what is considered abuse, the Abuse Prevention Policy and investigative procedures, reporting requirements and that any allegation of abuse is to be acted on immediately. (Attachment A) B. Staff in-service was conducted on facility Abuse Prevention Policy and Procedures. (Attachment B) 2. All residents had the potential for being affected by the alleged deficient practice. However, with the implementation of 1A-B, the alleged deficient practice will not recur. 3. No systematic changes are required at this time: A. Facility Abuse Prevention Policy was reviewed and was found to be in compliance with federal regulations. 4. The following Quality Assurance plans have been put into effect to ensure continued compliance of the alleged deficient practice. A. All allegations of suspected abuse	

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F 610	Continued From page 6 On 4/28/21 at 10:31 AM, V2 Interim Director of Nursing/Corporate Nurse stated that an investigation was not completed and the bruise was not reported to public health.	F 610	are to be reported to the Regional Clinical Director to ensure that the Facility Abuse Prevention Policy and Procedures are being executed. B. Facility will monitor compliance through the internal QA process. 5. Completion date: 05/19/2021	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.	F 660		5/19/21

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F 660	Continued From page 7 (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge	F 660		

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F 660	Continued From page 8 needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow the discharge plan and arrange outpatient therapy services for one of one residents (R40) reviewed for discharge planning in a sample list of 27. Findings include: R40's Interdisciplinary Discharge Summary dated 2/4/21 documents "Patient would benefit from regular therapy services to maintain physical and cognitive ability." Therapy Services to be continued after discharge: Speech, Physical and Occupational Therapy. On 4/28/21 at 8:20 AM V11 Social Service Director stated, "I would be the one to order therapies but I didn't realize (R40) needed therapy. I didn't order any. No one told me that (R40) needed it. (R40) walked out with a walker." On 4/28/21 at 8:45AM V12 (R40) Family Member stated, "(Therapy) would have been beneficial. They didn't set us up with it when (R40) discharged, but honestly (R40) could still use it now. Do you know if we can get it for (R40)?" On 4/28/21 at 2:35PM V20 Certified Occupational Therapy Assistant stated that (R40) was receiving Speech, Physical and Occupational therapy three	F 660	F660 – Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) 1. The following corrective actions have or will be accomplished for the resident found to have been affected (R40) by the alleged deficient practice: A. IDT has been inserviced on Discharge Planning. (Attachment A) B. IDT has been in-serviced on providing instructions for medication administration, any new medications prescribed, follow-up appointments and setting up outside services as recommended. (Attachment B) 2. All residents who intend on being discharged to home have the potential for being affected by the alleged deficient practice. However, with the implementation of 1A-B, no resident will be affected. 3. The following systematic measures will be followed to ensure the alleged practice has been corrected: A. IDT will review residents with a potential or desire for discharge weekly to ensure that that a discharge care plan is	

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F 660	Continued From page 9 times a week in the facility and needed to continue it out patient to maintain cognitive function.	F 660	completed, based on the needs of the residents and services that maybe required. (Attachment C) B. SSD will contact resident/responsible party within a week, post discharge, to see if any clarification is needed regarding discharge instructions. (Attachment D) 4. The following Quality Assurance plans have been put into effect to ensure Continued compliance of the alleged deficient practice: A. Compliance will be monitored through the internal QA process. 5. Completion date: 5/19/21	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		5/19/21

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F 688	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide passive range of motion to prevent contractures for one of one residents (R21) reviewed for contractures in a sample list of 27. Findings Include: R21's most recent Minimum Data Set dated 2/25/21 documents that R21 is not contracted. On 4/26/21 at 3:41 PM R21 was sleeping with arms contracted bilaterally inward. R21's hands were tightened in fists. On 4/28/21 at 3:54 PM R21 was sleeping with arms contracted bilaterally with hands tightened in fists. On 4/28/21 at 11:50AM V10 Certified Nursing Assistant (C.N.A.) stated (R21) has been contracted for awhile. On 4/28/21 at 11:05AM V6 Care Plan Coordinator stated, R21 was contracted in February, I must have missed it. We should be doing passive range of motion and we will get it started." On 4/28/21 at 11:00 AM V17 Restorative Aid stated, " I thought (R21) was on PROM." None were found. "(R21) should be on PROM and we will get that done." On 4/28/21 at 1:20PM V25 C.N.A. stated, "I came back to work here nine months ago and (R21) was contracted then."	F 688	F688 – Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) 1. For the residents found to have been affected by the alleged deficient practice, the corrective actions were implemented. A. Nursing staff were in-serviced on the facilities Restorative Nursing Policy and Range of Motion. (Attachment A). B. R21 was a hospice resident and expired on 5/1/2021 C. Residents at risk for contractures were reviewed to ensure that they were receiving ROM. 2. All residents who are at risk for contractures have the potential to be effected by the alleged deficient practice. However, due to the implementation of 1 (A-C) the alleged practice will not recur. 3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur. A. Nursing Management will do random audits to ensure restorative nursing programs are being followed as ordered. (Attachment B). 4. The following Quality Assurance programs have been implemented to ensure The alleged deficient practice will not recur: A. Restorative Nursing Programs will be	

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F 688	Continued From page 11	F 688	reviewed weekly during morning QA meeting to ensure that compliance with facility Restorative Nursing Policy. B. Quality Assurance Committee will monitor for compliance through the internal QA process. 5. Completion Date: 5/19/2021	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on Observation, Interview and Record Review the facility failed to provide adequate hydration for two of two residents (R21, R35) reviewed for hydration in the sample list of 27.	F 692	F692 – Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	5/19/21

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F 692	Continued From page 12 Findings include: Facility Preventative Skin Care Policy revised date 1/18 documents, "b) Keep fluids within reach of the resident and or offer frequently." 1.) R21's Physician Order Sheet dated April 2021 includes the diagnoses: Dementia with Psychotic Behaviors, Hypertension, Schizophrenia, Neurogenic Bladder, Psychosis, Osteoarthritis and Constipation. On 4/26/21 at 3:41 PM there was not a water glass, water pitcher or mouth care swabs at R21's bedside. Oral mucosa appeared dry. R21 was sleeping with R21's mouth open. On 4/27/21 at 10:30 AM there was not a water glass, water pitcher or mouth care swabs at R21's bedside. R21 was sleeping with R21's mouth open. R21's oral mucosa appeared dry. On 4/28/21 at 10:35AM there was not a water glass, water pitcher, or mouth swabs at R21's bedside. R21 was sleeping with R21's mouth open. R21's oral mucosa appears dry. On 4/28/21 at 10:40 AM V9 C.N.A. (Certified Nursing Assistant) stated, "(R21) should have water and swabs. I will go get some." On 4/28/21 at 1:20 PM V21 Licensed Practical Nurse (LPN), V9 LPN and V25 C.N.A completed wound care without incident and exited R21's room without providing mouth care or offering (R21) a drink of water.	F 692	1. The corrective action for the alleged deficient practice regarding R27 has been achieved by the following: A. Filled water pitcher and mouth swabs were provided to R21. B. Filled water pitcher was provided to R35. C. Nursing staff was in-serviced that all residents are to have hydration at bedside, be offered fluids between meals and during cares, unless resident is NPO. (Attachment A) 2. Residents that are unable to obtain own fluids have the potential to be affected by the alleged deficient practice. However, due to the implementation of 1 A-C, the alleged deficient practice will not recur. 3. The following systematic measures are in place to ensure the alleged deficient practice does not recur: A. Department Supervisors will ensure that filled water pitchers are at bedside, during rounds. (Attachment B) 4. The following Quality Assurance programs have been implemented to ensure continued compliance: A. Compliance will be monitored during weekly hydration QA. 5. Completion Date: 5/19/21	

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F 692	Continued From page 13 2.) R35's physician order sheet dated April 2021 includes the diagnoses: Alzheimers Disease, Urinary Tract Infections, Diabetes Type II, Hypertension, Nausea/Vomiting, Ovarian Cancer, and Acute Kidney Injury. On 4/26/21 at 2:56 PM there was not a water glass or pitcher at R35's bedside. On 4/27/21 at 1:45 PM there was not a water glass or pitcher at R35's bedside. On 4/27/21 at 1:40 PM V8 Registered Nurse stated, "(R35) has chronic urinary tract infections and has been on several antibiotics for them." On 4/27/21 at 1:50PM V9 Certified Nursing Assistant (C.N.A.) and V10 C.N.A. provided incontinence care to R35. After completing cares, no water was offered. On 4/27/21 at 1:52PM V9 CNA stated, "(R35) should have water at (R35's) bedside."	F 692		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		5/19/21

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F 727	Continued From page 14 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide a full time Director of Nursing (DON) since March 5, 2021, and failed to have a Registered Nurse 8 hours a day 7 days a week. These failures have the potential to affect all 39 residents in the facility. Findings include: On 4/26/21 there was no Director of Nursing at the facility. On 4/27/21 at 10:24 AM, V2 Corporate Nurse stated V2 is only in the building two days a week and the facility last had a full time Director of Nursing on March 5, 2021. The facility's April 2021 Nursing schedule documents no Registered Nurse (RN) on the schedule for Saturday 4/3/21, Sunday 4/4/21, Tuesday 4/13/21, and Saturday 4/17/21. On 4/28/21 at 9:34 AM V2 confirmed the facility did not have RN coverage on 4/3/21, 4/4/21, 4/13/21 and 4/17/21. The facility's Resident Census and Conditions of Residents form dated 4/26/21 documents 39 residents reside in the building.	F 727	F727 483.35(b)(1)-(3): RN 8 Hrs/7 days/Wk, Full Time DON 1. The corrective action for the alleged deficient practice has been achieved by the following: A. Job advertisements for the DON position were immediately posted when the position became vacant. (Attachment A) B. Additional job advertisements for the DON position have since been placed, including on Indeed, Social Media, and local newspapers. (Attachment B) C. Facility continues to advertise for RN's on Indeed, Social Media and area colleges. (Attachment B) D. The DON duties have been reviewed and the essential functions are being completed by a facility RN and other nurse managers. 2. All residents in the facility have the potential to be affected by the alleged deficient practice. However, due to the implementation of 1A-C, no resident will be affected. 3. The following systematic measures have been implemented to ensure compliance with facilities policies and procedures: A. RN and other nurse managers are being utilized to complete DON duties and ensure compliance with facility policies	

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F 727	Continued From page 15	F 727	and procedures. B. Facility will continue to advertise for RN's. C. All residents are screened prior to admission to ensure all needs can be met by current nursing staff. 4. The following Quality Assurance programs have been implemented to maintain and continue to achieve substantial compliance with the alleged deficient practice: A. Facility will continue to utilize Nurse Managers to complete DON duties. B. Concerns and follow-up of any nursing concerns will be addressed during morning QA. 5. Completion Date: 5/19/21	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		5/19/21

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F 732	Continued From page 16 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to post daily nurse staffing information for 33 days. This had the potential to affect all 39 residents residing in the facility. Findings include: On 4/26/21 at 11:06 AM, the posted Daily Staffing was located in the window of the Nursing office near the Front Lobby. The Daily Staffing documented the staffing numbers, hours, and census for 3/19/21, 3/20/21, 3/21/21, 3/22/21, 3/23/21, 3/24/21 and 3/25/21. On 4/27/21 at 10:10 AM, V2 Corporate Nurse confirmed the posted staffing this day was dated	F 732	F732 – Posted Nurse Staffing Information CFR(s): 483.30(g)(1)-(4) 1. For all residents that allegedly could have been affected by the alleged deficient practice, the following was completed: A. Nurse Staffing Information posting was re-initiated on 4/27/21. B. Nurse Management and Administrator were in-serviced on the requirements for nurse staff posting and that current Nurse Staffing has to be posted for all to see and not kept in a binder. (Attachment A) 2. All residents had the potential to be	

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F 732	Continued From page 17 3/19/21. On 4/28/21 at 10:45 AM, V6 Care Plan Coordinator stated posted staffing use to be done by the Director of Nursing(DON) and when the DON left the Assistant Director of Nursing (ADON) did it but the ADON left and no one did it until today. The facility's Resident Census and Conditions of Residents dated 4/26/21 documents 39 residents reside in the facility.	F 732	affected by the alleged deficient practice however, with the implementation of 1A, the alleged deficient practice will not recur. 3. The following systematic changes have been implemented to ensure compliance with alleged deficient practice: A. Administrator will do random monitoring to ensure that the proper form for posting nurse staffing information is being utilized, kept current and posted in the designated area. (Attachment B) 4. The following Quality Assurance Programs have been implemented to ensure compliance with the alleged deficient practice: A. Any concerns identified by the Administrator will be conveyed during morning QA meeting and proper interventions will be discussed for compliance. B. Compliance will be monitored through the internal QA process. 5. Completion Date: 5/19/21	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		5/19/21

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F 758	Continued From page 18 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to attempt gradual dose reductions (GDR) of antipsychotic medication for two of five residents (R5, R23) reviewed for unnecessary medications in the sample list of 27. Findings include: 1.) R5's Physician Order Sheet (POS) dated 4/1/21 through 4/30/21 documents diagnoses including Dementia with Behavioral Disturbances and Agitation. This POS documents an order for Quetiapine ER (Extended Release/Antipsychotic) 50 mg (milligrams) by mouth twice a day with a start date of 9/12/19. R5's Minimum Data Set (MDS) dated 1/25/21 documents R5 received antipsychotic medication 7 days a week and no gradual dose reduction has been attempted. This MDS documents zero behaviors occurred. R5's Behavior Tracking Record for January 2021 documents one episode of verbal aggression. R5's Behavior Tracking Record for February 2021 documents zero behaviors. R5's Behavior Tracking Record for March 2021 documents three episodes on one day of verbal aggression and three episodes of physical aggression on the same day and no other behaviors in March. R5's Behavior Tracking Record for April 2021 documented zero behaviors through 4/28/21. On 4/28/21 at 11:00 AM, V2 Corporate Nurse stated there is no record of any seroquel (Quetiapine) reduction attempts in R5's medical record.	F 758	F758 – Free from Unnec Psychotropic Meds/PRN Use CRF(s): 483.45(c)(3)(e)(1)-(5) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 1 For the residents found to have been potentially affected by the alleged deficient practice, the corrective action is as follows: A. In-service with Nursing Management on following up with Pharmacy Consultant Recommendations. (Attachment A) B. In-service was conducted with Nursing staff on the Psychotropic Medication Policy and Gradual Dose Reductions. (Attachment B) C. R5's Seroquel was reviewed with the physician and was decreased. (Attachment C) D. R23's Seroquel was reviewed with the physician and was decreased. (Attachment D) 2 All residents who currently receive or may be prescribed Psychotropic Medications have the potential to be affected by the alleged deficient practice. However, due to the implementation of 1A-B, the alleged deficient practice will not recur. 3 The following systemic measures have been implemented to ensure the alleged deficient practice does not recur: A. IDT will review resident's receiving Psychotropic Medications weekly during	

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F 758	Continued From page 20 On 4/28/21 at 1:00 PM, V11 Social Services Director confirmed R5's Behavior Tracking Sheets were correctly filled out. 2. R23's Physician Order sheets documents an order for Seroquel (antipsychotic) 25 mg 1/2 tablet by mouth twice daily dated 1/20/20. R23's consent for Seroquel 25 mg 1/2 tablet documents a consent dated 5/17/18. R23's Behavior Tracking record dated January through April of 2021 documents R23 is being tracked for verbal aggression for Dementia with Behavioral Disturbances. These tracking records do not document any episodes of verbal aggression. R23's psychotropic medication assessment dated 1/4/21 and 3/15/21 signed by V6 Licensed Practical Nurse, Care Plan Coordinator documents R23 is receiving Seroquel for Dementia with Behavioral Disturbance for the targeted behavior of verbal aggression. This assessment documents R23 as not having any behaviors. This assessment documents that a gradual dose reduction has not been attempted. This assessment marks a zero for clinical contraindications for a gradual dose reductions. On 4/28/21 at 3:00 PM, V6 stated R23 is receiving Seroquel 25 milligrams 1/2 tablet twice daily for verbal aggression. V6 stated R23 has no documentation of verbal aggression for January through April of 2021. V6 stated R23 has not had a gradual dose reduction for the Seroquel in the last year. V6 stated V6 was not sure when the Seroquel was last reduced. V6 stated there is not	F 758	weekly Psychotropic QA Committee meeting to ensure: accurate evaluation, assessment, GDR's, PRN Psychotropic Medications and Pharmacy Recommendations are addressed. (Attachment E) 4 To ensure all corrections are achieved the following Quality Assurance measures have been implemented: A. Weekly Psychotropic QA Meeting will be conducted to ensure compliance. B. Compliance will be monitored through the internal QA process. 5 Completion Date: 5/19/21	

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F 758	Continued From page 21 a clinical contraindication for a gradual dose reduction. The facility's psychotropic medications policy with a revision date of 11/28/17 documents, "9. Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue the drugs. Any resident receiving psychotropic medication will be reviewed at a minimum of every quarter by the interdisciplinary team. 10. Reductions shall be attempted at least twice a year unless the physician documents the need to maintain the resident regimen according to the Regulatory Guidelines for such."	F 758		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to hold a medication used for behaviors when lethargy was present, failed to transcribe a physician's order related to medication administration for two months and failed to notify the physician of the resident's continued significant lethargy during this time. This failure affects one of one residents (R15) reviewed for death on the sample list of 27. This failure resulted in R15 having a significant weight loss and the development of three stage 3 facility acquired pressure ulcers due to continued untreated lethargy.	F 760	F760 – Residents are Free from Significant Medication Errors CFR(s): 483.45(f)(2) 1. Corrective Action for the alleged deficient practice, involving R15, has been achieved by the following: A. Nursing staff was in-serviced on identifying medications utilizing the 6 rights of medication administration, proper transcription of medication orders, monitoring for any adverse reactions and notification of physician if adverse reactions are	5/19/21

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F 760	Continued From page 22 Finding include: R15's Admission Assessment dated 1/12/21 at 8:50 AM written by V8 Registered Nurse documents R15 has an admitting diagnosis of Dementia with Behavioral Disturbances. This note documents R15 as weighing 184.2 pounds and documents skin as warm and dry with no excoriation, pressure areas of vascular ulcers. R15's Nurse's Note dated 1/12/21 at 8:50 AM written by V8 documents R15 ambulates independently with verbal cues, wanders facility and needs redirection. This note documents R15 appears well nourished. R15's 3 Day Weights sheet documents R15 weighed 195 pounds on 1/15/21. R15's Fall Risk Assessment dated 1/12/21 documents R15 does not have gait or balance problems and has not had a history of falls. R15's Pressure Ulcer Risk assessment dated 1/12/21 documents R15 is at moderate risk for the development of pressure ulcers. This assessment documents that R15 does not have pressure ulcers and has not had a history of pressure ulcers in the last 90 days. R15's Nursing Note dated 1/22/21 at 9:20 AM, documents R15 was sent to the hospital for a psychiatric evaluation due to physical aggression. R15's Social Service note dated 2/10/21 at 1:25 PM documents R15 was readmitted to the facility. This note documents, "(R15) arrived via stretcher. (R15) lethargic and responds to name by moving head towards speaker. Requiring (extensive)	F 760	Identified. (Attachment A) 2. All residents have the potential to be affected by the alleged deficient practice. However, due to the implementation of 1A, no residents will be affected. 3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur: A. Nursing Management will do random medication pass observations to ensure compliance with Medication Administration P&P. (Attachment B) B. A member of Nursing Management has been assigned to audit charts, review medication orders, review MARs and POS's to ensure accuracy. (Attachment C) 4. The following Quality Assurance programs have been implemented to ensure continued compliance is maintained: A. Any medication errors will be reviewed by the Administrator and Nursing Management during morning QA meeting to determine root cause of the error and interventions implemented to prevent any further medication errors. B. Compliance will be monitored through the internal QA process. 5. Completion Date: 05/19/2021	

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assist of 2 for all transfers. Totally dependent on staff for all ADLs (Activity of Daily Living) including meals."

R15's Physician order sheet dated 2/10/21 documents orders for the following psychotropic medications Divalproex 125 milligrams (mg) 6 capsules by mouth twice a day, Divalproex 125 mg four capsules at noon, Gabapentin 100 mg at hours of sleep, Quetiapine 50 mg every morning, Quetiapine 100 mg every evening, Risperdal 1 mg twice at day, Risperdal 0.5 mg every day, Remeron 15 mg at hours of sleep, Trazodone 50 mg every evening, and Melatonin 10 mg at hour of sleep.

On 4/28/21 at 2:40 PM, V18 Licensed Practical Nurse stated when R15 was admitted(1/12/21), R15 was aggressive and would walk around. R15 was cognitively impaired. R15 could walk when R15 was first admitted but towards the end of R15's stay R15 could not walk at all. R15 was more lethargic towards the end of R15's stay and wouldn't eat much. After R15 was sent to the hospital and came back (2/10/21) R15 was more lethargic and couldn't do as much.

R15's Physician Progress Notes dated 2/17/21 written by V24 Nurse Practitioner documents R15 is having, "(increased) lethargy, weak; (decreased) appetite, weight loss (10 pounds) just returned from geri-psych in Indiana." This note documents an order to check Valproic acid (Depakote) level, stop Melatonin and hold Depakote (Divalproex) if sleepy.

R15's Physician Order sheet nor Medication Administration Record (MAR) for March and April of 2021 document the new order to hold

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	146039	A. BUILDING _____ B. WING _____	04/29/2021

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Depakote if sleepy. R15's MAR does not document that R15's Divalproex was held after 2/22/21.

R15's ADL flowsheet for March of 2021 documents R15 did not walk and required extensive assistance to total dependence of one to two staff for transfers, total dependence with bed mobility, dressing, eating, and toileting.

R15's Physical Therapist Progress and Discharge Summary dated 3/17/21 documents under outcome that, "(R15) was unable to make progress in therapy due to multiple underlying conditions. (R15) presently requires total assist for all mobility tasks due to cognitive deficits." This Summary also documents, "(R15) requires total assist and wheelchair for mobility." This note documents start of therapy as 2/17/21 and end of therapy as 3/17/21.

R15's Occupational Therapy (OT) Plan of Care dated 2/22/21 documents, (R15) was referred to skilled OT after recent psych (psychiatric) hospitalization stay after choking a CNA (Certified Nursing Assistant) and resulting in sacral wound, weakness, balance, and endurance deficits, and three recent falls out of bed. R15's Occupational Therapist Progress and Discharge Summary dated 3/22/21 documents under outcome that, "(R15) discharging due to max potential achieved and plateau in progress due to various fatigue levels, alertness, command following, and aggression. (R15) will remain at this SNF (skilled nursing facility) with assist in all aspects of self care, transfers, positioning and use of high back reclining wheelchair for positioning." This note documents start of therapy as 2/22/21 and end of therapy as 3/22/21.

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R15's Monthly weight and vital sheets documents R15 weighed 188 pounds in January 2021, 172.8 pounds in February of 2021, and 159.2 pounds in March of 2021. R15's Dietary notes dated 4/14/21 documents R15's weight as 159.2 pounds and documents R15 is underweight and has had a significant weight loss of 8.4 % in thirty days.

R15's wound evaluation and management summary written by V22 wound physician dated 2/18/21 documents an unstageable deep tissue injury of the coccyx caused from pressure measuring 3 centimeters by 4 centimeters and a stage two pressure wound of the right buttock caused from pressure measuring 1.2 centimeters by 1 centimeter. R15's wound evaluation and management summary dated 3/4/21 documents R15 as having a stage 3 pressure ulcers to the sacrum measuring 2 by 1.5 centimeters by not measurable, stage 3 pressure ulcer to the right buttock measuring 2 by 1.5 by 0.1 centimeters and stage 3 pressure wound of the left buttock measuring 1 by 0.8 by not measurable. This summary documents a recommendation for a gel cushion to the chair.

On 4/29/21 at 2:00 PM, V26 Certified Nursing Assistant stated R15 could walk unassisted, feed self, and turn self in bed. V26 stated when R15 returned from the hospital (2/10/21) R15 was chair and bed bound. V26 stated R15 could no longer turn self in the bed. V26 stated when R15 would try to feed self R15 would miss R15's mouth. V26 stated R15 had to be fed but wouldn't eat much because R15 was too sleepy. V26 stated R15 slept a lot.

On 4/28/21 at 3:00 PM, V6 Care Plan Coordinator

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stated R15 was admitted to the facility on 1/12/21. R15 was ambulatory and had behaviors. R15 was not easily redirected. R15 began to be physically abusive to the staff so R15 was sent to a geriatric psychiatric facility for an evaluation. R15 returned to the facility on 2/10/21. R15 was more lethargic when R15 returned. R15 stated a couple days later they had a psychotropic meeting due to R15 being so lethargic from R15's medication. After that the physician was called and the nurse practitioner (V24) came in to see R15 on 2/17/21. V24 gave orders for labs and an order to hold the Divalproex if lethargic. V6 stated R15 remained lethargic. V6 stated R15 could not feed self and would not eat. V6 stated R15 wouldn't stay awake to eat. V6 stated R15 had a significant weight loss. V6 stated could not ambulate. V6 stated R15 ended up getting pressure ulcers due to R15's not getting up out of the chair and not eating. V6 stated the facility did not call to report that R15 continued to remain lethargic after R15 was initially seen on 2/17/21. V6 stated the order to hold the Divalproex if sleepy wasn't carried over onto the March and April 2021 physician orders or medication administration records.

On 4/29/21 at 9:20 AM, V24 Nurse Practitioner stated R15 was prescribed Divalproex for behaviors. V24 stated V24 gave the order to hold the Divalproex when R15 was sleepy/lethargic. V24 stated when V24 reviewed the medication list that V24 gave the order to hold the Divalproex because it is known to cause sleepiness. V24 stated R15 was seen by telehealth on 3/3/21 and was seen on 4/7/21 but the staff reported no concerns. V24 stated V24 would have expected the facility to hold the Divalproex when R15 was lethargic and would have expected them to call

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F 760	Continued From page 27 and report that R15 continued to be lethargic. R15's psychotropic medication care plan dated 2/19/21 documents, "Observe for antipsychotic side effects: somnolence...Notify (physician) of noted side effects to determine if benefit of therapy outweigh the side effects." The facility's Medication Administration Policy with a revision date of 11/18/17 documents, "18. Omit giving a medication if the resident has symptoms suggestive of an undesirable reaction to the drug and report your observations to the physician as soon as practicable."	F 760		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and	F 849		5/19/21

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to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual

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F 849	Continued From page 29 resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the	F 849		

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F 849	Continued From page 30 LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient.	F 849		

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F 849	Continued From page 31 (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement a process of communication between the facility and the hospice company to provide care coordination for one of one (R40) residents reviewed for hospice care coordination in a sample list of 27. Findings include: R40's Hospice Care Plan documents admission to the Hospice company on 2/15/21. Facility contract with the Hospice Company dated August 21, 2013 states, "(b) Designation of Facility Team/Hospice Representative, for each Hospice patient, the Facility must designate a member of its interdisciplinary team to be responsible for working with Hospice Representatives to coordinate the care to the a resident provided by the Facility and Hospice Staff. The designated interdisciplinary team	F 849	F849 – Hospice Services CFR(s): 483.70(o)(1)-(4) 1. For the resident found to have been affected by the alleged deficient practice (R40), the following corrective action was implemented. A. Meeting was held with Hospice and need to coordinate resident care with the facility by providing their plan of care and any other important documentation in order to provide coordination of care. (Attachment A) 2. All residents have the potential to be affected by the alleged deficient practice; however, due to the implementation of 1A, the alleged deficient practice will not recur.	

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F 849	Continued From page 32 member must have a clinical background, function within their State scope of practice act to assess Hospice residents. Their responsibility includes, communicating and collaborating with the Hospice Representative and other practitioners that participate in the provision of care for the patient and family. The Facility Representative is responsible for ensuring the Hospice staff is oriented to the policies and procedure of the facility including patient rights, appropriate forms and record keeping requirements while caring for Hospice patients." On 4/28/21 at 3:25PM, V23 Hospice Registered Nurse stated, " I am usually in the facility twice a week. I document in computer software. I just talk to whatever nurse that is at the desk before I leave, but I don't think that the nurses ever see my notes." On 4/29/21 at 12:30PM V6 Licensed Practical Nurse/Care Plan Coordinator (LPN/CPC) said that (V6) was not aware of where the hospice notes were kept. V6 stated that if the staff can't see the information, they can't collaborate care. On 4/29/21 at 1:00 PM V21 Licensed Practical Nurse (LPN) confirmed that V23 Hospice Registered Nurse does not leave any notes in the chart for collaboration of care.	F 849	3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur: A. IDT will review resident medical records to ensure that individual plan of care and orders are provided by Hospice. (B) 4. The following Quality Assurance programs have been implemented to ensure continued compliance: A. Compliance will be monitored through the internal QA Process. 5. Completion: 5/19/21	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 881		5/19/21

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F 881	Continued From page 33 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow their Antibiotic Stewardship policy by failing to document the duration of antibiotic therapy and failing to ensure a culture was collected before starting an antibiotic for two of two residents (R29,R35) reviewed for antibiotic use in the sample list of 27 residents. Findings include: The facility's Antibiotic Stewardship Program policy dated 4/16/21 document, "Purpose: To improve the use of Antibiotics in healthcare to protect residents and reduce the threat of antibiotic resistance through a set of commitments and actions designed to optimize the treatment of infections while reducing adverse events associated with antibiotic use. This will be accomplished utilizing the Core Elements." The facility's Resident Infection Control and Antimicrobial Log dated March 2021 documents R35 and R29 were receiving antibiotics for UTI (Urinary Tract Infection) Prophylaxis. This log documents R35 was receiving Macrobid 100 mg by mouth once a day and R29 was receiving Macrobid 100 mg by mouth once a day. The facility's Resident Infection Control and Antimicrobial Log dated April 2021 documents R35 and R29 are receiving antibiotics for Prophylaxis. This log documents R35 is receiving Cephalexin (antibiotic) 500 mg (milligrams) by	F 881	F881 Antibiotic Stewardship Program CFR(s):483.80 (a)(3) 1. For the residents identified, affected by the alleged deficient practice, the following was completed: A. Administrator met with Medical Director to explain the facilities mission in regard to Eastview Terrace's Antibiotic Stewardship Program. B. R35's Cephalexin was discontinued. (Attachment A) C. R29's Macrobid was discontinued. (Attachment B) D. In-service was conducted with Nursing Staff on Antibiotic Stewardship. (Attachment C) 2. All residents have the potential to be affected by the alleged deficient practice. However due to the implementation of 1A-C, the alleged deficient practice will not occur. 3. The following systematic measures have been implemented to ensure compliance: A. The Infection Control/Antimicrobial Log will be reviewed daily during morning QA meetings to ensure the log includes all necessary information, supporting documentation for use of antibiotics, appropriate antibiotic/dosage related to	

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F 881	Continued From page 34 mouth once a day and R29 is receiving Macrobid (antibiotic) 100 mg by mouth once a day. 1.) R35's Physician Order Sheet (POS) dated 1/1/21 through 1/31/21 documents diagnoses including Alzheimer's Disease and UTI (Urinary Tract Infection). This POS documents an order for Nitrofurantoin (Macrobid/antibiotic) 100 mg by mouth once daily for diagnosis of Recurrent UTI dated 11/7/20 with no stop date. R35's POS dated 2/1/21 through 2/28/21 documents the same order for Nitrofurantoin with no stop date. This POS also documents an order dated 2/26/21 for Amoxicillin (antibiotic) 500 mg one tablet by mouth three times a day for seven days for the diagnosis of UTI. R35's POS dated 3/1/21 through 3/31/21 documents the same order for Nitrofurantoin with no stop date. This POS also documents an order dated 3/14/21 for Augmentin (antibiotic) 500 mg one tablet by mouth twice a day for 10 days. R35's POS dated 3/25/21 through 3/31/21 documents an order dated 3/25/21 for cefdinir (antibiotic) 300 mg one capsule by mouth once daily for 5 days. This POS also documents an order dated 3/25/21 for Cephalexin (antibiotic) 500 mg one capsule by mouth daily once the Cefdinir is completed. R35's POS dated 4/1/21 through 4/30/21 documents an order for Cephalexin 500 mg one capsule by mouth once daily, "start after Cefdinir is completed." This POS documents "Clarify Stop Date/Dx (diagnosis)" but this statement is crossed out with a line drawn through it and hand written in ink underneath was, "UTI Prophylaxis"	F 881	identified infection and pharmacy review. Any antibiotics ordered inappropriately will be discussed with the prescriber. 4. The following Quality Assurance programs have been implemented to maintain and continue to achieve substantial compliance with the alleged deficient practice: A. The Infection Control/Antimicrobial Log will be reviewed daily during morning QA meetings to ensure the log includes all necessary information, supporting documentation for use of antibiotics, appropriate antibiotic/dosage related to identified infection and pharmacy review. Any antibiotics ordered inappropriately will be discussed with the prescriber. B. Compliance will be monitored through the internal QA process. 5. Completion Date: 05/19/2021	

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EASTVIEW TERRACE	**100 EASTVIEW PLACE SULLIVAN, IL 61951**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 35 and no stop date. R35's Urinalysis Laboratory results report dated 2/4/21 documents >(greater than) 100,000 cfu/ml (colony-forming unit/milliliter) of Providencta Stuartii (bacteria). This report documents an order for Levaquin (antibiotic) 500 mg by mouth once daily for seven days. This report documents this bacteria is susceptible to Levofloxacin (Levaquin). This report also documents that this bacteria is resistant to Nitrofurantoin which R35's February 2021 POS documents R35 was receiving Nitrofurantoin daily since 11/7/20. R35's Urinalysis Laboratory results report dated 3/11/21 documents >100,000 cfu/ml of Proteus Mirabilis (bacteria). This report documents an order for Augmentin (antibiotic) 500 mg twice a day for 10 days. This report documents this bacteria is susceptible to Augmentin. This report also documents that this bacteria is resistant to Nitrofurantoin which R35's March 2021 POS documents R35 was receiving daily since 11/7/20. 2.) R29's POS dated 1/1/21 through 1/31/21 documents diagnoses including Dementia with Agitation, Parkinson's and UTI. This POS documents an order for Nitrofurantoin (antibiotic) 100 mg by mouth once daily for a diagnosis of Prophylactic/Recurrent UTI dated 12/8/20 with no stop date. This POS also documents an order dated 1/25/21 for Cipro (antibiotic) 500 mg by mouth twice a day for 7 days for a diagnosis of UTI. R29's POS dated 2/1/21 through 2/28/21 documents the same order for Nitrofurantoin with no stop date.	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146039	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTVIEW TERRACE	100 EASTVIEW PLACE SULLIVAN, IL 61951

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 36 R29's POS dated 3/1/21 through 3/31/21 documents the same order for Nitrofurantoin with no stop date. This POS also documents an order dated 3/23/21 for Levaquin (antibiotic) 500 mg by mouth daily for 7 days. R29's POS dated 4/1/21 through 4/30/21 documents the same order for Nitrofurantoin with no stop date. R29's Urinalysis Laboratory results report dated 1/20/21 documents >100,000 cfu/ml of Klebsiella Pneumoniae (bacteria). This report documents an order for Cipro (antibiotic) 500 mg by mouth twice a day for 7 days. This report documents this bacteria is susceptible to the Cipro but this report documents that this bacteria is resistant to Nitrofurantoin which R29's January 2021 POS documents R29 was receiving daily since 12/8/20. R29's Urinalysis Laboratory results report dated 3/23/21 documents >100,000 cfu/ml of Klebsiella Pneumoniae. This report documents an order Levaquin 500 mg by mouth every day for 7 days. This report documents this bacteria is sensitive to Levoquin (Levofloxacin). This report also documents that this bacteria is resistant to Nitrofurantoin which R29's March 2021 POS documents R29 was receiving daily since 12/8/20. On 4/29/21 at 9:22 AM, V6 Care Plan Coordinator stated V27 Physician prescribed the prophylactic antibiotics for R29 and R35. V6 stated they sent a request to V27 to discontinue the prophylactic antibiotics but V27 denied the request.	F 881		