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ALTA REHAB AT OAK BROOK	2013 MIDWEST ROAD OAK BROOK, IL 60521

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S 000	Initial Comments First Probationary Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 4 300.696b) Section 300.696 Infection Prevention and Control b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure visitors wore the appropriate PPE (personal protective equipment) in a resident's room on strict isolation, and failed to ensure staff wore the appropriate PPE when doing wound care for a resident on enhanced barrier precautions (EBP) for 2 of 2 residents (R2, R3) reviewed for infection control in the sample of 14.	S9999		

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The findings include:

1. R2's Admission Record, printed by the facility on 5/22/24, showed she had diagnoses including Parkinsonism, major depressive disorder, anxiety disorder chronic kidney disease, stage 3, and dementia. R2's Order Summary Report, printed by the facility on 5/22/24, showed an order dated 5/20/24 for "Single Room Strict Contact Isolation for C. Diff (inflammation of the colon caused by the bacteria Clostridium difficile that can be transmitted from person to person by spores). R2's lab results showed R2 tested positive for C. difficile on 5/20/24. R2's care plan dated 5/21/24, showed she was on strict contact isolation due to C-Diff. The care plan showed Contact Isolation: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry. Disinfect all equipment used before it leaves the room. The care plan showed "Educate staff, resident, family and visitors of patient regarding signs and symptoms, and precautions of C-Difficile."

On 5/21/24 at 11:43 AM, R2 was lying in bed on her left side. V22 (R2's daughter) was in R2's room, sitting on the side of R2's bed with her hand on R2's right hip. V22 did not have a gown or gloves on. At 12:03 PM, V22 was sitting in the chair next to R2's bed with no gown or gloves on. A male (V23) was sitting on R2's bed at this time. V23 did not have a gown or gloves on. At 12:28 PM, V23 got up and walked out of R2's room without washing his hands. V23 identified himself as R2's son. At 12:30 PM, V22 put on a gown and gloves. V22 said she got to the facility at 8:15 AM and was in R2's room until about 9:30 AM with no

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gown or gloves on. V22 said she left for a little while and returned to the facility around 11:30 AM. V22 said no one said anything to her about the need to put on a gown and gloves until just now (12:30 PM). V22 said staff have been going in and out of the room and not wearing a gown and gloves on while she was there today (5/21/24).

A sign on the wall outside R2's room showed "Stop. Contact Precautions Enteric. Standard Precautions also in effect. Visitors must see nurse before entering room. Upon entering the room: Perform hand hygiene with alcohol-based hand rub or soap and water. Gloves required. Gown required. Before leaving the room: Remove gown and gloves. Wash hands with soap and water only."

On 5/22/24 at 2:21 PM, V2 (Director of Nursing-DON) said R2 is on strict contact isolation. Staff and visitors should wash their hands or sanitize their hands before entering and put on a gown and gloves before entering the room. V2 said this should be done whether the person entering the room is providing care or not. V2 said C-diff spores can stay on surfaces and there is a risk for cross-contamination. V2 said gloves and gown should be removed, and hands washed before exiting the room. V2 said it is important to ensure visitors wear the proper PPE for residents on isolation, to prevent the spread of infection.

On 5/23/24 at 12:40 PM, V3 (Assistant Director of Nursing/Infection Control Nurse) said C-Diff is very contagious and can still be present on surfaces for a long time. It is important to wear a gown and gloves when in R2's room. Even visitors and family members should wear a gown

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and gloves because they can spread it to other surfaces in the facility.

2. R3's Admission Record, printed by the facility on 5/22/24, showed she had diagnoses including dementia, malignant neoplasm of breast, type 1 diabetes mellitus, and pressure ulcers on her sacral region, and bilateral heels.
On 5/22/24 at 10:01 AM, V19 (Licensed Practical Nurse/Wound Nurse) was preparing the supplies to do the wound care for R3's multiple pressure wounds. A sign on the wall outside R3's room showed "Stop. Enhance Barrier Precautions. Everyone must: Clean their hands, including before entering and when leaving the room. Providers and Staff must also: Wear gloves and a gown for the following high-contact resident care activities ...Changing briefs or assisting with toileting ...Wound care: any skin opening requiring a dressing." V19 took the supplies into R3's room and placed them on a clean field on R3's nightstand. V19 informed R3 that she was going to do the dressing changes to R3's pressure wounds. V19 put on clean gloves (no gown) and pulled the covers back. After positioning R3 onto her right side, V19 pulled R3's incontinent brief back. R3 had been incontinent of stool. V19 cleaned the stool from R3 and removed the soiled brief from under R3. V20 (Certified Nursing Assistant-CNA) knocked and entered R3's room to assist V19. V20 was wearing a gown and gloves. V19 performed the wound care to the pressure wound on R3's sacral area, left buttocks, right and left heels and her left great toe. At no time during R3's wound care did V19 put a gown on.

On 5/22/24 at 2:16 PM, V2 (Director of Nursing-DON) said V19 should have worn a

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gown when she was providing incontinent care and wound care for R3. V2 said there are so many organisms that are resistant to antibiotics. V2 said a resident with wounds would be at risk for those organisms. V2 said it is important for staff to wear the correct PPE when caring for these residents. V2 added, it is for the resident's safety and to prevent transmission to other staff and residents.

On 5/23/24 at 12:40 PM, V3 (Assistant Director of Nursing/Infection Control Nurse) said Enhanced Barrier Precautions is one way of protecting high-risk patients from acquiring MDROs (multidrug-resistant organisms) and other infections.

R3's care plan dated 4/30/24, showed she was on enhanced barrier precautions related to wounds. The care plan showed gown and glove during high-contact resident care activities (such as dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care/use, and wound care.

R3's facility assessment dated 4/9/24 showed she had moderate cognitive impairment, required partial to moderate assistance from staff for toileting, personal hygiene, and bed mobility. The assessment showed R3 is occasionally incontinent of bowel and bladder, and she had one or more unhealed pressure injuries.

The facility's policy and procedure titled Enhanced Barrier Precautions, with a revision date of 5/7/24, showed the purpose was to reduce risk of transmitting multidrug-resistant organisms (MDRO) and targeted MDRO when contact precautions do not apply for residents

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S9999	Continued From page 5 identified as higher risk. The policy showed "Guidelines: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care activities." The policy showed EBP are indicated for residents with any of the following ...Chronic wounds and/or indwelling medical devices. The policy showed pressure ulcers are an example of chronic wounds. (B) 2 of 4 300.1210b)5 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. The requirement was not met as evidenced by:	S9999		

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Based on interview and record review the facility failed to safely transfer a resident using a mechanical lift. This applies to one of two residents (R5) reviewed for falls in the sample of 14.

The findings include:

The facility face sheet for R5 shows she was admited to the facility with diagnoses to include vascular dementia, persistant mood disorder and atrial fibrillation. The May 2024 Physician orders shows R5 was admitted to hospice care on 5/6/24. The facility assessment dated 3/26/24 shows R5 to have severe cognitive impairment and required maximal assist from staff for transfers. R5's facility care plan for activities of daily living shows on 4/18/24, R5's abilities were downgraded from a one to a two assist for transfers to be completed safely. On 4/10/24 the intervention of transfer with a mechanical lift was added to R5's care plan.

On 5/21/24 at 12:00 PM, V21 (R5's daughter) stated her mother was dropped from the mechanical lift due to staff not applying the sling correctly, and her mother fell to the ground and broke her left ankle. V21 said the family was told only one staff member was present and the sign above her mothers bed clearly stated that two staff are to be present for all transfers. V21 said her mother had been placed on hospice care due to her declining condition and now she was not doing well and is in more pain.

On 5/21/24 at 12:00 PM a sign was observed above R5's bed showed mechanical lift-two staff.

The nursing progress note dated 5/16/24 at 11:47 PM written by V15 RN (Registered Nurse) shows,

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[CNA (Certified Nursing Assistant) reported to writer resident had fallen from the mechanical lift while being transferred into bed. Per CNA R5 had fallen because the sling was not placed properly and resident fell.]

The nursing note dated 5/17/24 at 12:12 PM for R5 shows hospice came to the facility and made arrangements for R5 to go to the hospital for an x-ray.

The hospital notes dated 5/17/24 shows R5 was sent to the emergency room after a fall from a mechanical lift. The note shows there was an obvious deformity to the left ankle. The x-ray report dated 5/17/24 shows a displaced fractures to the distal tibia and fibula. (Lower leg bones)

The facility reported incident report dated 5/16/24 for R5 shows while R5 was being transferred she began to slide out of the sling and was lowered to the ground. The final report with the same date shows R5 requires two person assist mechanical for transfers. The report shows while the resident was in the lift swing, she started sliding out and lowered to the floor. R5 sustained a fracture. The staff were inserviced on mechanical lift transfers.

On 5/22/24 at 9:58 AM, V15 said she was the nurse working the night R5 fell from the mechanical lift. V15 said she was across the hall with another resident when she heard a scream and a loud thump. V15 said she ran over to R5's room and saw R5 on the floor on her left side, with the arm of the mechanical lift in the high position. V15 said no sling was observed under R5 and V16 CNA was the only staff person in the room. V15 said she completed an assessment on R5 and she would grimace with any movement to her left lower leg and the ankle area was

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beginning to swell. V15 said she called the hospice and got the OK for an x-ray at the facility and then called the doctor for the order. V15 said she called the x-ray company to order a stat x-ray but they never showed up while she was on duty. V15 said she told the oncoming nurse someone was coming to do an x-ray.

On 5/22/24 two messages were left for V16, but she never returned my calls. V16 is employed by an agency that helps staff the building.

On 5/22/24 at 11:30 AM, V13 and V14 both CNA's said whenever a mechanical lift is needed to transfer a resident, two staff must be present for the residents safety.

On 5/23/24 at 9:32 AM, V2 Director of Nursing said two staff are supposed to be present when a transfer is being done using a mechanical left for the safety of the resident. V2 said V16 reported to her the loops of the sling came off on the left side and R5 slid out of the sling onto the floor. V2 said if two staff are present, one staff can run the lift and the second staff member is with the resident and making sure the loops are properly attached as the resident is raised up.

An inservice completed by the facility on 5/17/24 shows to follow appropriate number of staff assistance for transfers. Use of mechanical lift transfers require two staff assist. Ensure sling pads are securely placed prior to transfers.

The facility policy for manual gait belt and mechanical lifts with a revision date of 1/19/18 shows in order to protect the safety and well bing of the staff and residents, and to promote quality care, this facility will use mechanical lefting devices... 5. the transferring needs of residents

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S9999	Continued From page 9 will be assessed on an ongoing basis and designated into one of the follwoing caregories: H=mechanical lift with two caregivers. (A) 3 of 4 300.1210d)5 Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review the facility failed to identify an area of pressure prior to becoming a deep tissue injury, failed to implement pressure relieving interventions, and failed to perform wound care in a manner to prevent cross contamination for 3 of 4 residents (R7, R6, R3) reviewed for pressure	S9999		

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ulcers in the sample of 14.

The findings include:

1. R7's face sheet printed on 5/21/24 showed an admission date of 5/2/24 and diagnoses including but not limited to right femur fracture, orthopedic aftercare, and falls. R7's facility assessment dated 5/6/24 showed no cognitive impairment and staff assistance needed for toileting, hygiene, and transfers. The same assessment showed R7 is occasionally incontinent of urine and always incontinent of bowel. The assessment showed R7 at risk for pressure ulcer development.

R7's admission skin report dated 5/2/24 showed sacrum/buttocks skin intact and surgical wounds present to the right hip.

R7's wound assessment report dated 5/8/24 showed a right buttock, facility acquired DTI (deep tissue injury). The area measured 5 x 5.5 x unknown centimeters.

R7's wound assessment report dated 5/15/24 showed the right buttock measuring 5 x 7 x unknown centimeters (worsening).

R7's weight log summary showed a weight of 154.3 pounds as of 5/21/24.

On 5/21/24 at 9:56 AM, R7 was lying in bed on a pressure reducing air mattress. The mattress setting was at the 250 + pounds level. R7 was transferred by V7 (Certified Nurse Aide) from the bed to the toilet. R7 was incontinent of bowel and urine. R7 stood up from the wheelchair and an egg size, oozing pressure ulcer was visible on her right buttocks. There was no dressing on the

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area. R7's was transferred back to bed by V7 and laid down on bed linens clearly visible with bowel movement. R7 said she had been given a laxative the night before and was having bowel movements all night long. R7's right hip was observed and multiple stitches were visible. There were no dressings on the area. R7's heels were observed and both had protective bandages on them. R7 heels were not being floated before or after the toileting and heel protectors could not be located anywhere in her room. V6 (Wound Care Nurse) opened and prepared supplies for R7's wound care in the hallway. V6 used shared scissors to cut a dressing down to size and did not sanitize them before using them. V6 entered the room and laid the supply tray at the foot of R7's bed, on top of the soiled bed linens. V6 then exited the room and returned with a clean drape which she placed on the bed and laid the tray on top of it. V6 cleansed R7's buttock wound with normal saline while using the same gauze pad repeatedly to blot the area. V6 stated R7 should always have dressings on her buttocks and surgical wounds. They are needed to help with healing and prevent infection. V6 did not know why the dressings were not present.

R7's May 2024 physician order report was reviewed and showed orders for the three surgical areas to the right hip to be cleansed with normal saline and covered with dry dressings daily. The report showed orders for the right buttock to be cleansed, santyl, calcium alginate, and dry dressings daily and as needed. The report showed orders for offloading boots to both feet when in bed.

On 5/23/24 at 9:20 AM, V2 (Director of Nurses) stated nurses should be doing skin checks weekly and the aides during all daily care. Any

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skin changes should be reported immediately to reduce the potential of the area getting worse. Any untreated skin issues should be addressed as soon as it is noticed. Pressure ulcers should be identified at an early stage. Staff should be finding them during admission assessments and while doing routine care. Finding a pressure ulcer at an advance, unstageable level is a problem. High pressure areas like the back, buttocks and heels are especially prone to pressure ulcers. It is important interventions are started and in place right away. Lack of interventions can lead to more break down. Aides should be reporting all missing dressings immediately. Open wounds need protection to prevent infection. Urine and bowel movement is a big potential for infection and worsening of wounds. V2 said wound care should be done in a manner to prevent the spread of germs. Supplies need to be sanitized, a clean field should be in place, and cleansing needs to be correct. Nurses should be moving from clean to dirty and never cross over. It is a cross contamination problem.

R7's care plan showed a focus area initiated 5/8/24 for buttocks pressure ulcer. Interventions included: Administer treatments as ordered and monitor for effectiveness, follow facility policies/protocols for the prevention/treatment of skin breakdown, monitor dressing every shift to ensure it is intact and adhering, report lose dressing to treatment nurse, and resident requires a low air loss mattress.

The facility's Skin Condition Assessment & Monitoring-Pressure and Non-Pressure policy dated 6/8/18 stated: "Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA ...Care givers are responsible for promptly notifying the

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charge nurse of skin breakdown."

The facility's Pressure Ulcer Prevention policy dated 1/15/18 states: "1. Maintain clean/dry/skin during daily hygiene measures. 3. Change bed linen per schedule and whenever soiled with urine, feces or other material. 11. Use positioning devices or pillows, rolled blankets, etc. to reduce pressure and friction/shearing from heels, toes, and malleoli as indicated."
The facility's Dressing Change-(Clean/Non Sterile) policy dated 1/8/18 states: "2. Prepare a clean, dry work area at bedside. 3. Bring supplies into resident's room. Individual resident supplies may be placed on the over bed table after it has been disinfected and/or a protective barrier placed on the table (clean towel, plastic bag, small choux, foam tray, etc). 7. Prepare/open any necessary supplies and place on top of clean barrier. 14. Clean area/wound with solution specified in treatment order. 16. Apply prescribed ointment and/or dressing per doctor order. Follow manufacture's recommendations for application of dressing/ointments/creams/moisturizers, etc".

2. The facility face sheet for R6 shows she was admitted with diagnoses to include dementia, bipolar disorder and rheumatoid arthritis. The facility assessment dated 3/28/24 for R6 shows she has severe cognitive impairment and is dependent on staff for bed mobility.

On 5/21/24 at 12:00 PM, 5/22/24 at 9:20 AM and on 5/23/24 at 9:00 AM R6's air mattress on her bed was set at 250 pounds.

On 5/23/24 at 9:10 AM, V18 Licensed Practical Nurse and wound care coordinator adjusted R6's air mattress to 150 pounds after being asked how

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the air mattress was supposed to be set. V18 said when the air mattress is placed on the bed, the weight of the resident is checked and the air mattress is set at that weight. V18 said R6 weighs 152 pounds now. V18 said these air mattress's are new to the facility and the wound nurses are to check the pressure on the air mattress daily to make they are set at the correct pressure. V18 said R6 was admitted to the facility and developed moisture associated skin disorder to her sacrum and this turned into a deep tissue pressure injury.

On 5/23/24 at 9:00 AM, V17 wound nurse said the goal is for a resident to never develop a pressure injury while at the facility. V17 said R6 has a facility acquired deep tissue injury to her sacrum. V17 said she did not have anything to do with the air mattress, the maintanance department puts them on the bed. V17 referred me to V18 for more information on the air mattress.

On 5/23/24 at 9:25 AM,V2 Director of Nursing said the air mattresses are set up based on the weight of the resident. V2 said the purpose of the air mattress is to relieve constant pressure to a bony prominence.

The facility weights for R6 shows on 5/6/24 she weighs 152 pounds.

The facility admission assessment dated 3/23/24 shows R6 was admitted with no skin breakdown.

The Braeden skin observation assessment dated 4/13/24 shows R6 is at risk for skin breakdown.

The wound assessment details report dated 4/30/24 shows R6 had developed a facility

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acquired deep tissue injury on 4/25/24 to her sacrum. The area measured 4 by 3 centimeters with 50% intact skin and 50% deep maroon tissue. The wound assessment dated 5/15/24 shows the areas measured the same was staged as unstageable with 50% deep maroon tissue and 50% loosley adherent slough (to seperate dead tissue from living tissue).

The facility care plan for pressure injury sacrum related to immobility initiated on 5/8/24 shows interventions to include the bed to be as flat as possible to reduce shear, requires assistance with turning and repositioning every 2 hours and the resident requires a low air loss mattress.

The operator's manual for the low air loss mattress shows to determine the resident's weight and set the control knob to that weight on the control unit.

3. R3's Admission Record, printed by the facility on 5/22/24, showed she had diagnoses including dementia, malignant neoplasm of breast, type 1 diabetes mellitus, and pressure ulcers on her sacral region, and bilateral heels. R3's 5/20/24 Wound Assessment Details Report showed she had a deep tissue pressure injury to her right heel measuring 1.5 centimeters (cm) x 1.5 cm x 0.1 cm with 50% bright pink or red tissue and 50% loose, adherent slough tissue (dead tissue, usually cream or yellow in color, that impedes healing of the wound.

On 5/22/24 at 10:01 AM, V19 (Licensed Practical Nurse/Wound Nurse) prepared the supplies to do the wound care for R3's multiple pressure wounds. V19 took the supplies into R3's room and placed them on a clean field on R3's nightstand. V20 (Certified Nursing Assistant-CNA)

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knocked and entered R3's room to assist V19. V19 performed the wound care to the pressure wound on R3's sacral area and left buttocks. V19 removed the old dressing from the wound on R3's right heel and was showing V24 (R3's husband) the wound. While talking to V24 about the status of R3's wound to her right heel, V19 touched the wound bed, the skin around the wound and the wound bed again several times with her gloved hand. V19 did not clean the wound on R3's right heel prior to applying Therahoney (a wound gel that promotes the removal of dead and non-viable skin tissue, maintains a moist environment for the wound, and promotes a healing environment), alginate and the dressing to R3's right heel.

On 5/23/24 at 9:22 AM, V2 (Director of Nursing-DON) said V19 should have cleaned the wound bed on R3's right heel after touching the wound because cross-contamination could have occurred.

On 5/23/24 at 12:45 PM, V3 (Assistant Director of Nursing/Infection Control Nurse) said it is important to clean the wound bed during a dressing change to remove any dead tissue and remove bacteria out of the wound. V3 said cleaning is the best way to prevent infection.

R3's facility assessment dated 4/9/24 showed she had moderate cognitive impairment, and one or more unhealed pressure injuries.

R3's care plan dated 3/6/24 showed she had a pressure ulcer. The care plan showed "Administer treatments as ordered and monitor for effectiveness."

R3's Order Summary Report, printed by the facility on 5/22/24, showed an order dated

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S9999	Continued From page 17 5/13/24 for "Right heel: Cleanse wound with NSS (normal saline solution). Pat dry. Therahoney, alginate, cover with dry dressing daily." (B) Statement of Licensure Violations 4 of 4 300.1630a) 300.1630a)2)3) 300.1630f) Section 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. 2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. (See Section 300.1810.) 3) Self-administration of medication shall be permitted only upon the written order of the licensed prescriber. f) Nurses' stations shall be equipped as per Sections 300.2860 or 300.3060 and shall have all necessary items readily available for the proper administration of medications.	S9999		

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S9999	Continued From page 18 This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure intravenous medications were administered by qualified staff (R8, R14), failed to ensure residents were assessed to self-administer medications (R7, R9, R12) and failed to ensure medication carts were stocked prior to the scheduled administration times (R7, R12, R2) for 6 of 7 residents reviewed for medication administration in the sample of 14. The findings include: 1. R8's May 2024 physician order report showed an order dated 5/18/24 for IV (intravenous) Zosyn 3.375 milligrams (antibiotic) three times per day for a pelvic abscess for 21 days. R8's May 2024 medication administration report was reviewed from 5/18 to 5/21. The report showed the IV Zosyn was administered by an LPN (Licensed Practical Nurse) five out of the seven scheduled doses. R14's May 2024 physician order report showed an order dated 5/7/24 for IV vancomycin 750 milligrams (antibiotic) one time daily for orthopedic aftercare following amputation. R14's medication administration report was reviewed from 5/7 to 5/22. The report showed the IV vancomycin was administered by an LPN four out of the sixteen scheduled doses. On 5/22/24 at 9:59 AM, V5 (LPN) stated she administers R14's IV medication around 4 PM on the days she works. V5 said she has been doing it around that time for several days now. V5 stated she was an LPN and not a RN (Registered Nurse).	S9999		

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S9999	Continued From page 19 On 5/23/24 at 8:58 AM, V2 (Director of Nurses) stated there were only two IV certified LPNs working at the facility. V2 said any LPN giving IV medications needs to be certified before giving the medication. If there is not an IV certified LPN available, then an RN is needed to give the medication. The IV certification is required for the LPN to be working within the scope of practice per the state of Illinois rules. V2 said the certification ensures the LPN is properly trained and administering the IV medication correctly. The facility supplied list of IV certified LPNs were not the LPNs documented on R8 and R14's medication administration reports. The facility did not provide a policy related to LPN versus RN for IV medication administration. 2. On 5/21/24 at 9:56 AM, R7 was lying in bed and two clear baggies with eye drop medications inside were on the table next to her. V4 (LPN) stated R7 likes to do the eye drops by herself. They are always left in the room so she can give them to herself. On 5/22/24 at 11:32 AM, the eye drops were still in the baggies and laying on the table next to R7. R7 stated she does them by herself and does a few drops in each eye every day. On 5/22/24 at 8:26 AM, R12 was lying in bed and an inhaler was lying on the table next to her bed. V10 (LPN) stated she does the inhaler by herself so he would not be administering it. R12 verified she had done the inhaler alone earlier in the morning, just like she does every day. On 5/22/24 at 11:36 AM, R9 was lying in bed and two medication cups were next to him on the	S9999		

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table. One cup had a yellow liquid inside and the other had four various colored pills. R9 said he had no idea what the medications were. A housekeeping staff member was present in the room and mopping the floor. V2 (DON) walked by the room and was questioned about the medications. V2 said leaving the pills unattended was a problem and the nurse should not have left them there.

On 5/23/24 at 9:03 AM, V2 (DON) said medications should not be left unattended in resident rooms. There is the potential for doses to be missed or someone else could take the medication. There is the potential for double doses if the medications are not taken at the correct time. Residents need to be screened and show a return demonstration before they are allowed to administer their own medications. It is important to ensure they are understanding the correct way and time to take their medications. Residents need a physician order and care plan interventions showing they can effectively self-administer medications. V2 said nurses should not be documenting a medication as given, unless they are the individual giving the medication. It is a safety issue.

R7, R9, and R12's May 2024 physician orders and care plans were reviewed. There were no orders or interventions related to the ability to self-administer medications.
R7 and R9's May 2024 medication administration records showed documentation that the eye drops and inhaler were administered by the nursing staff.

The facility did not provide a policy related to resident self-administration of medications.

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3. On 5/21/24 and 5/22/24, medication administration was performed by V4, V10, and V11 (License Practical Nurses). The three LPNs were scheduled on different units of the facility. Every nurse was missing multiple scheduled and stock medications in their medication carts. V4 was missing three routine scheduled medications for R7 and had to go to a stock room. V4 said they were missing in the cart because they have not been delivered from the pharmacy yet. R7's diuretic was in a locked computer system and would not allow V4 to access the system. V2 (DON) had to be alerted and she stated she needed to contact the physician to get the situation corrected.

V10 (LPN) was passing medications for R12 and had to go to medication storage rooms repeatedly for missing scheduled and stock medications. A hospice nurse approached V10 during the pass and asked for a pain pill for the resident. A second resident wheeled himself up to the cart during the pass and requested a pain pill. V10 was busy locating missing cart medications and could not respond quickly to the requests.

V11(LPN) was passing medications for R2 and was missing an antibiotic that was scheduled for 4 times daily. V11 had to go the storage room and was not able to access the locked computer system. V3 (ADON) had to be alerted to get access to the system.

Both V10 and V11 apologized to the surveyor for the unorganized and long lag time needed for the residents to receive the scheduled medications.

On 5/23/24 at 9:00 AM, V2 (DON) stated the floor nurses should be checking and restocking the medication carts on every shift. The night nurses

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S9999	Continued From page 22 are responsible for reviewing the entire cart and replace medications that are running low. Nurses need to be organized prior to starting their shift. Repeated trips to the stock rooms can cause residents to question the confidence and ability of nurses. Unorganized medication carts can cause medications to be given later than the scheduled time. Refill requests should be sent to the pharmacy two to three days before the medication runs out. Nurses should be communicating between each shift what is running low and what has been reordered. Nurses need to be able to respond quicker to pain medication requests. The facility's undated Administration: Procedures for All Medications policy states: "To administer medications in a safe and effective manner". (B)	S9999		