STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145720	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Clara's Rehab & Senior Care	1450 Castle Manor Drive Lincoln, IL 62656

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 34131 Based on interview and record review, the facility failed to notify in writing, and maintain a copy in the medical record notification to the Ombudsman of residents that were reviewed for notices before transfers. This failure has the potential to affect all 94 Residents residing in the Facility. Findings include: Admission and Discharge/Transfer log reviewed with multiple residents discharged /transferred. On 5/1/24 at 8:41 AM, V1 Assistant Administrator was unable to provide any documentation the Ombudsman was notified of resident transfers. We notify the Ombudsman of resident admits and discharges out of the building but not if they transfer to the hospital. Facility Application for Medicare/Medicaid, dated 5/1/24, documents 94 Residents reside in the Facility.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34542 Based on observation and interview, the facility failed to ensure pressure ulcer wound treatment was completed in a manner to prevent potential cross contamination of the wound for one resident (R55) of five residents reviewed for pressure wounds, in a total sample of 39. FINDINGS INCLUDE: On 05/01/24, at 11:00 a.m., V6/Licensed Practical Nurse provided wound care for R55's stage II (dime-sized/no drainage) coccyx area pressure wound. V6 turned R55 on R55's left side; opened R55's incontinence brief and exposed R55's wound/no dressing noted on wound; washed the wound area with spray cleanser and patted dry with 4 by 4 gauze; V6 allowed R55 to roll back on to the incontinence brief with the cleansed wound touching the incontinence brief; prepared R55's medication and dressing (Peptospermum Honey and Hydrocolloid), rolled R55 back on to R55's left side; applied the medication and dressing (Peptospermum Honey and Hydrocolloid) leptospermum to the wound; assisted R55 back on to incontinence brief; and then pulled up the front of the R55's incontinence brief. At 11:10 a.m., V6 confirmed after cleansing R55's pressure wound, R55 should not have allowed R55 to roll back over resulting in the cleansed wound touching the incontinence brief which was on R55 prior to and during R55's wound care.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33971 Based on observation, interview, and record review the facility failed to identify target behaviors to warrant the use of an antipsychotic medication, failed to ensure a resident received the lowest effective dose of psychotropic medication (R17), and failed to ensure PRN (as needed) psychotropic medication had a 14 day stop date (R295) for two of six residents (R17 and R295) reviewed for unnecessary medications in the sample of 39. Findings include: 1. The facility's Psychotropic Medication Policy revised 11/28/17 states, Intent: Residents are free from unnecessary psychotropic medication use. These medications are to be given to treat a specific condition/medical symptom that is diagnosed and documented in the clinical record. Specific condition/medical symptoms alone are not enough to justify pharmacological use. B. Dose, Duration, Monitoring: 1. Evaluation of pharmacological ongoing effectiveness towards therapeutic goal. 2. Evaluation of the effectiveness of the non-pharmacological approaches prior to medication administration. 3. Quarterly evaluation or more frequent if needed to determine if a reduction is warranted. C. Gradual Dose Reduction: 1. Residents should receive the lowest effective dose of psychotropic medication for the residents' physical, mental, and psychosocial well-being. The Policy also documents Initial PRN (as needed) order of antipsychotic medication should not exceed 14 days. A new order must be obtained after the physician or prescribing practitioner believes that to extend beyond the 14 days and has documented to rationale and indicated the rationale. R17's Face Sheet documents R17 admitted to the facility on [DATE] with diagnoses to include but not limited to: Unspecified Dementia with Psychotic Disturbance; Anxiety Disorder, and Depression. R17's current Care Plan documents R17 takes an antipsychotic medication related to psychosis. This same Care Plan does not document R17's specific behaviors related to R17's antipsychotic use. R17's Note to Attending Physician/Prescriber dated 2/7/24 documents a pharmacy recommendation to decrease R17's Seroquel Antipsychotic medication from 50 mg to 25 mg in an effort for a dose reduction. This same note documents V5 (R17's Physician) signed and agreed with the recommendation. R17's Physician Order Sheet dated July 2023-May 2024 documents orders for Seroquel (Antipsychotic) 25-50 milligrams/mg by mouth at bedtime for unspecified Psychosis with R17 currently receiving 50 mg by mouth at bedtime. R17's Medication Administration Records (MAR) dated February 2024 documents between 2/1/24 and 2/22/24 R17 received Seroquel 50 mg by mouth nightly. This same MAR dated 2/23/24-2/29/24 documents R17 received Seroquel 25 mg by mouth nightly. The MAR for the entire month of February 2024 documents NO behaviors exhibited by R17 were observed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R17's MAR dated March 2024 documents between 3/1/24 and 3/26/24 R17 received Seroquel 25 mg by mouth nightly. This same MAR documents between 3/27/24-3/31/24 R17 received Seroquel 50 mg by mouth nightly. The MAR for the entire month of March 2024 documents NO behaviors exhibited by R17 were observed. R17's MAR dated 4/1/24-4/30/24 documents R17 received Seroquel 50 mg by mouth nightly for the entire month. This same MAR documents NO behaviors exhibited by R17 were observed. R17's Behavior Tracking Logs dated 12/30/23-5/1/24 documents No Behaviors Observed for this period. On 4/30/24 at 11:10 AM, R17 was sitting up in a chair in R17's bedroom. R17 was calm, alert, oriented and able to answer questions well. R17 stated R17 could not recall why R17 was on the antipsychotic medication Seroquel. R17 stated, I think I was angry when I first came in, so they put me on Seroquel. I have Dementia too. That might also be why. Around 12:30 this same day, R17 was observed ambulating independently throughout the facility, socializing, and interacting with other residents well. No abnormal behaviors were observed. On 5/2/24 at 8:52 AM, V4 (Licensed Practical Nurse) stated that R17's Seroquel dose was decreased from 50 mg to 25 mg in February 2024 in response to V5's (R17's Physician) physician response to a Pharmacy Recommendation. V4 stated R17's Seroquel dose was increased back to 50 mg from 25 mg because R17 and V11 (R17's Power of Attorney) refused the reduction. V4 denied that R17 exhibited behaviors to justify the medication dose increase. On 5/1/24 at 3:14 PM, V7 (Regional Director of Operations) verified R17's behavior tracking logs were not specific to R17's behaviors for antipsychotic use and verified R17's behavior logs did not document any behaviors to warrant the use of R17's antipsychotic medication. V7 stated psychotropic medications cannot be increased for family preference if there are no associated behaviors. On 5/1/24 at 3:20 PM, V1 (Assistant Administrator) denied that R17 exhibits any behaviors to justify the use of an antipsychotic medication. 34542 2. R295's Electronic Medical Record (EMR) document R295's diagnosis to include: Unspecified Dementia; Gastro-Esophageal Reflux Disease, Anxiety Disorder, Hallucinations, and Hypertension. R295's EMR document Physician's Order, dated 4/10/24, Lorazepam Oral Tablet 0.5 MG (milligrams). Give 1 tablet by mouth every 6 hours as needed for Anxiety. indefinite. On 5/2/24, at 11:55 a.m., V8/Regional Nurse Consultant confirmed the PRN medication should have had a 14-day stop date.