STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008973	A. BUILDING: _____ B. WING _____	C 10/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE ST JOSEPH CENTER	659 EAST JEFFERSON STREET FREEPORT, IL 61032

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S 000	Initial Comments Facility Reported Incident Investigation of 9/19/18/IL106551	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210a) 300.1210b) 300.1210d)1)2)3) 300.3220f) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be	S9999		

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S9999	Continued From page 2 made by nursing staff and recorded in the resident's medical record. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These Regulations were not met as evidence by: Based on interview and record review the facility failed to ensure pain management was provided to a resident. The facility failed to ensure the pain patch was ordered and was available to a resident on hospice services. This failure resulted in R11 experiencing medication withdrawl including restlessness and diaphoresis, and experiencing generalized pain throughout her body. This applies to 1 of 4 residents (R11) reviewed for controlled medications in the sample of 4. The findings include: On October 18, 2018, R11 was resting in her bed with oxygen in place and her caretaker at the bedside.	S9999		

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S9999	Continued From page 3 R11's current diagnosis sheet includes diagnoses of dementia, osteoarthritis, respiratory failure, and failure to thrive. R11's nursing note dated October 17, 2018 at 3:21AM by V14 RN (Registered Nurse) showed, "Residents fentanyl patch did come in tonight when pharmacy came at 11:30 PM. Author went in to change this residents patch, while I was changing her patch resident did complain of pain and she was notably sweating, and restless. Her Fentanyl patch was supposed to be changed on Sunday 10/12/18. I placed the new patch in the middle of her back. I will report off to oncoming staff and administration per charge nurse. Resident did state late in the shift that she was feeling a little better. I will continue to monitor this resident ..." On October 18, 2018, at 2:01 PM, V14 Registered Nurse (RN) said she arrived for her shift starting at 10 PM on October 16th. V14 said she received report from the previous nurse that R11's pain patch would be in the pharmacy delivery tonight (October 16) and that the old patch was left on until the new ones arrive. V14 said the pain patch was supposed to be changed on October 15 but was not changed until after 12:00 AM on October 17th (approximately 28 hours late). V14 said she assessed R11 early in her shift (around 10PM) and noticed she was a little "clammy", she said when she went back in a little later to check and make sure that the old patch had actually been left on, (R11)'s back was sweaty and she seemed restless. V14 said R11 usually does not move around very much but she was moving her legs around. V14 said R11 does not never complain of pain but on this night she described generalized pain all over.	S9999		

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S9999	Continued From page 4	S9999		

R11's eMAR (electronic medication administration record) for October 2018 showed V14 changed R11's pain patch on October 15, 2018. On October 18, 2018, at 2:01 PM, V14 stated she was not in the facility on October 15, 2018 but was working on October 17, 2018. V14 said when she made the nursing note on October 17, 2018 regarding the application of R11's pain patch, R11's signs and symptoms of pain, sweating and restlessness and signed out the pain patch. V14 said the documentation showing the October 15th pain patch change must have been an error in the documentation system due to the medication showing overdue at the time of administration on October 17, 2018. R11's narcotic sign out sheet for the pain patches showed V14 signed a patch out on October 17, 2018. The pharmacy delivery sheet signed by V14 showed the delivery of R11's pain patch to the facility at 11:30 PM on October 16, 2018.

On October 18, 2018, at 2:30 PM, V2 DON (Director of Nursing). said she was not aware that the pain patches were not sent from the pharmacy. V2 said if there is a missing pain medication she would expect the nursing staff to check the emergency supply of medications. If the missing medication is not stocked in the emergency medication supply she would expect the nurse to contact the on call physician and obtain the medication for the resident. V2 said there is no reason to delay. V2 said that R11 had an order for another pain medication and she would have expected the nurse to administer the available pain medication because R11 could have been having breakthrough pain due to the pain patch not being effective anymore. The eMAR for October 2018 showed no doses or other pain medication were administered on October 16th or 17th.

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S9999	Continued From page 5	S9999		

On October 18, 2018, at 3:00 PM, V1 Administrator said she would expect the supply of medication to be available. If the medications were not available for the resident she would expect the nurse to contact the pharmacy and get it from the emergency supply if it is in the emergency box of medications.

On October 19, 2018, at 9:30 AM, V15 Pharmacy Manager V15 said the pain patch releases 12mcg of the medication per hour for 72 hours. V15 said after the first 72 hours passes even if the patch is left on the resident the amount of medication being released would be at a lesser rate. V15 said typical withdrawal symptoms from the pain patch would include reports of pain, diaphoresis (sweating), and anxiety or restlessness. V15 stated R11 has been on fentanyl for quite a while and the pharmacy usually sends out a partial fill for 5 patches at a time. V15 said the patches that were sent to the facility on October 16, 2018 were the second fill for the prescription. To get those patches the nurses would usually fax them a reorder sticker to let them know they needed to send the next refill. At 9:50 AM, V15 called the surveyor back and stated he searched through all of the refill requests faxed to the pharmacy from October 9 through October 16, 2018 and could not find one from the facility for the fentanyl patches for R11. V15 stated he could find no documentation of phone calls from the facility verbally requesting the refill.

R11's care plan with onset date of August 8, 2018 showed R11 has the potential for pain as reported by her/family or as observed by changes in ADLs (activities of daily living) or behavior. The interventions on R11's care plan showed to initiate intervention as ordered by physician.

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S9999	Continued From page 6 R11's hospice care plan with problem onset date of February 12, 2018 showed the goal as: will be made as comfortable as possible by alleviating or controlling pain. The interventions for the hospice care plan include: observe and assess for any signs of distress, increased pain, and initiate appropriate interventions, administer medications as ordered by physician, assess for signs and symptoms of increased pain: i.e. increased anxiety, irritability, moaning, yelling out, increased restlessness and/or thrashing around in bed and notify physician of such. R11's electronic MDS (Minimum Data Set) dated August 6, 2018 showed R11 has moderately impaired cognitive function. R11's physician order sheet for October 2018 showed an order for a 12 mcg per hour pain patch to be applied to R11 every three days and an order for morphine 10-20 mg to be administered every hour as needed for pain. The facility's policy for Emergency Pharmacy Services and Emergency Medication Supplies reviewed August 11, 2018 showed emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the provider pharmacy. The provider pharmacy supplies emergency medications including emergency drugs, antibiotics, controlled substances or products for infusion in limited quantities in compliance with applicable state regulations. (A)	S9999		