Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003172	A. BUILDING: ______ B. WING ______	C 10/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	701 SHADWELL AVENUE FLORA, IL 62839

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2058243/IL127841	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)2) 300.3220f) 300.3240a) 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

Continued From page 1

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. (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to administer an antibiotic as ordered by the physician for 1 (R3) of 6 residents reviewed for medication administration in a sample of 18. This failure caused a delay in treatment of R3's urinary tract infection causing R3 to become septic and requiring a hospital admission for treatment.

Findings include:

On 10/21/20 at 2:45 PM, V25 (Family Member) stated R3 went to the hospital on 10/05/20 and was diagnosed with a UTI (Urinary Tract Infection). V25 stated R3 was sent back to the facility that evening with orders to start taking an antibiotic. V25 stated during a phone conversation with the facility on 10/08/20, V29 (Family Member/Power of Attorney/POA) became aware staff did not know R3 was supposed to be taking an antibiotic. V25 stated there was a 3-day delay in R3 receiving this medication and R3 got worse as a result to the point she had to go back to the hospital and had severe sepsis and her kidneys had started to shut down.

R3's hospital record dated 10/05/20 documents diagnoses, in part for "Today's Visit" as urinary

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S9999	Continued From page 2 tract infection without hematuria; Start taking LevoFloxacin 500 mg (milligram) tablet 1 by mouth once daily for 7 days. A handwritten note on this hospital record under this antibiotic order documents, "noted 10/08/20 by V22 (Registered Nurse/RN)." R3's nurse's notes document the following, in part: 10/08/20 - 2:30 PM - V29 called to check on resident's condition r/t (related to) ER (emergency room) visit on 10/05. Upon review of chart discovered med discrepancy. Levaquin 500 mg was ordered for 7 days to treat UTI. Admin (administrator) notified and MAR (Medication Administration Record) and POS (Physician's Order Sheet) corrected; 2:40 PM - V19 (Primary Care Physician - PCP) notified of med error and med ordered from pharmacy; 10:00 PM - Started po (by mouth) Levaquin 500 mg will monitor for ADR (adverse drug reaction). R3's POS dated 10/01/20 to 10/31/20 documents a handwritten note under physician's orders dated 10/05/20 as: 1) Levaquin 500 mg qd (every day) x 7 days - UTI. R3's October MAR documents a handwritten medication dated 10/05/20 for Levaquin 500 mg po qd x 7 days at 8:00 PM for UTI. This MAR confirms R3 received her first dose of Levaquin on 10/08/20 at 8:00 PM. On 10/16/20 at 1:33 PM, V3 (Registered Nurse/RN) stated, "We get new orders, but they are received on the front side office fax machine. Due to Covid-19 someone from the 'clean side' will bring our faxes around to our outside door when we get one, since all the residents reside on the Covid-19 wing at this time."	S9999		

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S9999	Continued From page 3 R3's record documents a hospital admission on 10/13/20 and discharge back to facility on 10/15/20 for end of life/comfort care with the following diagnoses, in part: Acute cystitis with hematuria, sepsis, and severe sepsis. On 10/23/20 at 10:04 AM, V19 (Physician) stated, "...the delay in antibiotic directly contributed to R3 going septic. ABX (antibiotics) treat the bug in the urine and if not given the infection goes to the blood stream. This could have been avoided..." V19 confirmed he oversees V14's (Master of Physician Assistant Studies/Physician Assistant - Certified/ MPAS/PA-C) notes and the facility should be following her orders. V19 stated, "V14 is 'my right hand'." (A)	S9999		