

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6012165</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/07/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY REHAB AT NORTHMOOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1500 WEST NORTHMOOR ROAD PEORIA, IL 61614</b>
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(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  Second Probationary Licensure Visit	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610 a) 300.1210 d)1) 300.1620 a)</p> <p>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.</p> <p>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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon</p>	S9999	<p><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

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

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S9999	<p>Continued From page 1</p> <p>the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.</p> <p>These REQUIREMENTS are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to administer medications as ordered by the physician for one of one residents (R4) reviewed for medication administration in the sample of four.</p> <p>Findings include:</p> <p>The facility's "Standards and Guidelines: SG Medication Administration" policy, revised, 11/1/16, states, "Standard: It will be the standard of this facility to administer medications in a timely manner and as prescribed by the physician, unless clinically indicated or necessitated by other circumstances such as lack of availability of medication or refusals of medication by the resident. 7. After successfully identifying the resident to receive medication administration, the individual administering the medication should ensure that the right medication, right dosage, right time and right method of administration are verified."</p> <p>On 1/5/21 at 8:52 A.M., V8 (Licensed Practical Nurse) began preparing morning medications for</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>R4. V8 removed R4's medication card from the medication cart for the Hydrochlorothiazide (HCTZ) 25mg tablets, and dispensed four tablets into a medicine cup with R4's other prepared medications.</p> <p>On 1/5/21 at 8:58 A.M., V8 entered R4's room and began to administer R4's medications to R4. V8 spoon fed R4's medications, and R4 swallowed them whole with sips of water and a liquid nutritional supplement. R4's medication pass was completed at 9:20 A.M.</p> <p>The medication label on R4's HCTZ card documents Hydrochlorothiazide 25mg tab (tablet) Give one tab by mouth once daily.</p> <p>R4's current physician orders as of 1/5/21, and R4's current Medication Administration Record (MAR), documents an order for "Hydrochlorothiazide 25mg (milligram) tab (tablet) Give 1 (one) tablet by mouth one time a day related to Essential (primary) hypertension." These same forms also document R4 with an order for "Hydralazine 100mg tab Give one tablet by mouth three times a day related to Essential (primary) Hypertension."</p> <p>On 1/5/21 at 9:26 A.M., V8 stated, "It (R4's current Physician Order Sheet/POS) says 25 (mg) but the EMAR (Electronic Medication Administration Record) said 100 (mg). So, with the 25 (mg tablets), I gave four (tablets). I am going to have to clarify." At this same time, V8 verified R4's current POS also documents an order for Hydralazine 100mg tablets.</p> <p>R4's progress notes, dated 1/5/21 at 9:42 A.M., completed by V3 (Registered Nurse), states, "med error occurred during morning med pass.</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>(R4) was given a different dose than what was ordered. (V11/R4's Physician) and (V12/R4's family) was immediately notified. V11 gave the following orders: Hold HCTZ for the next three days; get a stat BMP (Basic Metabolic Profile/lab work) today and a BMP daily x (times) two days; monitor BP (Blood Pressure) q (every) shift."</p> <p>R4's Incident Report, dated 1/5/21 at 1:26 P.M., completed by V2 (Assistant Director of Nursing), states, "Incident Description: Nurse was passing meds to resident (R4). (R4) has order for Hydrochlorothiazide 25mg daily and an order for Hydralazine 100mg tid (three times a day). Hydrochlorothiazide 100mg was given as well as Hydralazine 100mg. The medication variation is that 75mg too much of Hydrochlorothiazide was given..."</p> <p>On 1/5/21 at 10:30 A.M., V2 and V8 verified that the incorrect dose of HCTZ was given to R4, and that R4 should have only received one tablet of HCTZ, not four. V8 stated, "I read the dosage of the Hydralazine for the Hydrochlorothiazide."</p> <p>(B)</p>	S9999		
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