

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001010	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/11/2019
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NAME OF PROVIDER OR SUPPLIER APERION CARE BLOOMINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701
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S 000	Initial Comments Complaint 1964875/IL113671	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)1)3) 300.1630d) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 07/26/19
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S9999	<p>Continued From page 1</p> <p>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:</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>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 made by nursing staff and recorded in the resident's medical record.</p> <p>Section 300.1630 Administration of Medication</p> <p>d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation and a notation made in the resident's record.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to provide and administer a physician ordered scheduled narcotic pain medication on two separate occasions and failed to implement interventions to manage pain for a resident with a diagnosis of pain for one resident (R2) reviewed for Pain. These failures resulted in R2 experiencing an exacerbation of uncontrolled extreme pain, nervousness, agitation and opioid withdrawal symptoms on two different occasions and seeking emergency medical care for pain management on one occasion.</p> <p>Findings include:</p> <p>The facility's Pain Management Program policy dated 7/6/18, documents "Purpose: To establish a program which can effectively manage pain in order to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness. Guidelines: It is the goal of the facility to facilitate resident independence, promote resident comfort, preserve and enhance resident dignity and facilitate life involvement. The purpose of this policy is to accomplish that goal through an effective pain management program. Definition: The resident's descriptive words regarding the quality, duration, and location of pain will be used to evaluate the pain and to identify changes in pain." This policy also documents "13. Interventions to be considered to supplement not replace drug therapy to manage pain may include the following: a. Repositioning, b. Ambulation, c. Mild exercise, d. Therapeutic massage, back rub, e. Diversion techniques, i.e.,</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>television, video viewing or reading, f. Therapeutic communication, g. Spiritual counseling, h. Visitation from family and significant others, i. Relaxation breathing exercises."</p> <p>The facility's Medication Administration Policy, dated 1/1/15, documents "Medications must be administered in accordance with a physician's order, e.g., the right resident, right medication, right dose, right route, and right time. Medication/Treatment errors: If a medication and/or treatment error occurs, the licensed nurse will: a. Immediately notify the attending physician, b. Describe the error and the resident's response in the Nurse's notes, c. Complete an Incident Report, d. Identify the error on the 24 hour report and e. Monitor the resident's status." This policy also documents "Any discrepancy must be reported immediately to the Director of Nursing or his/her designee."</p> <p>The facility's (undated) Emergency Drug Kit policy documents "Purpose: To provide medication in emergencies and when drugs are not available in the individual resident containers." An emergency drug kit medication list, provided by V1 (Administrator), documents the emergency box contains six Oxycodone five milligram tablets.</p> <p>R2's Minimum Data Set (MDS) assessment, dated 6/3/19, documents R2 has a Brief Interview for Mental Status score of 15, indicating that R2 is cognitively intact.</p> <p>R2's Current care plan, dated 6/4/19, documents "I (R2) have acute and chronic pain, related to chronic back pain." This same care plan documents pain interventions to "Administer analgesia as per orders. Give a half an hour</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>before treatments or care. Evaluate effectiveness of pain, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact cognition. Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician."</p> <p>R2's current physician order sheet, dated 7/9/19, documents R2 has diagnoses of: low back pain, episodic cluster headache, fusion of spine-lumbar region and anxiety disorder. This same order sheet documents R2 has an order for Oxycodone 20 milligrams (narcotic pain medication) to be given by mouth every four hours for pain.</p> <p>R2's Medication Administration Record (MAR), dated 6/1/19-6/30/19, documents that on 6/2/19 R2's 12:00 PM, 4:00 PM, and 8:00 PM doses of Oxycodone 20 milligrams were not given and "see progress notes."</p> <p>R2's only nursing progress note dated 6/2/19 documents at 2:01 PM "(R2) did not want to wait for an updated script for Oxycodone tablet 20 milligram. Called 911 to be transported to (local emergency room). Seek medication."</p> <p>R2's Emergency room note, dated 6/2/19, documents at 12:30 PM "(R2) resides in (facility). He is here because of chronic pain, back issues. (R2) has had nine surgeries in the past couple of years. The reason for coming today is that his Oxycodone 20 milligram prescription has run out at the nursing home. They (the facility) were not able to get a prescription filled from (the facility).</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>He is having increasing back pain as it's time for his next dose."</p> <p>R2's MAR, dated 7/1/19-7/31/19, documents on 7/4/19 R2's pain level was a five out of ten for first shift and an eight out of ten for second shift. This same MAR documents on 7/4/19 at 8:00 AM and 12:00 PM, R2's Oxycodone 20 milligrams was not given and "see progress notes." R2's Medical Record and Progress notes do not include any other pain relieving measures utilized to try and control R2's pain on 7/4/19.</p> <p>R2's nursing progress note, dated 7/4/19 at 11:05 AM, documents "(R2) is currently upset about Oxycodone being out, received his last dose at 4:00 AM. Nurse called out to on call for (V13/R2's physician's) office." This same note documents "(R2) stated that if his medications were not here by 2:00 PM, he would be checking out and going to (local clinic) for detox."</p> <p>On 7/9/19 at 2:35 PM, V14 (Licensed Practical Nurse) stated "One day we were out of (R2's) Oxycodone medication and he called 911 on his own. (R2) was pacing the hall and stated he was going to be sick. (R2) takes 20 mg of Oxycodone, and the emergency box does contain enough for at least one dose. I'm not sure why the nurse taking care of him wouldn't have used the emergency box."</p> <p>On 7/10/19 at 2:45 PM, V2 stated "The nurses use the emergency box when they get permission from the pharmacy. (R2) could essentially get one dose of Oxycodone from the emergency box. He should not ever be running out of that medication (Oxycodone) since he takes it every day scheduled and clearly needs it."</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>On 7/11/19 at 11:43 AM, V12 (Registered Nurse) stated "I didn't pull (R2's) Oxycodone from the emergency box when I realized he was out. I don't think anyone has ever pulled from the emergency box for (R2). I don't know why they haven't or why I didn't pull from it to get him a dose of Oxycodone."</p> <p>On 7/9/19 at 10:20 AM, R2 was sitting in his room in bed. R2 got up to look for items in his room and used a walking cane for ambulation. R2 stated "I've had about six surgeries and I am narcotic dependent for pain control. I went to the emergency room in early June because (the facility) ran out of my Oxycodone. I was getting sick and in a lot of pain as well. It hurts bad and I have extreme constant pain in my back when I don't take my medicine. I take Oxycodone 20 milligrams and they (facility nurses) wouldn't take it out of the emergency box. So it took 24 hours to get the medication. I missed several doses and was hurting very bad. It makes it hard to function when you have that much pain. The emergency room doctor did not give me any medicine in the emergency room, but he gave me a prescription to last a few doses and get me thru until the full script could be filled. In addition to having vomiting, sweating, and feeling bad, I had extremely terrible back pain. They ran out of my medication on 7/4/19 also. I missed a couple doses and started experiencing pain and discomfort until they could get my prescription refilled. I don't understand why they keep running out of the Oxycodone. No one ever tries to help me relieve pain with other intervention like breathing and relaxing exercises. I don't know if they would work or not but it's never been tried."</p> <p>On 7/10/19 at 12:30 PM, V17 (Assistant Vice President) stated "Zero on the pain scale rating</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>indicates the resident has no pain and a ten on the pain scale indicates a resident is experiencing the worst pain of their life."</p> <p>On 7/9/19 at 2:00 PM, V2 (Director of Nursing) stated "(R2) did not have oxycodone for two doses on the fourth of July, 2019. (R2) had excruciating pain to the back and was very upset. When the dose ran out at the facility our nurses did not get it ordered through (R2's) physician timely to ensure (R2) got his doses as scheduled. (R2) got very verbal and agitated with staff when (R2) ran out of the oxycodone and was blaming staff for not having the oxycodone. (R2) was complaining of having withdrawal symptoms. (R2) had missed the 8:00 AM and 12:00 PM doses." The nurses should have got a prior authorization before (R2) ran out of medicine and before the holiday. (V13/R2's Physician) was upset because we were dealing with this on the holiday and did not get it taken care of before (R2) ran out."</p> <p>On 7/10/19 at 2:05 PM, V13 (R2's Physician) stated "The facility never let me know a reason as to why it (oxycodone) ran out. Theoretically someone who is on high doses of narcotics like (R2) is for an extended period of time could begin having opioid withdrawal symptoms when a dose or two are missed. With a couple missed doses he could also begin to have pain and the pain could potentially be worse since it is failed to be controlled. Being without the oxycodone could cause him transient worsening of pain or uncomfortable withdrawal symptoms. They (the facility) should have contacted me prior to the oxycodone running out. It would be ideal if his medication was not running out. It is a medication error due to the fact that it could cause him transient worsening of pain or</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>uncomfortable withdrawal symptoms.</p> <p>On 7/11/19 at 1:40 PM, V1 (Administrator) stated they do not have any incident report investigations, as directed by the facility policy, for R2's missed doses of Oxycodone on 6/2/19 and 7/4/19.</p> <p>(B)</p>	S9999		