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
	IL6000285	A. BUILDING: ______ B. WING ______	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF DECATUR	444 WEST HARRISON STREET DECATUR, IL 62526

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S 000	Initial Comments Complaint Investigation: 1860295/IL99536	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210d)2) 300.1620a) 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 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:	S9999		

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S9999	Continued From page 1	S9999		

2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon 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.

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. (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 medications per physician

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S9999	Continued From page 2	S9999		

orders for two of five residents (R1, R2) reviewed for medication administration in the sample of 13. This failure resulted in ongoing untreated extreme pain for R2 which impacted R2's activities of daily living including ability to sleep and particpate in daily activity.

Findings Include:

1. R2's undated facesheet documents R2 was admitted to the facility on 7/17/17. The facility's computerized ongoing Diagnoses List documents the following Diagnoses: Perineum Abscess, Left Below the Knee Amputation, and Peripheral Neuropathy.

R2's POS (Physician Order Sheet) dated January 2018 documents an additional Diagnosis of Scrotum Wall Abscess. This POS documents the following order: Hydrocodone-Acetaminophen (Norco) {Narcotic Pain Reliever} 10-325 mg (milligrams) every four hours, scheduled at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM.

R2's MDS (Minimum Data Set) dated 12/16/17 documents R2 is alert and oriented, receives scheduled pain medication and has moderate pain frequently.

R2's Care Plan dated 12/21/17 documents R2 has pain related to wound, {scrotum} abscess, neuropathy, arthritis, and GERD (Gastroesophageal Reflux Disease) with interventions of: administer pain medication per physician orders.

On 1/18/18 at 11:20 AM, R2 stated, "Since I've been here {at the facility}, I've ran out of pain medicine three or four times. They {nurses}

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S9999	Continued From page 3	S9999		

blame it {not having pain medication} on the doctor (V6) not sending a new script. (V6) is slow as molasses, but that's why I tell them to order it when I'm down to five to ten pills. I get them six times a day so they go quick but no, they wait until I'm out to re-order them. It usually happens on the evening shift." R2 stated at times R2 has missed anywhere from two doses to an entire day, or more of pain medication. R2 stated, "I'm use to the pain, the medicine doesn't really work but does take the edge off" but that when R2 misses doses of the pain medication, "the pain is just through the roof and I can't do anything. I stay in bed and just try and get on my side to relieve some pressure." R2 stated the pain is from R2's waist down to R2's toes. "I have phantom pain, severe neuropathy, plus I've been cut on both sides of my testicles and from my rectum to my scrotum for abscesses, which is extremely painful. Them {facility} not having my pain medicine is a huge problem!"

R2's Progress Notes dated 12/29/17 by V9 RN (Registered Nurse) documents, "Resident is still out of his pain medication. MD (Medical Doctor, V6) notified again regarding refill authorization. Refill authorization faxed over. Awaiting further detail."

On 1/18/18 at 1:15 PM, V2 DON (Director of Nursing) stated controlled medications are signed out on the MAR (Medication Administration Record) as well as the Controlled Substance Report but that the Controlled Substance Report would be the most accurate because medications need signed out and accounted for. V2 also stated, the facility has had problems with controlled substances being refilled recently because, "I was not getting the re-order request from the pharmacy. They {pharmacy} were

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S9999	Continued From page 4 sending them to the old interim DON, who no longer works here. The nurses are capable of filling out the order forms themselves and should have been, or they could have called the pharmacy and got the medication through the E-Box (Emergency Box)." R2's Controlled Substances Records for December 2017 document R2 did not receive the following scheduled doses of Norco: 12/4/17 - 12:00 AM dose 12/7/17 - 12:00 AM and 4:00 AM dose 12/8/17 - 12:00 AM, 4:00 AM, 8:00 AM and 12:00 PM doses 12/19/17 -12:00 PM and 4:00 PM doses 12/24/17 - 4:00 PM dose 12/29/17 - 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM doses 12/30/17 - 12:00 AM, 4:00 AM and 8:00 AM doses For a total of 18 missed doses in December 2017. On 1/18/18 at 2:59 PM, V6 Physician stated, for controlled substances, the facility sends V6 a form to fill out to get the controlled medication refilled. The issue with R2 not getting R2's Norco {controlled substance} refilled "is because the facility will send the fax in the evening, after hours, or on the weekend, when I am not at the office and then call and ask why it hasn't been signed yet. That (R2) is out of medicine. I have a policy that all medication refills be allowed 48 hours. I understand that sometimes that can not happen but they need to send over the request in the morning then, not 8:00 pm." V6 also stated, R2 "has a peculiar condition where he gets infected sweat glands in the perineum and axilla. You would have to see it to believe it. He is not imagining the pain, I'm sure it is real, I don't know	S9999		

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S9999	Continued From page 5	S9999		

how he tolerates the pain really. He needs his pain medications in order to function." V6 also stated, R2 "has neuropathy also, which is extremely hard to control."

On 1/29/18 at 9:35 am, R2 stated, "last week they {facility} ran out of pain meds again and I couldn't stand to do anything, it just hurts so bad. I need to talk to the doctor about this. The pain meds help for an hour or two but then the pain gets out of control again. At night without my meds, I can't fall asleep due to the pain. There is just no way to get comfortable and then I can't get going in the morning due to the pain. There have been times that I wasn't able to go to activities or therapy in the mornings due to the pain from not having my meds throughout the night."

R2's Controlled Substances Records for January 2018 document R2 did not receive the following scheduled doses of Norco:
1/19/18 - 12:00 pm dose
1/21/18 - 8:00 am dose

R2's Progress Notes dated 1/19/18 by V2 DON documents V6 Physician was made aware of the "medication errors without harm" for the omitted doses of Norco and that the wrong dose of Norco was given on two occasions.

On 1/29/18 at 12:15 pm, V1 Administrator stated the wrong dose of Norco was given twice because the facility had ran out of Norco and the staff had to pull the medications out of the EDK (Emergency Drug Kit), and when staff pulled the Norco, they pulled 5/325 mg tablets instead of 10/325 mg tablets. V1 stated staff was not aware that the wrong dose of medication was given until they received the EDK Controlled Substance Daily Usage Sheet back from pharmacy which

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S9999	Continued From page 6	S9999		

documented two doses of 5/325 mg Norco were removed from the kit instead of two doses of 10/325 mg.

On 1/29/17 at 2:30 pm, V2 DON stated V2 considered the medication error to be without harm because "there was no physical harm in which (R2) had to be sent to the hospital however there was harm due to (R2) having increased pain that interfered with his ADL's."

The facility Prescribing and Ordering of Medications/Products Policy dated 5/1/13 documents; New orders for Scheduled II controlled drugs require a written prescription prior to dispensing, unless there is an "Emergency Situation". In an Emergency Situation, the "Nursing Center physicians/prescribes must provide Pharmacy with verbal authorization for Scheduled II controlled substances", "An Emergency situation is one in which the prescribing practitioner determines: 2.1 Immediate administration of the Scheduled II controlled substance is necessary for proper treatment of the intended ultimate user; and 2.2 There is no appropriate alternative treatment available, including administration of a drug that is not a Scheduled II controlled substance; and 2.3 It is not reasonable for the prescribing practitioner to provide a written prescription to be presented to the person dispensing the substance prior to the dispensing", "If the controlled substance is needed before the pharmacy can make arrangements for a timely delivery, Nursing Center should call the pharmacy to request authorization to remove a controlled substance from the Emergency Drug Supply", "It is the responsibility of both the pharmacy and nursing center to ensure that all required prescriptions are signed by the

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S9999	Continued From page 7	S9999		

physician/prescribe in order to meet the needs of the patient as well as adhere to DEA (Drug Enforcement Administration) and state regulations/laws."

2. R1's Care Plans dated 1/17/18 document R1's diagnoses including Other Specified Mental Disorders Due to Known Physiological Condition, Anxiety Disorder, Unspecified Conduct Disorder, Restless and Agitation, Alzheimer's Disease, Pain, Tremors, Recurrent Depressive Disorders. These Care Plans also document R1 is at risk for mood and behavior, takes Xanax (Anti-anxiety), is at risk for pain and to administer medications as per Medical Doctor (MD) orders. These Care Plans document R1 is receiving Hospice care due to terminal illness with a goal to be comfortable.

R1's Physician's Orders dated January 2018 document Xanax (Anti-Anxiety) 0.5mg (milligrams) one tablet (tab) by mouth twice daily at 8:00am and 4:00pm. These orders also document Xanax 0.25mg one tab by mouth once daily at 12:00pm.

R1's Controlled Substances Records labeled Xanax 0.5mg tabs and Xanax 0.25mg tabs document errors in administration as follows:

Missing doses of Xanax:
12/12/17, 12/17/17, 12/26/17, 1/18/18- No 12pm dose of the 0.25mg tab
12/17/17, 12/18/17, 12/19/17, 12/26/17, 12/27/17, 1/22/18- No 4pm dose of the 0.5mg tab
1/5/18- No 12pm dose of the 0.25mg tab. (Medication Administration Record dated January 2018) MAR documents it was not given "sleeping," with no order to hold the medication.

Wrong doses of Xanax:

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S9999	Continued From page 8	S9999		

Continued From page 8

12/3/17- 4pm- Administered two 0.5mg tabs instead of one 0.5mg tab
12/5/17, 12/14/17, 12/16/17- 12pm- Administered one 0.5mg tab instead of one 0.25mg tab
12/8/17- 4pm- Administered 0.25mg tab, 4:30pm administered one 0.5mg tab for a total of 0.75mg
12/14/17, 12/21/17, 1/25/18, - 4pm- Administered one 0.25mg tab instead of one 0.5mg tab
12/18/17, 12/19/17, 12/21/17, 12/28/17, 1/29/18- 8am- Administered one 0.25mg tab instead of one 0.5mg tab
12/22/17, 12/23/17, 12/24/17, 12/25/17- 4pm- Administered 0.25mg tab instead of one 0.5mg tab
1/10/18- 5pm- Administered one 0.25mg tab instead of one 0.5mg tab
1/18/18- 4pm- Administered one 0.5mg tab, then administered one 0.25mg tab at 5pm for a total of 0.75mg

Wrong time of administration of Xanax:
12/27/17- 12:00am- Administered one 0.5mg tab at 12am instead of at 8am as ordered

R1's Physician's Orders document an order for Fentanyl 25mcg (micrograms)/hr (hour) patch, apply one patch topically every 72 hours.

R1's Controlled Substances Records labeled Fentanyl (Analgesic) 25mcg/hr patch document errors in administration as follows:

12/8/17 at 8am documents R1's Fentanyl 25mcg/hr patch was administered. This patch was due to be changed in 72 hours on 12/11/17 at 8am. The next documented administration of R1's Fentanyl 25mcg/hr patch was not until 12/12/17 at 1:00pm (29 hours after the patch was due).

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S9999	Continued From page 9 12/18/17 at 8 (illegible time of day) documents R1's Fentanyl 25mcg/hr patch was administered. This patch was due to be changed in 72 hours on 12/21/18 at 8:00am. This record documents a new patch was placed on 12/19/18 at 8:00am which was not the scheduled date to be changed. 12/25/17 at 8am documents R1's Fentanyl 25mcg/hr patch was administered. These records document the 12/25/17 patch was the last dose available from R1's supply at the facility. This patch was due to be changed in 72 hours on 12/28/17 at 8am. The next documented administration (on the Emergency Medication Kit sheet dated 12/28/17) of R1's Fentanyl 25mcg/hr patch was not until 12/28/17 at 3pm (7 hours after the patch was due to be changed). 1/9/18 at 8am documents R1's Fentanyl 25mcg/hr patch was administered. This patch was due to be changed in 72 hours on 1/12/18 at 8am. The facility's Incident Report dated 1/12/18 documents the Fentanyl 25mcg/hr patch was replaced on 1/12/18 at 1:00pm (5 hours after the patch was due to be changed) when the new prescription was received from V10, R1's Physician due to R1's Fentanyl patch prescription being expired. 1/22/18 at 8am documents R1's Fentanyl 25mcg/hr patch was administered. This patch was due to be changed in 72 hours on 1/25/18 at 8am. This record documents a new patch was placed on 1/24/18 at 8:00am which was not the scheduled date to be changed.	S9999		
	R1's Physician's Orders dated January 2018 document an order for Nitroglycerin (Anti-angina) 0.2mg (milligrams)/hr (hour) Patch, apply one patch topically every morning and remove at			

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S9999	Continued From page 10	S9999		

bedtime. These orders document to apply to chest only.

R1's Medication Administration Record dated January 2018 documents R1's Nitroglycerin Patch was not placed on R1 at 8am on 1/11/18 as ordered. This record documents the patch was "not found" at 8pm on 1/11/18 when scheduled to be removed. There is no documentation as to how long R1 was without the Nitroglycerin patch.

On 1/17/18 at 1:25pm, V8, Registered Nurse (RN) stated V11, RN removed R1's Fentanyl Patch instead of removing R1's Nitroglycerin Patch on 1/15/18. V8 stated on 1/16/18 at 8am, V7, R1's family noticed R1's Nitroglycerin Patch was still on from the evening before and that it should have been removed the evening of 1/15/18. V8 stated "a little bit later" V12, Licensed Practical Nurse (LPN) came to V8 and asked if V8 knew about R1's Fentanyl Patch not being in place. V8 stated she checked with V11, RN who stated she removed the Nitroglycerin Patch, not the Fentanyl Patch. V8 stated the area where V11 stated she removed the patch was the area where the Fentanyl Patch was located per R1's Medication Administration Record (MAR). V8 stated V11 removed the Fentanyl Patch on 1/15/18 instead of the Nitroglycerin Patch as ordered. When discussing supply of medications, V8 stated, "Unfortunately sometimes the nurses let the medications run out and then we (facility) have to scramble around (to obtain prescriptions and/or medications)" for the residents.

On 1/17/18 at 11:30am, V7, R1's family, who was tearful and shaking, stated the facility keeps running out of R1's Xanax medication. V7 stated V7 knows when R1 does not receive the medication or receives it incorrectly as V10, R1's

Illinois Department of Public Health

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S9999	Continued From page 11 Physician ordered. V7 states V7 knows due to R1's behaviors including "more jittery, acting like in pain and not eating and drinking as (R1) normally does." V7 stated on 1/11/18 at 6:00pm, R1 did not have a Fentanyl patch or Nitroglycerin patch on (which is not due to be removed until 8pm. V7 stated the facility does not consistently remove the Nitroglycerin patch at night as ordered because V7 finds them on R1 the next day. V7 stated V7 spoke with V1, Administrator and V2, Director of Nursing (DON) on 1/12/18 in the morning related to concerns with the Fentanyl Patch and Nitroglycerin patches not being in place and the Xanax medication not being administered as ordered. V7 stated V7's family thought R1 "was dying" between 1/11/18 and 1/12/18 due to the behaviors of increased agitation and restlessness R1 was having. V7 stated the facility did not replace R1's Fentanyl Patch until 1/12/18 at 5pm and the Nitroglycerin Patch was not replaced until 1/12/18 at 12:00pm. V7 stated from 1/15/18 at 6pm through 1/16/18 at 8am, R1 did not have a Fentanyl Patch in place but did have a Nitroglycerin Patch in place that should have been removed on 1/15/18 in the evening. V7 stated when V7 got the the facility on 1/16/18 at 8:00am, R1 was shaky, anxious and agitated and that R1 still did not have a Fentanyl Patch on. V7 stated R1 had been without the Fentanyl Patch pain medication through the night because the facility had removed the Fentanyl patch the evening before instead of the Nitroglycerin Patch. V7 stated V7 notified an unidentified nurse regarding the missing Fentanyl patch and thought the nurse would take care of it but didn't. V7 stated there have been multiple times of the facility running out of R1's Xanax medication as well as not having the Fentanyl patches in place as ordered and not administering the Nitroglycerin patch as ordered.	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF DECATUR	**444 WEST HARRISON STREET** **DECATUR, IL 62526**

(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
S9999	Continued From page 12 On 1/30/18 at 4:30pm, V2, Director of Nursing (DON) stated she was unaware of the Nitroglycerin Patch error on 1/11/18. V2 stated she should have been made aware of the error but was not. The facility's Medication and Treatment Administration Guidelines dated December 2014 document medications are to be administered according to the rights of medication administration including, right medication, right dose, right time and right documentation. These guidelines also document medications not administered according to physician's orders will be reported to the attending physician and documented in the clinical record. The facility's General Dose Preparation and Medication Administration policy dated 5/1/13 documents the nursing center staff should verify that the medication name and dose are correct. This policy documents prior to medication administration, the nursing center staff should verify each time a medication is administered that it is the correct drug, at the correct dose and the correct time. (A)	S9999		