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S 000	Initial Comments Investigation of Complaint 1871670/IL101038. A partial extended survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 1 300.610a) 300.1010h) 300.1210b) 300.1210d)2)3) 300.1630d)e) 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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:	S9999		

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S9999	Continued From page 2 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 made by nursing staff and recorded in the resident's medical record. Section 300.1630 Administration of Medication 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. e)Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report. 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)	S9999		

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These requirements were not met as evidence by:

Based on interview and record review the facility failed to administer chemotherapy, anti-rejection, anticonvulsant and anticoagulant medications to residents as ordered by the physician, and failed to follow the facility policy for medication administration. Facility failed to provide the chemotherapy medication, Nilotinib to R1 from February 6, 2018 to March 5, 2018. The facility also failed to administer R1's kidney transplant anti-rejection medication, Tacrolimus every evening from March 9, 2018 through March 15, 2018. The facility failed to administer R2's anticonvulsant medication, Lacosamide from March 8, 2018 through March 15, 2018. The facility failed to administer R4's anticoagulant medication, Enoxaparin as ordered from February 15, 2018 to March 25, 2018. This applies to 3 of 5 residents (R1, R2, R4) reviewed for improper nursing in the sample of 5.

The findings include:

1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility in September 2016 with multiple diagnoses including chronic myeloid leukemia not having achieved remission, seizures, diabetes and aftercare following kidney transplant.

R1 returned to the facility on March 9, 2018 following scheduled seizure monitoring at the hospital. Hospital orders dated March 9, 2018 at 12:50 PM showed multiple medications including Tacrolimus (anti-rejection medication) 1 mg. by mouth nightly. The order was never transcribed

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to the POS (physician's order sheet) and R1 did not receive the medication as ordered. The EMR shows R1 was on the Tacrolimus 1 mg. by mouth nightly prior to his hospitalization.

On March 19, 2018 at 10:43 AM, V23 (Nephrologist) said, "[R1] could reject his transplanted kidney because of the missed doses of Tacrolimus. It isn't something that happens right away, it usually takes some time. Even if his lab work is normal right now, we still won't know the repercussions of this. Time will tell and we will have to monitor him closely."

On March 20, 2018 at 9:49 AM, V2 (DON) said the nurse missed the order for Tacrolimus 1 mg. every evening when she entered the orders into the computer, and therefore, R1 never received the medication as ordered by the physician. V2 said as of March 14, 2018, the facility did not have a procedure in place to ensure the nursing staff accurately entered medications into the computer when a resident returns to the facility from the hospital.

On February 6, 2018, V13's (RN-Registered Nurse) documentation shows a refill of R1's Nilotinib (chemotherapy medication) was requested from V5 (Oncologist) on February 6, 2018.

The nursing documentation shows R1's Nilotinib was not available at the facility from February 6, 2018 at 5:00 PM until R1's discharge to the hospital for seizure monitoring on March 5, 2018. Despite the medication not being available at the facility, V14, V15, V16, V17, and V18 (nursing staff) documented the medication was administered to R1 between February 10 and 28, 2018. The facility did not have documentation to

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show V5 (Oncologist) was notified of the missed doses of Nilotinib.

On March 20, 2018 at 9:49 AM, V2 (DON-Director of Nursing) said R1 was never given the Nilotinib medication despite documentation in the medical record by five nurses showing the medication was administered. "The nurses never gave the Nilotinib medication. This is not acceptable."

On March 19, 2018 at 12:10 PM, V4 (ADON-Assistant Director of Nursing) said, R1 did not receive the medication because the facility has been waiting for the insurance to approve the medication. Two specialty pharmacies were involved. V4 said, "We didn't know the situation was all disconnected and all messed up."

On March 15, 2018 at 5:35 PM, V22 (Oncology Nurse) said, "I work in the oncology office of [V5]. We sent out the refill for the Nilotinib as soon as it was requested on February 6, 2018. He had refills in January 2018 of 120 pills, as well as 2 refills. No one ever called us and told us they were working on getting the medication filled and that he wasn't getting the medication. He was last seen at the office here on January 16, 2018 and we verified he was taking the medication at that time."

On March 19, 2018 at 12:54 PM, V9 (Certified Pharmacy Technician, Public Aid Insurance Carrier) said, "A pre-approval authorization is necessary to have this specialty medication approved by the insurance company. Physician notes, labs and other information needs to be sent to the insurance company. If the facility was having trouble getting the medication filled due to insurance issues, the DON or nurse manager

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from the facility should have contacted us about this and we could have helped them get the approval started. No one from the facility ever contacted us to make that happen.

On March 20, 2018 at 3:45 PM, V5 (Oncologist) said, "[R1] will always have leukemia, but the medication Nilotinib is like a miracle drug for this type of disease. The medication keeps the leukemia in check. I was not aware that [R1] is not receiving the medication. I have not spoken to [V20] (physician) or anyone from the facility about [R1] not receiving the medication. It is not ideal that he is off the medication. I'm hoping it won't be too detrimental."

2. The EMR shows R2 was admitted to the facility in February 2018 with multiple diagnoses including autistic disorder, bipolar disorder, hemiplegia and unspecified convulsions.

On March 5, 2018, V4 (ADON-Assistant Director of Nursing) documented: "[R2] went out to [local hospital] this morning for procedure, [family member] stays with her during procedure.

Called [family member] at 7:00 PM to check out how is the procedure doing. [R2] is going to be admitted due to seizure after the procedure..."

Facility documentation shows R2 returned to the facility on March 8, 2018. Hospital discharge orders showed an order for Lacosamide (anticonvulsant) 200 milligram (mg) in addition to R2's other anti-seizure medications including levetiracetam 100 mg, phenytoin 100 mg, and divalproex 500 mg.

The EMR shows the Lacosamide was not available at the facility from March 8, 2018 at 5:00

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PM through March 15, 2018 at 9:00 AM. Despite the medication not being available, V14, V24, V25, and V26 (nursing staff) documented the medication was administered to R2 between March 8, 2018 at 5:00 PM through March 14, 2018 at 5:00 PM. The facility did not have documentation to show the physician, pharmacy or DON were notified the medication was not available.

On March 15, 2018 at 4:00 PM, V12 (Pharmacy Consultant) said R2's Lacosamide was never sent to the facility because the medication is a controlled substance and the facility needed to send a hard copy of the order before the pharmacy would dispense the medication to the facility. "The responsibility is on the facility to get the prescription over to the pharmacy when the medication is a controlled substance. Without the medication, [R2] would be at increased risk for seizures."

On March 19, 2018 at 9:30 AM, V2 said the facility missed sending the hard copy of the Lacosamide prescription to the pharmacy and 4 nurses documented they administered the medication to R2, but never did.

On March 20, 2018 at 11:20 AM, V19 (Physician) said, "If [R2] doesn't receive the Lacosamide, she could have rebound seizures. The facility should have requested a hard copy of the prescription from us right away. Our turnaround time on those is 1 to 1-1/2 hours, especially in this case. I am concerned. How can they document they are giving the medication if the resident isn't receiving it. If I go there and look at the medical record and see that nurses are documenting they are giving the medication, I would assume she is receiving the medication. If she starts having seizures, I

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would change her medications and that would be unnecessary since she never received the medication. That is a huge error. If the patient doesn't get the medication as ordered, she can end up back in the hospital and this could cause very bad problems."

On March 20, 2018 at 1:25 PM, V21 (Neurologist) said, "We had to change the battery in [R2's] vagal nerve stimulator and she went into status epilepticus. [R2] was started on the Lacosamide in the ICU (Intensive Care Unit) at the hospital and it worked quite well for her. The implication of her not receiving the medication would be she could go into seizures again. She has had a difficult go of it, and my plan was to take her off of some of her other medications and use the Lacosamide and one other medication. That wouldn't be safe if she had not been receiving the medication as ordered."

3. The EMR shows R4 was admitted to the facility in October 2017 with multiple diagnoses including diabetes, atrial fibrillation, acute pancreatitis, venous insufficiency, cirrhosis of the liver and major depressive disorder.

Nursing documentation shows R4 was transferred to the local hospital on February 9, 2018 with elevated blood sugar and was admitted to the hospital the same day with diagnoses of pancreatic mass and pancreatitis. R4 returned to the facility on February 12, 2018 with multiple medication orders including Enoxaparin Sodium Solution (anticoagulant) subcutaneously two times a day to treat a newly diagnosed splenic vein thrombosis.

The facility does not have documentation to show R4 received the Enoxaparin medication 12 times

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during the period February 15, 2018 through March 25, 2018. Nursing documentation shows the medication was not available on March 4, 5, 13 and 15, 2018.

On March 26, 2018 at 1:02 PM, V12 (Pharmacist) said, "The pharmacy dispensed the Enoxaparin to the facility in five day increments. The facility documentation shows some missed doses for a whole day and other days where [R4] missed the medication one time during the day. The doses that are being missed coincide with the days the refills are due. The facility needs to order the medication before it runs out and then there won't be the gaps with missed medications."

On March 27, 2018 at 12:40 PM, V28 (Hematologist) and V29 (NP-Nurse Practitioner) said, "[R4] should receive the anticoagulant medication Enoxaparin every 12 hours. If he does not receive the medication the clot will increase in size or another clot will develop elsewhere. He was already anticoagulated with another medication when he developed the splenic vein thrombosis. Now he is only on the Enoxaparin that must be given every 12 hours. The facility never contacted either of us to let us know that [R4] was having missed doses of the medication."

On March 27, 2018 at 1:18 PM, V30 (Medical Director) said, "I was not aware that we had residents with medication concerns until this was brought to my attention in the past few days. Any medication not being given as prescribed is a concern. [R4] was very lucky he did not have any clotting issues after missing his anticoagulant medication. The other huge issue at the facility is the nurses signing the MAR when the medications weren't even administered. I am

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shocked this is even happening in this day and age. Maybe no one was aware of the problem because the nurses were signing the MARs that they gave the medications even though they did not. It was never brought to my attention that [R1] needed a chemotherapy medication that he was not receiving or that his primary care physician was not comfortable monitoring the medication in the absence of the oncologist."

The facility's Medication Administration Procedure dated June 2011 shows: "3. Review the resident's Medication Administration Record (MAR). 4. Read each order entirely. ...17. Return to medication cart and document medication administration with initials in appropriate spaces on Medication Administration Record (MAR). 23. If medication is ordered but not present, call the pharmacy or supervisor to obtain the medication. Return locked medication cart to the medication room after use."

The facility's undated Medication Reconciliation Policy shows: "Purpose: To ensure that the resident's medications are reconciled. Standard: Medications that the resident has ordered by the physician are compared to those that the resident is actually taking or should be taking and any discrepancies are resolved. Discrepancies include omissions, duplications, contraindications, unclear information, and changes. II. Readmission: a) Identify current medications from the hospital, facility, or other living environment of the resident. b) Review previous medication orders with the current list of medications and identify any discrepancies. c) Review all medications with the physician when obtaining readmission orders. Inform physician of any known discrepancies in the medication list. If physician does not order medications that were

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