STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007041	A. BUILDING: _____ B. WING _____	C 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PA PETERSON AT THE CITADEL	1311 PARKVIEW AVENUE ROCKFORD, IL 61107

(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 2116466/IL137822 State licensure findings were cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)1) 300.1620a) 300.1630d) 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	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 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 300.1630 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.	S9999		

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S9999	Continued From page 2 This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to administer an extended release (ER) pain medication as ordered for 1 of 3 residents (R1) reviewed for medication administration in the sample of 3. The findings include: R1's facesheet shows diagnoses of: chronic pain, fracture of right lower leg and polyneuropathy. R1's Physician's Order Sheet printed on 9/7/21 shows an order dated 7/28/21 for, "oxycodone HCl ER tablet ER 12 hour abuse deterrent 60 mg (milligrams)-Give 1 tablet by mouth two times a day related to other chronic pain." R1's September Medication Administration Record (MAR) shows that he received oxycodone HCl ER 60 mg-1 tablet twice a day. No administration of Oxycodone immediate release (IR) was documented on his September MAR. On 9/7/21 at 12:39 PM, R1's medication cards in the narcotic drawer showed he had Oxycodone (IR) 30 mg tablets. The narcotic drawer did not contain any oxycodone ER 60 mg tablets for R1. On 9/7/21 at 12:30 PM, R1 said that he has tried multiple pain medications in the past for his pain in his legs and arms. R1 said that he usually takes oxycodone ER but the facility has been giving him the IR all weekend because they are out of the ER. R1 said that his pain is around a 5-6 on the ER and it has increased to a 9 on the IR.	S9999		

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S9999	Continued From page 3 On 9/7/21 at 1:12 PM, V3 (Registered Nurse) said that on 9/4/21 she went to give R1 his scheduled oxycodone and he had none left. V3 said that she got 6-10 mg oxycodone pills out of the emergency container to give to him that morning and then re-ordered his medication. V3 said that when the medication came in, it was the wrong medication. It was oxycodone 30 mg IR tablets instead of his ordered 60 mg ER tablet. V3 said that she notified V5 (Nurse Practitioner) and she said to just give him 2 pills and she would call in the correct prescription. V3 said that when she came in on 9/7/21, she noticed that he was still getting the wrong medication so she notified V5 and V2 (Director of Nursing). On 9/7/21 at 12:49 PM, V2 said that R1 usually takes oxycodone ER tablets and not the IR tablets. V2 said that the prescription was called in wrong. V2 said that the wrong pills came in on 9/4/21 at 3:00 PM. V2 said that at that time, V5 should have been notified of the incorrect medication and a new prescription should have been sent to the pharmacy. V2 said that they would have probably received the new medication in time for his next dose on 9/4/21. V2 said that ER medications have a longer half life and are better for residents with chronic pain. V2 said that if IR is given instead of ER the resident could overdose or could have increased pain due to the medication wearing off before the next dose is due. On 9/7/21 at 1:57 PM, V3 said that medications should be re-ordered when the resident has 7-8 pills left. V3 said that since R1 takes the medication twice a day, she would reorder the medication when he had about 12 pills left so he did not run out of the medication. V3 stated, "If his medication was re-ordered earlier, this would	S9999		

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S9999	Continued From page 4 have never been a problem. No resident should ever have to go without their ordered medications." R1's Controlled Drug Receipt/Record/Disposition Form shows that oxycodone (IR) 30 mg tablets were received on 9/4/21 and were administered 9/4/21-9/7/21. No documentation was found in R1's clinical record regarding him receiving oxycodone IR instead of oxycodone ER. The facility's Administering Medications Policy revised on 4/2019 shows, "Medications are administered in accordance with prescriber orders....The individual administering medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication." (B)	S9999		