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
	IL6013015	A. BUILDING: ______ B. WING ______	04/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	**205 PARK AVENUE** **PANA, IL 62557**

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Z 000	COMMENTS ANNUAL CERTIFICATION SURVEY-EXTENDED ANNUAL LICENSURE INSPECTION OF CARE	Z 000		
Z9999	FINDINGS Statement of Licensure Violations 350.620a) 350.1210b) 350.1420a) 350.1430e) 350.1440a) 350.1840b) 350.1840e) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate	Z9999	**Attachment A** **Statement of Licensure Violations**	

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supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.

Section 350.1420 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 350.1610. 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 350.1430 Administration of Medication

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 350.1440 Labeling and Storage of Medications

a) All medications for all residents shall be properly labeled and stored at or near the nurses' station in a locked cabinet, in a locked medication room, or in one or more locked mobile medication

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carts of satisfactory design for such storage.

Section 350.1840 Diet Orders

b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered.

e) A therapeutic diet means a diet ordered by the physician as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet).

Section 350.3240 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 regulations were not met as evidence by:

Based on observation, interview and record review, nursing failed to: implement their policies to prevent neglect by not notifying the physician of weight changes for 2 (R1 and R3) of 2 individuals; ensure thorough monitoring of weight for 2 of 2 individuals inside the sample who fell outside their ideal body weight (R1 and R3); ensure the quarterly nursing assessments were complete systems review for 2 of 3 individuals in the sample who require complete systems review quarterly (R1, R2); ensure quarterly nursing assessments for 2 of 3 individuals in the sample (R1, and R3) were complete; ensure all

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medications are administered without error for 1 of 3 individuals (R7) outside the sample; ensure all medication errors were reported immediately to the nurse trainer affecting 1 of 3 outside the sample (R7); and ensure medications stored in the medication room were secured, potentially affecting all 12 individuals residing in the home (R1-R12).

Findings include:

1. Facility Abuse and Neglect Policy dated 12/18 documents, "Policy: It is the policy of this facility that all residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, misappropriation of property and neglect. Residents are not to be subjected to abuse, corporal punishment, and misappropriation of property or neglect by anyone, including, but not limited to facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. Definitions: Neglect - failure to provide goods and/or services necessary to avoid physical harm, mental anguish or mental illness."

1.a. The Individual Service Plan (ISP) dated 3/18/21 identifies R1 as a 31 year old female who functions within the Moderate Range for Individuals with Intellectual Disabilities.

R1's Physician's Office Diagnosis Sheet dated 3/31/21 documents the following diagnoses: diabetes mellitus type 2, controlled. morbid obesity with BMI of 60.0-69.9, gait disturbance, neuropathic pain of both legs, sleep apnea.

Facility failed to document diagnosis of diabetes

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on R1's ISP, physician order sheet, and quarterly nursing assessments.

R1's ISP dated 3/18/21 documents, "R1's Ideal weight 99-121 pounds."

Facility Height/Weight Report received 3/30/21 documents, "R1's weight on 3/31/20: 420 pounds. R1's weight on 3/7/21: 466 pounds."

R1's Health Care Report dated 10/13/20 documents, "Dietary Guidelines: Heart Healthy, Low Concentrated Sweets, Consistent Carbohydrates. "

Observation on 3/29/21 at 7:17 am showed R1 sitting at dining room table and was given eggs with cheese, oatmeal, toast with butter and sausage. E6 (Direct Support Person-DSP) then came out of the kitchen and asked R1 if she wanted brown sugar for her oatmeal and R1 responded, "Yes." E6 brought over brown sugar and R1 added the brown sugar to her oatmeal. Staff did not encourage R1 to follow her diet.

Observation on 3/29/21 at 11:50 am showed R1 sitting at dining room table and E8 (DSP) came out of the kitchen and asked R1 if she wanted macaroni and cheese for lunch. R1 responded, "Yes." E6 brought R1 macaroni and cheese, broccoli cheese soup, and green beans for lunch. Staff did not encourage R1 to follow her diet.

During interview on 3/30/21 at 8:41 am E7 (DSP) was asked if she does the weights at the facility. E7 stated, "Yes." E7 was asked if they notified E4 (Registered Nurse Trainer-RN-T) of R1's weight increase. E7 stated, "Yes."

During interview on 3/30/21 at 9:11 am E4 was

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asked if she updated the doctor on R1's weight increase. E4 stated, "Probably not." E4 was asked should the doctor have been notified. E4 stated, "Yes."

During interview on 3/30/21 at 9:44 am E4 was asked if the staff keep track of how much and what R1 eats. E4 stated, "No."

During interview on 3/30/21 at 2:22 pm E1 (Interim Administrator) was asked if the staff should encourage R1 to follow her prescribed diet. E1 stated, "Yes."

During interview on 3/30/21 at 4:17 pm Z1 (Physician Nurse) was asked if the physician was aware of R1's 46 pound weight gain over a year. Z1 stated, "No." Z1 was asked if the facility should have notified the physician. Z1 stated, "Yes, R1's diabetic." Z1 was asked if the staff should encourage R1 to follow her heart healthy, low concentrated sweet, consistent carbohydrate diet. Z1 stated, "Yes." Z1 was asked if the facility should be keeping track of what R1 is eating and how much. Z1 stated, "Yes."

During interview on 3/31/21 at 11:18 am Z1 was told that facility had on their physician's order sheet under the R1's medication of Metformin a diagnosis of amenorrhea. Z1 was asked if that was a correct diagnosis for that medication. Z1 stated, "No, diabetes."

During interview on 3/30/21 at 4:44 pm Z2 (Guardian) was asked if she would want the staff to encourage R1 to follow her prescribed diet. Z2 stated, "Yes, if R1 wants something other than her diet I want them to try to get her to follow her diet as much as possible. I know she can be stubborn, but I do want them to encourage her to

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follow it."

1.b. Record review of R1's quarterly nursing assessments for 3/4/20, 5/28/20 and 9/23/20 show no complete system review for R1. The quarterly for 3/4/20 documents E4 (Registered Nurse Trainer-RN-T) noted next to signature, "No assessment done."

There is no evidence of R1's nursing quarterly for 2/21.

During interview on 3/29/21 at 10:49 am E1 (Interim Administrator) was asked if E4 (Registered Nurse Trainer-RN-T) was able to produce R1's 2/21 quarterly nursing assessment. E1 stated, "E4 told E1 that she didn't have 2/21 quarterly done."

During interview on 3/30/21 at 9:11 am E4 was asked if she did a head to toe body assessment on individuals for their quarterlies on the ones that were missing (R1: 3/4/20, 5/28/20, 9/23/20). E4 stated, "No."

2. The 11/19/20 ISP identifies R3 as a 24 year old male who functions within the Moderate Range for Individuals with Intellectual Disabilities. R3 has additional diagnoses of Cerebral Palsy and Scoliosis.

R3's ISP documents, "Eating: Total Assistance. Ideal Body weight: 127-156 lbs."

Facility Height/Weight Report received on 3/29/21 documents, "R3's weight on 6/27/20: 99 pounds. R3's weight on 3/7/21: 82 pounds."

Observation on 3/29/21 at 8:00 am showed R3 did not get up for meal.

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Observation on 3/29/21 at 12:26 pm showed R3 ate half of tuna sandwich, one bite of pudding and all of green beans. Staff did not encourage R3 to eat more. Staff did not offer substitute.

During interview on 3/29/21 at 12:05 pm E3 (Residential Service Director-RSD) was asked if the doctor was updated on R3's weight loss. E3 stated, "I'm not sure; we will call the doctor and see what she wants us to do." E3 was asked if E4 has called the doctor before today on R3's weight loss. E3 stated, "I'm not sure." At 12:11 pm E3 stated, "E4 said she does not remember calling the doctor about his weight loss. But there are no nursing notes."

During interview on 3/30/21 8:41 am E7 was asked if they notified E4 of R3's weight loss. E7 stated, "Yes, every time a weight has been taken and there was a decrease, E4 has been notified." E7 was asked if E4 suggested to get weights more often. E7 stated, "No, we just weigh him monthly like everyone else."

During interview on 3/30/21 at 9:11 am E4 was asked if she updated the physician on R3's weight loss. E4 stated, "Probably not." E4 was asked should the physician have been updated. E4 stated, "Yes." E4 was asked if the DSP's updated her on R3's weight loss. E4 stated, "Yes, on the Saturdays that I was here."

During interview on 3/30/21 at 2:22 pm E1 was asked if E4 should have updated the physician on R3's weight loss. E1 stated, "Yes."

During interview on 3/30/21 at 4:17 pm Z1 was asked if the physician was aware of R3's weight loss. Z1 stated, "No." Z1 was asked if they were

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aware that R3 was 82 pounds. Z1 stated, "No, they never notified them and not even on their last telehealth appointment on an ER follow up." Z1 was asked should the nurse have notified the physician of R3's weight loss. Z1 stated, "Yes, May of last year R3 was 98 pounds." Z1 was asked should the staff be keeping track of what R3 is eating. Z1 stated, "Yes, they should be doing an intake and output and a percentage of meals."

3.a. The ISP dated 5/21/20 identifies R2 as a 71 year old male who functions within the Profound Range for Individuals with Intellectual Disabilities. R2's ISP has additional diagnoses of Obsessive Compulsive Disorder, Impulse Control Disorder, Hypertension, Cataracts OU (both eyes), Bleoharitis and Cerebral Palsy.

Record review of R2's quarterly nursing assessments for 8/29/20 and 11/30/20 show no complete system review for R2.

There is no evidence of R2's nursing quarterly for 5/20 and 2/21.

During interview on 3/30/21 at 9:11 am E4 was asked if she did a head to toe body assessment on individuals for their quarterlies on the ones that were missing (R2: 8/29/20 and 11/30/20). E4 stated, "No."

3.b. The 11/19/20 ISP identifies R3 as a 24 year old male who functions within the Moderate Range for Individuals with Intellectual Disabilities. R3 has additional diagnoses of Cerebral Palsy and Scoliosis.

During interview on 3/30/21 at 9:11 am E4 was asked if the 5/20 or 2/21 quarterlies for R3 were

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done. E4 stated, "No."

4. Administrative Code Part 116 ADMINISTRATION OF MEDICATION IN COMMUNITY SETTINGS Section 116.20 documents, "Definitions: "Medication error"- The administration of medication other than as prescribed, resulting in the wrong medication being given; or medication given at the wrong time, in the wrong dosage, via the wrong route, or by the wrong person; or medication omitted entirely."

Section 116.70 a) documents, "All orders shall be given as prescribed by the physician and at the designated time."

Section 116.70 c) documents, "In the event of a medication error, authorized direct care staff shall immediately report the error to the registered professional nurse, Nurse-Trainer or person licensed to prescribe medication in Illinois to receive direction on any action to be taken. All medication errors shall be documented in the individual's record and a medication error report shall be completed within eight hours or before the end of the shift in which the error was discovered, whichever is earlier. The medication error report shall be sent to the Nurse-Trainer for review and further action within 7 calendar days after the occurrence."

Facility's Medication Administration-Errors Policy dated 3/18 documents, "Policy: It is the policy of this facility that medication be administered according to universal standards of practice to prevent medication errors. Definition: Medication errors are defined as the following: 2) Administering the wrong dosage of medication. 3) Administering the wrong medication. 5)

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Administering the medication at the wrong time. Procedure: 1) When a medication error is discovered, the error will be reported to the RN Nurse Trainer or her back up within 1 hour or as soon as practical (if during the night report as soon as practical the next day) and the RSD. 2) A medication error reporting form will be completed by the staff discovering or making the error no later than 8 hours after discovery of the error or before the end of the shift whichever is sooner."

4.a. Facility Roster received 3/29/21 documents R7 as an individual who functions within the Mild Range for Individuals with Intellectual Disabilities.

R7's Physician's Order Sheet dated 3/2021 documents, "7:00 am medication: Calcium+D3 600-800 one tablet."

Observation at 6:46 am showed R7 received Calcium 600 mg.

During interview on 3/29/21 at 7:57 am E5 (Direct Support Person-DSP) was asked if R7 was supposed to get Calcium+D3 600-800 one tablet. E5 stated, "E4 (Registered Nurse Trainer RN-T) said we are out of the Calcium+D3 600-800, to just give Calcium 600 mg."

During interview on 3/29/21 at 8:58 am E4 was asked if she instructed staff to give R7 Calcium 600 instead of Calcium+D3 600-800. E4 said, "I'm going to get it ordered."

4.b. R7's Physician's Order Sheet dated 3/2021 documents, "7:00 am medication: Flonase Spray one spray each nostril."

Observation at 6:46 am showed R7 came into laundry room for 7:00 am medication. R7 did not

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receive her Flonase during the medication pass.

During interview on 3/29/21 at 8:02 am E5 was asked if R7 was supposed to receive nasal spray during morning medication pass. E5 stated, "Oh yes, I forgot. I'll give it to her now. I can give that whenever."

Observation at 8:04 am showed R7 received Flonase one spray each nostril.

During interview on 3/30/21 at 9:24 am E4 was asked if she was notified that R7 received her Flonase outside the hour time of administration. E4 stated, "No."

5. Facility Roster received 3/29/21 documents R4-R9 and R12 as individuals who function within the Mild Range for Individuals with Intellectual Disabilities; R1 and R10 as individuals who function within the Moderate Range for Individuals with Intellectual Disabilities; R3 as an individual who functions within the Severe Range for Individuals with Intellectual Disabilities; and R2 as an individual who functions within the Profound Range for Individuals with Intellectual Disabilities.

Section 116.80 a) documents, "All medications shall be stored in locked compartments or within the locked medicine container, cabinet or closet."

Observation on 3/29/21 at 7:33 am showed R1 sitting at dining room table. At the opposite end of R1's table was a red cup with liquid in it. R9 was sitting at a table next to R1's table. R1 then said, "Hey, this cup down there has medication in it." No staff was present at that time.

Observation on 3/29/21 at 7:36 am showed E6 (DSP) walk by dining room and into kitchen.

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During interview on 3/29/21 at 7:36 am E6 was asked if the red cup at the end of the table where R1 was sitting had medication in it. E6 stated, "I'm not sure, I'm not med certified." E6 then walked into the dining room and grabbed the red cup and placed it in the refrigerator in the kitchen, which has no locking mechanism on it.

During interview on 3/29/21 at 7:42 am E5 was asked if she put medication in the red cup that was sitting on the end of the table where R1 was sitting. E5 stated, "Yes, it had R3's PEG (Polyethylene Glycol) in it. I usually put it in the refrigerator."

Observation on 3/29/21 at 8:00 am showed R3's cup with medication still remained in unlocked refrigerator.

Observation on 3/29/21 at 8:06 am showed R3's cup with medication still remained in unlocked refrigerator. R6 was sitting at dining room table.

During interview on 3/29/21 at 8:58 am E4 was asked if staff was supposed to leave medications unattended. E4 stated, "No." E4 was asked if staff was to leave medication in refrigerator in kitchen. E4 stated, "No."

(B)