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
	IL6010433	A. BUILDING: ______ B. WING ______	11/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPARTA TERRACE	1501 MELMAR DRIVE SPARTA, IL 62286

(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
Z 000	COMMENTS LICENSURE FOLLOW UP TO SURVEY DATE OF 05/28/2021 SPARTA TERRACE IS IN COMPLIANCE WITH THE PLAN OF CORRECTION FOR: 350.700a) 350.1210 350.1220j) 350.1230d)3) 350.3210o) REPEAT: 350.620a) 350.1230b)7) 350.1230d)1)2) 350.3240a)	Z 000		
Z9999	FINDINGS REPEAT Statement of Licensure Violation: 350.620a) 350.1230b)7) 350.1230d)1)2) 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.	Z9999	Attachment A Statement of Licensure Violations	

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Section 350.1230 Nursing Services
b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following:
The DON shall participate in:
7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.
d) Direct care personnel shall be trained in, but are not limited to, the following:
1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.
2) Basic skills required to meet the health needs and problems of the residents.

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 requirements were not met as evidenced by:

Based on record review and interview, the facility failed to correct the findings within the time period specified in the plan of correction, when they failedto ensure:

-Staff were trained to perform neurological checks after a head injury for 1 individual in the sample, (R1).
-Nursing staff followed the facility's policy and procedure by their failure to review pertinent documentation affecting 1 individual in the sample, (R1).
-Staff followed the facility's policies and procedures by their failure to notify the registered nurse when a resident was out of a medication affecting 1 individual in the sample, (R1).
-Notification of the primary care physician

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Z9999	Continued From page 2 affecting 1 individual in the sample, (R1) regarding an out of stock controlled medication, which resulted in multiple missed doses. -Staff followed the facility's policy and procedure by their failure to obtain vital signs after a seizure episode affecting 1 individual in the sample, (R1). -Notification to the Illinois Department of Public Health within the designated time frame regarding a hospitalization for 1 individual in the sample, (R1). -Guardian notification of medication errors affecting 1 individual in the sample, (R1). -Staff completed accurate documentation for medication errors affecting 1 individual in the sample, (R1). Findings include: The facility's policy titled, "Neurological Checks," dated 3-2016, documents in part, "Policy: It is the policy of this facility that neurological checks will be completed when ordered by a physician. Additionally, neurological checks may be initiated as a nursing measure when there is reason to suspect a head injury or other adverse neurological events has occurred. Procedure: 4. Assess the resident's level of consciousness using facility accepted scale. 5. Assess the resident's pupil reaction to light. 6. Assess the resident's hand grasps. 7. Assess the resident's ability to move all extremities. 8. Assess response to pain by gently pushing your knuckle against the resident's sternum or lightly pinching the resident's finger tip and monitor reaction." The facility's policy titled, "Contacting the RN Protocol," dated 5/2021, documents in part: POLICY: An RN (Registered Nurse) is available by phone 24 hours a day and make frequent	Z9999		

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visits to the facility each month. PROTOCOL: Documentation: RSD's, LPN's (Licensed Practical Nurses), and DSP's are to keep a log of their concerns and calls placed to the RN. The log shall include the date and time the call was placed, the information being relayed to the RN and any recommendations that the RN has to offer. The log shall be reviewed by the RN during her next scheduled visit to the facility. The RN will sign off on the log sheet to indicate that she was contacted at the time of the incident and has reviewed and will provide any necessary follow-up instructions." The policy further documents, "Oversight: RSD will monitor for compliance and report any discrepancies to the administrator."

The facility's policy titled, "Direct Support Partner," dated 7-2005, documents in part, "Job Summary: Under the direction and supervision of the Resident Services Director and participates as a member of the facility team to ensure safe and effective residential facilities. Job Duties and Responsibilities: The statements below describe the general nature and level of work being performed in this role. They are not intended to be a complete list of all duties and additional responsibilities may be delegated as required: 3. Document and inform Nurse/RSD (Residential Service Director) of problems noted."

The facility's policy titled, "Abuse and Neglect Program," dated 10-2021, documents in part: "Policy: It is the policy of this facility that residents have the right to be free from verbal, sexual physical and mental abuse, corporal punishment, involuntary seclusion, misappropriation of property an 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,

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other residents, consultants or volunteers, staff or 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.

The facility's policy titled, "Emergency Care-Basic," dated 6-2021, documents in part, "Seizure-Tonic/Clonic: 6. When seizure is finished, assess vital signs."

The facility's policy titled, "Incident/Accident-Resident or Visitor," dated 3-2019, documents in part: "4. I.D.P.H. (Illinois Department of Public Health) will be notified in writing by fax within 24 hours of any incident requiring outside services."

The facility's policy titled, "Medication Administration - Errors," dated March 2018, documents in part: "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: #8. Omission of a medication. PROCEDURE; 1. When a medication error is discovered, the error will be reported to the Registered Nurse (RN) Trainer or her back up with 1 hour or as soon as practical and the Residential Services Director (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 of the error or before the end of the shift whichever is sooner. 3. The medication error report will contain the following information: notification of: Physician (as soon as practical after error discovered). Pharmacist (as soon as practical after error discovered). RN Nurse

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Trainer. Guardian. Illinois Department of Public (IDPH) (report if there is an adverse reaction). 4. The medication error will be reported by fax/telephone within 24 hours to IDPH (if there is an Adverse reaction), the physician, pharmacy and guardian."

The facility's policy titled, "Documentation-General," dated 3-2007, documents in part, "PROCEDURE: 13. Mistakes are corrected by drawing a single line through the entry, write "error" near it and include date, time and initials."

R1's Physician Order (PO) dated 9/2021, documents R1 functions in the Mild Range of Intellectual Disabilities with additional diagnoses of Hyperlipidemia, Suicidal Ideation, Schizophrenia, Paranoia and Distressed Thought Process. Further review of R1's POS, documents R1 is prescribed Lorazepam 1mg (milligrams) 3 times daily.

Review of R1's ISP (Individual Service Plan) dated 11-5-21, documents R1 is prescribed Lorazepam 1mg for Schizophrenia.

Review of R1's Incident Report, dated 10-1-2021 at 2:40 PM, completed by E4/DSP (Direct Support Person) documents, R1 acquired a head injury after falling out of bed.

Review of R4's neurological check sheet dated 10-1-21 through 10-4-21, documents E2/RSD and DSP staff, E4-E8 completed a neurological assessment on R1 which included: Level of consciousness, pupil reaction, movement of extremities, pain response and vital signs.

Review of R1's RN Trainer sheet dated 10-1-21,

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documents R1 fell out of bed and acquired a head injury. Further review of R1's RN Trainer sheet documents in part, "RN Instructions: Complete neuro checks, GER, RN, Watch for any signs of injury." The document was signed by E4/DSP. The area where the RN would sign off on the sheet was left blank.

Interview with E4/DSP on 11-9-21 at 2:22 PM, E4 was asked how do you check for pupil response? E4 stated, "You do this with your finger." E4 then raised her right index finger and moved it horizontally from right to left. E4 was then asked if there is anything else that is checked for with pupil response? E4 stated, "Not that I know of, I'm not a nurse." E4 was asked if the RN provided any instructions on how to complete neuro checks? E4 then stated, "I wrote any instructions on the RN Trainer sheet."

Interview with E1/Administrator on 11-9-21 at 1:56 PM, E1 was asked when is the last time E3/RNT had been in the facility? E1 stated, "October 28th and November 3rd."

Interview with E2/RSD on 11-10-21 at 1:35 PM, E2 confirmed R1's 10-1-21 RN Trainer sheet should be signed off by the RN.

Review of R1's Medication error report for 11/6/21 and 11/7/21, documents in part; "Medications involved: Lorazepam 1 mg, three times a day. Description of Events: Medication ordered on 10/31/21 and again on 11/3/21. Home was not notified about lack of refills. E3/RNT notified at 6:45 AM."

Interview with E2/RSD on 11-9-21 at approximately 3:00 PM, E2 stated, "I was notified R1 ran out of her Lorazepam. I instructed E8 to

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notify the RNT. The staff did not follow instruction and contact the RNT."

Interview with Z1/Primary Physician on 11/10/21 at 12:07 PM, Z1 was asked if she was notified of R1 being out of Lorazepam on 11/6/21? Z1 stated, "I got a phone message from E3/RNT on 11/9/21 about 12:00 PM." Z1 was asked if she should have been notified prior to the medication running out? Z1 stated, "Yes, very commonly I would have sent a bridge prescription for the Lorazepam until the order could obtained from the consulting psychiatric doctor." Z1 was asked if R1 not getting her prescribed Lorazepam 1mg on 11/6/21 and 11/7/21, could have caused the seizure activity on 11/8/21? Z1 stated, "It is possible."

Review of R1's incident report dated 11-8-21 at 6:30 AM, documents R1 was observed to have a seizure lasting 2 minutes.

Interview with E1/Administrator on 11-9-21 at 11:40 AM, E1 was asked if vital signs were obtained after R1's seizure on 11-8-21? E1 confirmed vital signs were not obtained once seizure activity had stopped.

Review of R1's faxed report to the Illinois Department of Public Health (IDPH) dated 11-9-21 at 11:41 AM, documents notification of R1's seizure and subsequent hospitalization. Interview with E2/RSD on 11-9-21 at 10:30 AM, E2 confirmed IDPH notification of R1's transport to outside services had not occurred as of yet.

Interview with Z2/R1's Guardian on 11/10/21 at 12:45 PM, Z2 was asked if she was notified of the medication errors of R1 not having Lorazepam 1 mg for 6 doses? Z2 stated, "The physician at the

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Z9999	Continued From page 8 hospital told me, but I was not notified by the facility." Interview with E2/RSD on 11/10/21 at 1:35 PM, E2 was asked if E3/RNT was notified on 11/6/21 at 6:45 AM, as stated on the Medication Error Report for R1? E2 stated, "That was an error on my part. E3 was notified on 11/9/21." (REPEAT A)	Z9999		