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
	IL6012827	A. BUILDING: ______ B. WING ______	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA OF ELGIN	1950 LARKIN AVENUE ELGIN, IL 60123

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S 000	Initial Comments Complaint Investigation: 2273026/IL145927	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)1 300.1210d)2 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

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

These Requirements wer NOT MET as evidenced by:

Based on interview and record review, the facility failed to provide narcotic pain medication per physician orders to a resident in severe pain due to stage IV (4) breast cancer with metastases to liver and bone.

The failure resulted in R1 not receiving the scheduled physician-ordered pain medication and experiencing uncontrolled pain. This failure also resulted in R1 being hospitalized due to worsening, uncontrolled pain.

This applies to 1 of 3 residents (R1) reviewed for pain in a sample of 10.

The findings include:

1), POS (Physician Order Sheet), printed on 4/18/22, shows R1 was admitted to the facility on

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S9999	Continued From page 2 4/26/21. The document shows R1's diagnoses included malignant neoplasms of the bone, liver, and breast, pathological fracture in neoplastic disease, pain in right and left legs, pain in left and right hip, dorsalgia. major depression, anxiety, and protein-calorie malnutrition. MDS (Minimum Data Sheet), dated 5/10/21, shows R1 was cognitively intact. On 4/18/22 at 12:45 PM, V3 (Friend of R1) stated R1 called V3 a couple days after she was admitted to the facility and told V3 that R1 had not been provided pain medications for at least 24 hours when she first arrived at the facility and was in severe pain. V3 stated R1 told V3 she was in great discomfort and R1 was crying. POS, printed on 4/18/22, shows R1 had a physician order for Morphine Sulfate ER Tablet Extended Release 15 mg (milligrams) every 12 hours for pain which was ordered on 4/26/21 and started on 4/27/21 at 9:00 AM. The POS also shows R1 had a physician order, dated 4/26/21, for a 2 mg hydromorphone HCl (hydrochloride) tablet to be given to R1 as needed for pain every three hours. MAR (Medication Administration Record), dated 4/1/21-4/30/21, shows R1 did not receive her first two doses of morphine sulfate extended release 15 mg tablet on 4/27/21 at 9:00 AM and 9:00 PM per physician order. The MAR shows R1 received her first dose of morphine sulfate on 4/28/21 at 9:00 AM. The MAR also showed R1 did not receive any of her hydromorphone HCl (Hydrochloride) tablet as needed for pain on 4/27/21. The MAR shows R1's first dose of hydromorphone was offered to R1 on 4/28/21 at 2:52 AM for a pain level of 10 out of 10 (10 being	S9999		

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S9999	Continued From page 3 the highest amount of pain possible). Progress note, dated 4/28/21 at 6:00 AM, shows R1 stated her follow-up pain rating was 7 out of 10, with 10 being the worst pain possible. MAR, dated 4/28/21 at 6:02 AM shows R1 stated her pain level was 7 out of 10 and R1 was provided her hydromorphone medication. Progress note, dated 4/28/21 at 7:54 AM, shows R1 stated her follow-up pain rating was 6 out of 10. MAR, dated 4/28/21 at 9:03 AM, shows R1 received a hydromorphone tablet for pain that R1 reported measured 8 out of 10. Progress note, dated 4/28/21 at 10:03 AM, R1 stated her follow-up pain rating was documented as 5 out of 10. MAR, dated 4/28/21 at 12:03 PM, shows R1 again received her as needed hydromorphone tablet for pain which R1 stated measured 7 out of 10. Progress note, dated 4/28/21 at 1:51 PM, shows R1 stated her follow-up pain rating was documented as 6 out of 10. Nursing progress notes, dated 4/27/21 to 4/28/21, failed to document any attempts to contact R1's physician regarding R1's undelivered morphine sulfate medication or R1's consistent pain ratings greater than, or equal to, 5 out of 10. The progress notes failed to document any attempts to obtain the morphine sulfate from the emergency narcotic storage.	S9999		

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S9999	Continued From page 4 On 4/18/22 at 4:10 PM, V11 (Quality Assurance Pharmacist) stated the pharmacy received the first physician order for R1's morphine sulfate from the facility on 4/27/21 at 1:05 AM however the order did not have a valid signature from the physician and could not be filled. V11 stated the first valid prescription the pharmacy received from the facility for R1's morphine sulfate was on 4/27/21 at 7:03 PM. V11 stated the medication was delivered to the facility on 4/27/21 at 11:07 PM with the next scheduled pharmacy delivery. V11 stated the medication was not ordered as STAT (Urgent) so it was delivered during the next scheduled delivery. V11 stated the pharmacy received R1's physician order for her hydromorphone tablet on 4/26/21 at 11:45 PM however that prescription was also missing a valid physician signature. V11 stated the first valid prescription they received for R1's hydromorphone medication was on 4/27/21 at 7:03 PM and the medication was delivered on 4/27/21 at 11:07 PM. On 4/19/22 at 10:45 AM, V12 (Physician) stated regarding R1 not receiving her scheduled pain medications on admission, "I would have ordered a STAT order to the pharmacist. Same for when she ran out of the medication. There is no excuse .... With a patient like this I want uninterrupted medication. There is no excuse." V12 stated there were several options to avoid R1 missing her scheduled pain medications including V12 calling the pharmacist and providing a verbal STAT order for immediate delivery to the pharmacy. V12 stated his expectation was that the staff call him so that he could call the pharmacy. V12 stated someone was always on call for him if they could not reach him, but V12 stated he is always available by text and by cell phone.	S9999		

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S9999	Continued From page 5 Care plan, initiated 5/7/21, shows, R1 "would like the nurse to notify the physician if interventions are unsuccessful or if current complaint is a significant change from [R1's] past experience of pain." Narcotics emergency storage drug inventory, dated 4/2021 and 5/2021, show the facility had morphine sulfate 100 mg/5 ml (15 ml) on hand at the facility for use. Facility Pain Policy/Procedures, revised 7/28/21, show "It is the policy of the facility to ensure that all residents are assessed for pain in every situation where there is a potential for pain .... 1. ....If available in the convenience box or facility house stock, the pain medication ordered will be administered to the resident as soon as possible. After the administration of PRN (As Needed) pain medication, the resident will be assessed for the effectiveness of the pain medication. If the resident is still unrelieved of pain despite pharmacologic and nursing measures, the resident's physician will be called to refer the lack of relief." Pharmacy Controlled Substance Prescriptions Policy/Procedures, revised 8/2020, show, "Before a controlled drug can be dispensed, the pharmacy must be in receipt of a clear, complete and signed written prescription from a person lawfully authorized to prescribe controlled substances. A chart order is not equivalent to a prescription for controlled medications. Therefore, the prescriber issuing the chart order must also provide the pharmacy with a valid prescription to ensure delivery of medication. The written prescription may be faxed to the pharmacy for long-term care facility residents.	S9999		

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S9999	Continued From page 6 Verbal orders for controlled medications are permitted for Schedule II substances only in emergency situations .... Verbal orders received by pharmacists from prescribers must also be communicated to the facility before authorized nursing facility staff may access any controlled substances from the emergency supply located at the facility. This may be done either by the prescriber directly or via telephone order from the pharmacist to the facility .... II New Prescriptions - New prescriptions for controlled medications meeting all state and federal requirements must be received by the pharmacy in one of the following ways. 1. A valid hard copy of the prescription must be transmitted via fax to the pharmacy by the prescriber .... 2. A valid electronic prescription may be transmitted by the prescriber to the pharmacy ... 4. A verbal prescription for a Schedule II medication may be called in to a pharmacist directly by the prescriber only, if: a. Immediate administration of the controlled medication is necessary for proper treatment of the intended ultimate user ...." 2). On 4/18/22 at 12:45 PM, V3 (Friend of R1) stated on Memorial Day weekend of 2021 (5/29/21 and 5/30/21), R1 told V3 that R1 was again not receiving her scheduled pain medications and was in severe pain. V3 stated R1 told V3 the facility said they had nothing to give R1 for the pain because the physician had not provided a refill on her pain medication. R1 asked V3 and V3's husband to transport R1 from the facility to the hospital to get pain relief because she was in so much pain. V3 stated her husband transported R1 in their personal car from the facility to the hospital where she was admitted. V3 stated, "Nobody who is a stage 4 cancer patient should have to go without their	S9999		

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pain medication. Ever .... We got a phone call at 7:00 AM and she told us to come get her because she was in pain. She was sweating, shaking, and crying inconsolably."

MAR, dated 5/29/21 at 9:00 PM, shows R1 reported her pain rating as 5 out of 10 however R1 did not receive her scheduled morphine sulfate pain medication at 9:00 PM as ordered.

Progress notes, dated 5/29/21 at 10:33 PM, shows R1's morphine sulfate medication was on order from the pharmacy. Progress note, dated 5/29/21 at 10:33 PM shows R1 reported her pain rating was 5 out of 10.

MAR, dated 5/30/21 at 3:47 AM shows R1 reported her pain rating was an 8 out of 10 and R1 was provided an as needed pain medication. The MAR shows the medication was ineffective at controlling R1's pain. The MAR shows no further doses of the as needed pain medication were provided until 9:13 AM.

MAR, dated 5/30/21 shows R1 again failed to receive her 9:00 AM scheduled morphine sulfate pain medication as ordered. Progress note associated with the missed dose, dated 5/30/21 at 10:15 AM, shows the medication was not delivered in spite of the prescription being faxed to the pharmacy on 5/29/21 and the nurses calling the pharmacy twice requesting the medication. MAR, dated 5/30/21 at 9:09 AM, shows R1 reported her pain as 7 out of 10 and received another as needed dose of pain medication at 9:13 AM. The record also shows R1 received Tylenol 325 mg on 5/30/21 at 9:07 AM however the MAR shows R1's pain was documented as 5 out of 10.

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S9999	Continued From page 8 Progress note, dated 5/30/21 at 9:54 AM shows R1 had a change of condition regarding generalized pain which began on 5/30/21 and worsened. The progress note shows R1 was transferred to the hospital by a friend, however does not specify at what time R1 was picked up. The progress note fails to provide any assessment regarding R1's pain evaluation and the pain section of the documentation was left blank. Face sheet, dated 4/25/22, shows R1 was discharged from the facility on 5/30/21 at 10:30 AM. Progress note, dated 5/30/21 at 1:48 PM shows "Friend take her to [Hospital]." R1's Hospital Emergency Department Admission physician note, dated 5/30/21, shows, "Patient presents with Pain Control - Patient is at a rehab center ... and they do not have her pain medication. C/O (Complains of) severe spine and leg pain. This is a 52-year-old female ... who presents with diffuse pain related to her metastatic breast cancer. The patient is currently in a rehab facility and states that her medication orders expired and they could not contact her physician at the rehab center and so she has not had any pain medication for over two days. She states her pain is diffuse and that she is miserable .... Physical Exam- General: She is in acute distress." Physician Discharge Summary, dated 6/4/21, shows, "R1 with a history of stage IV breast cancer with metastases to the liver and spine is being admitted from her skilled nursing facility due to a poor pain control. She was unable to get her morphine over the holiday weekend and thus	S9999		

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S9999	Continued From page 9 was admitted." On 4/18/22 at 4:10 PM, V11 (Quality Assurance Pharmacist) stated the pharmacy received a prescription from the facility for morphine sulphate on 5/29/21 at 2:01 PM which was delivered on 5/30/21 at 4:02 PM. V11 stated if the facility needed it sooner, they could have had the physician contacted the pharmacy for a STAT delivery which would have been delivered within three to four hours. On 4/19/22 at 10:45 AM, V12 (Physician) stated, V12 stated his expectation for staff was that they know that R1 has a history of pain and if they do not have a prescription for pain medication, they should call V12 to call the pharmacy and order the medication STAT. V12 stated he would have also ordered R1's as needed pain medications differently to provide R1 better pain management. Pharmacy Controlled Substances Policy / Procedure, revised 8/2020, shows, " ....8. All controlled medications are requested when a minimum of a five-day supply remains, or in accordance with facility policy, to allow time for acquisition and transmittal of the required original written prescription to the provider pharmacy, if necessary." (B)	S9999		