STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009310	A. BUILDING: _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE MANOR	920 N SEMINARY AVE WOODSTOCK, IL 60098

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S 000	Initial Comments Initial Complaint Investigation Survey 2312388/IL157863	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3220f) 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 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 Section 300.3220 Administration of Medication	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act These regulations have not been met as evidenced by: Based on interview and record review, the facility failed to ensure it was free from significant medication errors for one of four residents (R1) reviewed for medications in the sample of four. This failure contributed to R1 experiencing a change in condition that resulted in a hospitalization. The findings include: R1's Face Sheet shows he was admitted to the facility on 10/7/22. R1's nurse practitioner progress note dated 3/9/23 shows R1 was awake and alert on 3/9/23. R1's nurse practitioner note dated 3/11/23 shows R1 was alert and oriented x 1-2. V3's (R1's Neurologist) visit note dated 3/9/23 shows R1 was alert and answering questions appropriately. "Trial of effexor for anxiety, daytime sleepiness, and freezing of gait. Goal would be to titrate him up to 150 mg daily, but will first try a low dose beginning with 37.5 mg for two weeks then increase to 75 mg daily. At this dose it would be safe to stop if patient has any adverse effects. Trial of pimavanserin (Nuplazid) for	S9999		

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S9999	Continued From page 2	S9999		

hallucinations, agitation, anxiety. Would wait to start until after patient is stable on effexor for one month."

Prescriptions written by V3 for R1's new medication orders dated 3/9/23 shows Effexor XR 37.5 mg capsule, extended release, take one tab for two weeks, then increase to two tabs daily. Pimavanserin (Nuplazid) 34 mg capsule take one capsule by oral route earliest fill date on 3/31/23.

R1's Medication Record for 3/2023 shows Nuplazid 34 mg was given to R1 on 3/11/23 and it shows that effexor ER was given to R1 on 3/11/23. Nuplazid had a start date of 3/10/23.

R1's Interdisciplinary Notes dated 3/12/23 at 6:09 PM shows, "Resident has been in his bed all day, eyes close, snoring. Appears to be comfortable. Breathing even and unlabored. Tried waking several times throughout the day, keeps eyes closed, mumbles a few words, pushes away with his hand. No intake of food or liquid. Daughter notified." 3/13/23 11:47 AM, "Writer spoke with [V7-R1's daughter], status update given, resident remains lethargic, [V7] agreeable to send resident to emergency room for further evaluation." 3/13/23 9:11 PM, "Update from [V7], resident is being admitted, they do not know what is going on, CT of brain is unremarkable, all tests have come back fine." 3/14/23 9:29 AM, "Call place to [local hospital] admitting diagnoses is encephalopathy."

On 3/22/23 at 2:10 PM, V3 said R1 was very sensitive to medications. V3 said that R1 had a bad reaction to seroquel in the past. V3 said R1 doesn't respond well on antipsychotics. V3 said she ordered the medications to be given a month apart so she could see how he would react to

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each medication. If R1 experienced any side effects she would have been able to tell which medication caused the side effects. V3 said the medications should not have been started together and it was unfortunate that they were.

On 3/22/23 at 1:45 PM, V4 RN (Registered Nurse) said she assessed R1 on the day of his transfer to the local emergency room. V4 said R1 was much more drowsy and unresponsive than his baseline. V4 said that R1 only opened his eyes a little bit with a sternal rub. V4 said she notified the nurse practitioner, R1's power of attorney and his primary nurse. V4 said that R1 was sent out to the local hospital.

On 3/22/23 at 2:00 PM, V5 LPN (Licensed Practical Nurse) said she is the nurse that entered R1's orders from his doctors appointment. V5 said that V6 LPN asked V5 to entered R1's new orders. V5 said there were two medication orders that she entered and faxed the prescription to the pharmacy. V5 said after she entered the orders, she placed the orders in a bin for a second nurse to verify the orders were correct. V5 said she didn't know if a second nurse verified the orders. V5 said she did not understand what the "earliest fill date of 3/31/23" meant. V5 did not clarify what this meant. V5 said that her second nurse check or the pharmacy should have caught the discrepancy in regards to nuplazid order and the start date.

On 3/22/23 at 2:29 PM, V6 LPN said when R1 returned from his neurologist appointment, the driver showed V6 that R1 had two new medicines. V6 said on that day, she was responsible for passing medications to residents on two different floors so the supervisor (V5) took the orders and entered them. V6 said typically

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S9999	Continued From page 4 when a nurse enters a new order, they put it in a folder and the order is to be check by a second nurse. V6 said she did not see the "earliest fill date" on the nuplazid prescription. V6 said she didn't know if a second nurse checked R1's new orders or not. V6 said on the day of R1's transfer to the local hospital, R1 had been sleeping for a full day. On 3/22/23 at 2:58 PM, V2 DON (Director of Nursing) said R1's prescriptions from V3 shows that the nuplazid has an earliest fill date of 3/31/23 and that means that the prescription should not be filled until 3/31/23. V2 said that he expects his staff to see that information on the prescription. The facility's Medication Administration Policy revised on 6/24/21 shows, "To establish procedural guidelines for the correct administration of medications for the protection and safety of all residents of [facility name]. All nurses administering medications must have a knowledge of each medication given: nature of the medication, effect expected, signs of over dosage or cumulative effect, indications of adverse or allergic reactions, minimum and maximum dosage. All nurses must possess an awareness of responsibility to follow physician's orders precisely, but also to exercise good judgement if orders should be questioned by discussing concerns with nursing supervisor. All orders will be double-checked by another nurse." The facility's Order Entry Policy revised on 6/28/21 shows, "When orders are received from the ordering practitioner, the nurse is responsible for entering the order into the Physician's Order section of the EMR (Electronic Medical Record). All elements that are appropriate for the order will	S9999		

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S9999	Continued From page 5 be completed, including order date; order type, start date; medication/instructions; amount/dosage; route; frequency; MAR (Medication Administration Record) time code; check PRN (as needed) if appropropriate; start time; number of does; quantity; refill; diagnosis; ordering provider; additional information tab; nurse signature. The nurse entering the order should verify the content on the EMR for accuracy." (B)	S9999		