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
	IL6014666	A. BUILDING: ______ B. WING ______	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF ST CHARLES	850 DUNHAM RD ST CHARLES, IL 60174

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S 000	Initial Comments Complaint Investigation: 2378924/IL165935	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1)3) 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 of the resident. d) Pursuant to subsection (a), general nursing	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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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.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3220 Medical Care
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)

This REQUIREMENT is not met as evidenced by:

A. Based on interview and record review the facility failed to call to clarify a medication order and failed to obtain prescriptions for a resident's medication. This failure resulted in a 4-day delay in R1 receiving her psychotropic medications and experiencing symptoms of mania. This applies to 1 of 3 residents (R1) reviewed for pharmacy services in the sample of 3.

B. Based on interview and record review the facility failed to ensure a resident's pain was being managed after being discharged from the hospital for an ankle fracture. This failure

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resulted R1 experiencing uncontrolled pain for 4 days. This applies to 1 of 3 residents reviewed for pain (R1) in the sample of 3.

The findings include:

R1's face sheet shows she was admitted to the facility on 10/17/23 from a local community hospital with diagnoses including Bipolar Disorder, Mood Disorder, Depression and Pathological fracture to her right ankle. R1's 10/20/23 facility assessment shows her cognition is intact and she has no memory impairments.

R1's hospital records show she was admitted to a local community hospital on 10/14/23 following a fall resulting in an ankle fracture. R1's hospital discharge transfer summary completed on 10/17/23 shows R1 should continue to take the following medications upon admission to the facility: Dextroamphetamine-amphetamine XR (Adderall XR- a stimulant medication for attention deficit hyperactivity disorder) one time a day in the morning, lamotrigine (Lamictal-a mood stabilizer for bipolar disorder) 450 milligrams (mg) every night at bedtime, clonazepam (Klonopin-medication used to treat panic disorder) 1 mg every night at bedtime, Quetiapine (seroquel-anti-psychotic medication to treat bipolar disorder) 200 mg every night at bedtime, and Hydrocodone-acetaminophen 5-325 mg (Norco-pain medication) 1-2 tablets every four hours as needed.

R1's nursing summary notes she was admitted to the facility on 10/17/23 at 7:40 PM. A nursing progress note completed by V9 (Registered Nurse/RN) on 10/18/23 at 12:29 AM states,

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"resident's medications were reviewed with the provider and reconciled." That note also says she is alert and oriented and has no behavioral symptoms and no neurological deficits.

R1's Physician Order Summary (POS) shows the following medications were entered into the system on 10/18/23
Amphetamine-Dextroamphetamine, Clonazepam, and Quetiapine. R1's Hydrocodone-Acetaminophen and Lamotrigine orders were not entered into the POS until 10/20/23.

R1's Medication Administration Record (MAR) from 10/1/23-10/31/23 shows she did not receive the following medications:
Amphetamine- Dextroamphetamine was not given on the following dates: 10/18/23, 10/19/23, 10/20/23 and 10/21/23. A code of 12 was entered into the MAR indicating the medication was not available.
Clonazepam was not given on 10/18/23, 10/19/23 and 10/20/23 and is coded the medication was not available.
Lamictal was not entered into the MAR prior to 10/20/23 (was supposed to start at the facility on 10/17/23) and was documented as not given due to being unavailable on 10/20/23.
Quetiapine was not given on 10/18/23 due to being unavailable.
R1's Hydrocodone (scheduled as needed) was entered into the MAR, but no doses were signed off as given until 10/21/23. The MAR shows on 10/18/23 R1 received Tylenol 500 mg 2 tablets and documents a pain of 5 on a pain scale of 1-10.

R1's nursing notes show on 10/20/23, V7 (RN) called a physician to clarify the order for R1's

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S9999	Continued From page 4 Lamictal and entered it into the POS. R1's nursing notes for 10/21/23 at 6:35 AM, show the facility called the pharmacy due to R1's missing medications and pharmacy informed the facility the following medications still need a physician prescription: Hydrocodone-acetaminophen, Amphetamine-Dextroamphetamine and clonazepam. There is no documented progress note that V3 (R1's Primary Care Physician) was contacted about changing or R1 needing pain medication prior. R1's MAR shows beginning 10/21/23 (once the medication was available) to present she started asking for and receiving her pain medication (Norco) 2-4 times a day and had documented pain levels ranging from 5-10. A nursing note completed by V5 (RN) on 10/21/23 at 9:19 AM, shows that prescriptions for the medications were received by R1's Primary Care Physician (V3) (4 days after her admission). There are no additional nursing notes from 10/18-10/20/23 that indicates anyone called to follow up with the pharmacy or V3 about R1's medications. On 10/31/23 at 8:25 AM, R1 said " I came here for my broken ankle. I didn't get most of my psychotropic medications here for about 5 days. I have been on medications for bipolar disorder for about 20 years. I kept telling anyone and everyone who would listen to me that I needed those medications. I was feeling psychotic, hearing voices and didn't sleep for several nights. I was also on isolation for Covid-19 which didn't help." At 12:28 PM, R1 said "It was a very rough first few days here, in addition to the medication not being here I was being told I had to wait for the doctor to send over prescriptions for my	S9999		

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Norco, Adderall and Klonopin. And I also didn't get my Lamictal. After a while I just quit asking because I felt so out of it and would get the same answers from staff that they are waiting on the scripts that's why the medications are not here yet, and Tylenol was not even touching my ankle pain. Now that I have the Norco my pain is much more manageable."

On 10/31/23 at 10:16 AM, V8 (Social Service Designee and RN) said about 3 days after R1 was admitted to the facility she was told by R1 that her pain medication and anxiety medications were not at the facility, and she needed them. V8 said R1 did appear to be very restless in bed and complained of pain and anxiety. She said she did report these concerns to the nurse on duty but was unable to recall who that was.

On 10/31/23 at 12:14 PM, V3 (R1's Physician and Medical Director) said he gets a lot of text messages from agency staff, and he cannot say exactly when he was first contacted about the pharmacy needing scripts for R1's medications but he does know he sent the prescriptions over for R1's Adderall, Klonopin and Norco on 10/21/23. V3 said he is not sure why R1's Lamictal was not started on 10/18/23 because that order does not need a script and it should have been started. He said without R1 receiving these medications she would have exhibited increased psychiatric symptoms of mania. V3 said if he was contacted sooner by pharmacy or the facility, he could have given a verbal order for an emergency supply of R1's Norco. V3 also said he saw R1 on 10/25/23 and wrote a note.

V3's physician note for R1 on 10/25/23 at 9:39 AM, shows R1 complained she had missed several days' worth of her medication and as a

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result experienced mania. The same note states, "pt. stable on lamotrigine, clonazepam and quetiapine dosage. After restarting medication, denies any current mania or depressive episodes, was manic off of the medications." The note also refers to R1 complaining of pain to her ankle as a 10/10 on a pain scale but is better since she is now receiving Norco.

On 10/31/23 at 12:25 PM, V11 (Certified Nursing Assistant/CNA) said R1 has always complained of pain since she was admitted and ask for pain medication, and they would tell the nurse.

On 10/31/23 at 12:40 PM, V10 (CNA) said R1 routinely complained of pain to her leg, and they would tell the nurses that she wants pain medication.

On 10/31/23 at 12:52 PM, V4 (Unit Manager) said she contacted V7 (RN) because she had done the chart audit after R1's admission. V4 said on 10/20/23, V7 called V3 to clarify something about R1's Lamictal and then she carried out the order. She is not sure if anyone else had called to clarify R1's Lamictal orders, but if they did then they should have documented that in nursing progress notes.

On 10/31/23 at 1:15 PM, V2 (Director of Nursing) said she was not aware there were any issues with R1's medications until today. She said the pharmacy will not send the medications without written prescriptions for Norco, Adderall and Klonopin. She said nurses should follow up with the physician and pharmacy if a resident's medication is not available and make sure the scripts are sent to obtain those medications. V2 said certain medications are available in their

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S9999	Continued From page 7 onsite medication dispensing system and the nurses could have called the pharmacy for an emergency access code to obtain R1's Norco. On 10/31/23 at 1:53 PM, V7 (RN) said she did place a call on 10/20/23 to V3 to clarify a question about R1's Lamictal order. She thinks the issue was the medication needed a diagnosis for it. R7 said she thinks she clarified on a couple other issues with medications also but did not ask about prescriptions for the other medications. On 10/31/23 at 2:10 PM, V12 (Pharmacist) said according to their computer system R1's order for her Lamictal was not sent over to them until 10/20/23. V12 verified that the reason for the delay in R1's Clonazepam, Norco and Adderall was due to waiting on prescriptions from the physician. V12 said the facility must call them to alert them that they need assistance to contact the physician if there is a delay in getting the prescriptions sent. V12 verified that Lamictal, Klonopin and Adderall would not be in the onsite medication dispensing system at the facility, but Norco is, and the facility could have requested a code to put in to obtain that medication. The facility provided Medication Administration policy revised on 7/21/23 says medications should be administered in a timely manner. If medication for newly admitted residents are not present in the onsite medication dispensing system at the facility the pharmacy and physician should be contacted and new orders should be received. The facility provided Pain Screening and Management policy revised on 3/26/21 shows the facility will screen residents for pain and watch for symptoms of pain. It also says a resident's	S9999		

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S9999	Continued From page 8 history and physical and physician orders should be reviewed and obtained as necessary for pain management. "B"	S9999		