

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010094	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/02/2023
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NAME OF PROVIDER OR SUPPLIER WINNING WHEELS	STREET ADDRESS, CITY, STATE, ZIP CODE 701 EAST 3RD STREET PROPHETSTOWN, IL 61277
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S 000	Initial Comments Facility Reported Incident of 10/12/23/IL165976	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210d)3) 300.1610a)1) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	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	<p>Continued From page 1</p> <p>includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>Section 300.1610 Medication Policies and Procedures</p> <p>a) Development of Medication Policies</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.</p> <p>These Requirements were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to administer a resident's pain medication as ordered, failed to manage a resident's pain at a comfortable level, and failed to obtain emergency doses of a resident's pain medication when it was unavailable. These failures resulted in R12's Norco supply becoming depleted, R12 missing 16 doses of a prescribed narcotic pain medication, and R12 experiencing increased pain levels.</p> <p>The findings include:</p> <p>R12's electronic face sheet printed on 11/2/23 showed R12 has diagnoses including but not limited to intracranial injury with loss of consciousness, hemiplegia, encephalopathy, epilepsy, contractures, and behavioral syndromes.</p> <p>R12's facility assessment dated 9/7/23 showed R12 has severe cognitive impairment and experiences pain almost constantly.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>R12's care plan dated 7/8/20 showed, "The resident is on pain medication therapy due to lower back pain. Administer analgesic medications as ordered by physician. Monitor/document side effects and effectiveness every shift."</p> <p>R12's most recent pain assessment dated 9/7/23 showed R12 experiences pain on a daily basis and has limited day-to-day activities because of pain.</p> <p>R12's physician's orders dated 4/15/20 showed R12 receives hydrocodone-acetaminophen 7.5-325mg three times a day for pain.</p> <p>R12's Medication Administration Records for September 2023-October 2023 showed R12's Hydrocodone-Acetaminophen 7.5-325mg was unavailable for 2 doses on 9/29/23, unavailable for 3 doses 9/30/23 and 10/1/23, unavailable for 2 doses on 10/2/23, unavailable for 3 doses from 10/28/23-10/30/23. (R12 missed a total of 16 doses over a 2 month period and was given Ibuprofen 600mg as a substitute pain medication).</p> <p>R12's pain assessments for September 2023-October 2023 showed R12 experienced non-verbal indicators of pain levels ranging from 2-10 during the days his pain medication was unavailable.</p> <p>R12's nursing progress notes dated 9/29/23 showed, "Hydrocodone 7.5/325mg not available, nurse practitioner notified, stock coming with delivery tonight." (R12's Hydrocodone was not delivered to the facility until 10/2/23).</p> <p>The facility's emergency narcotic box list from the</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>facility pharmacy showed, "Hydrocodone-Acetaminophen 7.5/325mg...Quantity: 12."</p> <p>R12's nursing progress notes from September 2023-October 2023 showed no evidence that R12's Hydrocodone-Acetaminophen 7.5/325mg was removed from the facility's emergency narcotic supply.</p> <p>On 11/2/23 at 12:24 PM, V3 (Director of Nursing) stated, "If a resident runs out of a medication, the nurse should immediately notify the physician and then call the pharmacy to reorder the medication for a STAT delivery. There is no reason why any resident should run out of their medications as it is the nurse's responsibility to reorder in the appropriate timeframe to get the medication delivered before any doses are missed. (R12) has chronic pain in his back and hip and should be kept on his scheduled pain medication so that he has the best quality of life and can keep doing the daily activities he enjoys without being in pain. As soon as the nurse realized that (R12) was out of his medication she should have notified the pharmacy, physician, myself or (V4-Assistant Director of Nursing) and then followed our process for removing his pain medication out of the emergency narcotic box. The reason we have the emergency box is for new orders but also if a resident happens to run out of their pain medications. We would have had plenty of supply for the nurse's to administer doses of Norco to (R12) so that he didn't miss any doses. This was poor judgement on their part just to let him go without it."</p> <p>On 11/2/23 at 1:17 PM, V11 (Pharmacist) stated, "If a medication is needed out of the emergency box, the nurse has to call the pharmacy, then we</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>verify there is an order for the medication then give them the code and send them a new sealed kit. There would be a proof of use slip that the nurse needs to fill out and that has to accompany the box so we can keep that for our records. We have not received any used kits or proof of use slips for (R12). Obviously if a pain medication is not given to a resident they are going to experience increased pain. I would not consider Ibuprofen an acceptable substitute for Norco. If the facility has a resident that is receiving Norco and they run out they can use their emergency supply."</p> <p>The facility's policy titled, "Medication Administration" dated 1/2020 showed, "21. The medication being unavailable is not a valid reason for not giving the medication, and should never be documented as the reason. a. if the medications is not in the emergency supplies, it must be called in to the pharmacy so it can be administered as soon as possible. b. The physician must be notified if the pharmacy cannot bring the dose by an acceptable time."</p> <p>The facility's policy titled, "Management of Pain" dated 10/2008 showed, "Our mission is to facilitate resident independence, promote resident comfort, and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our resident the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement...For the purposes of this policy, pain is defined as whatever the experiencing person says it is, existing whenever the experiencing person says it does."</p>	S9999			

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