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
	IL6008510	A. BUILDING: ______ B. WING ______	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC AT NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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
S 000	Initial Comments First Probationary Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 300.615e) 300.1630a)1)2)3) 300.1630b) 300.1630c) 300.1630d) 300.1630e) 300.1630f) 300.1630g) 300.2010a)1)2) 300.2010b)1)2 1. Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 failed to complete the required Criminal History Information Response Process (CHIRP) within 24 hours of admission to the facility for two residents (R10 and R11) of five reviewed for Identified Offenders. This failure has the potential to affect all 118 resident residing in the facility. Findings include: R10's Face Sheet dated 10/4/23 documents R10 was admitted to the facility on 9/29/23. R10's Resident Background Check request was dated 10/4/23. R11's Face Sheet dated 10/4/23 documents R11 was admitted to the facility on 9/29/23. R11's Resident Background Check request was dated 10/4/23. On 10/4/23 at 2:15pm, V3 Social Services Director stated V3 was over the Identified Offenders Program (IOP) until mid July and currently only handles the process if a CHIRP results with a HIT. V3 stated the process for new resident admissions to the facility is a resident background check request form is sent to corporate and the three websites are to be checked (Illinois Sex Offender Registry, National Sex Offender Registry, Illinois Department of Corrections). V3 stated this process is to be done within 24 hours of admission. V3 stated the resident background check request is what triggers the CHIRP. On 10/4/23 at 2:45pm, V15 Business Office Manager (BOM) stated V15 took over the IOP in July. V15 stated the resident background check request form is submitted to corporate and the CHIRP results are returned to V15. V15 stated V15 submitted background check requests to	S9999		

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S9999	Continued From page 2 corporate for new admissions from end of last week today (10/4/23). V15 stated, "I need to get better about it." On 10/4/23 at 2:52pm, V15 BOM stated, "doesn't have it" regarding R10's resident background check request being submitted. On 10/4/23 at 3:42pm, V1 stated background check requests for new resident admissions are to be done within 24 hours of admission to the facility. V1 stated the facility does not have a policy regarding resident background checks. The facility Daily Census Report dated 10/3/23 documents 118 residents reside in the facility. (C) 2. Section 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. 1) Medications shall be administered as soon as possible after doses are prepared at the facility and shall be administered by the same person who prepared the doses for administration, except under single unit dose packaged distribution systems.	S9999		

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S9999	Continued From page 3 2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. (See Section 300.1810.) 3) Self-administration of medication shall be permitted only upon the written order of the licensed prescriber. b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available , a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility. c) Medications prescribed for one resident shall not be administered to another resident. d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record,	S9999		

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S9999	Continued From page 4 and the error or reaction shall also be described in an incident report. f) Nurses' stations shall be equipped as per Sections 300.2860 or 300.3060 and shall have all necessary items readily available for the proper administration of medications. g) Current medication references shall be available, such as the current edition of "Drug Facts and Comparisons", "Hospital Formulary", "USP-DI (United States Pharmacopeia-Drug Information)", "Physician's Desk Reference" or other suitable references. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to prevent a significant medication error by not administering medication by physician order to one (R7) resident out of 13 residents reviewed for medications in a sample list of 11 residents. Findings include: R7's undated Face Sheet documents an admission date of 10/2/23. R7's Electronic Medical Record (EMR) documents medical diagnoses of Hypertension, Cerebral Vascular Infarction and Acute Pancreatitis without necrosis or infection. R7's Physician Order Sheet (POS) dated October 2023 documents a physician order starting 10/3/23 of Heparin Sodium Lock Flush intravenous solution give 10 units intravenously in the afternoon for Peripheral Intravenous Central Catheter (PICC) protocol for 18 days.	S9999		

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R7's Medication Administration Record (MAR) dated October 2023 documents V8 Registered Nurse (RN) administered Heparin Sodium 10 units to R7 on 10/3/23 at 2:00 PM.

R7's Medication Error Report dated 10/3/23 documents date of error as 10/3/23. This same medication error report documents V8 Registered Nurse (RN) misread R7's Heparin Sodium Lock Flush order causing the wrong dose to be administered. This same medication error report documents R7 could have an increased risk of bleeding caused by this medication error.

R7's Admission Assessment dated 10/2/23 documents R7 as cognitively intact.

On 10/3/23 at 3:00 PM Observed V8 Registered Nurse (RN) administer Heparin Sodium labeled 50 units/5 milliliter (ml) per Peripheral Intravenous Central Catheter (PICC) line. V8 RN administered entire 5 ml Heparin syringe via R7's PICC line after antibiotic Ceftraxione administration had infused.

On 10/3/23 at 3:30 PM V2 Director of Nurses (DON) stated "I called (V13) Physician to report (V8) Registered Nurse (RN) medication error. I told (V13) that (V8) gave (R7) 5 milliliters (ml) of Heparin Sodium in the flush instead of the 1 ml Heparin flush that was ordered. (V13) Physician told me to just monitor (R10) for any increased bleeding."

On 10/4/23 at 10:00 AM V8 Registered Nurse (RN) stated "I did give the 5 milliliters (ml) of Heparin instead of the 1 ml to (R7). I should have only given the 1 ml. The morning order was to give the 5 ml of Heparin so I thought it would be

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the same but it wasn't. I should have read the order better. I made that medication error and feel bad about it but the orders were very confusing to begin with and (R7) just admitted on 10/2/23 so sometimes there are kinks to get worked out. I guess we (facility) got that one worked out. (R7) hasn't had any extra bleeding from it. (V2) DON talked to me about it this morning."

The facility policy titled 'Medication Administration Policy' effective 8/2023 documents medications must be administered in accordance with Physician order, e.g., the right resident, right medication, right dosage, right route and right time.

(B)

3.
Section 300.2010 Director of Food Services

a) A full-time person, qualified by training and experience, shall be responsible for the total food and nutrition services of the facility. This person shall be on duty a minimum of 40 hours each week.

1) This person shall be either a dietitian or a dietetic service supervisor.

2) The person responsible for the food service may assume some cooking duties but only if these duties do not interfere with the responsibilities of management and supervision.

b) If the person responsible for food service is not a dietitian, the person shall have frequent and regularly scheduled consultation from a

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dietitian. Consultation, given in the facility, shall include training, as needed, in areas such as menu planning and review, food preparation, food storage, food service, safety, food sanitation, and use of food equipment. Clinical management of therapeutic diets shall also be included in consulting, covering areas such as tube feeding; nutritional status and requirements of residents, including weight, height, hematologic and biochemical assessments; physical limitations; adaptive eating equipment; and clinical observations of nutrition, nutritional intake, resident's eating habits and preferences, and dietary restrictions.

1) Intermediate care facilities: A minimum of eight hours of consulting time per month shall be provided for facilities with 50 or fewer residents. An additional four minutes of consulting time per month shall be provided per resident over 50 residents, based on the average daily census for the previous year.

2) Skilled nursing facilities: A minimum of eight hours of consulting time per month shall be provided for facilities with 50 or fewer residents. An additional five minutes of consulting time per month shall be provided per resident over 50 residents, based on the average daily census for the previous year.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review the facility failed to employ a Full Time Certified Dietary Manager. This failure has the potential to affect all 118 residents residing in facility.

Findings include:

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The facility Daily Census Report dated 10/3/23 documents 118 residents residing in facility.

Observations made on 10/3/23 and 10/4/23 showed the facility did not have a Certified Dietary Manager (CDM) onsite.

On 10/3/23 at 8:50 AM Observed V4 Certified Food Manager (CFM) managing kitchen staff and instructing dietary staff on day to day tasks.

On 10/3/23 at 9:05 AM V4 Certified Food Manager (CFM) stated "I am not a Certified Dietary Manager (CDM) but I do have my Certified Food Manager (CFM) certificate. I am not enrolled in the classes. I would like to become a CDM but I don't know when that will ever happen."

On 10/4/23 at 10:30 AM V4 CFM stated "I have now been enrolled in the CDM online classes and will start on Monday 10/9/23. I have already been online and am able to see what classes I should take and have reviewed the syllabi for the classes. I am looking forward to it."

On 10/4/23 at 1:00 PM V12 Regional Dietary Consultant stated "(V4) CFM is not a Certified Dietary Manager (CDM). (V4) is now enrolled in the classes and will start soon. We (facility) have been told this before with other surveys but the previous corporation told us that the CFM would suffice. There is a difference between the CFM and CDM. We (facility) are working towards getting (V4) her CDM."

(C)