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
	IL6007181	A. BUILDING: ______ B. WING ______	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE AUBURN	304 MAPLE AVENUE AUBURN, IL 62615

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S 000	Initial Comments Complaint Investigation 2349707/IL166939	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time	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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of notification.

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 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.

These Regulations are not met as evidenced by:

Based on interview, observation and record review, the facility failed to provide a physician prescribed narcotic to relieve pain for 1 of 5 residents (R8) reviewed for pain in the sample of 8. This failure left R8 without moderate pain medication from 11/17/23 - 11/20/23 while in the facility for rehabilitation from a broken hip.

Findings include:

R8's Admission Profile, print date of 11/21/23, documents R8 was admitted on 11/17/23 and discharged on 11/20/23 and had a diagnosis of Displaced Intertrochanteric Fracture of Right

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S9999	Continued From page 2 Femur. R8's Baseline Care plan, dated 11/17/23, documents that R8 does have pain related to a right hip fracture. R8's Physician Orders, dated November 2023, documents, "Tylenol Extra Strength Oral Tablet 500 MG (milligram) (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for Mild-Moderate pain." Start date of 11/17/23. R8's Physician Orders, dated November 2023, documents, "HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Moderate pain for 7 Days. "Start date of 11/17/23. R3's Medication Administration Record (MAR), dated November 2023, documents that Tylenol 500 mg 2 tablets were given on 11/18/23 at 2:26 PM for a pain rating of 7, on 11/19/23 at 10:31 AM for a pain rating of 8 and on 11/20/23 at 2:06 AM a pain rating of 10. This MAR does not document any HYDROcodone-Acetaminophen Oral Tablet 5-325 MG for moderate pain was given. R3's Nurses Notes were reviewed on 11/21/23 at 9:20 AM and the nurses' notes fail to document any doctor notification that R3 did not have a written prescription for the Hydrocodone. R3's Admission Assessment, dated 11/17/23 at 7:20 PM, documents, "Pain: Resident had frequently pain in the past 5 days. Pain frequently interferes with day-to-day activities. Resident rates pain as: Resident rates pain severe over the last 5 days."	S9999		

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R8's E-RX (prescription) New Prescription documents that V18 sent in a prescription for R8 of Norco 5 mg - 325 mg oral tablet with directions of 1 tablet by mouth every 6 hours as needed. This document is dated and timed 11/18/23 at 7:55 pm.

On 11/22/23 at 11:42 AM, R8 stated, "I was in horrible pain the whole time I was there. They were giving me Tylenol but that was it. I would say my pain was a 10 the whole time I was there. I couldn't sleep at all while I was there. The nurses kept telling me they were leaving messages for the doctor, but he didn't call back yet and that I would have to wait until Monday to see the doctor. At the hospital I was getting morphine and the Vicodin. I get there and they can't give me anything but Tylenol because they can't get the Vicodin. What was I going to do? I didn't want to throw a fit, but I was in pain."

On 11/21/23 at 8:50 AM V6, Licensed Practical Nurse (LPN), stated, "She (R8) came from the hospital without a script (prescription) for her narcotic. She had it ordered but they did not send a script. She had not seen our doctor so we couldn't get a script for her. We were trying to get the doctor to give and order for Vicodin. We were giving her Tylenol 500 mg for pain she did have an order for that.

On 11/21/23 at 12:38 PM, V19, Registered Nurse (RN), stated, "I took care of her (R8) over the weekend on night shift. She had told me that she was leaving in the morning, and she had all her stuff packed at the end of the bed. She said she was not getting her pain medication the way that she should, but she was leaving because she could do all that we were doing for her at home. I gave her the Tylenol that I had access to. The day

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shift told me she had a stronger pain medication, but it was not available yet and there is nothing I can do about that on the night shift."

On 11/21/23 at 12:45 PM, V17, LPN , stated that she had spoke to her (R8) for a short period of time on the night shift of Friday. "She had asked for some pain medication, so I brought her the Tylenol. She was ok with that. Her pain medication was not here yet. I let her know that I could not get the higher pain medication out of the cubix because it requires 2 nurses to sign out and we only have 1 nurse on night shift."

On 11/21/23 at 3:37 PM, V11, LPN, stated, "I admitted (R8). I put in all her orders. She got here about 5:30 PM on Friday (11/17/23). We have to have a written script (prescription) written and signed by a doctor for narcotics. She did not have one. The hospital knows this, and they are suppose to send one. I attempted to get a hold of (V18, Doctor). I couldn't get a hold of him. I did put in standing orders in for Tylenol 500 milligrams 2 tablets so at least she would have something for pain. I passed it on in report for the night shift that we still need a written script for her. I was then off and I didn't come back until today so I don't know what happened."

On 11/21/23 at 3:42 PM, V12, Certified Nurse Aide (CNA), stated, "She (R8) had her light on often and she would say she was uncomfortable in her hip and that she wanted the nurse."

On 11/22/23 at 9:37 AM, V14, CNA stated that, "I did overhear her telling the nurse and someone she was talking to on the phone that she needed pain medication."

On 11/22/23 at 2:19 PM, V3, MDS/ LPN, stated

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S9999	Continued From page 5 that the nurses were notifying her of R8 not having her narcotic. "I reached out to the hospital and spoke with R8's hospital care coordinator and asked if they could get a prescription sent out for us. I was told they would check and call me back. I never heard from them, so I called V18 (Medical Director) and he had me send all of the information over to him and he was going to send in a electronic script to the pharmacy. Which he actually did. I am not sure when this happened and why the medication was not available to be given to her." On 11/22/23 at 2:33 PM, V2, Director of Nurses (DON), stated, "If a resident comes without a script from the hospital, the nurses should notify the doctor and he will do what is necessary to get the needed medication. In this case, I think it was an error on the pharmacy side because the medication was never available to us even though (V18) had sent the script to pharmacy." The facility failed to provide a policy on receiving prescriptions for narcotics. (B)	S9999		