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
	IL6003917	A. BUILDING: ______ B. WING ______	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
H & J VONDERLIETH LVG CTR, THE	1120 NORTH TOPPER DRIVE MOUNT PULASKI, IL 62548

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S 000	Initial Comments	S 000		

Facility reported investigation to incident 10/09/19/IL116862

Statement of licensrue violations

S9999	Final Observations	S9999		

300.610a)
300.1210 b)
300.1210 d)1)
300.1620 a)
300.3220 f)
300.3240 a)

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

Attachment A
Statement of Licensure Violations

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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.

Section 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

Section 300.3220 Medical Care

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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

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Based on interview and record review, the facility failed to transcribe physician's orders accurately for two of three residents (R1 and R3) reviewed for accurate transcription of admission medication orders in a sample of three. This failure resulted in R1 suffering a stroke after not receiving an ordered anticoagulant while in the facility.

Findings include:

On 10-22-19 at 1:40 pm, V4 (Corporate Registered Nurse) stated the facility does not have a policy for transcription of physician's orders.

The facility's Process Improvement Plan, dated 10-11-19, documents the following: "2) Each order needs to be transcribed with the correct medication, dose, frequency, route, and end date if applicable. Notify PCP (primary care physician) for any discrepancies for clarification. 6) All orders are to be verified for accuracy and completeness by another licensed professional with 24 hours from admission."

1. R1's POS (Physician Order Sheet) for October 2019 documents R1 has the following diagnoses: Atrial Fibrillation, Hypertension, History of Transient Ischemic Attack, and Cerebral Infarction without residual deficits.

R1's hospital transfer form, dated 10-3-19, documents R1 was to receive the following: Dabigatran 150 mg (an anticoagulant for treatment of Atrial Fibrillation), one capsule every twelve hours, starting with the evening dose on 10-3-19. R1's POS starting 10-3-19 does not contain the order for Dabigatran. R1's MAR (Medication Administration Record) does not

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have Dabigatran listed as a medication given.

R1's nursing notes, dated 10-8-19 at 10:20 am, document R1 was found not verbalizing, with left grip weaker than the right. R1's physician was notified, and R1 was sent to the emergency room for evaluation with stroke like symptoms.

R1's hospital discharge note, dated 10-18-19, documents R1 was admitted to the hospital on 10-8-19, and found to have suffered a Right Middle Cerebral Artery Stroke. "Etiology is suspected to be embolic from atrial fibrillation while missing doses of her OAC (anticoagulant)."

On 10-23-19 at 9:00 am, V5 (Hospital Nurse Practitioner for Neurology Department) stated the following: "(R1's) stroke is a direct result of not receiving Pradaxa (Dabigatran) in the nursing home." R1 had an embolic stroke which is consistent with someone having atrial fibrillation and not getting their anticoagulant. Just missing a few doses can have a negative effect.

On 10-22-19 at 11:20 am, V2 (Acting Director of Nursing) stated she was the nurse who missed the transcription of R1's Dabigatran from the hospital records to the facility order sheet and MAR. V2 stated she does not know how she missed the medication. V2 was unsure of the facility policy for transcribing orders.

R1's hospital transfer form, dated 10-3-19, documents R1 was to receive the following: Flagyl 500 mg (antibiotic) every eight hours for three days, with starting dose due the evening of 10-3-19, for the treatment of recent sepsis. R1's facility POS documents R1 was to receive "Flagyl 500 mg, give 1 tablet by mouth at bedtime, for infection for 3 days." R1's MAR documents R1

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received Flagyl 500 mg at bedtime, instead of three times a day as prescribed on the transfer orders.

On 10-22-19 at 11:20 am, V2 (Acting DON) stated she made an error when transcribing R1's orders. R1 should have received Flagyl 500 mg, three times a day, for three days, instead of one time a day for three days. V2 stated she was the nurse who missed the transcription of R1's Dabigatran from the hospital records to the facility order sheet and MAR.
V2 stated she does not know how she missed the medication. V2 was unsure of the facility policy for transcribing orders. V2 confirmed R1 did not receive the ordered ten doses Dabigatran 150 mg two times a day from the evening of 10-3-19 to the morning of 10-8-19.

R1's hospital transfer form, dated 10-3-19, documents R1 was to receive the following: The antibiotic Rochephin 2 gram IV (intravenous) every 24 hours through 10-5-19 PM, with the next dose due 10-4-19 at noon, for treatment of sepsis. R1's facility POS and MAR document R1 was to receive Rochephin "2 gm, use 2 gram intravenously in the afternoon for leukocytosis for 1 Day IV piggyback over 30 minutes." R1's MAR documents the Rochephin was only given on 10-4-19, and not on 10-5-19.

On 10-24-19 at 9:00 am, V2 (Acting DON) verified R1's Rochephin should have been given on 10-4-19 and 10-5-19. V2 stated there was a issue with how the computer processed the order. V2 stated pharmacy did not send the second dose, and R1 did not receive the ordered second dose.

R1's hospital transfer form, dated 10-3-19,

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documents R1 was to receive the following: Tylenol 500 mg, every six hours as needed for pain. R1's 10-3-19 POS and MAR do not contain an order for the Tylenol 500 mg every six hour as needed for pain.

R1's hospital transfer form, dated 10-3-19, documents R1 was to receive the following: Benzonatate 100 mg, three times daily, as needed. R1's 10-3-19 POS and MAR do not contain an order for Benzonatate 100 mg, three times a day, as needed.

On 10-22-19 at 1:00 pm, V2 (Acting DON) stated she also missed transcribing R1's Tylenol and Benzonatate medications. V2 verified R1 did not receive any of these medications during her 10-3-19 to 10-8-19 admission.

2. R3's POS (Physician's Order Sheet), dated 10-18-19, documents R3 has diagnoses of Dementia, Cerebrovascular Disease, and Hypertension.

R3's hospital discharge orders document R3 was admitted to the hospital on 10-10-19, and discharged back to the facility on 10-18-19. The 10-18-19 hospital discharge transfer medication orders document R3 was to receive Colace (stool softener), 100 mg, two times daily, as needed for constipation. R3's facility POS/MAR documents this order as "Colace 100 mg Give 1 capsule by mouth two times a day for constipation."

On 10-22-19 at 9:00 am, V1 (Administrator) stated due to recent medication transcription errors, the facility implemented a new procedure on 10-10-19 for admission/readmission physician orders. V1 stated two nurses have to check the orders for accuracy. V1 stated they have been

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S9999	Continued From page 6 auditing new admission/readmissions since 10-10-19. R3's Audit/Admission's checklist documents for R3's 10-18-19 admission, two nurses, V2 (Acting DON) and V3 (MDS Coordinator/Minimum Data Set) reviewed and verified the accuracy of the medications orders for R3. On 10-22-19 at 2:30 pm, V2 verified the medication error that R3 has been receiving the Colace two times a day, instead of the ordered two times a day as needed. The facility's Medication Administration policy, date January 11, 2010, documents, "It is the policy of this facility to accurately administer medication following physician's orders." (A)	S9999		