

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6004675</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ACCOLADE PAXTON SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>450 FULTON STREET PAXTON, IL 60957</b>
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S 000	Initial Comments  Complaint: 2062568/IL121672	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610a) 300.1210b) 300.1210c)1) 300.1630d) 300.3220f) 300.3240a)  Section 300.610 Resident Care Policies  a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999		

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>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>Section 300.1630 Administration of Medication</p> <p>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.</p> <p>Section 300.3220 Medical Care</p> <p>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)</p> <p>Section 300.3240 Abuse and Neglect</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review the facility failed to protect residents from significant medication errors for two residents (R2, R6) reviewed for intravenous antibiotic administration. This failure resulted in recurrence of pain, swelling/edema, and additional surgical procedures and hospitalization to treat exacerbation of an infection for R2.</p> <p>Findings include:</p> <p>The facility's Medication Errors policy dated August 2017 documents "Medication/Treatment Errors shall be documented on the Nursing Home Incident Reporting Form. An error shall be defined as any variation in administration of medication from the physician's orders and/or facility policy."</p> <p>1.) R2's Face Sheet dated 8/18/20 documents R2 admitted to the facility on 3/1/19 with diagnosis of Infection and Inflammatory Reaction due to Internal Right Knee Prosthesis.</p> <p>R2's Care Plan dated 3/4/19 documents R2 has an infection of the right internal knee with an intervention to administer antibiotics per physician orders.</p> <p>R2's Progress Note dated 4/11/2019 at 3:07 PM, V2 Nurse Practitioner documents R2 had a right total knee replacement in December 2018 and had complications with an infected total knee that</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>had to be removed. R2 has an antibiotic cement spacer in R2's right knee, and is being followed by R2's orthopedic surgeon (V12). This note documents R2 was recently sent back to the hospital after increased pain and swelling and was admitted to the hospital on 4/4/19. This note documents R2 had a repeat irrigation and debridement of R2's right knee and an antibiotic cement spacer was inserted. This note documents on 4/8 and 4/9 there was concern that there may be an infection migrating into the soft tissues of R2's thigh. R2 was discharged from the hospital and back to the facility on 4/11/19 on intravenous antibiotics.</p> <p>R2's Hospital Progress Note dated 4/7/19 at 9:37 AM, V12 Orthopedic Surgeon documents, " (R2) is doing some better. We did talk about (R2's) knee and the infection. It certainly appeared as if the infection was still there. We talked about the fact that we have to cure this. We even mentioned the possibility of an amputation as an end result if we cannot cure it." This note also documents R2's Rheumatoid Arthritis affects R2's immune system.</p> <p>R2's Hospital Discharge Orders dated 4/11/19 documents orders for Fortaz (Antibiotic) 2 grams intravenously every 8 hours and Vancomycin (Antibiotic) 1500 mg (milligrams) intravenously every 12 hours. R2's Aerobic Culture of the right knee dated 4/10/19 documents the presence of one colony of Coagulase negative Staphylococcus (bacteria.)</p> <p>R2's April 2019 Medication Administration Record (MAR) documents R2 did not receive scheduled Fortaz on 4/11 at 10:00 PM, 4/12 at 6:00 AM and 10:00 PM. This MAR documents R2 did not receive scheduled Vancomycin until 4/12 at 7:00</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>AM.</p> <p>R2's Progress Note dated 4/11/19 at 8:41 PM, V4 LPN (Licensed Practical Nurse) documents intravenous Fortaz 2 grams was "not on hand." R2's Progress Note dated 4/12/2019 at 5:12 AM by V4 documents intravenous Fortaz 2 grams "Meds (medications) not on hand, not an rn (Registered Nurse.)"</p> <p>R2's Progress Note dated 4/15/2019 at 1:51 PM, V2 Nurse Practitioner documents R2 has had increased leg pain and swelling, and R2 was concerned that did not receive all of R2's scheduled doses of antibiotics. R2's Progress Note dated 4/18/2019 at 12:28 PM, V2 documents R2 reported having a fever of 101.1 degrees Fahrenheit last night. R2 had returned from the hospital a week ago after having a second antibiotic knee spacer placed and R2's knee irrigated. This note documents R2 reported missing antibiotics to V2 on 4/15/19. R2 is to be seen today in V12's office. This note documents an addendum that V2 spoke with V6 (Physician's Assistant at V12's office) regarding R2's missed doses of intravenous antibiotics. This note documents "Discussed with (V6) that upon chart review it appeared pt (R2) did not have 2 doses of the fortaz, one the night of return and one the morning after. Also, discussed with (V6) that (R2) arrived at facility at 2:45 PM so this provider not sure if (R2) received the 2pm dose at the hospital and may have missed that dose as well. (R2) also did not have her vanc (Vancomycin) the night of (R2's) return. This provider was notified by the pt (R2) on 4/15 that (R2) missed doses of (R2's) antibiotic. This was discussed with the facility at that time. (V6) is discussing readmitting (R2) to the hospital and may need more surgery vs (versus) aspiration, ID (Infectious Disease)</p>	S9999		
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S9999	Continued From page 5  consult, and stressed this is a limb threatening situation.  R2's Hospital Progress note dated 4/16/19 at 4:33 PM, V6 Physician Assistant documents R2 had an irrigation and debridement of R2's right knee, deep cultures, and placement of an antibiotic cement spacer on 4/5/19. This note documents R2 was discharged six days ago to an extended care facility to receive regular Intravenous antibiotics. This note documents, "Apparently there were two and a half to three days where (R2) was getting either no antibiotics or not the complete intended ordered antibiotics." This note documents "Plan: Obviously an interruption and (in) antibiotics like this is not at all acceptable. It sounds like (R2's) antibiotics have resumed appropriately, but I am very concerned about the interruption."  R2's Hospital Procedure Summary Note dated 4/21/19 at 12:47 PM, V12 Orthopedic Surgeon documents " Preoperative Diagnosis: Right knee infection. Procedure: Right knee open excisional debridement with removal of antibiotic spacer and reapplication of antibiotic spacer. Indication for surgery: Missed antibiotic doses with recurrence of pain, swelling and edema."  On 8/18/20 11:44 AM V2 Director of Nursing/Nurse Practitioner confirmed R2 had missed doses of intravenous Vancomycin and Fortaz on 4/11 and 4/12/19. V2 stated V2 had spoken with V6 and R2 was admitted to the hospital for surgical intervention for R2's right knee infection. V2 stated it is hard to determine if the missed doses of antibiotics contributed to R2's infection since R2 had a history of prior infections in that knee. V2 stated if a medication is unavailable then the nurses should check the	S9999			



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S9999	<p>Continued From page 6</p> <p>facility's emergency medication supply, or notify the after hours pharmacy which can deliver the medication in 4 hours. V2 stated at the time R2's antibiotics were due, the nurses should have contacted V13 to obtain orders on how to proceed.</p> <p>On 8/21/20 at 4:04 PM, V6 Physician Assistant stated "There were problems when (R2) returned to the facility in April where (R2) did not receive (R2's) IV antibiotics. It was a big deal because we were trying to eradicate (R2's) infection. It is possible that missing the doses of the IV antibiotics made (R2) more vulnerable to requiring additional surgery."</p> <p>2.) The undated Nursing Home Incident Reporting Form documents R2 received two doses of intravenous (IV) Vancomycin (antibiotic) administered intravenously through a CADD (Continuous Ambulatory Delivery Device). This report documents V11 Physician was notified, labs were ordered, and R2's Vancomycin was held.</p> <p>R2's Physician Order Summary dated 8/18/20 documents an order for Vancomycin HCL (Hydrochloride) solution 1500 mg (milligrams)/15 ml (milliliters) use 1250 mg intravenously twice daily with a start date of 5/6/19.</p> <p>R2's Progress Note dated 5/7/2019 10:35 PM by V5 RN (Registered Nurse) documents "Medication Error happened. This RN (V5) hung the bag of Vancomycin 5/6 at 2300 (11:00 PM) and ran the whole bag of fluid. The bag was suppose to be for two doses using a cad (CADD) pump. The AM nurse also hung an entire bag of vancomycin (2 doses). This RN (V5) called Pharmacy on 5/6 x 2 asking how the CAD</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>(CADD) pump worked and it was never explained that there was two doses in one bag. MD (V11) called and notified of the med (medication) error and MD (medical doctor) (V11) said to hold the dose tonight and tomorrow am (morning) and draw the Vanco (Vancomycin) lab (laboratory test) in the am. Resident (R2) has had increased stool and is slightly nauseated. VS (Vital Signs) WNL (Within Normal Limits.) Will continue to monitor.</p> <p>R2's Vancomycin Trough (laboratory test) dated 5/8/19 documents an elevated level of 23.8, with the reference range of 15.0 - 20.0 micrograms/milliliter.</p> <p>On 8/18/20 at 10:21 AM, V5 stated the pharmacy had sent the Vancomycin premixed in a bag to administer intravenously to R2 through a CADD pump. V5 stated V5 was not aware that each bag of Vancomycin was meant to be used for two doses of the medication. V5 stated that on 5/6/19 at 11:00 PM V5 administered the entire bag of Vancomycin (2 doses) and the following morning another nurse administered an additional bag of Vancomycin (2 doses). V5 stated V5 had not received any training from the facility on the use of the CADD pump prior to administering R2's Vancomycin.</p> <p>On 8/18/20 11:39 AM, V9 Pharmacist stated administering double doses of the ordered Vancomycin could cause a person to develop Redman's Syndrome, including a rash and itching. V9 stated Vancomycin is dosed renally and could also have an affect on kidney function. V9 stated V9 would consider R2 receiving double the ordered dose of Vancomycin would be considered a significant medication error.</p> <p>3.) R6's Face Sheet dated July 19, 2020</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>documents R6 has diagnoses of Necrotizing Fasciitis, Abscessed Perineum, and Polymicrobial Infection.</p> <p>R6's Discharge Hospital Orders dated July 29, 2020 document orders for Ertapenem (Antibiotic) one gram intravenous, every 24 hours for five days.</p> <p>R6's Medication Administration Record dated July 2020 documents Ertapenem one gram to be given intravenous every 24 hours at 9:00 AM for five days, not given on July 30, 2020 or July 31, 2020.</p> <p>On 8/18/20 at 3:20 PM, V2 Director of Nursing confirmed that the Ertapenem one gram was not given on July 30, 2020 or July 31, 2020 and should have been given on July 30, 2020 and July 31, 2020.</p> <p>The facility's Administration of Medications policy revised on 11/21/18 documents "Residents shall receive their medications on a timely basis in accordance with state and federal guidelines, and within established facility policies."</p> <p>The facility's Drug Orders from Pharmacy policy revised on September 2018 documents "The purpose of this policy is to provide necessary to the pharmacy to assure accurate dispensing and prompt delivery of medications. The facility will provide information to the pharmacy when new medication or a change in medication order is received." This policy documents "D. If possible new drug orders should be ordered before the pharmacy makes late afternoon delivery. E. If new drug orders have been received after the usual late delivery, the pharmacists are available for 24 hour emergency call."</p>	S9999		
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