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
	IL6007306	A. BUILDING: ______ B. WING ______	C 07/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

(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 Original Complaint # 2124924/ IL 135931	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)1) 300.1210d)2) 300.3220f) 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. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3220 Medical Care	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to administer antiepileptic and anticoagulant medication as ordered by the Physician for one of three residents (R1) reviewed for medication administration in the sample of seven. This failure resulted in R1 having multiple seizures and being admitted to the hospital. Findings include: The facility's Medication Pass Guidelines (effective 3/2000) document "Physician's Orders- Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition or a medication order seems to be unrelated to the resident's current diagnosis or condition, contact the physician for clarification prior to administration of the medication. Document the interaction with the physician in the progress notes and elsewhere in the medical record, as appropriate. The nurse who receives the order is responsible for transcribing to the chart." R1's medical record documents diagnoses of Metachromatic Leukodystrophy; Epilepsy, Intractable with Status Epilepticus; Vanishing	S9999		

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S9999	Continued From page 2 White Matter Disease/Dementia; Pulmonary Embolism; and History of other Venous Thrombosis and Embolism. R1's Progress Notes dated 7/8/21 at 12:48pm document "Resident had a 90 second (approximate) seizure at about 12:30pm. MD (Medical Doctor) notified. Awaiting response." R1's Progress Notes dated 7/8/21 at 5:48pm document "Certified Nursing Assistant (CNA) reported seizure activity-approximately 5 (five) minutes. Resident's (family member, V11) notified and wants resident sent to (hospital). AMT (Advanced Medical Transport) contacted at 5:34pm and MD and management notified at 5:37pm. (R1) left the facility at 5:45pm." R1's AMT transport record dated 7/8/21 documents "(R1) had another seizure as transport was started. Seizure had twitching of the arms and face noted. This lasted for approximately 90 seconds." R1's ED (Emergency department) Provider Notes dated 7/8/21 at 6:55pm document "Shortly after labs obtained, (R1) had approximately 92 second of generalized tonic-clonic activity." R1's ED notes document R1 was admitted to the hospital. R1's Valproic acid blood level drawn on 7/8/21 at 7:20pm in the Emergency Department (ED) documents a measurement of less than 13 mcg (micrograms)/ ml (milliliter), and the therapeutic range is documented as 50-100 mcg/ml. R1's hospital Neurology Progress Note dated 7/9/21 at 4:01pm documents "Assessment/Plan: Seizures secondary to subtherapeutic drug levels. Depakote (Valproic acid) found to be undetectable with dosage at facility reported as	S9999		

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S9999	Continued From page 3	S9999		

625mg twice daily."

R1's Physician Orders document an order for Valproic Acid 250 mg (milligrams)/5 (five) ml(milliliters), give 12.5ml two times a day with a start date of 5/4/21 and a discontinuation date of 7/13/21.

R1's Physician Order dated 4/30/21 documents "Discontinue Levetiracetam (Keppra) solution 100 mg/ml. Prescriber written order incorrect, 25ml bid (twice a day)," and was written by V10, Registered Nurse (RN).

On 7/15/21 at 10:00am, V2, Director of Nursing (DON), provided an investigation dated 7/15/21 for R1's low Valproic acid level and hospitalization. This investigation documents "((V10, Registered Nurse (RN)) failed to write the corrected order for Keppra when correcting the order on 4/30/21." The investigation also documents "Upon review with the supply and demand of Depakote (Valproic acid) with Prime Care Pharmacy it was noted that the resident (R1) received and used the appropriate amount of Depakote as ordered." At this time, V2 confirmed that R1 received no Keppra from 5/1/21-7/8/21.

R1's Medication Administration Record (MAR) documents R1 received no Keppra May 2021-July 8/2021. R1's MAR dated 7/1/21-7/8/21 documents R1 received Valproic acid as ordered.

On 7/16/21 at 12:04pm, V5, Registered Pharmacist/Primary Care Pharmacy, stated R1's Valproic acid was dispensed on 5/29/21 and not again until 7/9/21. V5 stated the bottle of Valproic acid solution dispensed on 5/29/21 would last for 18 days if properly administered.

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S9999	Continued From page 4 On 7/16/21 at 10:40am, V3, Assistant Director of Nursing, stated the bottle of Valproic acid solution dispensed on 5/29/21 was dated as opened on 6/18/21. On 7/16/21 at 12:04pm, V5, Registered Pharmacist, stated if the bottle of Valproic acid solution was opened on 6/18/21, it would be empty by 7/4/21 or 7/5/21. V5 stated there was not enough medication in the bottle to last until 7/8/21. On 7/16/21 at 10:59am, V6, Primary Care Physician (PCP), stated the facility did not notify him that R1's Keppra had been incorrectly discontinued on 4/30/21, and that R1 had not received it for over two months. V6 stated "Not receiving the Keppra would have lowered R1's seizure threshold and caused her to have seizures." V6 also stated he was not notified that R1 missed some of her doses of Valproic acid. R1's Physician Orders dated 6/9/21 document an order for Coumadin 6 (six) mg at bedtime from 6/9/21-6/15/21, and an order for Coumadin 6mg from 6/23/21-6/30/21. There is no order for Coumadin in R1's Physician Orders for 6/16/21-6/23/21. R1's MAR dated June 2021 documents she received no Coumadin from 6/16/21-6/22/21. A Medication Incident and Discrepancy Report dated 6/23/21 documents on 6/23/21 V7, Licensed Practical Nurse (LPN), "discovered (R1) did not have an order (for Coumadin) available. Upon further investigation, it was noted the order entered by (V17), Registered Nurse (RN) on 6/9/21 had ended on 6/15/21 and another PT/INR	S9999		