

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004279	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2021
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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-SPRINGFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH RUTLEDGE SPRINGFIELD, IL 62702
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S 000	Initial Comments	S 000		
	Annual Health Survey			
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)1) 300.1220 b)2) 300.1630 d) 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.	S9999		
	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.		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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S9999	<p>Continued From page 1</p> <p>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:</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</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>These requirements are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to administer antipsychotic medication as ordered by the physician for one of seven residents (R84) reviewed for significant medication errors in the sample of 59. This failure resulted in R84 not receiving Clozapine (an antipsychotic medication) as ordered and being hospitalized for psychiatric symptoms.</p> <p>Findings include:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>R84's Electronic Medical Record (EMR), dated 8/2021, documents R84 was admitted to the facility on 7/1/2020, with diagnosis to include Schizoaffective Disorder.</p> <p>R84's Physician Order Sheet (POS), dated 6/1/21 to 6/30/21, documents Clozapine 150 milligrams (mg) by mouth in the morning related to Schizoaffective Disorder.</p> <p>R84's Care Plan, dated 7/14/20, documents "(R84) has diagnosis of schizoaffective disorder & anxiety. Displays inattention, disorganized thinking and at times resist care. He has made statements that he would be 'better off dead'". R84's Care Plan Interventions document "Administer medications as ordered. Notify physician for any side effects. See medication administration record for current dose. Review psychotropic meds/behaviors quarterly."</p> <p>R84's Minimum Data Set (MDS), dated July 5, 2021, documents R84 is cognitively intact.</p>	S9999		
	<p>R84's Medication Administration Record (MAR), dated 5/1/21 to 5/31/21, documents Complete Blood Count (CBC) every month for Clozapine usage due on 5/14/21. There was no documentation this was done.</p> <p>R84's Medication Administration Record (MAR), dated 6/1/21 to 6/30/21, documents Clozapine 150 mg by mouth at bedtime related to Schizoaffective Disorder. The MAR documents Clozapine was not given on 6/6/21, 6/8/21, 6/9/21, 6/10/21, 6/12/21, 6/13/21, 6/14/21, 6/16/21, 6/17/21 and 6/18/21.</p> <p>R84's Health Status Note, dated 6/19/2021 at</p>			

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S9999	<p>Continued From page 3</p> <p>1:34 AM, documents, "Resident had a period where he was yelling out, appeared to be having hallucinations, talking to someone other than those present in the room, when asked what was wrong his reply was you know.' After taking night meds he calmed down."</p> <p>R84's Health Status Note, dated 6/19/2021 at 6:00 AM, documents "Placed call to pharmacy re: clozapine, MAR states was received 6/16/21 but unable to find it. After hours pharmacist stated unable to get from back up due to needing labs etc. Stated no one at Pharmacy until 10:00 am, he will try to get hold of someone at Pharmacy sooner to call facility back. Relayed information to on coming shift."</p> <p>R84's Health Status Note, dated 6/19/2021 at 8:30 AM, document "Received in report this am that resident had not received his Clozapine 150 mg since approximately 6/6 and was acting strangely. Resident could be heard laughing loudly and screaming out random names of people not present. Upon entering room, resident recognized writer but then began screaming again with eyes darting back and forth as if he was looking at people beside writer even though writer was alone. New orders received to send resident to Emergency Room (ER) for evaluation and treat."</p> <p>R84's Health Status Notes, dated 6/19/2021 at 10:12 AM, documents "Resident left for ER via stretcher accompanied by Ambulance staff. Power of Attorney (POA) aware of situation and transfer to ER."</p> <p>R84's Health Status Not, dated 6/19/2021 at 3:44 PM, document, "Received call from ER. Resident is being admitted related to (r/t) psychosis and</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>Urinary Tract Infection (UTI)."</p> <p>R84's Hospital History and Physical (H&P), dated 6/19/21, documents R84 was a 67-year-old gentleman with past medical history of schizoaffective disorder. The H&P documented, "Patient presented from a nursing home due to altered mental status and being off clozapine since 6/5 as he ran out of the medication. Patient will be admitted for further management. Schizoaffective Disorder Agitation. Patient has history of schizoaffective disorder on clozapine. He has not received clozapine since 6/5 due to miscommunication between pharmacy and nursing."</p> <p>On 8/12/21 at 10:20 AM, V3, Assistant Director of Nurses (ADON), stated, "I don't know what actually happened, why he didn't get the lab work done, probably the order was never put in the computer. The Pharmacy will not send the medication if the lab work was not done."</p> <p>V44, Corporate Nurse, emailed Pharmacy on 6/25/21 asking why a CBC needs to be done before the Clozapine can be dispensed. On 6/25/21, V45, Pharmacist, replied, "Unfortunately,</p>	S9999		
	<p>all pharmacies that dispense Clozapine are required to participate in the Clozapine REMS program. Clozapine is associated with severe neutropenia (absolute neutrophil count (ANC) less than 500/uL), which can lead to serious and fatal infections. The requirements to prescribe, dispense, and receive clozapine are incorporated into a single shared program called the Clozapine Risk Evaluation and Mitigation Strategy (REMS). A REMS is a strategy to manage known or potential risks associated with a drug or group of drugs, and is required by the Food and Drug Administration (FDA) for clozapine to ensure that</p>			

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S9999	<p>Continued From page 5</p> <p>the benefits of the drug outweigh the risk of severe of severe neutropenia. The REMS program requires to enter the lab data (CBC with diff) online in order to dispense the medication."</p> <p>On 8/12/21 at 10:44 AM, V43, Certified Pharmacy Technician, was asked if she had called the facility and notified them that labs needed to be drawn before R84's Clozapine could be dispensed. She stated, "I talked to several nurses and told them he needed labs done, I didn't write down their names or the times. I know (V25) Licensed Practical Nurse (LPN) was one. Prior to 6/19/21, the last time his medications were dispensed was on 4/21/21, a 30 day supply."</p> <p>On 8/12/21 at 1:30 PM, V25 stated, "I don't recall ever getting an order to draw a CBC on (R84)."</p> <p>On 8/12/21 at 1:32 PM, R42, Pharmacist, stated, "(R84)'s last lab work prior to 6/19/21 were drawn on 4/15/21." R42 stated, "On 6/19/21 a nurse called and stated (R84) needed Clozapine as soon as possible (ASAP). 6/19/21 was a Saturday and we were closed until 10:00 AM. When a Pharmacist called the facility back the resident had already gone out to the hospital. The facility was notified the last lab values we received were drawn on 4/15/21 and we needed updated labs (CBC w/differential) prior to dispensing Clozapine."</p> <p>On 8/12/21 at 4:10 PM, V47, R84's medical doctor's nurse, stated, "I cannot find any notes in (R84)'s medical record that the doctor was notified that (R84) was not getting his medications."</p> <p>The facility Policy and Procedure for Medication Administration, dated 1/11/10, documents</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>"Medication Administration Objective: To provide accuracy during medication pass to assure quality care for residents. Policy: It is the policy of this facility to accurately administer medication following physician's orders. Procedure: 16. Report known med errors as soon as possible. Notify physician of known medication error and follow orders received. Monitor resident and document incident, complete medication error report and council and or inservice as needed."</p> <p>(B)</p>	S9999		