STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006282	A. BUILDING: _____ B. WING _____	C 02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE CREEK VILLAGE	2530 NORTH MONROE STREET DECATUR, IL 62526

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S 000	Initial Comments Complaint Investigation #2161200/IL131202	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210d)1) 300.1210d)3) 300.1610a)1) 300.1630e) 300.3240a) 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 Requirements for Nursing and Personal Care d)1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. d)3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
Section 300.1610 Development of Medication Policies
a)1)Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.

Section 300.1630 Administration of Medication
e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Regulations are not met as evidenced by:

Based on interview and record review, the facility

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S9999	Continued From page 2 failed to administer 10 doses of scheduled Narcotic pain relief medication to R1 and failed to administer 20 doses of a scheduled Benzodiazepine, Anti-Anxiety medication to R1. These failures affect one of three residents (R1) reviewed for pain control in the sample of three. These failures resulted in R1's uncontrolled pain and anxiety causing R1 to require emergency room treatment and being unable to sleep. Findings include: R1's Physician Order Report dated 2/24/2021 documents R1's diagnoses including Injury of the left ankle, Abdominal Pain, Muscle Weakness, Anxiety Disorder, Migraines, Chronic Pain Syndrome and Ulcerative Colitis. This report documents R1's medication orders including the following: 2/3/21 Oxycodone (Narcotic) 30mg (milligrams) one tablet (tab) by mouth twice daily (BID) with an order end date of 2/4/21. 2/4/21 Oxycodone 30mg one tab by mouth every 12 hours for one week, then decrease to 15 mg for 14 days and discontinue (d/c) with an order end date of 2/10/21. 2/12/21 Oxycodone 15mg one tab by mouth twice daily with an order end date of 2/26/21. 2/4/21 Clonazepam (Benzodiazepine) 0.5mg tab, one tablet by mouth daily at bedtime. R1's Medication Administration Record (MAR) dated February 2021 documents R1 did not receive 10 doses of R1's Oxycodone pain medication as prescribed:	S9999		

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S9999	Continued From page 3 2/3/21 8:00pm 2/4/21 8:00am 2/7/21 8:00pm 2/8/21 8:00am and 8:00pm 2/10/21 8:00pm 2/11/21 8:00am and 8:00pm 2/12/21 8:00am 2/23/21 8:00pm R1's MAR dated February 2021 documents R1 did not receive 20 doses of R1's Clonazepam 0.5mg as prescribed 2/4/21-2/23/21. R1's Minimum Data Set (MDS) dated 2/10/21 documents R1 has had trouble falling or staying asleep. R1's hospital records dated 2/9/21 R1 was sent to the emergency room with diagnoses including Abdominal Pain and Chronic Pain and received Fentanyl (narcotic pain medication) for R1's pain. These records document Chronic Pain is when pain lasts longer than 6 months that is present even when the "body has healed." On 2/24/2021 at 9:30am R1 became tearful and stated R1 had an appointment on 2/23/21 which was 2 hours away and the ride in the transport vehicle was a "nightmare" and "awful" due to R1's severe pain. R1 stated R1 was in so much pain from being up in the wheelchair and the roads were not smooth and had a lot of bumps and holes. R1 stated R1 spoke with V1, Administrator related to medications not being given but R1 is still having issues. R1 stated R1 feels R1 is being tortured by the facility because R1's pain medications have been not given at all sometimes. R1 stated R1 has been treated by V14, R1's Pain Specialist Physician for "years." R1 stated all R1 can do is cry sometimes	S9999		

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S9999	Continued From page 4	S9999		

because "(R1) hurts so bad" from not receiving R1's Oxycodone. R1 stated it is "inhumane" to not ensure residents are receiving the pain medications as ordered for pain control. R1 stated R1 has not received the Clonazepam as ordered and has been having a difficult time sleeping as well as increased anxiety.

On 2/24/2021 at 1:15pm, V6, Nurse Practitioner (NP) stated V6 is in the facility Monday through Friday. V6 stated the facility is aware and the staff should have came to me/contacted me to write a prescription so pharmacy would send R1's Clonazepam medication.

On 2/25/2021 at 9:40am, V14, R1's Pain Specialist Physician stated V14 stated V14 began providing care for R1 due to R1's "Advanced Osteoarthritis of bilateral hips and knees in June 2016." V14 stated V14 has "seen (R1) for many years" and when R1 initially started with V14's practice, R1 was still living independent at home. V14 stated V14 has never had any concerns related to R1's Oxycodone dose or use and that there has never been any evidence suggesting R1 was abusing the Oxycodone medication. V14 stated R1 was eligible for chronic pain control due to the Advanced Osteoarthritis and taking the medication as prescribed and was doing well. V14 stated if R1 is not receiving the Oxycodone medication as ordered and/or goes without the Oxycodone for a day or more, R1 will go through withdrawal symptoms which may include nausea, vomiting, increased pain and anxiety. R1 stated R1 "needs" the Oxycodone medication due to the pain related to R1's Advanced Osteoarthritis. V14 stated you cannot abruptly stop or miss doses of an opiod medication or the resident will have increased pain and withdrawal symptoms that will occur. V14 stated if R1 was not receiving R1's

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S9999	Continued From page 5 Clonazepam as ordered R1 would also have withdrawal as well as an increase in anxiety which could contribute to an increase in R1's pain. The facility's Controlled Substance Prescriptions policy dated 10/25/2014 documents the prescriber is contacted to verify or clarify a prescription when needed. If changes to a controlled substance prescription are necessary the prescriber must communicate the new order to the facility for documentation in the chart and communicate or transmit the new prescription to the pharmacy prior to dispensing. The facility's Back-up Pharmacy Policy dated 6/18/18 documents facilities specify that "pharmaceutical services must be responsive to the needs of a resident. Timely delivery of drugs is necessary so that a resident's prescribed treatment plan is not disrupted." (B)	S9999		