

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005979	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/31/2022
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NAME OF PROVIDER OR SUPPLIER HALLMARK HC OF CARLINVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 826 NORTH HIGH CARLINVILLE, IL 62626
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S 000	Initial Comments Complaint Investigation 2242502/IL145238	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)1) 300.1220 b)7) 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 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general	S9999	<p>Attachment A Statement of Licensure Violations</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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>7) Coordinating the care and services provided to residents in the nursing facility.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview, observation, and record review, the facility failed to obtain and administer prescribed pain medications as ordered for 1 of 5 residents (R2) reviewed for pain management in the sample of 5. This failure resulted in R2, a newly admitted resident with post-surgical repair of a fractured leg with an Open Reduction Internal Fixation (ORIF) device, not receiving her pain medication, being in excruciating pain for over 48 hours to the point of attempting to go back to the hospital for pain control.</p> <p>Findings include:</p> <p>R2's Discharge Orders from the hospital, dated 3/26/22, documents medications to take after discharge, including Hydrocodone-Acetaminophen 5-325 mg every six hours for pain.</p> <p>R2's Medication Administration Record (MAR) documents on 3/26/22, R2 received Cyclobenzaprine 5 mg at 5:00 PM, Lorazepam 0.5 mg at 5:00 PM, and Tylenol 500 mg at 6:57</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>PM.</p> <p>R2's Care Plan, dated 3/26/22, documents "(R2) Self-care deficit: Needs assistance with Activities of Daily Living (ADL). Interventions: Non-Weight bearing to Right Lower Extremity (RLE), Ambulation restrictions/precautions, Pressure redistribution device." It continues "(R2) Short term stay in facility for rehabilitation." It continues "(R2) is at risk for falls and injuries related to medications: Psychotropic medications, Diuretic medications, Cardiovascular medications, and Pain medications."</p> <p>R2's Progress Note, dated 3/26/22 at 4:51 PM, documents, "Writer (V1, Administrator) spoke with (V8, R2's daughter) regarding concerns for her mother's (R2) medications. She advised her mother called her regarding her medications. I advised (V8) that since her mom just arrived at the facility, all medications would be sent to the facility by the pharmacy and that we could give her mother what we have in stock until her medications arrive. She voiced understanding."</p> <p>R2's Progress Note, dated 3/27/22 at 4:07 PM, documents, "Staff nurse from the (local hospital) called to notify this RN (V3) that the Physician that released the resident states he cannot write a script for Norco and Toradol for (R2) as (R2) has left their facility. This RN contacted (another local hospital) again to request the on-call MD (Medical Doctor) to write the script for (R2). Again, Awaiting call back."</p> <p>R2's Progress Note, dated 3/27/22 at 7:12 PM, documents, "Received call from the on-call MD, who stated that he would not provide scripts for controlled substances since (R2) has not been seen by a MD yet and that (the discharging</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>hospital) will need to provide scripts."</p> <p>R2's Progress Note, dated 3/27/22 at 7:34 PM, documents, "Call placed to (discharging hospital) and spoke with charge nurse, who stated the resident's scripts were sent to (local pharmacy) in (another city) because that is the pharmacy the resident listed and that they are unable to send scripts to us. Writer (V10, Licensed Practical Nurse, LPN) made resident and daughter aware."</p> <p>R2's Physician's order (PO), dated 3/27/22, documents, "Norco Tablet 5-325 mg (Hydrocodone-Acetaminophen) give one tablet by mouth every six hours as needed for pain."</p> <p>R2's Progress Note, dated 3/28/22 at 00:01 AM, documents, "External fixation with five pins in place to right ankle. Currently awaiting scripts for controlled substances. (R2) upset with transition to facility."</p> <p>R2's Progress Note, dated 3/28/22 at 8:05 AM, documents, "Writer (V1) went to (local pharmacy) in (another city) to pick up scripts that (local hospital) advised were sent there for (R2). (Local Pharmacy) advised writer that they do not have scripts from (local hospital) for (R2)."</p> <p>R2's Progress Note, dated 3/28/22 at 10:28 AM, documents, "(R2's) pain level a 10, (R2) states she wants to go back to the hospital in order to get pain under control. (R2) came into facility via ambulance from (local hospital) without orders for pain medication. Unable to get pain medication over the weekend due to resident not being in system for on-call MD. Ambulance called, they would not take resident for pain only to hospital, (V5, Physician's Assistant, PA) to order pain prescription. Resident stated understanding."</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>R2's Progress Note, dated 3/28/22 at 1:05 PM, documents "(R2's) order for Norco received and given."</p> <p>On 3/29/22 at 2:40 PM, R2 was sitting in R2's wheelchair with R2's right leg elevated. R2 has an ORIF (Open Reduction Internal Fixation) device attached to R2's right leg with a clean, dry dressing attached. R2 was on Oxygen at two liters per nasal cannula continuously. R2 had an abdominal peg tube that was capped off and not being used at that time. R2 was grimacing in pain, and described R2's pain level to be at a seven (on a scale of 1-10).</p> <p>On 3/29/22 at 2:50 PM, R2 stated, "I was admitted to the facility on Saturday (3/26/22) from (a local hospital) where I was a patient for forty five days. I don't even know what exactly happened. I somehow broke my right leg and the next thing I knew, I woke up in the intensive care unit. I was told I have super brittle bones and they had to take some bone from my upper leg to fix my lower leg. I was discharged from the hospital on Saturday and got here around 3:00 PM, they had most of my medications available except for the pain pills. The hospital wouldn't send them because they were narcotics. The facility tried to call their Physician and he did not answer or call back. The hospital said they called the prescription in to my pharmacy in (another city) and someone from this facility went there to get it, but the pharmacy did not receive the prescription. I am thinking the hospital sent the prescription to the wrong pharmacy. I went from 12:30 PM Saturday (3/26/22) until my first dose around 12:00 PM yesterday (3/28/22) without any pain medications. The pain was excruciating and I asked for them to send me to the ER (Emergency</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>Room) so I can get some pain medicine. They finally got a hold of our Medical Director's Physician Assistant (PA) who wrote the prescription for Norco, and then he came and visited me yesterday."</p> <p>On 3/30/22 at 8:10 AM, R2 stated, "They are keeping up with my pain medications. As soon as I can have some, they bring them to me. I am still hurting at maybe a six (on a scale of 1-10) today, but it feels like a different pain this morning."</p> <p>On 3/30/22 at 11:50 AM, V5, PA, stated, "The facility's staff called me on Sunday (3/27/22) around 9:00 PM to explain the situation about (R2). I believe they went down the Physician call list and even called the hospital where she was discharged from to get some help. (R2) wasn't part of our patient list so she wasn't in our system. She was assigned to (V6, Medical Director) because she was at that facility, but he nor I actually saw her before. The hospital should have sent a prescription with the resident, even if it was for a couple days to hold her over. If she was in our system, I would have come right in and taken care of things. I had to get her face sheet and information and enter her into the computer system in order to write her the prescription. I did come in and actually assess her after I sent the prescription. Unfortunately, this happens too often when a patient leaves the hospital and something should be done to avoid this again."</p> <p>On 3/30/22 at 8:25 AM, V3, Registered Nurse (RN), stated, "I was here when (R2) was admitted on Saturday. The hospital did not send her (R2) prescriptions for her pain medication because it was a narcotic. I asked them to please send with her so we can give her the medications and they</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>did not do it. I called the hospital back and talked to the physician there and he would not write the prescription because she was out of their care now. I tried to call our on-call physician (V6, Medical Director) three times and did not get a hold of him. I called the (local hospital) who always has a physician covering him when he is off and that physician would not write the prescription either because he did not see her. (R2) did get all of her other medications but not the pain medication. This happens frequently when we get someone discharged from hospital on the weekends. The Director of Nursing (DON) did come in and try to work things out, but I don't think she was able to do anything either."</p> <p>On 3/31/22 at 9:40 AM, V9, Certified Nursing Assistant (CNA), stated, "I came in on Sunday morning (3/27/22) and she (R2) was already here. I remember she kept putting her call light on asking if her pain medications ever came in. I could tell she was in pain because she was making faces and grimacing. She looked like she was in pain."</p> <p>On 3/30/22 at 1:15 PM, V6, Facility's Medical Director, stated "I just saw (R2) and I increased the frequency of her pain medicine to try and get her pain controlled a little better. My PA (V5) talked to me about this situation and the hospital should have at least given a prescription for maybe seventy two hours worth to get her through the weekend. The Hospitalist or the discharge planners need to address problems like this. It shouldn't happen at all. I have never seen (R2) before and if she is not in our computer system, it is a big hassle to get prescriptions written. I was not on call the evening that she was admitted here. (V7, Medical Doctor) was on call. I did not receive any phone calls on my cell phone</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>from this facility, especially not three of them. If I would have even gotten one call, I always respond back, even if I'm not on call. I would have at least called them and helped to take care of this situation. I will make sure they are calling the correct number."</p> <p>On 3/31/22 at 9:20 AM, V1, Administrator, stated, "We have a hospital liaison that works for us. That person usually makes sure all of the resident's discharge orders and prescriptions are ready and the prescriptions are sent to our pharmacy. If it is a controlled substance, we have to have a hard copy of that prescription come with the resident. That hard script will be faxed directly to our pharmacy and they will fill it and send us the medication. As for (R2), there were no hard scripts sent for her Norco so the pharmacy would not fill it. We even called 911 to send her (R2) to the hospital to get pain medications. They showed up here with three Emergency Medical Technicians (EMT) and then refused to take her to the hospital."</p> <p>On 3/31/22 at 9:25 AM, V1, Administrator, stated, "Yes, the staff should have gone ahead and called our Medical Director, even though he wasn't on call, once the on-call physician refused to write the script. I just don't think they were thinking that way. They just figured since he was not on call, they couldn't call him."</p> <p>On 3/31/22 at 2:15 PM, V2, Director of Nursing (DON), stated, "I really didn't do much for this situation. I came in on Sunday morning because I thought we were going to get the prescription and it takes two nurses to get a controlled medicine out of the cubex machine. When I found out the doctor wasn't going to write a script, I left. I think the staff did all that they could do, but we couldn't</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>get someone to write a script. Yes, the staff probably should have called our Medical Director to help us out, but they were told if he is not on call to use the physician on call. I'm new here and didn't realize the policy stated that verbal orders are permitted for Schedule II Controlled Medications. I think we all have some learning to do."</p> <p>The facility's "Admission Criteria" policy, dated 3/2019, documents "1. The objectives of our admission criteria policy are to:" It continues, "c) address concerns of residents and families during the admission process;" and, "e) assure that the facility receives appropriate medical and financial records prior to or upon the resident's admission." It further documents, "5. Prior to or at the time of admission, the resident's Attending Physician provides the facility with information needed for the immediate care of the resident, including orders covering at least:" It continues, "b) Medication orders, and c) Routine care orders to maintain or improve the resident's function until the physician and care planning team can conduct a comprehensive assessment and develop a more detailed Interdisciplinary Care Plan."</p> <p>The facility's Pharmacy Policy "Controlled Substance Prescriptions", dated 9/2018, documents "A chart order is not equivalent to a prescription for controlled medications. Therefore, the prescriber issuing the chart order must also provide the pharmacy with a valid prescription to ensure delivery of the medication. The written prescription may be faxed to the pharmacy for long-term facility residents. Verbal orders for controlled medications are permitted for Schedule II substances only in emergency situations."</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>The facility's Pharmacy Policy "Receiving Controlled Substances", dated 9/2018, documents "Controlled substances prescribed for a specific resident are delivered to the facility only if a valid prescription has been received by the pharmacy prior to dispensing."</p> <p>The facility's Pharmacy Policy "Emergency Pharmacy Service and Emergency Kits", dated 9/2018, documents "Emergency pharmacy service is available twenty four hours a day. The provider pharmacy supplies emergency medications including emergency drugs, antibiotics, controlled substances, and products for infusion in limited quantities in portable, sealed containers in compliance with applicable state regulations." It continues "2. The facility should ensure there is a Physician on call twenty four hours a day/seven days a week. 3. The pharmacy is called if an emergency arises requiring immediate pharmacist consultation concerning appropriateness of therapy, drug information, etc. 4. The pharmacy supplies emergency or STAT medications according to the pharmacy provider agreement." It continues "6. The emergency supply along with a list of supply contents and expirations dates are maintained in the medication room, or in accordance with facility policy and state regulations."</p> <p>The facility's "Pharmacy Emergency Supply Kit" labeled as "Cubex Contents", undated, documents there are several pain medications available at the facility in their locked medication dispenser including Hydrocodone-Apap 5-325 mg tabs, Hydrocodone-Apap 7.5-325 mg tabs, and Hydrocodone 10-325 mg tabs.</p> <p>(B)</p>	S9999		

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