STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002299	A. BUILDING: _____ B. WING _____	C 12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL PINES REHAB & HCC	335 NORTH ILLINOIS AVENUE CRYSTAL LAKE, IL 60014

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S 000	Initial Comments Complaint Investigation: 2219546/IL153856	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1610a)1) 300.1620a) Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 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 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. This REQUIREMENT is not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Based on interview and record review the facility failed to administer an antipsychotic medication to a resident as ordered. The facility failure resulted in R1 having a return of psychiatric behaviors and which required hospitalization. This applies to one of three residents (R1) in the sample of three. The findings include: The facility face sheets shows R1 to have diagnoses to include metabolic encephalopathy, schizophrenia, bipolar, depression and anxiety. The facility assessment dated 9/1/2022 shows R1 required assistance of one staff for ADL's. The medication administration record (MAR) for 10/2022 shows an order for the antipsychotic medication one tablet every morning and two tablets every evening at bedtime. The MAR dated October 2022 shows R1's antipsychotic medication was not given on 10/9/22 evening dose to 10/13/22. The medication is listed as not available in the nursing progress notes. On 12/8/2022 at 1:45 PM, V3 (Registered Nurse/RN) said he discovered that R1 had not received his antipsychotic medication for at least 3 whole days. V3 said he called the POA and V6 (Nurse Practitioner/NP) right away to report what had happened. V3 said V6 told him she was not familiar with this particular antipsychotic and would have to check with the manufacture to see what the protocol was for this type of situation. V3 said he then called the pharmacy and was told the medication could not be dispensed until the provider completed the proper paperwork. On 12/8/2022 at 12:10 PM, V6 said she was the provider ordering the antipsychotic medication for	S9999		

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S9999	Continued From page 2	S9999		

R1. V6 said she was required by the pharmacy to complete the information on the Rems website (website to track this antipsychotic medication), order the lab work and order the medication refills. V6 said she completed this as she was told. V6 said she was shocked when V3 called her to tell her that R1 had missed so many doses of his antipsychotic medication. V6 said this definitely led to R1 needing to be hospitalized. V6 said if this medication is missed for more than 48 hours, the resident will have to start the medication again at lower doses and work their way back to the correct dosage.

On 12/8/2022 at 12:55 PM, V4 (Pharmacist) said this antipsychotic medication requires the provider to complete the Rems website with each refill of the medication. Lab work must be completed prior to the dispensing of the medication each time. V4 said the medication was not dispensed to the facility because this had not taken place for R1. V4 said they were not notified from the facility until 10/13/22 that R1 needed more of the antipsychotic medication. V4 said that since R1 had not received the medication for over 48 hours, R1 would have to restart the medication and work his way back to his original prescribed dose.

On 12/8/22 at 3:50PM, V2 (Director of Nursing) said the nurses need to follow-up with any medication as to why that medication is not available. V2 said she was planning to do an in-service on this to prevent medications from not being given due to not being available.

The facility communication form and progress note dated 10/20/2022 shows R1 was transferred to the hospital for a change in condition. The form shows R1 refusing to open his mouth, stripping

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S9999	Continued From page 3 his clothes off and having an increased need for ADL assistance. The form also shows increased confusion and new or worsening behaviors. The question on the form asking the RN "what do you think is going on with the resident?" was answered, "side effects of not being on his medication". The NP progress note dated 10/18/2022 shows nursing staff brought to her attention that R1 had missed at least 3 full days of his antipsychotic medication and is having delusional thoughts and trouble swallowing medications and food. The pharmacy worksheet for this antipsychotic medication shows the pharmacy was notified on 10/13/22 of the need for the medication to be dispensed (4 days after first missed dose). The nursing progress notes for R1 shows on 10/9/22, 10/10/22, 10/11/22 and 10/12/22 the antipsychotic medication was not given as it was not available. The nursing progress note dated 10/12/22 shows an RN called the pharmacy to inquire about the missing medication for R1 (4 days after first missed dose). On 10/12/22 the NP entered a progress note showing R1 had not received his antipsychotic medication since 10/9/22 and would have to have stat labs drawn and his dose would have to be dropped and titrated back to his original dose. The facility policy with a revision date for 4/21 for administration of medications shows if for any reason a physician's order cannot be followed, the physician shall be notified as soon as is reasonable. A notation shall be made on the nurse's progress notes in the patient's clinical record.	S9999		

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S9999	Continued From page 4 "B"	S9999		