STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000723	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-CARLINVILLE	1200 UNIVERSITY AVENUE CARLINVILLE, IL 62626

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) 300.1210d)2) 300.1630b) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 300.1630 Administration of Medication b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available , a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility. These requirements are not meet as evidenced by: Based on interview and record review, the facility failed to follow Physician's hospital discharge orders for a high-risk anticoagulant medication for 1 of 2 residents (R49) reviewed for anticoagulant medications in the sample of 27. This failure	S9999		

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S9999	Continued From page 2	S9999		

resulted in R49 receiving double the ordered dose of Eliquis for three days and being hospitalized for 11 days with the diagnosis of Severe Blood Loss Anemia, Acute on Chronic with a differential diagnosis of GI (Gastrointestinal) Bleed, AAA (Abdominal Aortic Aneurysm), and Autolysis.

Findings include:

R49's Face Sheet documents, R49 was admitted to the facility on 12/24/22, with the diagnoses to include: Embolism and Thrombosis of Lower Extremities, Other Long Term (Current) Drug Therapy, Anemia, and Paroxysmal Atrial Fibrillation.

R49's Hospital Discharge Orders dated 02/24/23 documents, the following order: Eliquis 2.5 mg, (milligram), give 5 mg every 12 hours.

R49's Facility Physician Order Summary Report, dated 02/24/23 documents, the order dated 02/24/23: Apixaban (Eliquis) Give 10 mg by mouth every 12 hours, related to Embolism and Thrombosis of Arteries of the Lower Extremities. This Physician order summary also, documents the order dated 02/24/23: All medications to be reviewed/confirmed by Physician.

R49's Hospital Progress Notes dated 02/28/23 document, he was admitted to the hospital with the diagnoses of Acute Blood Loss Anemia, Severe Anemia, Acute on Chronic, and lists R49's differential diagnoses as GI (Gastrointestinal) Bleed, AAA (Abdominal Aortic Aneurysm), and Autolysis. The hospital progress notes document, "Of note, SNF, (Skilled Nursing Facility), had placed, (R49), back on 10 mg Eliquis BID, (twice a day), instead of 5 mg BID dosing sent back to

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S9999	Continued From page 3 Skilled Nursing Facility. It is unclear why the increase back to 10 mg. The facility's "Occurrence Report" for R49's medication error dated 02/27/23 documents, Resident admitted on 02/24/23. All orders checked by DON, (Director of Nursing), and noted error with medication. Resident was being monitored for decreased HGB (hemoglobin), related to use of Eliquis in hospital. It was noted that medication was entered in (Electronic Medical Record) incorrectly. Resident was to be receiving Eliquis 5 mg BID and had received 10 mg Eliquis BID x 6 doses. HGB noted at 6.8 (low). Order to send to ER (Emergency Room) obtained. Resident remained at hospital for observation and to receive 1-unit PRBCs, (Packed Red Blood Cells). POA (Power of Attorney), PCP (Primary Care Physician), and Pharmacy all made aware of med error. Hospital made aware of doses received x 6 doses. Medication updated with correct dose. On 04/12/2023 at 10:42 AM, V2 Director of Nursing (DON), stated, the med error was caught when she was checking all the orders for admission from R49 returning from the hospital. V2 stated, the nurses were given him Eliquis 10mg twice daily and he was given six doses of the wrong dose, he was supposed to be getting 5 mg of Eliquis instead of 10mg. The nurses put the orders in the system upon new admission. V2 stated, a red flag immediately when she reviewed the discharge orders from the hospital. V2 stated, he was admitted back to the facility on a Friday afternoon, and she didn't check the orders till she returned back to the facility after having the weekend off.	S9999		

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S9999	Continued From page 4 On 04/12/23 at 10:52 AM, V2 DON stated, her expectations are all nurses should be double checking any orders on new admissions or readmission. She said, the dose of Eliquis is much higher than the normal dose of Eliquis. V2 stated, the nurses should be calling the Primary Physician, or on call Physician to confirm medication orders. On 04/13/2023 at 1:45 PM, V12 Registered Nurse, (RN), stated, she did not confirm R49's Eliquis orders when he was admitted on 02/24/23. She stated, if the admissions are after hours, they normally call the Physician. She stated, she did not call. She stated, she faxed the orders over to the Physician's office around 2:30 PM but, did not hear back from the Physician on the fax. V12 stated, she put the medication order of Eliquis 10mg in the computer wrong and that's the cause of R49 having to go to ER at the local hospital. She said she was not in the facility when he had a change of condition and had to go to ER. On 04/14/2023 at 10:27 AM, V22, R49's Physician stated, that 10mg Eliquis is a significant higher dose of the normal dose of Eliquis and giving Eliquis 10mg would only be in an acute care setting like the hospital. Eliquis 10 mg is out of range to be given in the facility. V22 stated he would expect the nurses to call him to question an order for Eliquis 10mg and he expects the discharge orders to be followed as ordered by the physician. V22 stated, that giving 10mg of Eliquis could cause the bleed in that excessive dose that was given. The facility's policy, Anticoagulant Policy, and Procedure dated 4/2009 documents, "It is the policy of this facility to treat and monitor residents	S9999		

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S9999	Continued From page 5 receiving anticoagulant therapy by following physician's orders, assessing changes in resident's condition, and reporting changes to the resident's physician for further testing if needed. Procedure: Give medication per orders following best practices." (A)	S9999		