

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/26/2023
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NAME OF PROVIDER OR SUPPLIER RIDGEVIEW HEALTH & REHAB CNTR	STREET ADDRESS, CITY, STATE, ZIP CODE 413 RIDGE LANE OBLONG, IL 62449
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S 000	Initial Comments Investigation of Facility Reported Incidents of 05-31-2023/IL160847 F580D, F760G, and F761F	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)1)3) 300.1620a) 300.1630d) 300.3220f) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	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>of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</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>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and 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.</p> <p>Section 300.1620 Compliance with Licensed Prescriber's Orders</p> <p>a) All medications shall be given only upon</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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.</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>Section 300.3220 Medical Care</p> <p>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)</p> <p>These Regulations are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure residents are free from significant medication errors for one (R6) of eight residents reviewed for medication errors in the sample of eight. This failure resulted in a 15-day delay, from 6/5/23 to 6/19/23, in the initiation of R6's antibiotic therapy, with R6 experiencing pain and burning on urination during that period and being at risk of</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>developing sepsis.</p> <p>Findings include:</p> <p>R6's Face Sheet documented an admission date of 10/27/21, and diagnoses including Congestive Heart Failure, Diabetes Type 2, and Anxiety Disorder.</p> <p>On 6/20/23 at 11:05am, V3 (Licensed Practical Nurse/LPN) stated she works 6pm to 6am on Thursday through Sunday. V3 stated the facility has issues with running out of resident medications on the weekends, as the pharmacy is closed on weekends.</p> <p>On 6/20/23 at 1:15pm, V12 (LPN) stated she works 6am to 6pm varying days from Monday through Friday. V12 stated there is an ongoing problem with getting resident medications from the pharmacy in a timely manner. V14 stated that R6 was just started on an antibiotic for a UTI (Urinary Tract Infection) yesterday that had been ordered several days ago.</p> <p>On 6/20/23 at 1:40pm, R6 was alert and oriented to person, place, and time. R6 stated she did not feel well that day as she was having severe burning and pain on urination. R6 stated she had been diagnosed "several days ago," with a UTI. R6 stated she was initially put on "an IV (Intravenous) antibiotic," but she preferred to have a pill or a shot to the IV, so the IV antibiotic order was never administered. R6 stated, "They just started me yesterday on something else, it's in a shot (intramuscular injection). Meanwhile, it burns like fire when I (urinate). This has been going on for days now."</p> <p>R6's Nurses Notes read as follows:</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>6/2/2023: "New order received from (V16, Physician) for Urinalysis (UA) and C&S (Culture and Sensitivity) if indicated related to resident complaining of dysuria and frequency."</p> <p>6/2/2023: "New order received from (V16) for (Levaquin) 250 milligrams (mg) by mouth once daily for seven days for UTI...will attempt to obtain (the medication) from back up pharmacy tomorrow."</p> <p>The June POS (Physicians Order Sheet) documented a 6/2/23 order for Levaquin 250mg one tablet by mouth every 24 hours.</p> <p>The June 2023 MAR (Medication Administration Record) documented the Levaquin was administered 6/3/23, 6/4/23, and 6/5/23.</p> <p>A 6/3/23: UA (Urinalysis) with C&S (Culture and Sensitivity) documented the urine was cloudy with the presence of red and white blood cells and proteus organisms, with the organism being resistant to Levaquin.</p> <p>The Nurses Notes continued as follows: 6/3/23: "Received preliminary report of UA, faxed to (V16's) office." 6/5/23: "Received (order) to discontinue Levaquin and start Ertapenem 500 mg IV daily for 14 days."</p> <p>The June POS documented a 6/5/23 order for Ertapenem Sodium Solution Reconstituted, use 500 mg intravenously one time a day for UTI for 14 days.</p> <p>R6's June 2023 MAR documented the following: 6/6/23, 6/7/23, 6/8/23: "MN-Medicine Not Available. (Not Administered.)" There was no entry on 6/5/23 to indicate if the medication had been administered or if it was available.</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>The Nurses Notes continued as follows: 6/9/23: "Resident refusing to allow nurses to place peripheral IV access to administer her antibiotic per (V16) orders. Resident states (V16) can give her something oral for her UTI... This nurse called (V16) office and updated (about) resident's condition and refusal of IV medication, awaiting call back at this time." 6/10/23: "Obtained new order to discontinue IV medication related to resident refusal and start IM (Intramuscular) Ertapenem once daily for 14 days...unable to obtain medication due to pharmacy being closed." The June POS documented a 6/10/23 order for Ertapenem Sodium injection solution reconstituted inject 500 mg IM daily at bedtime. The June 2023 MAR documented the following: 6/12/2023, 6/13/23, 6/15/23, 6/16/23: (All these entries are identical): "Ertapenem Sodium Injection Solution Reconstituted. Inject 500 milligrams intramuscularly at bedtime for UTI for 14 Days: (Not given); Medicine not available. "There was no documentation to indicate if the medication was available or given on 6/10/23 and 6/11/23. The Nurses Notes continued as follows: 6/16/2023: "Changed residents IM (trade name Ertapenem) to start on Monday 06/19/23 due to unavailable until then." 6/19/2023: "First dose of IM antibiotic given in left buttock with no adverse effects noted..." On 6/20/23 at 2:10pm, V2 (Director of Nurses/DON) stated she is aware of problems with residents not having medications available. V2 verified the above documentation of the delay</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>in R6's antibiotic. V2 stated the pharmacy is not open on the weekend, and their backup pharmacy at a local hospital is not able to deliver medications. V2 stated the pharmacy only does one route per day, so if medications are needed later in the day, they cannot be delivered. V2 stated she became aware of the issue with R6's antibiotic on 6/16/23 at which time she called the pharmacy, they said they had to order it and it would be in on 6/19/23. V2 stated her staff had, in error been contacting the pharmacy the facility uses only for IV medications, who were apparently not returning their calls. V2 stated she and V1 (Administrator) have notified corporate staff that they are having problems with the pharmacy, but they are unable to obtain services from a different pharmacy without corporate approval.</p> <p>On 6/22/23 at 10:25am, V19 (Pharmacist) stated she is aware the facility is having difficulty getting resident medications timely. V19 stated when the facility entered into a contractual agreement with them in November 2022, the facility was well aware of the pharmacy's limitations, such as being closed on weekends, being located 30 minutes away from the facility, and only having one driver who runs a set route only once a day. V19 stated additional delivery trips can be made at a cost of \$50 per trip, which the facility has never utilized. V19 stated the pharmacy at a local hospital is able to fill medications on the weekend, but they do not offer delivery, narcotics, nor IV medications. V19 stated her pharmacy also does not have the capability to do IVs, and the facility has a different pharmacy for that. V19 stated apparently the facility was contacting the IV pharmacy to try to obtain the IM Ertapenem instead of calling them. V19 stated an additional concern is that facility staff don't think ahead</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>about what medications residents are going to need, and it is not at all unusual for staff to call them on a Friday at 4:00pm. V19 stated they service 4 assisted living facilities with none of these issues.</p> <p>On 6/22/23 at 4:00pm, V16 (Physician) stated he was not aware the facility was having issues with pharmacy services. V16 stated R6 has a history of UTIs, the most recent as outlined above has proteus in the urine. V16 stated R6 going without antibiotic therapy for several days would definitely result in continued symptoms of pain and burning as well as a potential for sepsis.</p> <p>On 6/23/23 at 10:30am, V1 (Administrator) stated she was unaware of the extent of the problem with residents not getting their medications timely. V1 stated she and corporate staff have met with the pharmacy to try to work out problems, and she feels another meeting is probably needed.</p> <p>On 6/26/23 at 1:40pm, V1 stated the facility met with the pharmacy this morning. The pharmacy will be working with a pharmacy in the same town to provide resident medications more timely, and the facility is looking for a different backup pharmacy for weekend coverage. V1 stated V2 will more closely monitor resident medication orders.</p> <p>A Medication Error Policy dated 10/23/22 stated, "A Medication error shall be defined as any variation in administration of medication from the physicians orders and/or facility policy."</p> <p>(A)</p>	S9999		