

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009682	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/07/2019
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NAME OF PROVIDER OR SUPPLIER WALKER NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 530 EAST BEARDSTOWN STREET VIRGINIA, IL 62691
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	Initial Comments Facility Reported Incident of 5/1/19, IL 111976.	S 000		
S9999	Final Observations Statement of Licensure Violations. Section 300.610 (a) Section 300.1210 (d)(1) Section 300.3240 (a) 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 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.	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 05/24/19
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S9999	<p>Continued From page 1</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on record review and interviews the facility failed to prevent a nurse (V3) from stealing medication and replaced it with water for one of three residents reviewed for medications in a sample of three (R1). R1 was given water instead of Lorazepam 31 times and had 13 documented episodes of increased agitation and yelling during this time period.</p> <p>Findings include:</p> <p>R1's Minimum Data Set dated 5/1/19 notes that R1 has anxiety disorder with delusions and hallucinations. R1 has severe cognitive impairment and is unable to be interviewed. R1's physician's order sheets note two orders for Lorazepam. 1. Lorazepam concentrate 2mg/ml (milligrams/millileter), 0.5 ml liquid every four hours for anxiety. 2. Lorazepam concentrate 2 mg/ml, 0.5 ml every two hour as needed for anxiety.</p> <p>Incident Summary dated 5/3/19 notes that on 5/1/19 at 9:40 A.M. V4 (Registered Nurse) and V5 (Licensed Practical Nurse) came to V2 (Director of Nursing) stating they think that R1's Lorazepam is the wrong consistency. V2 agreed with V4 and V5, thinking it seemed to be more of a watery consistency. An investigation was started at this time and police were called. All nurses with access to the medication room were</p>	S9999		
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S9999	Continued From page 2 drug tested. V3 (Registered Nurse) tested positive for Benzodiazepines (Lorazepam). Video surveillance from the medication room was reviewed and on 4/25/19 at approximately 9:51 P.M. V3 was observed on video, taking R1's liquid Lorazepam from the medication cart and refilling it with water. Police officer notified of video evidence and V3 terminated from employment. (B)	S9999		
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