STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004709	A. BUILDING _____ B. WING _____	12/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS PRESBYTERIAN HOME	2005 WEST LAWRENCE SPRINGFIELD, IL 62704

(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
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210d)1 300.1630b) 300.1640a)2 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. 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. Section 300.1640 Labeling and Storage of Medications a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage. 2) All mobile medication carts shall be under the visual control of the responsible nurse at all times when not stored safely and securely. This requirement is not met as evidenced by:	S9999	**Attachment A** **Statement of Licensure Violations**	

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Based on observation, interview, and record review the facility failed to administer medications as ordered. There were 30 opportunities with 3 errors resulting in a 10%medication error rate. The errors involved (R1, R2 and R3) observed during medication administration in the sample of 5. The facility also failed to keep the medication cart in visual view during medication administration for 3 of 5 residents (R1, R2, and R3) residing in the infirmary unit of the facility.

Findings include:

1. R1's Physician's Order Sheet dated 12/1/16 documents, R1 having the following diagnoses: Hypertension, Coronary Artery Disease, Depression, Gastroesophageal Reflux Disease, Hypothyroidism, Spinal Stenosis, and Memory Loss.

On 12/21/16 at 7:13 AM during medication administration, E5, Licensed Practical Nurse (LPN) administered Amlodipine Besylate (Norvasc) 5 mg (milligram) tablet to R1. R1 ingested Norvasc 5 mg medication by mouth with water.

R1's Physician's Order Sheet (POS) dated 12/16/16 documents Norvasc 10 mg po (by) mouth daily for Hypertension for R1.

On 12/21/16 at 3:28 PM, E12, LPN, dispensed R1's medications, walked into R1's room out of visual view of the medication cart. E12 did not lock the medication cart prior to leaving it. E3, LPN/Assistant Director of Nursing (ADON) walked up to the medication cart, proceeded to lock the cart, and stated to E12, "Remember to lock your cart when you are in (resident's room) giving medications."

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2. R2's Physician Order Sheet dated 12/1/16 documents, R2 having the following diagnoses of Arthritis and History of Bilateral Hip Replacement.

On 12/21/16 at 7:20 AM during medication administration, E5 administered Preservision AREDS2 one capsule to R2. R2 ingested 1 capsule of the medication given by E5 with water and then reminded E5 that she was suppose to get two capsules not one. E5 administered the 2nd capsule after being cued by R2. E5's POS dated 12/1/16 documents R2 is to receive Preservision AREDS2 two (2) capsules by mouth once daily.

3. On 12/21/16 at 7:29 AM after completing 2 of 4 medications consumed by R2, E5 walked out of the Infirmary Dining Room's visual view of the medication cart to retrieve the Narcotic Administration Booklet from another location down the hall. E5 did not lock the medication cart. R1 through R5 were in the dining room during the observation period. R1 and R5 are ambulatory residents.

4. R3's POS dated 12/1/16 documents R3 having the following diagnoses of Hypertension, Depressive Disorder, Cornea Problems, and Dementia.

On 12/21/16 during morning medication pass at 7:20 AM, E5 omitted Calcium 600 mg with Vitamin D 125 International Units to R3. The POS dated 12/1/16 documents R3 to receive Calcium 600 mg W/D (with Vitamin D) 125 IU (International Units) 2 capsules by mouth daily with food.

On 12/21/16 at 12:15 PM, Z1(Pharmacist) stated

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part of the duties of the pharmacist during monthly review is to watch a medication pass with nurses in the facility and would expect nurses to pass all medications per the nurse's scope of practice, and not locking carts when out of visual view, is not standard practice.

Facility's policy entitled "12.0 Medication Procedures," undated states in part, "During the medication administration process, the med (medication) cart must always be locked. If left unlocked it must be in the full view of the nurse or licensed personnel. Any deviation from specified and recommended procedures in dispensing or administering medications to the resident requires documented approval by the facility and shall be in concurrence with current statues and regulations."

(B)

300.1010h)
300.1210d)6
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, safely or welfare of a resident. 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.
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:
6) All necessary precautions shall be taken to assure that the residents' environment remains

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as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

This requirement is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to adequately assess falls for causative factors and develop an effective prevention plan with individualized interventions to prevent further occurrence for 1 of 2 residents (R1) reviewed for multiple falls in the sample of three. The facility failed to notify the physician timely following falls for 2 of 2 residents (R1 and R3) reviewed for falls.

Findings include:

1. R1's Physician's Order Sheet dated 12/1/16 documents, R1 having the following diagnoses: Hypertension, Coronary Artery Disease, Depression, Gastroesophageal Reflux Disease, Hypothyroidism, Spinal Stenosis, and Memory Loss.

R1's Incident Report documented on 8/20/16, R1 was found next to the bed on R1's knees. Physician was not notified until 8/22/16 at 3:00 PM. The Report documented the interventions for R1 was to leave the door open for observation, and was moved closer to the nurses' station;

R1's Incident Report documented on 9/5/16 at 2:00 PM, R1 rolled out of bed and hit head on the side of the table. Physician was not notified 9/6/16 at 3:55 PM. The Report documented no change in interventions, as R1 was closer to the nurses' station.

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R1's Incident Report documented on 10/30/16 at 6:50 AM, R1 fell backwards, walking with a walker and received a skin tear. Physician was not notified until 11/1/16 at 2:30 PM. No new interventions implemented.

R1's Incident Report documented on 11/22/16 at 1:30 AM R1 rolled out of bed. Physician was not notified until 7:00 PM the same day. The Report documented no new interventions implemented.

R1's Incident Report documented on 11/28/16 at 8:40 AM, R1 was found on the floor next to the sofa. The Report documented no new interventions implemented.

On 12/21/16 at 11:00 AM, R1 was assisted in transfer to her chair from bed in her room with the assistance of one staff member, E13 Certified Nurse Aide (CNA.) Gait was unsteady.

E2, Nursing Director, on 12/21/16 at 10:01 AM stated interventions have not been updated and the facility is working on a process to get interventions more individualized for each resident. E8 RN consultant, confirmed the facility is working towards progress in both care planning and in servicing staff on upcoming changes ensuring current interventions are more staff centered versus resident centered.

On 12/22/16 at 1:09 PM, E8 stated facility is working towards progress of a Fall Prevention Program for staff.

Facility Policy, undated, does not reflect developing an individualized Fall Prevention Plan to decrease the risk of repeated falls.

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2. The Admission Record identifies R3 to be an 86 year old female admitted to the facility on 11/19/14 with diagnoses of Depression Disorder, Cornea Problems and Dementia in part. The care plan dated 11/2/16 documents R3 as a high risk for falls.

An Accident or Incident Report dated 3/5/16 documents R3 fell at 1:45 AM. Time of notification to the physician and family member is documented on 3/7/16 at 10:20 AM, two days after the fall. The Nurses Notes confirm notification on the fall was made on 3/7/16 at 10:20 am.

An Accident or Incident Report dated 4/10/16 documents R3 fell at 1500 (3pm) with notification to the son done immediately at 1520 (3:20pm.) The Nurses Notes document R3's physician notified at 9am the next day, 4/11/16. The Accident or Incident report has only a check mark for physician notified with the time listed as 1515 (3:15pm.)

On 7/16/16, the Accident or Incident Report documents R3 fell at 1830 (6:30pm) with the family member notified at 1850 (6:50pm) and the physician notified at 1115 (11:15am). The nurse ' s notes confirmed the family notified at 1835 but has no information as to time of physician notification.

On 12/22/16 at 9:20 am, E3 Assistant Director of Nurses/Licensed Practical Nurse (ADON/LPN) reviewed the information and agreed that physician notification on 7/16/16 had to be the next day if documented at 1115 (11:15am) since the fall occurred at 6:30pm on 7/16/16.

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On 11/29/16 at 2:15 am, the Accident or Incident Report documents R3 was again found on the fall following a fall. The report documents the son notified at 4:30pm, 14 hours after the fall and includes no information on physician notification except a check mark with any date/time included.

The facility's policy entitled "Resident Fall Procedure" (undated) documents when a resident has fallen, staff will "notify resident's doctor and family immediately about the fall" (if the fall occurs after office hours and the telenurse will be notified.) If not then, the day nurse is responsible for notifying the resident ' s doctor if there is no injury, the resident is stable and is not requiring medical attention. The policy also documents staff are to list the extent of the fall, injuries if any and the doctor and family notification in the nurses notes.

(B)

Section 300.2100 Food Handling Sanitation
Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750).
(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

This requirement is not met as evidenced by:

Based on observation and interview, the facility failed to ensure the ice machine had an appropriate air gap for drainage. This has the potential to affect 5 of 5 residents residing in the licensed beds of the facility.

Findings include:

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1. On 12/20/16 at 1:00 pm, the ice machine drains thru a clear plastic tube which extends along the floor and passed into the cabinet next to it which is under a hand washing sink. The end of the tubing rests inside the depressed drain below the level of the floor by approximately 1/2 inch. There was no air gap present to prevent backflow.

On 12/20/16 at 1:45 pm, E7, Cook acknowledged the tubing draining into the drain under the sink and resting down inside to the drain. E7 stated the ice machine was the only one in the facility and is used for dietary drinks.

On 12/21/16 at 1:20 pm, E9, Maintenance, confirmed the ice machine tubing is not positioned to allow for an air gap and is laying down inside the grain under the sink.

At 8:30 am on 12/21/16, E10, Dietary Manager, stated the facility has this one machine that services all the facility for drinks and water in the rooms.

The Facility's Census Sheet, dated 12/20/16 documents the facility has 5 residents residing in the licensure portion of the facility.

(B)

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.1510g) 330.1520a) Section 330.1510 Medication Policies g) All medications having an expiration date that has passed shall be disposed of in accordance with the written policies and procedures established by the facility in accordance with Section 330.1510. Section 330.1520 Administration of Medication a) All medications taken by residents shall be self-administered, unless administered by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. This requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to administer medications as ordered. There were 29 opportunities with one error resulting in a 3.4 % medication error rate. The error involved one resident (R104) observed during medication administration in the sample of five. The facility failed to remain in visual view until medication consumption. This affected two	S9999	Attachment A Statement of Licensure Violations	

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of five residents (R105, R106) observed during medication administration.

Findings include:

1. R104's Physician's Order Sheet dated 12/1/16 documents, R104 having the following diagnoses: Hypertension,Spinal Stenosis, and Atrial Fibrillation.

Expiration date on a bottle of stock Tylenol in E5's(Licensed Practical Nurse/LPN) medication cart shows an expiration date of 11/2015.

On 12/20/16 at 12:11 PM, E5, Licensed Practical Nurse, LPN, administered from the stock supply Tylenol 325 mg, (milligrams), two tablets to R104. Physician's Order documents Tylenol 325 mg 2 tablets by mouth every 4 hours as needed for pain or fever. Do no exceed 3000 mg Tylenol in 24 hours.

2. On 12/20/16 at 12:18 PM, E5 administered R105 Stock Centrum Silver Multivitamin one tablet by mouth. E5 did not remain in visual view of R105 during consumption of medication.

3. On 12/20/16 at 12:22 PM, E5 administered 325 mg of Tylenol, two tabs to R106. E5 did not remain in visual view of R106 during consumption of medication.

On 12/21/16 at 12:15PM, Z1(Pharmacist) stated part of the duties of the pharmacist during monthly review is to watch a medication pass with nurses in the facility and would expect nurses to pass all medications per the nurse's scope of practice, and not locking carts when out of visual view, is not standard practice.

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S9999	Continued From page 2 Facility policy, undated entitled 12.0 Medication Administration Procedures states, "After the resident has been identified, administer the mediation, watch patient consume medication until gone and immediately chart doses administered on the medication administration record." Facility policy, undated entitled 10.0 Storage and Maintenance of Medication states in part, "8. Medication must be checked regularly for expiration dates and deterioration. Expired medications are removed from use and returned to Uvanta (pharmacy)." (B) Section 330.2000 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 700). (Source: Amended at 13 Ill. Reg. 6562, effective April 17, 1989) This requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure the ice machine had an appropriate air gap for drainage. This has the potential to affect all 48 residents in the shelter care facility. Findings include: 1. On 12/20/16 at 1:00 PM, the ice machine drains thru a clear plastic tube which extends along the floor and passed into the cabinet next to it which is under a hand washing sink. The end of the tubing rests inside the depressed drain below the level of the floor by approximately 1/2	S9999		

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inch. There was no air gap present to prevent backflow.

On 12/20/16 at 1:45 PM, E7, Cook, acknowledged the tubing draining into the drain under the sink and resting down inside to the drain. E7 stated the ice machine was the only one in the facility and is used for dietary drinks.

On 12/21/16 at 1:20 PM, E9, Maintenance, confirmed the ice machine tubing is not positioned to allow for an air gap and is laying down inside the grain under the sink.

At 8:30 AM, on 12/21/16, E10, Dietary Manager, stated the facility has this one machine that services all the facility for drinks and water in the rooms.

The Facility's Census Sheet, dated 12/20/16, documents the facility has 48 residents residing in the Sheltered Care portion of the facility.

(B)