Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005490	A. BUILDING: _____ B. WING _____	C 12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN VILLAGE HEALTHCARE	2202 NORTH KICKAPOO STREET LINCOLN, IL 62656

(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 Complaint Investigation #2329970/IL167257	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210d)3) 300.1610a)1) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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: 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. Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies	S9999		

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S9999	Continued From page 2 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. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure narcotic pain medication was available upon a resident's readmission following hip surgery for one of three residents (R1) reviewed for pain in the sample of six. This failure resulted in R1 experiencing excruciating pain for over 48 hours causing R1 to cry, not eat and scream in distress. Findings include: The facility's Pharmacy Receiving Controlled Substances policy dated 10/25/2014, states "5) A nurse notifies the pharmacist if controlled substance orders or doses are missing or incorrect." The facility's Pharmacy Emergency Pharmacy Service and Emergency Kits policy dated 10/25/14, states "Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved Emergency Medication Kit/Box or by special order from (the pharmacy). (The pharmacy) supplies emergency medications	S9999		

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S9999	Continued From page 3 including emergency drugs, antibiotics, controlled substances, and products for infusion in limited quantities in compliance with applicable state and federal regulations to serve the immediate clinical needs of the residents. A. Telephone/fax numbers for emergency pharmacy service are posted at nursing stations. C. The dispensing pharmacy supplies emergency or 'stat' medications according to the dispensing pharmacy provider, noncontract, or infusion therapy products agreement." R1's Hospital Discharge Orders dated 11/27/23 at 11:21 a.m., states "Start Norco (narcotic pain medication) 7.5/325 mg (milligram) 1-2 tabs every six hours as needed for pain. Stop Norco 5/325 mg 1 tab every twelve hours as needed for pain." R1's Progress Notes dated 11/27/23 at 3:54 p.m., state "(R1) returned from (local hospital to the facility) at 12:15 p.m. (R1) returned with a new order for (Norco) 7.5/325 mg 1-2 tabs every six hours for pain. R1's Progress Notes do not include any further documentation about R1's pain or that R1's Norco 7.5/325 mg had not been received from pharmacy on 11/27/23 per physician orders. R1's progress notes do not document the pharmacy was notified until 11/29/23 at 8:35 a.m. R1's Progress Notes completed by V2 (Director of Nursing) dated 11/29/23 at 8:35 a.m., state "Called (the pharmacy) about (R1's) pain medication. Pharmacy reported the signed (prescription) was in (R1's legal name) and not (R1's nickname). The error has been corrected as of this time. We are unable to pull from the (automated medication dispensing cabinet), therefore, the medication will be (rushed)	S9999		

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S9999	Continued From page 4 delivered today. (R1)/Floor nurse were updated." R1's Progress Notes dated 11/29/23 at 8:46 a.m., states "(R1 complains of) pain to right hip (10 on a scale of 10). (R1's as needed) Tramadol (pain medication) and extra strength Tylenol administered by floor nurse. R1's Progress Notes dated 11/29/23 at 4:47 p.m., states "Spoke to (V3/R1's representative) regarding her (new prescription for Norco 7.5/325 mg). Explained to her that the Norco has arrived and R1 has received her first dose around 2:00 p.m. and is able to get it every six hours." R1's Pain Care Plan dated 11/18/23, documents an updated approach on 11/27/23 was implemented for "Staff to increase monitoring of pain management (due to) recent right hip surgery." This same Care Plan documents to Administer medication as ordered and monitor for effectiveness of relief, complete pain assessment, notify (R1's physician) if current pain medication is not effective). R1's Medication Administration Record dated 11/25/23 through 11/30/23, documents R1 did not get the physician ordered Norco 7.5/325 mg to start on 11/27/23 until 11/29/23 at 2:11 p.m. The Pharmacy Timeline received from V6 (Pharmacy Director of Nursing), dated 12/14/23, documents the following: Original order for Norco was faxed to pharmacy on 11/28/23 at 1:50 p.m.; The prescription was written for R1's legal name in which the pharmacy had never seen in their system; On 11/28/23 at 10:22 p.m. R1's name was confirmed and the Norco order was processed but missed the 10 p.m. cutoff for delivery that night; On 11/29/23 the facility sent an	S9999		

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S9999	Continued From page 5 order to pharmacy for R1's Norco STAT (Immediately) at 8:35 a.m.; R1's Norco was delivered to the facility on 11/29/23 at 12:49 p.m. The Pharmacy Packing Slip Proof of Delivery form documents R1's Norco 7.5/325 mg 12 tablets was delivered to the facility on 11/29/23 at 12:49 p.m. R1's Controlled Drug Record form documents R1's Norco 7.5/325 mg was started on 11/29/23 at 2:00 p.m. On 12/12/23 at 10:45 a.m., R1 stated she fell and broke her hip on 11/21/23 and had to have the hip surgically repaired. R1 stated she was re-admitted on 11/27/23 with orders for a new higher dose of Norco (narcotic pain medication) 7.5/325 mg (milligram) 1-2 tablets every six hours as needed for pain. R1 stated for an unknown reason the nurses did not receive the Norco from the pharmacy until 11/29/23 in the afternoon. R1 stated she was in excruciating pain for over 48 hours with no relief and nothing was done about it. R1 stated she didn't want to eat due to the pain. R1 stated she tried to hold still and sleep to keep her hip from hurting. R1 stated it was "a long 48 hours." R1 stated she had a mild pain pill ordered but it "didn't touch the pain." R1 stated the hospital ordered the increased dose of Norco because of the severe pain she was experiencing after the hip fracture and surgical repair. On 12/12/23 at 11:00 a.m., R6 stated she has been R1's roommate for a long time and they know each other very well. R6 stated when R1 returned from the hospital on 11/27/23 she had a lot of pain that progressively got worse as the day went on because she did not receive any pain medications. R6 stated R1 was crying and	S9999		

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moaning in pain. R6 stated "I tried to get her to eat her meals, but she didn't feel like it. I felt so helpless. The nurses didn't seem too concerned about it for some reason. They said they were working on getting the pain medications delivered yet they didn't come." R6 stated it was the afternoon of 11/29/23 before R1 finally received her prescribed Norco pain medication. R6 stated R1 would try to lie still and sleep to keep from hurting but she would wake up moaning.

On 12/13/23 at 2:10 p.m., V3 (R1's Representative) stated she had spoken to R1 and knew she was in horrible pain since she returned from the hospital, but no one could tell her why her pain medications had not been delivered. V3 stated then on 11/29/23, V2 (Director of Nursing) called and told V3 that there was confusion with R1's name on the prescription and that had to be clarified. V3 stated that was ridiculous to take over 48 hours to clarify the name of a resident that has resided in the same facility for almost four years. V3 stated the nurses gave her a mild pain medication but it was not good enough to help the pain of her hip repair.

On 12/12/23 at 3:30 p.m., V8 (Pharmacist) stated R1's Norco was not delayed due to the name needing clarified. V8 stated the order wasn't received by pharmacy until 11/28/23 at 1:49 p.m.

On 12/12/23 at 12:45 p.m., V9 (Licensed Practical Nurse) stated she sent R1's Norco order to the pharmacy on 11/27/23 when she was readmitted from the hospital. V9 stated when she got to work on 11/28/23 R1 told her she still had not received her Norco and was in a lot of pain. V9 stated "I called the pharmacy and they told me they didn't received the prescription for (R1's Norco) so I had them stay on the phone and

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S9999	Continued From page 7 verify they got the fax while I was talking to them. I did not have them send it STAT. I probably should have. The Norco should have arrived early morning on 11/29/23 but I guess it still wasn't here when (V2/Director of Nursing) got to work. The nurse on night shift 11/27/23 did not document any attempts to notify the pharmacy that I can see." On 12/12/23 at 1:00 p.m., V2 stated V2 was notified that R1 had not received her Norco as ordered on 11/29/23 when she came in to work. V2 stated she went down to see R1. V2 stated R1 was crying in pain and visibly in distress. V2 stated R1 should have received her pain medication in a timely manner and not gone over 48 hours without her newly ordered Norco for the hip pain. V2 stated the nurses should have intervened and got something done with the pain medications whether it was through the pharmacy or R1's physician. V2 stated R1 should have had her new pain medications from the pharmacy delivered the night of 11/27/23 into 11/28/23. V2 stated the medications could have been ordered emergency service and they would have been at the facility in four hours or less or they could have acquired them from a local pharmacy with a different prescription from R1's physician. (B)	S9999		