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
	IL6009815	A. BUILDING: ________ B. WING ________	C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE FAIRFIELD	305 N.W. 11TH STREET FAIRFIELD, IL 62837

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S 000	Initial Comments Complaint Investigation 2451208/IL169755	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)1)2) 300.1630d) 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 resident to meet the total nursing and personal	S9999		

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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

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.

This requirement was not met as eveidnce by:

Based on interview and record review, the facility failed to administer regularly scheduled ordered pain medication for 1 (R1) of 5 residents reviewed for pain management. This failure resulted in R1 experiencing loss of sleep and significant pain to R1's shoulders, back, and knees due to missing R1's 2/5/24 pm dose of her regularly scheduled pain medication.

Findings:

R1's face sheet documents an admission to the facility on 4/19/2023 with diagnoses of Chronic Kidney disease, Stage 3 Unspecified, Malignant neoplasm of uterus, part unspecified, other intervertebral disc degeneration, lumbar region, unspecified osteoarthritis, unspecified site, other

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sleep apnea.

R1's Minimum Data Set (MDS) dated 1/09/2024, documents R1 has a Brief Interview for Mental Status (BIMS) score of 13, indicating she is cognitively intact. R1's MDS Section J, Pain Management, documents she has a scheduled pain medication regimen.

R1's Care Plan documents a Focus of: R1 has chronic pain; Goal: R1 will not have an interruption in normal activities due to pain through the review date; Interventions: Administer analgesia per orders; Evaluate the effectiveness of pain interventions; Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition; Monitor/document for side effects of pain medication; Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician.

R1's Physician's Orders dated 4/20/2023 documents Pain Assessment every day and night shift; 4/19/2023 documents Acetaminophen 500mg (milligrams) (2 tabs) every 4 hours as needed for pain; 4/21/2023 documents Percocet 5/325mg three times a day for pain (Unspecified Osteoarthritis, Unspecified site; Other Intervertebral disc degeneration, lumbar region); 2/6/2024 documents Hydrocodone 5/325mg every 8 hours as needed for pain (may substitute if Percocet is unavailable).

R1's Medication Administration Record (MAR) dated February 1 - 29, 2024 does not document Percocet 5/325mg was given on 2/5/2024 (9:00

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PM); 2/6/2024 (5:00 AM, 1:00 PM, 9:00 PM) and 2/07/2024 (1:00 AM).

R1's MAR dated February 1-29, 2024 documents pain assessment every day and night shift completed with pain rating on 2/5/2024 to be 6 and on 2/6/2024 to be 7. No alternative medication was ordered until 2/6/2024 and first dose was given at 5:37 PM.

R1's Narcotic Administration Sheet for Percocet 5/325mg documents last dose given on 2/5/2024 at 1:00 PM and documentation of Percocet 5/325mg received on 2/7/2024 (30 tabs) with the next dose given on 2/7/2024 at 12:30 PM.

R1's Progress Notes dated 2/06/2024, 6:00 PM (Late Entry) by V4 (Quality Assurance/Licensed Practical Nurse/LPN) documents in part...R1 came to this nurse and spoke about being out of her pain pills...asked R1 if she was having pain and R1 stated she was and had been to a doctor's appointment...told R1 a nurse sent a script to V20 (Primary Nurse Practitioner/NP), Monday (2/5/2024) to get signed...it came back Tuesday morning (2/6/2024) that it didn't have quantity amount or DEA (Drug Enforcement Administration) number on it...so V20 was going to escribe it to pharmacy...told R1 that hopefully it would come in on the delivery we would get Tuesday night...When pharmacy delivered Tuesday evening around 10:30 PM, did not have R1's pain medication.

R1's Progress Notes dated 2/07/2024, 11:58 AM, documents in part...med delivery guy had been there and delivered R1's pain medications.

On 2/14/2024, at 12:30 PM, R1 stated "Last week either Sunday or Monday evening, the nurse

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came in and told me that I was out of my regular pain medication." R1 stated they told her a new nurse forgot to reorder it. R1 stated that the nurse told her that it probably wouldn't be here until "tomorrow night" and R1 stated that she was not offered any other type of pain medication until the following day. R1 stated that she has arthritis in her shoulders, back, and has had multiple knee replacements. R1 stated that she didn't get any sleep for three nights after missing her regularly scheduled pain medication and her pain was unbearable in her shoulders, back, and knees. R1 stated that she has been on scheduled Percocet for over twenty years and that is the only medication that helps to relieve her pain.

On 2/14/2024, at 1:10 PM, V2 (Director of Nursing/DON) stated that R1's Percocet medication is not in the facility's emergency medication kit (E-Kit). V2 stated that it is the expectation of her nurses to have any medication that needs to be refilled, to be refilled in a timely manner before the medication runs out. V2 stated that it is the expectation of the nurses to call the primary physician when a medication runs out and get it refilled as soon as possible or get another order for an alternative medication to be given. V2 stated that R1 did get offered an alternative medication on 2/6/2024 and on 2/7/2024.

On 2/14/2024, at 1:25 PM, V6 (Ombudsman) stated that V19 (Family) contacted her and told her that R1 ran out of her pain medication. V6 stated that she called R1 and R1 stated to her that she had not received her pain medication for 24 hours. V6 stated that R1 told her that she had been on regularly scheduled Percocet for over 20 years and that is the only pain medication that works for her. V6 stated that she offered R1 a

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grievance form to fill out. V6 stated that she spoke with V1 (Administrator) and was told R1 was offered an alternative medication but that she refused. V6 stated that V1 verified to her that R1's Percocet was not in the facility's emergency medication kit. V6 stated that V1 verified to her that R1 had missed 5-6 doses of her Percocet medication. V6 stated that V1 told her that R1's Percocet did arrive on 2/7/2024 and that the facility is monitoring to make sure this doesn't happen again.

On 2/14/2024, at 1:40 PM, V1 (Administrator) stated that he spoke with V6 (Ombudsman) and told her that R1 ran out of her pain medication and that a back-up alternative was offered and given. V1 stated that R1's Percocet was ordered on 2/5/24 & 2/6/24 and received on 2/7/2024.

On 2/14/2024 at 2:00 PM, the emergency medication kit was observed to have no Percocet available. There was hydrocodone 5/325mg available in the emergency medication kit.

On 2/14/2024 at 3:05 PM, V9 (Registered Nurse/RN) stated that she works 6:00 AM - 6:00 PM regularly and she worked on 2/5/2024, day shift. V9 stated that she was told in report by V5 (RN) that R1 had one Percocet pill left and that it would need to be reordered. V9 stated that she called V20 (Primary Nurse Practitioner) and told her that we needed a new script for R1's Percocet medication. V9 stated that she gave R1 her last dose of Percocet at 1:00 PM on 2/5/2024. V9 stated that she told V5 (RN) in report that R1's Percocet medication was supposed to come in that evening.

On 2/14/2024 at 3:10 PM, V5 (RN) stated that she worked Sunday night, 2/4/2024, and noticed

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that R1 only had one dose of Percocet left after she gave R1 her regularly scheduled 5:00 AM dose. V5 stated that she did not notify the primary physician at that time, just told V9 (RN) that R1 only had one dose of Percocet left and it needed to be reordered.

On 2/20/2024 at 8:10 AM, V10 (RN) stated that she worked on 2/6/2024 and R1 was out of her Percocet medication. V10 stated that she called V20 (Primary Nurse Practitioner) and got an alternative medication (Hydrocodone 5/325mg) ordered for her until the Percocet would come in from the pharmacy. V10 stated that she offered Tylenol to R1 but R1 refused stating, "That will not work for me" and V10 stated she offered the hydrocodone to her and R1 refused the first time, stating, "Those will not work for me, I threw 120 tablets away because that medication would not work for me." V10 stated that she talked to R1 and explained to her that hydrocodone was equivalent to Percocet and R1 finally agreed to take a dose of it. V10 stated that R1 was experiencing more pain than usual that day. V10 stated that R1's Percocet was supposed to arrive from pharmacy later that evening.

On 2/20/2024 at 8:20 AM, V11 (Licensed Practical Nurse/LPN) stated that she worked on 2/6/2024, the night shift and was told in report that R1 was out of her Percocet medication and that hydrocodone could be given as needed until her Percocet medication could be delivered from pharmacy. V11 stated that R1's Percocet medication was supposed to arrive to the facility on 2/6/2024 but did not show up that evening. V11 stated that she called the pharmacy and they told her that it would arrive on the next pharmacy delivery, which would be in the morning. V11 stated that she administered the hydrocodone as

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ordered for R1 when she was able to have it.

On 2/20/2024, at 8:40 AM, V20 (Primary Nurse Practitioner) stated that she was notified on 2/5/2024 that R1 needed her Percocet re-ordered. V20 stated that she reordered R1's Percocet that day but it was sent to the wrong pharmacy. V20 stated that she received another phone call on 2/6/2024 regarding R1 needing her Percocet reordered. V20 stated that when she went into the computer to order it again on 2/6/2024, she noticed she had sent the initial Percocet order to the wrong pharmacy. V20 stated that she reordered the Percocet again as well as ordered an alternative pain medication, hydrocodone 5/325mg that could be given as needed until the Percocet became available. V20 stated that it is her expectation for the nurses to notify her in a timely manner to refill medications and not wait until residents run out of medications.

The facility's Pain Management policy dated 7/6/2018 documents in part ...Purpose: To establish a program which can effectively manage pain in order to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness.

The facility's concern/compliment form dated 2/7/2024 documents being filled out by R1 stating: "I have to have my pain med regularly; I got my evening med and the nurse told me we were out of percocet and she would check to see if they were ordered; I didn't get my pain med until 2/7/2024 at noon; A very painful 2 days and nights."
(B)

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