		AND HUMAN SERVICES			FORM	05/04/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. Buile	ILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
145890		B. WING	Э	C 01/19/2012		
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 A JEFFERSON STREET		
FOUNTAINVIEW				ELDORADO, IL 62930		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 333	Continued From page 1 and transcription errors.		F 33	33		
	(Administrator) find on 12/28 with an or change from 4mg to incident narrative si documented on De (Physician's Order December's MAR" Record) The narra a breakdown in our order failed to pull t cart. From 12/28/1 3mg until an LPN n Coumadin 4mg and then pulled the 3mg to pharmacy for ret 4mg. He then rece hospitalization on 1	ht report prepared by E1 Is the medication errors began order for Coumadin dose o 3mg. The facility's 1/15/12 tates "The new order was cember and January POS' Sheets), but only on (Medication Administration tive further states "There was r system as the nurse receiving the 4mg Coumadin from med 1 until 01/04/12 (R1) received noticed the MAR still read d had been signed for. She g Coumadin from cart and sent urn, assuming the order was sived 4mg daily until /10/12. Upon arrival to ER ), an INR (International Ratio) ned."				
F9999	December and Jan the Coumadin orde the incorrect dosag		F999	99		
	LICENSURE VIOL	ATION				
	300.1210d)1) 300.1620a) 300.3240a) Section 300.1210 C Nursing and Person	General Requirements for nal Care				

Facility ID: IL6003248

If continuation sheet Page 2 of 5

		AND HUMAN SERVICES				FORM	05/04/2012 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
145890		B. WI	NG _		01/19/2012		
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
FOUNTAINVIEW				1001 A JEFFERSON STREET ELDORADO, IL 62930			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	<ul> <li>d) Pursuant to subs care shall include, a and shall be practic seven-day-a-week I</li> <li>1) Medications, incl intravenous and intra administered.</li> <li>Section 300.1620 C</li> <li>Prescriber's Orders a) All medications s written, facsimile or prescriber. The facs licensed prescriber licensed prescriber accordance with Sec orders shall have th unique identifier) of (Rubber stamp sign These medications ordered-by the licer designated time.</li> <li>Section 300.3240 A a) An owner, licens agent of a facility sh resident.</li> <li>These regulations a the following:</li> <li>Based on record re failed to ensure that significant medication residents reviewed errors on the samplinospitalization and</li> </ul>	Section (a), general nursing at a minimum, the following bed on a 24-hour, basis: luding oral, rectal, hypodermic, ramuscular, shall be properly Compliance with Licensed shall be given only upon the relectronic order of a licensed simile or electronic order of a shall be authenticated by the within 10 calendar days, in ection 300.1810. All such he handwritten signature (or the licensed prescriber. natures are not acceptable.) shall be administered as need prescriber and at the Abuse and Neglect ee, administrator, employee or nall not abuse or neglect a are not met, as evidenced by eview and interview the facility t residents remain free of on errors for 1 of 3 (R1) for significant medication le of 3. This failure resulted in diagnosis of Upper GI) bleed and correction of 1.	F9	999			

If continuation sheet Page 3 of 5

DEPAR <sup>-</sup> CENTEI		FORM	APPROVED 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
			A. BU B. WI			С	
145890			D. WI			01/19/2012	
					REET ADDRESS, CITY, STATE, ZIP CODE 1001 A JEFFERSON STREET		
FOUNTA	INVIEW			E	ELDORADO, IL 62930		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From page 3		F9999				
	<ul> <li>299 Continued From page 3</li> <li>R1's admission record states R1 was admitted to the facility on 6/1/10 with diagnoses including: Cardiovascular Accident, Hypertension, Myocardial Infarction, and Atrial Fibrillation. On 1/10/12 Nursing Notes at 9:30am state R1 had foul smelling coffee ground emesis, a distended abdomen and bowel signs times four. A 1:20pm nurses notes finds R1 was admitted to the hospital for observation with diagnosis of UGI bleed. E2 (Director of Nursing) on 1/19/12 at 12:10 pm stated after R1 was admitted to the hospital , E3 (charge nurse) began a review of R1's record. E3 found errors in Coumadin dosage changes, administration of wrong dosage and transcription errors.</li> <li>The 1/10/12 incident report prepared by E1 (Administrator) finds the medication errors began on 12/28 with an order for Coumadin dose change from 4mg to 3mg. The facility's 1/15/12 incident narrative states "The new order was documented on December and January POS' (Physician's Order Sheets) , but only on December's MAR" (Medication Administration Record) The narrative further states "There was a breakdown in our system as the nurse receiving order failed to pull the 4mg Coumadin from med cart. From 12/28/11 until 01/04/12 (R1) received 3mg until an LPN noticed the MAR still read Coumadin 4mg and had been signed for. She then pulled the 3mg Coumadin from cart and sent to pharmacy for return, assuming the order was 4mg. He then received 4mg daily until hospitalization on 1/10/12. Upon arrival to ER (Emergency Room), an INR (International Ratio) of 5.4 was determined."</li> </ul>						

Facility ID: IL6003248

If continuation sheet Page 4 of 5

PRINTED: 05/04/2012

DEPART CENTER	PRINTED: 05/04/2012 FORM APPROVED OMB NO. 0938-0391						
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
145890			B. WING			01/19/2012	
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FOUNTA	INVIEW				1001 A JEFFERSON STREET ELDORADO, IL 62930		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ige 4	F9	99	9		
	A review of R1's P December and Jan the Coumadin orde the incorrect dosag	POS and MAR sheets from uary confirms the confusion of ers and the administration of the of Coumadin from 1/4/12 to pspitalized on 1/10/12 with the					

Facility ID: IL6003248