STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145266	A. BUILDING _____ B. WING _____	07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FONDULAC REHABILITATION & HCC	901 ILLINI DRIVE EAST PEORIA, IL 61611

(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) COMPLETION DATE
F 520	Continued From page 40 should attend every quarterly meeting. On 7-03-12 at 2:30p.m. E1 stated that she was unable to provide the facility policy for QAA meetings. E1 did state that it is a facility policy that a physician, the Director of Nurses, the Administrator, and someone from pharmacy attend all quarterly QAA meetings. E1 also acknowledged that a physician did not attend the QAA meeting dated 2-10-12. Resident Census and Condition Report signed by E1 on 06/26/12 documents facility census at 70.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1630c) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.	F9999		

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F9999	Continued From page 41 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 care needs of the resident. Section 300.1630 Administration of Medication c) Medications prescribed for one resident shall not be administered to another resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are NOT MET as Evidenced by: Based on record review and interview the facility failed to follow their policy on medication administration and administered the wrong medication to one of 16 residents (R9) reviewed for medications and one resident (R11) on the supplemental sample. This failure resulted in R9 developing a swollen tongue, lethargy, and hallucinatory behavior requiring R9 being sent to the emergency room for treatment.	F9999		

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F9999	Continued From page 42 Findings include: 1. Incident Report for R9 dated 03/14/12 documents that R9 received Clozaril 200mg and Wellbutrin 150mg that were not ordered by the physician. Nurses notes for R9 dated 03/14/12 document that R9 developed a swollen/red tongue, difficulty swallowing, disorganized speech, hallucinations, and inability to grasp objects. The same nurses notes for R9 document that on 03/15/12 at 5:10AM the resident was sent to the emergency room for treatment. Hospital History dated 03/16/12 documents that R9 was sent to the emergency room after receiving Clozaril 200mg by mistake and was treated with Decadron (steroidal anti-inflammatory) and Benadryl (anti-histamine). A written statement dated 03/16/12 and signed by E18 (LPN/Licensed Practical Nurse) documents that E18 set up medications for another resident (R20) who was to receive Wellbutrin and Clozaril. When E18 noticed that R20 was not in the dining room, E18 put the medications in the top drawer of the medication cart. E18 then went to R9's room and took the medications intended for R20 out of the medication cart and administered them to R9. Facility Medication Administration Policy dated 10/2007 documents the following: "Medication must be identified by using the five rights of administration: 1) Right resident; 2) Right dose; 3) Right drug; 4) Right time; and 5) Right route." The same policy also documents the following: "Destroy medications prepared for a resident if not used immediately."	F9999		

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F9999	Continued From page 43	F9999		

On 06/27/12 at 2:00PM, E2 stated, "We terminated that nurse (E18) because of the error made. She should never have set up medications ahead of time and should have made sure the resident was in the dining room before setting up those meds."

2. R11's POS for August, 2011 contains the order dated 8-12-12 to decrease Lasix to 60 mg daily alternating with 60 mg twice a day. The POS also contains a subsequent order dated 8-18-11 to discontinue Lasix.

R11's MAR for August 2011 shows R11 was given the alternating Lasix dose for 8-31-11 (for 13 days after the medication was discontinued).

The Medication Discrepancy Report dated 9-2-11 shows the medication error was found on 9-1-11. R11's physician was notified 9-1-11 with orders to decrease R11's Lasix to 60 mg per day.

R11's POS for December, 2011 contains an order dated 12-6-11 for Bactrim DS 800/60 one tablet two times a day for seven days for a urinary tract infection.

R11's MAR for December 2011 shows R11 was given Bactrim DS 800/60 one tablet three times a day (instead of twice daily as ordered) starting 12-6-12 at 4pm thru 12-12-11 at 8am.

The Medication Discrepancy Report dated 12-11-11 states the physician order was for Bactrim DS 800/60 twice a day for 7 days but the medication was transposed to the MAR as three times a day.

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F9999	Continued From page 44 R11's physician orders and nursing notes for December 2011 show no orders related to follow up of this error. On 6-28-12 at 2:10 pm, E2 stated she was not there at the time of the medication errors and does not know what follow up if any was implemented after the above errors. (A)	F9999		