

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007561	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/23/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE CITY REHAB & H C	STREET ADDRESS, CITY, STATE, ZIP CODE 825 E MAIN STREET, RR #2, BOX 97 PRAIRIE CITY, IL 61470
---	---

(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
S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)1) 300.1210d)2) 300.1620a) 300.1630d) 300.3240a)</p> <p>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</p> <p>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.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,</p>	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007561	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/23/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE CITY REHAB & H C	STREET ADDRESS, CITY, STATE, ZIP CODE 825 E MAIN STREET, RR #2, BOX 97 PRAIRIE CITY, IL 61470
---	---

(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
S9999	<p>Continued From page 1</p> <p>seven-day-a-week basis:</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>Section 300.1620 Compliance with Licensed Prescriber's Orders</p> <p>a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.</p> <p>Section 300.1630 Administration of Medication</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>THESE REQUIREMENTS ARE NOT MET AS</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007561	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/23/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE CITY REHAB & H C	STREET ADDRESS, CITY, STATE, ZIP CODE 825 E MAIN STREET, RR #2, BOX 97 PRAIRIE CITY, IL 61470
---	---

(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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 2</p> <p>EVIDENCED BY: Based on interview and record review the facility failed to procure and administer newly ordered diuretic medication by neglecting to follow facility policy for medication administration to 2 of 3 residents(R1and R2) reviewed for medication administration. The failures resulted in R2 experiencing Acute on Chronic systolic congestive Heart Failure and Atelectasis in both lungs with Pleural Effusion and a prolonged hospitalization, limiting R2's participation in Activities of Daily Living and her rehabilitative therapy. The facility also failed to document the omission of the medication and notify the prescribing physician of the omission, both are tasks required by facility policy.</p> <p>FINDINGS INCLUDE:</p> <p>The Medication Administration Policy, (revised on 10/07) states, "19. Document all medications not administered for any reason by circling initials and documenting on the back of the MAR the date, the time, the medication and dosage, reason for omission and initials. 21. If the medication is not available for a resident, call the pharmacy and notify the physician when the drug is expected to be available. Like medications are not to be 'Borrowed' from one resident for another. 22. Notify the physician as soon as practical when a scheduled dose of a medication has not been administered for any reason."</p> <p>1. R2's Physician Order Sheet (POS), dated February 27, 2014, (date of admission) documents the following diagnoses: Congestive Heart Failure, Atrial Fibrillation and Hypertension. R2's POS documents that R2 is to receive Lasix 40 mg one tablet one time a day.</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007561	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/23/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE CITY REHAB & H C	STREET ADDRESS, CITY, STATE, ZIP CODE 825 E MAIN STREET, RR #2, BOX 97 PRAIRIE CITY, IL 61470
---	---

(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
S9999	<p>Continued From page 3</p> <p>R2's February 2014 Medication Administration Record (MAR) documents that R2 did not receive the prescribed Lasix on 02/28/2014 - 03/03/2014 or on 03/05/2014.</p> <p>Per R2's February and March 2014 MAR the recorded weight upon admission was 159 lbs. (pounds) R2 was re-weighed on 03/03/2014 and 161 lbs was recorded. On 03/06/2014, R2 weighed 164 lbs and on 03/08/2014 her weight was recorded at 167 lbs.</p> <p>The Nurses Notes, dated 03/06/2014 at 10:00 AM, states, "(R2) continues to have +1 edema in BLE (bilateral lower extremities)."</p> <p>E8's (Medical Director) progress notes from hospital, dated 03/07/2014, document "Increased Weight 169 lbs, increased edema...+3. Acute and Chronic Congestive Heart Failure and Atrial Fibrillation."</p> <p>On 04/17/2014 at 01:55 PM E4, Licensed Practical Nurse (LPN) stated "on 03/03/2014 she was going to administer the medication (Lasix) but it was not available so I faxed the pharmacy and they sent it right out the next night. I must have forgotten to complete the documentation on the back of the MAR."</p> <p>On 04/17/2014 at 01:10 PM E2, Director of Nursing stated, "Yes I know that (R2) missed some doses of the Lasix. I took her to her first doctor appointment on the 7th (March). (E8) was very concerned due to the pitting edema and the amount of weight gain. She was crying and telling (E8) that she didn't want to be hospitalized. (E8) knew that (R2) wasn't getting the Lasix and he (E8) was extremely upset. He (E8), really</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007561	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/23/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE CITY REHAB & H C	STREET ADDRESS, CITY, STATE, ZIP CODE 825 E MAIN STREET, RR #2, BOX 97 PRAIRIE CITY, IL 61470
---	---

(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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 4</p> <p>made that clear to me that this was a failure for (R2). (E8) did allow the resident to remain out of the hospital for the weekend thinking she may recover with increased Lasix. She however did not and was hospitalized on the next Monday straight from (E8)'s office. I do not know why the nurses did not call the pharmacy and report the missing medication to them ... I also have no idea why the nurses are not completing the charting on the MAR for medication omission per the policy."</p> <p>On 04/22/2014 at 11:00 AM, E8, Medical Doctor for R2 stated, "In her case, having been very unstable with a cardiac ejection rate of 20-25%, this error is significant. The failure to receive this Lasix definitely complicated (R2's) medical situation...she still has not recovered. "</p> <p>The Local Hospital Admission Notes, dated 03/10/2014, list admitting diagnosis as 1. Acute Respiratory Distress secondary to Acute Decompensated Systolic Congestive Heart Failure and Basilar Atelectasis with Effusion."</p> <p>2. R1 was admitted to the facility on 02/24/12 with diagnoses of Congestive Heart Failure and Hypertension. R1's March 2014 POS (Physician Order Sheet) and Medication Administration Record (MAR) list medications including Lasix 80 mg (milligrams) to be given one time a day in the morning and 40 mg a day in the evening. The March 2014 MAR documents omitted doses of Lasix on 03/18/2014 and 03/24/2014 with no documentation of reason for omission or physician notification.</p> <p>On 04/18/2014 at 09:40 AM E2, Director of Nursing stated "I don't know why that medication wasn't given to (R1) and I have no idea why the nurses are not completing the requirements for</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007561	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/23/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PRAIRIE CITY REHAB & H C	STREET ADDRESS, CITY, STATE, ZIP CODE 825 E MAIN STREET, RR #2, BOX 97 PRAIRIE CITY, IL 61470
---	---

(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
S9999	Continued From page 5 medication omission charting for these residents." (A)	S9999		