STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	C 07/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	**3611 NORTH ROCHELLE PEORIA, IL 61604**

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F 000	INITIAL COMMENTS Original Complaint # 2124924/ IL 135931	F 000		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to administer antiepileptic and anticoagulant medication as ordered by the Physician for one of three residents (R1) reviewed for medication administration in the sample of seven. This failure resulted in R1 having multiple seizures and being admitted to the hospital. Findings include: The facility's Medication Pass Guidelines (effective 3/2000) document "Physician's Orders-Medications are administered in accordance with written orders of the attending physician. If a dose seems excessive considering the resident's age and condition or a medication order seems to be unrelated to the resident's current diagnosis or condition, contact the physician for clarification prior to administration of the medication. Document the interaction with the physician in the progress notes and elsewhere in the medical record, as appropriate. The nurse who receives the order is responsible for transcribing to the chart." R1's medical record documents diagnoses of Metachromatic Leukodystrophy; Epilepsy,	F 760	This Plan of Correction is being submitted in accordance with the Federal and Medicaid Requirements. Submission of this Plan of Correction is not an admission of guilt or that a deficiency was cited correctly. This Facility reserves the right to contest any violation that may be forthcoming. F 760 The Facility became aware of R1's lab level that were completed at the hospital on 7/8/21 prior to this survey. The Facility promptly began an investigation which was completed and typed up on 7/15/21. See attachment #1 The Director and Assistant Director of Nurses at the same time checked all the g-tube pills and liquid medications amounts against the orders to make sure there was the correct amount of medications that matched the dosage and frequency. The medications they checked were medications that require therapeutic levels to be affectiveThe medications noted matched what would have been present based on when they were	7/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/02/2021

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F 760	Continued From page 1 Intractable with Status Epilepticus; Vanishing White Matter Disease/Dementia; Pulmonary Embolism; and History of other Venous Thrombosis and Embolism. R1's Progress Notes dated 7/8/21 at 12:48pm document "Resident had a 90 second (approximate) seizure at about 12:30pm. MD (Medical Doctor) notified. Awaiting response." R1's Progress Notes dated 7/8/21 at 5:48pm document "Certified Nursing Assistant (CNA) reported seizure activity-approximately 5 (five) minutes. Resident's (family member, V11) notified and wants resident sent to (hospital). AMT (Advanced Medical Transport) contacted at 5:34pm and MD and management notified at 5:37pm. (R1) left the facility at 5:45pm." R1's AMT transport record dated 7/8/21 documents "(R1) had another seizure as transport was started. Seizure had twitching of the arms and face noted. This lasted for approximately 90 seconds." R1's ED (Emergency department) Provider Notes dated 7/8/21 at 6:55pm document "Shortly after labs obtained, (R1) had approximately 92 second of generalized tonic-clonic activity." R1's ED notes document R1 was admitted to the hospital. R1's Valproic acid blood level drawn on 7/8/21 at 7:20pm in the Emergency Department (ED) documents a measurement of less than 13 mcg (micrograms)/ ml (milliliter), and the therapeutic range is documented as 50-100 mcg/ml. R1's hospital Neurology Progress Note dated 7/9/21 at 4:01pm documents "Assessment/Plan: Seizures secondary to subtherapeutic drug levels.	F 760	ordered. This was completed on 7/14/21. The Director and Assistant Director of Nurses also checked the medication records on all the residents that have an order for any type of seizure medication. No other discrepencies were found. This was completed on 7/14/21. The Director of Nurses held an in-service with the nurses and discussed the findings of their investigation and this survey results. Completed 7/28/21. See attachment #2. The Assistant Director of Nurses is now tracking the lab orders along with the lab results. If there is a missing labor anything else is found to be wrong, the Assistane Director of Nurses will investigate what happened and report her findings to the Director of Nurses.Completed 7/12/21 and on-going. See attachment #3. Any changes in medications or lab orders , the nurses will complete a telephone order and give a copy to the Nursing Offic for tracking purposes. Completed 7/28/21. See attachment #4. Nurses were again directed to write a progress note when receiving an order from the physician . Completed 7/28/21. See attachment #5. The Director of Nurses will monitor by reviewing progress notes, telephone orders and other orders received in Point Click Care during the day. Orders	

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F 760	Continued From page 2 Depakote (Valproic acid) found to be undetectable with dosage at facility reported as 625mg twice daily." R1's Physician Orders document an order for Valproic Acid 250 mg (milligrams)/5 (five) ml(milliliters), give 12.5ml two times a day with a start date of 5/4/21 and a discontinuation date of 7/13/21. R1's Physician Order dated 4/30/21 documents "Discontinue Levetiracetam (Keppra) solution 100 mg/ml. Prescriber written order incorrect, 25ml bid (twice a day)," and was written by V10, Registered Nurse (RN). On 7/15/21 at 10:00am, V2, Director of Nursing (DON), provided an investigation dated 7/15/21 for R1's low Valproic acid level and hospitalization. This investigation documents "((V10, Registered Nurse (RN)) failed to write the corrected order for Keppra when correcting the order on 4/30/21." The investigation also documents "Upon review with the supply and demand of Depakote (Valproic acid) with Prime Care Pharmacy it was noted that the resident (R1) received and used the appropriate amount of Depakote as ordered." At this time, V2 confirmed that R1 received no Keppra from 5/1/21-7/8/21. R1's Medication Administration Record (MAR) documents R1 received no Keppra May 2021-July 8/2021. R1's MAR dated 7/1/21-7/8/21 documents R1 received Valproic acid as ordered. On 7/16/21 at 12:04pm, V5, Registered Pharmacist/Primary Care Pharmacy, stated R1's Valproic acid was dispensed on 5/29/21 and not	F 760	received in the evening or on weekends will be reviewed by the Director of Nurses on his next scheduled work day. If an error is found the physician will be notified and a Medication Error report will be completed. The Director of Nurses will be responsible to monitor the above procedures to ensure compliance. The Director of Nurses will report the results of the new procedures to the QA and QAPI Committees when scheduled. Completion date 7/28 and on-going.	

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F 760	Continued From page 3	F 760		

again until 7/9/21. V5 stated the bottle of Valproic acid solution dispensed on 5/29/21 would last for 18 days if properly administered.

On 7/16/21 at 10:40am, V3, Assistant Director of Nursing, stated the bottle of Valproic acid solution dispensed on 5/29/21 was dated as opened on 6/18/21.

On 7/16/21 at 12:04pm, V5, Registered Pharmacist, stated if the bottle of Valproic acid solution was opened on 6/18/21, it would be empty by 7/4/21 or 7/5/21. V5 stated there was not enough medication in the bottle to last until 7/8/21.

On 7/16/21 at 10:59am, V6, Primary Care Physician (PCP), stated the facility did not notify him that R1's Keppra had been incorrectly discontinued on 4/30/21, and that R1 had not received it for over two months. V6 stated "Not receiving the Keppra would have lowered R1's seizure threshold and caused her to have seizures." V6 also stated he was not notified that R1 missed some of her doses of Valproic acid.

R1's Physician Orders dated 6/9/21 document an order for Coumadin 6 (six) mg at bedtime from 6/9/21-6/15/21, and an order for Coumadin 6mg from 6/23/21-6/30/21. There is no order for Coumadin in R1's Physician Orders for 6/16/21-6/23/21.

R1's MAR dated June 2021 documents she received no Coumadin from 6/16/21-6/22/21.

A Medication Incident and Discrepancy Report dated 6/23/21 documents on 6/23/21 V7, Licensed Practical Nurse (LPN), "discovered (R1)

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F 760	Continued From page 4 did not have an order (for Coumadin) available. Upon further investigation, it was noted the order entered by (V17), Registered Nurse (RN) on 6/9/21 had ended on 6/15/21 and another PT/INR (Pro time/ International Ratio) lab draw had not been ordered." On 7/20/21 at 12:55pm, V2, Director of Nursing, stated V12 (RN) failed to order the PT/INR for R1 to be drawn on 6/16/21, so another Coumadin order was not received by the Physician. V2 confirmed that R1 did not receive any Coumadin from 6/16/21-6/22/21.	F 760		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor a PT/INR (Protime/International Ratio) for one of three (R1) residents reviewed for therapeutic monitoring of medications in the sample of seven. Findings include: The facility's Coumadin Protocol (undated) documents "It is the policy of (the facility) to monitor residents on any anticoagulant therapy by	F 770	The Director of Nurses investigated how the PT/INR lab was missed 0n 6/23/221, prior to this survey. At that time the nurses were tracking the PT/INR labs for Coumadin and completing the lab requisitions. A med. Error report was completed and the physician was notified and he gave a new Coumadin and lab order. Completed 6/23/21. See attachment #6.	7/30/21

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F 770	Continued From page 5 administering the medication as ordered by the physician and by measuring the therapeutic level by having Protimes (PT level) drawn according to the physician's order. After each lab draw, the physician will be notified of the results. Orders will be processed as received." R1's Physician Orders document diagnoses of Pulmonary Embolism and History of other Venous Thrombosis and Embolism, and that R1 takes Coumadin for personal history of Pulmonary Embolism. R1's Physician Order dated 6/9/21 documents R1 was to have a PT/INR drawn in one week. A Medication Incident and Discrepancy Report dated 6/23/21 documents on 6/23/21 V7, Licensed Practical Nurse (LPN), "discovered (R1) did not have an order (for Coumadin) available. Upon further investigation, it was noted the order entered by (V17), Registered Nurse (RN) on 6/9/21 had ended on 6/15/21 and another PT/INR (Pro time/ International Ratio) lab draw had not been ordered." The report documents the contributing factor to the Coumadin error/omission as "Failure to complete lab requisition for repeat PT/INR causing medication to be omitted." R1's Lab results document her PT/INR was not monitored from 6/16/21-6/22/21. On 7/20/21 at 12:55pm, V2, Director of Nursing, stated V12 (RN) failed to order the PT/INR for R1 to be drawn on 6/16/21.	F 770	The Assistant Director of Nurses has taken over the PT/INR lab tracking effective 6/23/21. See attachment #7. Currently there is not any resident in the Facility receiving Coumadin. If and when we admit someone with a Coumadin order these procedures will be followed for them too. The Director of Nurses in-serviced the nurses on how to complete the Coumadin and PT/Inr orders. See attachment #8. Completed 7/28/21. The Assistant Director of Nurses will monitor this procedure by completing the tracking log. Attachment #9 Completed 7/28/21. The Director of nurses will monitor this procedure by reviewing the orders and tracking log on a weekly basis. The results of these procedures will be reported to the QA and QAPI Committees when the meetings are held.	