STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	C 12/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	**180 WEST IMBODEN DECATUR, IL 62521**

(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 000	INITIAL COMMENTS Complaint Investigation #1064017 / IL50010	F 000		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that 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 Antidepressant medications as ordered by the Physician for 2 of 3 sampled residents, on a sample of 3(R1,R2). The facility omitted 33 doses of Celexa(R1) and 6 doses of Wellbutrin(R2). Findings include: 1. The CAA(Care Area Assessment) dated 10/1/10 states R1 has had a decline in mood and has become more tearful. The CAA states R1 has "increased episodes of crying and repetitive statement of 'help me' or 'why me'....has poor self esteem and is anxious about what is happening to her medically....." There is a Physician's Order dated 10/12/10 for Celexa 20mg(milligrams) every morning for 30 days. The November 2010 Medication record has an entry dated 10/12/10 for R1 to receive Celexa 20mg every morning for 30 days. The November Medication Record documents that R1 received the Celexa from 11/1-11/17.	F 333		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	C 12/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	**180 WEST IMBODEN DECATUR, IL 62521**

(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 333	Continued From page 1 The Minimum Data Set dated 11/18/10 states R1 has feelings of "feeling down, depressed or hopeless" and is "feeling bad about yourself-or that you are a failure or have let yourself or your family down." The hospital "Emergency Room Document" dated 11/18/10 states R1 was admitted to the hospital for "acute disorientation/change in mental status." The hospital History and Physical dated 11/18/10 states R1 has a history of Cerebrovascular Accident, underlying Anxiety/Depression, Hypertension and Seizure Disorder. The Consultation report dated 11/19/10 states "change in mental status, which I suspect is related to fentanyl patch that [R1] has been on since September. I recommend discontinuing it. Ativan can also be causing her to cry all the time and recommend discontinuing this..." The hospital transfer form dated 11/19/10 states R1 is to receive Celexa 20mg every day. There is a Physician Telephone Order dated 11/19/10 for Celexa 20mg daily. The November 2010 Medication Record does not document that R1 was given Celexa from 11/20 to 11/30/10. The entry for the Celexa is crossed through on the record. The Physician Order Sheet(POS) dated for December 2010 does not have the order for Celexa 20mg daily listed with R1's other routine medications. The December 2010 Medication Record does not have an entry for the Celexa and there is no documentation of R1 receiving	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	C 12/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	**180 WEST IMBODEN DECATUR, IL 62521**

(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 333	Continued From page 2 the Celexa from 12/1-12/23/10. E2, Licensed Practical Nurse(LPN), Clinical Coordinator, stated on 12/23/10 at 1:45pm that R1 returned to the facility from the hospital on 11/19/10 with an order for the Celexa to be given. E2 stated she did not see an order to discontinue the Celexa and it should have been started on 11/19/10. E2 stated she believed the error occurred because staff did not transcribe the new order for Celexa when R1 returned from the hospital on 11/19/10. 2. The July 2010 POS states R2 has diagnoses of Bipolar Disorder, Anxiety, Diabetes and Hypertension. The Physician Progress Note dated 7/19/10 states R1's mood is depressed with increased sleeping. The note documents a diagnosis of Bipolar Depression. There is a Physician's Order dated 7/19/10 for Wellbutrin 75mg daily. The July 2010 Medication Record documents that R2's Wellbutrin was not started until 7/26/10, even though it was ordered on 7/19/10. The facility Medication Treatment Error Report dated 7/25/10 states that R2's Wellbutrin 75mg was "not given" because "order [was] not put on MAR[Medication Administration Record]." E1, Administration, stated on 12/23/10 at 11:00am that R2's Wellbutrin was not started on 7/19 because of a transcription error. E1 stated the nurse wrote the order, the pharmacy sent the medication, but the medication was not written on	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	C 12/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	**180 WEST IMBODEN DECATUR, IL 62521**

(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 333	Continued From page 3 the Medication Record, so it was not given.	F 333		