

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/10/2024
NAME OF PROVIDER OR SUPPLIER  Toulon Rehab & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  Highway 17 East Toulon, IL 61483	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>30722</p> <p>Based on record review and interview, the facility failed to notify a physician per their facility policy of a medication error/omission for one resident (R1) of three residents reviewed for physician notification of changes in a total sample of three residents.</p> <p>Findings include:</p> <p>Policy last reviewed 09/27/17 titled Conformance with Physician Medication Orders Policy documents, (All) medications shall be given as prescribed by the physician and at the designated time. Procedure: 7. The resident's attending physician shall be notified of medications about to be stopped so the physician may promptly renew such orders to avoid interruption of the resident's therapeutic regimen.</p> <p>Policy Medication Administration last revised 11/18/17 documents under a section titled Procedure, 3. Medications must be prepared and administered within one hour of the designated time or as ordered. and 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; 22. Notify the physician as soon as practical when a scheduled dose of medication has not been administered for any reason. Report errors in medication administration immediately per policy.</p> <p>R1's Order Recap Report for October 2024 documents R1 has diagnoses which include Anxiety Disorder, Panic Disorder, Dementia and Alzheimer's Disease.</p> <p>R1's October 2024 Order Recap Report documents an order for Lorazepam 0.5 milligrams by mouth three times a day related to Anxiety Disorder changed from every eight hours as needed to three times daily on 09/12/24.</p> <p>R1's Controlled Substances Proof of Use log for Lorazepam 0.5 milligram tablet dated 07/17/24 and 09/21/24 document R1 did not have Lorazepam 0.5 milligrams signed out of her medication card between 09/15/24 at 12:00 AM and 09/21/24 at 8:00 AM.</p> <p>Fax Confirmation documents on 09/19/24 V4, Agency LPN (Licensed Practical Nurse), requested to remove one Ativan from the emergency supply.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's MAR/Medication Administration Record for 09/19/24 at 8:00 AM documents V4 charted 5 (hold/see progress notes) and then administered R1's 0.5 milligram Ativan at 4:00 PM. V4 documented in R1's progress notes on 09/19/24 at 12:15 that he reordered R1's Ativan 0.5 milligram tablets.</p> <p>V6/LPN charted on 09/17/24 at 12:00 AM and 09/20/24 at 12:00 the number 9 on R1's MAR which the key on R1's MAR indicates, Other/See Progress Notes. V6 documented on 09/16/24 at 11:46 PM, Unavailable, awaiting pharmacy and on 09/20/24 at 1:52 AM, Medication unavailable, awaiting pharmacy.</p> <p>Review of R1's September 2024 MAR documented R1's Ativan was administered by V3/LPN on 09/16/24 at 8:00 AM and 4:00 PM and 09/17/24 at 8:00 AM and 4:00 PM; by V7/Agency LPN on 09/15/24 at 12:00 AM, 09/16/24 at 12:00 AM, 09/18/24 at 12:00 AM and 09/19/24 at 12:00 AM; and by V5/LPN on 09/15/24 at 8:00 AM and 4 PM, 09/18/24 at 8:00 AM and 4:00 PM when there was no Ativan available in the building for R1.</p> <p>Incident Investigation Form dated 09/20/24 at 10:00 AM and signed by V2/Director of Nurses (DON) document V2 spoke with V5 who reported she did not give R1's medication because it was not available, but inadvertently signed off that V5 had given the medication.</p> <p>Incident Investigation Form dated 09/20/24 at 12:30 PM and signed by V2 document V2 spoke with V3 who reported she did not give R1's medication because it was not available, but inadvertently signed off that V3 had given the medication.</p> <p>Incident Investigation Form dated 09/20/24 at 8:00 PM and signed by V2 document V2 spoke with V7 who reported she did not give R1's medication because it was not available, but inadvertently signed off that V7 had given the medication.</p> <p>Remedy on the Incident Investigation Form written by V2 on 09/20/24 for V3, V5 and V7 documents, V3, V6 and V7) will notify physician, POA (power of attorney) and DON of medication unavailable for any resident under her care. She will also make all attempts necessary to obtain needed medication from E-kit (emergency kit) if available. She will also notify physician of any need for a new prescription before medication if exhausted and unavailable.</p> <p>On 10/09/24 at 12:25 PM V3 confirmed she did not have doses available to administer to R1 on several occasions during September and confirmed she did not request removal of the medication from the Emergency Box. V3 did not recall notifying R1's physician.</p> <p>On 10/09/24 at 2:02 PM V6 stated there were two occasions that R1's Ativan was not available to administer, and she made a progress note. V6 stated she didn't think to request R1's Ativan dose from the Emergency Box. V6 stated she did not contact R1's physician regarding not having Ativan to administer.</p> <p>On 10/09/24 at 2:30 PM V7 confirmed there were some occasions in September 2024 that R1's Ativan was not available. V7 stated V2 spoke with her regarding inadvertently documenting R1's medication was administered and that she should have obtained the dose from the Emergency Box, notified the physician and ensured the medication was re-ordered. V7 confirmed she did not contact R1's physician when Ativan was not available for administration.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/10/24 at 11:50 AM V2 confirmed R1 did not receive 15 doses of scheduled Ativan 0.5 milligrams by mouth between 09/15/24 at 12:00 AM and 09/20/24 at 12:00 AM. V2 confirmed he could not provide documentation that V3, V5, V6 or V7 contacted R1's physician during the 15 times her medication was unavailable. V2 also confirmed during interview he did not notify R1's physician per facility policy once the medication errors were discovered and investigated.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>30722</p> <p>Based on record review and interview, the facility failed to ensure one resident (R1) of three residents received prescribed medication for anxiety as per a physician order without significant error in a total sample of three resident reviewed for medication errors.</p> <p>Findings include:</p> <p>Policy last reviewed 09/27/17 titled Conformance with Physician Medication Orders Policy documents, (All medications shall be given as prescribed by the physician and at the designated time. Procedure: 7. The resident's attending physician shall be notified of medications about to be stopped so the physician may promptly renew such orders to avoid interruption of the resident's therapeutic regimen.</p> <p>Policy Medication Administration last revised 11/18/17 documents under a section titled Procedure, 3. Medications must be prepared and administered within one hour of the designated time or as ordered. and 19. Document any medications not administered for any reason by circling initials and reason for omission and initials. and 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 medication has not been administered for any reason. Report errors in medication administration immediately per policy.</p> <p>R1's Order Recap Report for October 2024, documents R1 has diagnoses which include Anxiety Disorder, Panic Disorder, Dementia and Alzheimer's Disease.</p> <p>R1's Minimum Data Sheet Section C, Cognitive Patterns dated August 4, 2024, documents R1 has a BIMS (Brief Interview for Mental Status) score of 10, moderate cognitive impairment.</p> <p>R1's October 2024 Order Recap Report documents an order for Lorazepam (Ativan) 0.5 milligrams by mouth three times a day related to Anxiety Disorder changed from every eight hours as needed to three times daily on 09/12/24.</p> <p>R1's Controlled Substances Proof of Use log for Lorazepam 0.5 milligram tablet dated 07/17/24 and 09/21/24 document R1 did not have Lorazepam 0.5 milligrams signed out of her medication card between 09/15/24 at 12:00 AM and 09/21/24 at 8:00 AM.</p> <p>Fax Confirmation documents on 09/19/24 V4, Agency LPN (Licensed Practical Nurse), requested to remove one Ativan from the emergency supply.</p> <p>R1's MAR/Medication Administration Record for 09/19/24 at 8:00 AM documents V4 charted 5 (hold/see progress notes) and then administered R1's 0.5 milligram Ativan at 4:00 PM. V4 documented in R1's progress notes on 09/19/24 at 12:15 that he reordered R1's Ativan 0.5 milligram tablets.</p> <p>(continued on next page)</p>		

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