| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146026 | A. Building<br>B. Wing | 07/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lewis Memorial Christian Vlg | 3400 West Washington<br>Springfield, IL 62702 |

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) |
|---|---|
| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>34964<br><br>Based on observation, interview and record review, the facility failed to ensure a resident is free from misappropriation of their property for 1 of 4 residents (R6) reviewed for misappropriation of property in the sample of 6.<br><br>Findings include:<br><br>On 7/9/24 at 9:16 AM V6, Licensed Practical Nurse (LPN) administered R1's morning medications to her. When V6 opened R1's Lidocaine patch she dropped the patch on the floor and discarded it after picking it up off the floor. V6 then went back to the medication cart to retrieve another Lidocaine patch and writer requested to see the package V6 got the patch from to check the dose, physician order and name on the package. V6 stated, I just used (R1's) last patch; that was the one I dropped on the floor. I just borrowed one from (R6). I will replace it when R6's patches come in because I will still be here tonight when pharmacy delivers them because I work 16 hour shifts on Tuesdays. I borrowed it from (R6) because it is not (R1's) fault that I dropped her patch on the floor. V6 stated she doesn't always borrow one resident's medication for another resident but sometimes she has to. V6 stated floating staff sometimes do not reorder medications when they work and residents run out of things, so she has to borrow from other residents. She stated she generally has resident's medications.<br><br>On 7/9/24 at 10:20 AM V2, Director of Nursing (DON) stated she would expect the nurses to follow the facility's general guidelines of the medication pass policy and not do anything from memory. She stated the residents' medications are prepackaged by pharmacy, including over the counter medications, so there are no over the counter medications in the med carts. She stated there are also no medications that can be borrowed. V2 stated the only medications in the emergency box are things like antibiotics and critical heart medications. She stated if they have to waste something like a Lidocaine patch, they can borrow from that same resident's own medications and notify pharmacy so they can send out a dose to replace that resident's own borrowed dose. She stated if she needed another Lidocaine patch, V6 should have called pharmacy, or notified her if it was something they could get over the counter and she could have sent someone out to get it. V2 stated it is never alright to take a medication from one resident and give it to another resident.<br><br>(continued on next page) |

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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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's policy, Prevention of Abuse, Neglect, and Exploitation Policy, revised 10/21/22 documents, It is the policy of (facility) to provide protections for the health, welfare, and right of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect , exploitation and misappropriation of resident property. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.<br><br>The facility's policy, Preparation and General Guidelines dated 9/1/23 documents: Medication Administration-General Guidelines: B)15) Medications supplied for one resident are never administered to another resident. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34964<br><br>Based on observation, interview and record review, the facility failed to follow Nursing Standards of Practice while performing medication administration for 3 of 3 residents (R1, R3 and R4) reviewed for medications in the sample of 6.<br><br>Findings include:<br><br>On 7/9/24 at 9:05 AM a Medication Pass Observation was done with V6 Licensed Practical Nurse (LPN) on 100 hall. V6 stated, I already signed out all my medications but I still have some residents to give their medications. My computer doesn't always work good and I work two 16 hour shifts, on Mondays and Tuesdays, and every other weekend, so I know everyone's medications. I have not let administration know about the computer not working sometimes, I just deal with it. If a resident refuses one of their meds, I just go back and strike it out. V6 did not use the computer on her medication cart to check the e-mar while passing medications.<br><br>On 7/9/24 at 9:07 AM V6 administered medications to R1. She read the names of the medications off the prepackaged pouch of medications pre-filled by pharmacy, but did not check the medications against R1's electronic medication administration record (e-mar) to ensure the correct medications were contained in the pre-filled pouch.<br><br>On 7/9/24 at 9:32 AM V6 administered medications to R3. She read the names of the medications off the prepackaged pouch of medications pre-filled by pharmacy, but did not check the medications against R3's electronic medication administration record (e-mar) to ensure the correct medications were contained in the pre-filled pouch.<br><br>On 7/9/24 at 9:45 AM V6 administered medications to R4. She read the names of the medications off the prepackaged pouch of medications pre-filled by pharmacy, but did not check the medications against R4's electronic medication administration record (e-mar) to ensure the correct medications were contained in the pre-filled pouch. V6 stated R4 normally asks for a pain pill, and she put a Norco 5/325 milligram (mg) tablet in a med cup (before assessing R4 and asking if she wants a pain pill) and stated R4 also normally asks for a Clonazepam for anxiety. V6 stated she gives R4 a green pill for her Clonazepam, but didn't know what the dose was. V6 pulled the card of Clonazepam from the drawer with the order documented on card, Clonazepam 1 milligram (mg) Give one tablet every (q) 12 hours (h) as needed (prn). At surveyor's request, V6 looked at R4's physician order, and R4 was ordered to receive Clonazepam 1 mg give 1/2 tablet Q12 hours prn. The order on R4's card of Clonazepam 1mg give one tablet (1mg) Q12H prn did not match her current physician's order. V6 stated the order to administer 1/2 tablet was dated 6/28/24. She stated R4 had been in the hospital and they must have changed it then but she did not know it had been changed. V6 confirmed she had worked yesterday and today and had administered medications to R4 on both days. When V6 went into R4's room to administer her medications, R4 stated she had been receiving a full pill, not a half pill of her Clonazepam, for the past 4 years .<br><br>R4's Minimum Data Set (MDS) dated [DATE] documented R4 is alert and oriented.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/9/24 at 10:20 AM V2, Director of Nursing (DON) stated she would expect the nurses to follow the facility's general guidelines of the medication pass policy and not do anything from memory.<br><br>On 7/9/24 at 2:05 PM V2, DON stated she had done a medication error report regarding R4's Clonazepam. She stated R4 had been on Clonazepam 1 mg before she went to the hospital and when she returned the order was changed to 1/2 tablet (0.5 mg). She stated a change of dose sticker should have been put on R4's card of Clonazepam to alert staff that the dose was changed. V2 stated if V6 had looked at R4's MAR while administering R4's medications, she would have seen her order for Clonazepam had been changed because the physician order would have carried over to her e-MAR.<br><br>The facility's policy, Preparation and General Guidelines, dated 9/1/23 documents, Medication Administration-General Guidelines: The facility will provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing , and administering of all medications, to meet the needs of each resident. Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the medication management system in the facility. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. 4) Five Rights- Right resident, right drug, right dose, right route, and right time are applied for each medication being administered. A triple check of these 5 rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. a. Check #1: Select a medication-label, container and contents are checked for integrity, and compared again the medication administration record (MAR) by reviewing the 5 Rights. b. Check#2: Prepare the dose-the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights. 5. Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label. I the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. B. Administration: 2) Medications are administered in accordance with written orders of the prescriber. Documentation (including electronic): 1) The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. |