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S 000	Initial Comments Complaint #1961040/IL109484 Complaint #1961054/IL109498 Complaint #1961318/IL109785	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b 300.1210d)1) 300.1620a) 300.1630b) 300.1630c) 300.3220f) 300.3240a) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

Section 300.1620 Compliance with Licensed Prescriber's Orders

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.

Section 300.1630 Administration of Medication

b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification.

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Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available , a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility.

c) Medications prescribed for one resident shall not be administered to another resident.

Section 300.3220 Medical Care

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidenced by:

Based on record review and interview the facility failed to administer the correct medications to the correct resident for one of three residents (R1) reviewed for medication errors in the sample of 41. This failure resulted in R1 being hospitalized in the critical care unit with respiratory failure.

Findings include:

The facility's Medication Administration policy with a revised date of 10/2007 documents, "The complete act of administration entails removing

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an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given." This policy also documents, "Medications must be identified by using the seven (7) rights of administration: Right resident, Right drug, Right dose, Right consistency, Right time, Right route, Right documentation." This policy also documents, "Identify each resident prior to medication administration. Two methods of verification must be utilized prior to administration of a medication: Check photograph, Ask resident his/her name, Verify resident's identity with another employee familiar with the resident, Call the resident by name and ask for confirmation."

The facility's Adverse Drug Reactions and Medication Discrepancy policy with a revised date of 10/2006 documents, "A medication discrepancy/error has been made when one of the following occurs: Wrong medication administered, Wrong dose administered, Medication administered by wrong route, Medication administered to wrong resident, Medication administered at wrong time, Medication not administered."

R1's Face Sheet documents an original admission date of 11/15/18. R1's Physician Order Sheet (POS) dated 1/25/19 documents the diagnoses of Diabetes, Closed Ovulsion at Left Hip, Altered Mental Status, Right Radial Fracture, Mild Alzheimer's and Hypertension. This POS documents R1 had medication orders for Venlafaxine HCL (hydrochloride) (antidepressant) 75mg (milligrams) twice a day and Lorazepam (antianxiety) 0.5mg twice a day as needed. R1's Medication Administration Record dated 2/1/19

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through 2/28/19 documents R1 received R1's scheduled Venlafaxine HCL 75mg twice on 2/9/19 at 8:00 AM and 4:00 PM.
R1's PRN (as needed) Medication information sheet documents R1 did not received any of R1's prn Lorazepam on 2/9/19.

R1's Minimum Data Set (MDS) dated 2/1/19 documents R1's BIMS (Brief Interview for Mental Status) score was 8/15 which indicates moderately impaired cognition.

R1's Medication Error Report dated 2/9/19 completed by V15 Registered Nurse (RN) documents the date of the error as 2/9/19 and the time of the error as 8:00 PM and a description of the error stating V15 gave the wrong resident another resident's medication. This report documents V15 gave R1 Prevastatin (cholesterol lowering medication) 20mg, Seroquel (antipsychotic) 400mg, Lamictal (anticonvulsant) 200mg and Risperdal (antipsychotic) 2mg. This report documents R1's Physician ordered medications to be administered at 8:00 PM was Bentyl 10mg. This report documents the time the error was discovered as 8:15 PM on 2/9/19.

R1's A.I.M. (Assess, Intercommunicate, Manage) for Wellness form documents V15 notified V27 Physician on call, of the medication error and V27 gave orders to monitor resident's blood pressure, respirations and oxygen saturation percentage every hour for four hours and if the systolic blood pressure drops below 100 or the oxygen saturation percentage drops below 88% (percent) to send R1 to the emergency room for evaluation.

R1's Nurses Notes dated 2/9/19 at 8:00 PM documents R1's first set of vitals after identifying the error were a blood pressure of 116/58, pulse

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of 80 beats per minute (bpm), respirations were 18 per minute and oxygen saturation was 96% on room air. R1's Nurses Notes documents on 2/9/19 at 9:15 PM, V15 returned to R1's room to recheck R1's vital signs. R1's vital signs at that time were a blood pressure of 70/40, respirations of 18, pulse of 83 bpm, oxygen saturation was 90% on room air. This Nurses Notes documents V15 called 911 (emergency help) and returned to R1. V15 documents R1 would arouse with the calling of R1's name but then R1's eyes would flutter shut. V15 placed a non-rebreather mask on R1 with oxygen at 15 liters per minute.

V15's Witness Statement completed on 2/10/19 documents after V15 rechecked R1's vital signs at 9:15 PM, V15 asked the CNA (Certified Nursing Assistant) to get V26 Licensed Practical Nurse (LPN) to help and to go get the crash cart. V15 goes on to document on this statement that V15 was not able to get R1 to respond again and R1's oxygen saturation was no longer registering on the pulseoximeter. V15 documents that V15 rechecked R1's blood pressure and R1's blood pressure at that time was 50/30 and the ambulance personal arrived at that time. V15 documents that the ambulance personal immediately transferred R1 to a gurney obtained R1's important paperwork and left the facility.

R1's hospital encounter information documents R1 arrived at the hospital on 2/9/19 at 9:48 PM. R1's hospital record documents R1's admitting diagnosis was Poisoning by Other Antipsychotics and Nueroleptics, Accidental. This hospital record documents R1's procedures as Respiratory Ventilation and Insertion of Endotracheal Airway into Trachea.

R1's hospital Progress Notes document R1 was

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admitted to the CCU (Critical Care Unit) on 2/10/19 at 12:15 AM from the emergency department. This notes also documents, "(R1) currently on ventilator and sedated with propofol (anesthetic)."

R1's hospital Discharge Summary documents admitting diagnoses as Accidental Drug Overdose and Acute Hypercapnic and Hypoxic Respiratory Failure. This Discharge Summary documents R1 was discharged from the hospital on 2/16/19 to a different facility.

On 1/21/19 at 1:22 PM, V15 stated V15 does not normally work at this facility V15 was just trying to help out. V15 stated 2/9/19 was total chaos. V15 stated there were six falls and they were trying to get fall vitals on them and then multiple alarms were going off. V15 stated there was a Dementia resident that kept removing their lap buddy. V15 stated V15 identified R1 and then got interrupted by the distractions. V15 stated when V15 returned V15 grabbed R4's medications and gave them to R1. V15 stated V15 did not realize the error had happened until a short time later when V15 reached R4's room. V15 stated at that moment V15 realized what V15 had done. V15 stated V15 immediately went to check on R1 and obtained a set of vital signs then paged the Physician on call. V27 Physician on call returned V15's call and gave orders to monitor R1's vital signs every hour for the next four hours and if the systolic blood pressure drops below 100 or the oxygen saturation drops below 88 percent to send R1 to the emergency room for evaluation. At this same time V15 stated V15 made the necessary notifications of the error then finished the medication pass. V15 stated it was not quite a whole hour since the last set of vital signs had been taken on R1 but V15 went ahead and

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checked on R1. V15 stated R1's blood pressure was 70 something over 40 something and R1 did not arouse easily. V15 stated V15 called 911 (emergency personal). V15 stated V15 returned to R1's room and checked the oxygen saturation which was 90-91 percent. V15 stated V15 requested V16 Certified Nursing Assistant (CNA) go get V26 Licensed Practical Nurse (LPN) to assist V15 and requested V16 retrieve the crash cart. V15 stated V15 placed a non rebreather mask on R1 and started to reassess R1. V15 stated R1's blood pressure was even lower and then the ambulance personal arrived. V15 stated V15 gave the ambulance personal the information they needed and they left quickly with R1.

On 2/25/19 at 10:04 AM, V15 added that V15 prefilled the medication before V15 went to pass the medication. V15 confirmed V15 prefilled R1 and R4's medication. V15 stated V15 identified R1 then got interrupted. V15 stated when V15 returned to the medication cart V15 grabbed R4's cup of medications instead of R1's cup of medications. V15 stated V15 gave R1 medications that were meant for R4.

On 2/21/19 at 12:30 PM, V16 Certified Nursing Assistant (CNA) confirmed V16 worked on 2/9/19 and stated V15 asked V16 to obtain vital signs on R1 every hour for four hours. V16 stated V16 did not know why but V16 agreed to get the vital signs. V16 stated it had not quite been a full hour from the last set of vital signs and V16 saw V15 go into R1's room. V16 stated a few minutes later V15 asked V16 to go get V26 Licensed Practical Nurse to help. V16 stated V16 got V26 right away and then V16 and V26 attempted to wake R1 up. V16 stated V16 was rubbing R1's legs and V26 was rubbing R1's chest with no response from R1. V16 stated V16 heard someone ask for the

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S9999	Continued From page 8 crash cart so V16 stated V16 ran to get the crash cart. V16 stated when V16 got back to R1's room the ambulance personal were arriving and they took R1 to the hospital. On 2/21/19 at 2:19 PM, V17 R1's Physician stated R1's respiratory failure was probably due to an accumulation of all of the medications R1 was given. V17 stated the combination of Lamictal, Seroquel and Ativan can cause respiratory depression. V17 stated the nurses should double check the resident's names before giving medications. V17 stated V17 thinks they just tried to go to fast, they need to slow down. (A)	S9999		