STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007884	A. BUILDING: _____ B. WING _____	C 08/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTHAVE HOME-WHITESIDE COUNTY	408 MAPLE AVENUE MORRISON, IL 61270

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S 000	Initial Comments Incident Report Investigation of July 27, 2017/IL 95820	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.1210d)1)2) 300.1620a) 300.1630c) 300.3220f) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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. 2) All treatments and procedures shall be administered as ordered by the physician. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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
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 2-104(b) of the Act)

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

This requirement is not met as evidence by:

Based on interview and record review the facility failed to ensure a resident was free of a

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significant medication error. This failure resulted in R1 being hospitalized with hypotension and hypoglycemia.

This applies to 1 of 3 residents (R1) reviewed for medications in the sample of 3.

The findings include:

The facility's Medication Error Report dated July 27, 2017, showed R1 was given the wrong medication by E1(RN-Registered Nurse). E1 had prepared R1 and R2's medication. E1 administered R2's medication to R1. E2 then gave R2 her medications. R2 stated the medications in the cup did not look right. E1 then realized she had given R1 the wrong medications. R1 was sent to the local emergency room for monitoring due to a low blood pressure.

The facility's Incident Report dated July 27, 2017, showed E1 administered R2's 8:00 AM scheduled medications to R1. The medications given to R1 included: one anti-depressant (Prozac), two diuretics(Lasix and Aldactone), one hypoglycemic (Glipizide extended release) and three anti-hypertensives (Isosorbide extended release, Losartaan Potassium and Metoprolol Tartate). R1's blood pressure was running low so she was transported to the local hospital for monitoring and observation.

R1's Minimum Data Set dated May 16, 2017 shows R1 has diagnoses of coronary artery disease, hypertension, thyroid disorder, dementia, multiple sclerosis, Parkinson's and overactive bladder. R1's Physician Orders for July 2017 shows that R1 does not take any medications for hypertension or for hyperglycemia. R1's Monthly Weights and Blood Pressures Log for 2017

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shows R1's usual blood pressure to be 130's (systolic) / 80's(diastolic).

On August 3, 2017 at 10:40 AM, R1 stated, " I went to the hospital last week because they (facility staff) gave me the wrong medicines. My blood pressure was low. They also kept checking my blood because my blood sugar was low. They gave me some medicine and an IV (intravenous fluids). I had a headache. It upset me because I had to go to the hospital, it takes so long when your are there."

On August 3, 2017 at 10:25 AM, E1(Registered Nurse) stated on the morning of July 27, 2017 she was doing her medication pass. E1 stated,"R1 and R2 sit at the same table. I gave R1 what I thought were her medications and then turned and handed R2 her medications. R2 poured out her medication and counted them. R2 said there were not 12 pills. At that point I realized that I gave the wrong pills to R1. I know R2 takes some heavy duty pills for her blood pressure. I checked R1's blood pressure and it was already going down. I called the nurse practitioner and she told me to send her out to the emergency room. R1's blood pressure was 80/54, which is low for R1." E1 was asked what she would have done differently. E1 stated," I should put resident's name on the medication cup so I know whose medications are whose."

On August 3, 2017 at 11:40 AM, E2(Director of Nursing) stated," when the nurses are administering medications they are to administer to one resident at a time. The nurse is to check the medication against the MAR-Medication Administration Record. Then give the medication to the resident. Lastly they are to sign out that the medication was given. After that is done then they

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can move on to the next resident. They should not prepare two residents medication the same time. There is too much room for error. R1 was sent out to the hospital because she was hypotensive. When R1 returned to the facility they were (facility staff) monitoring her blood sugar and blood pressure for any ill effects of the medication error."

On August 3, 2017 at 12:09 PM, Z2(Clinical Pharmacist) stated, " R1 was not on any anti-hypertensive's or antihyperglycemics. The medications given to R1 accidentally were concerning for lowering her blood pressure and blood sugar. It would take at least 24 hours for the medications to leave her system. Glipizide and Isosorbide are long acting medications and would be the most concerning."

On August 3, 2017 at 11:50 AM, Z1(Physician) stated," R1 was transferred to the emergency room for a low blood pressure. Her blood pressure initially was in the low eighties. She was given intravenous fluids to raise her blood pressure. We checked the half life of the medications she was given. the half life was 24 - 36 hours for the medications to leave her system, so she was admitted so we could monitor her blood pressure, heart rate and blood sugar. She was placed on a cardiac monitor and blood sugars and blood pressure were monitored. When administering medication to residents it should be done one resident at a time so this kind of thing doesn't happen".

R1's hospital admission history and physical dated July 27, 2017 showed R1 was admitted to the hospital with a diagnosis of hypotension and a risk of hypoglycemia following an accidental ingestion of Isordil and Glipizide. R1 is to be

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S9999	Continued From page 5 observed placed on cardiac monitoring and monitor glucose. R1's hospital discharge history and physical dated July 28, 2017, showed R1's final diagnoses for discharge were hypoglycemia and hypotension. R1 was accidentally administered another resident's medication with subsequent weakness, hypoglycemia and hypotension. R1 is to be discharged back to the nursing home with the following instructions; monitor for signs and symptoms of hypoglycemia. Blood sugars are to be checked every four hours today July 28, 2017. If the blood sugar is less than 100 start sugar feedings and recheck the blood sugar in 30 minutes. If the blood sugar is still less than 100, call 911. Be careful in administering medications. (B)	S9999		