STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008056	A. BUILDING: _____ B. WING _____	C 06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCOLADE HC OF EAST PEORIA	500 CENTENNIAL DRIVE EAST PEORIA, IL 61611

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S 000	Initial Comments Investigation of Facility Reported Incident of June 9, 2022/IL148008	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210c) 300.1210d)1) 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 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 intravenous and intramuscular, shall be properly administered. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure Physician orders were obtained and reconciled on admission, prior to administering medications facility; and failed to ensure a resident was given the correct dose of a Narcotic medication for one of three residents (R1) reviewed for medication errors in the sample of three. This failure resulted in R1 receiving an incorrect, increased dosage of a Schedule II Controlled substance (overdose of Methadone) and becoming unresponsive, requiring oxygen administration, being hospitalized, and receiving an overdose antidote due to impending respiratory failure. Findings include: The facility's Medication Errors policy dated 4/1/22, states, "Medication reconciliation is a safety strategy that involves comparing the list of medications the health care provider sends upon admission to the facility and the list of the medications the resident was on in the hospital. This process is done to avoid medication errors such as: Missing medications (omissions), Duplicate medications, Dosing errors, Drug interactions. Medication reconciliation should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting (such as being admitted or discharged	S9999		

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S9999	Continued From page 2 from the hospital), health care provider or level of care." The facility's Medication Administration policy dated 4/1/22, states, "Residents shall receive their medications on a timely basis in accordance with state and federal guidelines, and within established facility policies. Procedure: 1. Drugs and biological's may be administered only by licensed Physicians, licensed Registered or Practical nursing personnel, and must be administered in accordance with the written order of the attending Physician. 7. Should there be any doubt concerning the administering of medications, the Physician's order must be verified before the medication is administered." The Medication Administration policy dated 4/1/22, also states, "Medications will have the 6 Rights of Drug Administration completed prior to administration of those listed medications." The facility's Admission Check List Process (date unknown), states, "Completed within two hours: Ensure Narcotic scripts are signed and sent to pharmacy; Enter orders/2nd nurse open orders recheck (medications) and doses for correction." R1's electronic Medical Record documents R1 was admitted to the facility on 6/9/22 and discharged from the facility on 6/9/22. R1's Final Facility Report to the State Agency dated 6/14/22, states, "Upon admission (6/9/22), (R1) requested pain medication due to his pain being a 9 on the scale (out of 10). Hospice Nurse (V7/Hospice Registered Nurse) was in room with facility nurse (V4/Licensed Practical Nurse) and had with her the admission packet with the medication list. (V7) directed (V4) to give (R1) certain dose of Methadone (narcotic pain	S9999		

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S9999	Continued From page 3	S9999		

medication). (V4) asked (V7) four times to verify dosage. As (V4) was administering directed dosage she was then told to stop by (V7), and it was then discovered that a higher dosage than what was ordered had been given. (R1's Physician and representative) were notified and (R1) was sent out to the hospital."

R1's Admission Medication list (from transferring facility) dated 6/8/22, documents Methadone oral concentrate (10 milligrams/mg per milliliter/ml) give 8 mg every 6 hours.

On 6/22/22 at 10:52 a.m., V4 (Licensed Practical Nurse) stated R1 was in the process of being admitted to the facility on 6/9/22 and V7 (Hospice Registered Nurse) was onsite to assist in the admission process. V4 stated that R1 had only been in the facility approximately one and a half hours when R1 started to complain of severe pain (9 out of 10 on the pain scale). V4 stated R1's representative had already left R1's supply of medications and V7 had R1's physician orders in her hands. V4 stated V4 asked V7 how much of the Methadone concentrate was to be given and V7 responded "8 of the Methadone and 10 of water." V4 stated, "I had not processed any orders (for R1) at this time and did not look at the Physician orders prior to administering (R1's Methadone)." V4 stated that V4 prepared a 6 ml (milliliter) syringe with 6 ml (60 mg) of Methadone and started administering the Methadone via R1's rectal catheter. V4 stated, "I was questioning (V7) why they only had a 6 ml syringe if (R1) was supposed to get 8 ml of Methadone. (V7) said, 'Hold on let me look at the order' and after reading the orders told me to stop giving the Methadone because it was only supposed to be 0.8 ml (8 mg). (V3/Medical Director) was in the facility rounding on other residents and one of the

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S9999	Continued From page 4	S9999		

other nurses ran out and asked him for orders. (V3) stated to send (R1) to the hospital. (V7) had called the hospice Physician also who agreed to send (R1) to the hospital. (R1's) oxygen saturation was dropping down to 88%. I applied oxygen and his oxygen saturations went back up to over 90%. I was doing everything possible to keep (R1) awake. I kept talking to him and I even gave him a couple sternal rubs. (R1) did become very lethargic prior to the ambulance arriving. (R1) wasn't responding when he left (the facility). I take full responsibility for the error, and I should have verified (R1's) orders before giving him any medication."

R1's Hospital Nurse progress note dated 6/9/22 at 12:35 p.m., states, "EMS (Emergency Medical Services) states (R1) was given 60 mg of Methadone instead of 8 mg of methadone rectally. States nursing at facility stated (oxygen saturations) decreased. On arrival (R1) eyes open, does not respond to verbal, does not speak, does not follow commands."

R1's Emergency Department (ED) Progress Note dated 6/9/22 at 12:48 p.m., states, "(R1) was ordered to have 8 mg of methadone but was given 60 mg per nursing home. (R1) is presenting to the emergency department for evaluation of an accidental overdose. (R1's wife) relays (R1) is normally alert and responsive but is now unresponsive. (R1's wife) stated the patient can take solids and liquids by mouth but becomes very nauseated. Physical Exam: Cardiovascular: Rate and Rhythm: Regular rhythm. Tachycardia (rapid heartbeat) present; Bradypnea (abnormally slow breathing) present. No respiratory distress. Doesn't respond to painful or verbal stimuli-staring up and doesn't respond to his wife. He is noncommunicative. Medications ordered

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and administered in ED: Narcan (antidote for overdose) 2 mg/2 ml injection 0.4 mg subcutaneous given on 6/9/22 at 1:11 p.m.; Lab results: Methadone Screen: (positive); Electrocardiogram results 6/9/22 at 1:29 p.m.: Sinus Tachycardia; ED Course 6/9/22 1:59 p.m.: (R1's wife) agrees to giving (R1) Narcan, hoping 'it will work.' 0.4 mg of Narcan administered with immediate response. (R1) woke up and asked, 'Where am I?' (R1) then complained of tail bone pain which (R1's wife) says is chronic; Critical Care: 20 minutes of critical care time spent evaluating (R1), discussing treatment plan with (R1's wife), managing impending respiratory failure and administering antidote for overdose; Risk of Complications, Morbidity, and/or Mortality: Presenting problems=high, Diagnostic procedures=high, Management options=high; Critical Care: Total time providing critical care: 30-74 minutes (31 minutes). (R1) admitted to the hospital for observation."

On 6/22/22 at 9:05 a.m., V3 (Medical Director) stated V3 was in the facility seeing his residents on 6/9/22 at the time of R1's medication error. V3 stated at that time, he was not familiar with R1 and had not been given any orders or hospital records to review. V3 stated, "I was told that (R1) was given too much Methadone and it seemed like quite a bit. I hadn't met (R1) so I recommended they send (R1 to the hospital). I had no further involvement with (R1). It is certainly possible to become unresponsive with (that high of a dose of Methadone). You could see depressed respirations or even death as a worst-case scenario."

On 6/21/22 at 11:04 a.m., V2 (Director of Nursing) stated that R1 had just arrived for admission to the facility on 6/9/22 approximately one and a half

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S9999	Continued From page 6 hours prior to the medication error by V4. V2 stated R1's admission orders had not been processed or verified by R1's Physician (V3). V2 stated that V4 should have observed the orders herself and never taken a verbal order from another nurse. V2 stated R1 had a change in condition and was sent to the hospital as a result of the medication error on 6/9/22. (A)	S9999		