STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016158	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIEVIEW AT THE GARLANDS	6000 GARLANDS LANE BARRINGTON, IL 60010

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S 000	Initial Comments Facility Reported Incident of March 27, 2024/IL171695	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) 300.1210d)3) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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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.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to transcribe a resident's admission medication orders in a manner to prevent a significant medication error. This failure resulted in R1 developing hypotension (low blood pressure) and dizziness after receiving eight (8) doses of a diuretic medication (water-pill), one pill per day, from 3/20/24-3/27/24, instead of PRN (as needed), as shown per R1's hospital discharge orders. This failure applies to 1 of 6 residents (R1) reviewed for medication administration and significant medication errors in the sample of 6.

The findings include:

A facility incident report dated 3/27/24 showed R1 was admitted to the facility on 3/19/24, from a

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local hospital. The report showed R1 began complaining of dizziness on 3/27/24. The report showed R1's Metolazone (diuretic medication) "was entered incorrectly as scheduled, instead of daily as needed, for weight gain greater than 5 pounds. Physician notified and order received for STAT labs and to push fluids..."

R1's hospital History and Physical report dated 3/18/24 showed R1 had a significant history of CHF (congestive heart failure), dilated cardiomyopathy, and hypertension (high blood pressure). The report showed R1's blood pressure as 136/80.

R1's hospital discharge orders dated 3/19/24 showed R1 was admitted to the facility with a physician order for Metolazone (diuretic medication) 5mg (milligrams): Take one tablet by mouth daily, as needed, for a weight gain greater than 5 pounds.

A facility's physician order for R1, dated 3/19/24, showed the Metolazone medication was incorrectly ordered as "Metolazone oral tablet 5 mg: Give 1 tablet by mouth one time a day (at 9:00 AM) for edema/weight gain."

R1's March 2024 Medication Administration Record showed R1 was administered Metolazone, 5 mg (1 tablet) daily, from 3/20/24-3/27/24.

R1's progress note dated 3/27/24 showed R1 was assessed by staff due to her complaint of dizziness. R1's blood pressure was checked. R1 was hypotensive with a blood pressure of 94/52. R1 was given fluids. R1's physician was notified. During this incident, R1's medications were reviewed. R1's Metolazone medication was

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found to have been incorrectly transcribed/ordered by the facility.

On 4/10/24 at 10:25 AM, V8 (Family of R1) stated, "I was there (on 3/27/24) when (R1) had an episode but, she also had a similar episode the day before (3/26/24) where (R1) got pale, her blood pressure dropped, and she felt faint. My sister was there for that one. When I was there, it all happened so quick. It was kind of a frantic scene. (R1) suddenly got pale, felt faint, and her blood pressure dropped. I was scared. I thought she was going to die. She thought she was going to die. (R1) kept trying to tell us "no CPR", so we didn't do CPR (cardiopulmonary resuscitation) if it came to that. Staff came running in. They laid her flat. They tried to get her to drink water. That's when they found the medication error. I am just so thankful she survived. I saw my dad die. I couldn't go through that again."

R1's Weights and Vitals Summary record for March 2024 was reviewed. It showed R1 did have an episode of hypotension on 3/26/24 at 11:30 AM, as reported by V8 (Family of R1). R1's blood pressure dropped to 78/38 at that time. No progress notes or other documentation was noted related to R1's symptoms and hypotension on 3/26/24.

On 4/10/24 at 9:54 AM, V1 Administrator stated she did not know R1 had an episode of hypotension and dizziness on 3/26/24.

On 4/10/24 at 12:00 PM, V2 Director of Nursing stated the facility has a "double check" process in place to ensure a new admission's medication orders are transcribed correctly from the resident's hospital discharge medication orders. V2 stated, "The nurse that admits the resident,

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transcribes the admission medication orders into the computer, from that resident's hospital discharge orders. The oncoming night nurse is supposed to double check to make sure the orders were entered correctly. Unfortunately, in (R1's) case, that did not happen. (V5 Registered Nurse/RN) incorrectly transcribed (R1's) Metolazone order. The night nurse that took over for (V5) didn't double check (R1's) admission orders." V2 stated she did not know R1 had an episode of hypotension and dizziness on 3/26/24.

On 4/10/24, two attempts to contact V5 RN, via phone, for an interview were unsuccessful. V1 Administrator stated V5 was no longer employed by the facility.

On 4/10/24 at 10:45 AM, V6 (Pharmacist) stated, "Metolazone is a medication used to help residents, with CHF, get rid of extra fluid. I see here in the computer that (R1's) admission order for Metolazone was sent us (from the facility) with an order for the medication to be given daily, not PRN (as needed). It wasn't transcribed correctly. If the medication is not given as ordered, it can cause dehydration, low blood pressure, and possibly cause someone to pass out. I see she (R1) is also on Lasix (another diuretic medication). If someone is on both Metolazone and Lasix, it can be potentially dangerous for someone if not given correctly."

On 4/10/24 at 11:02 AM, V7 (R1's Physician) stated, "(R1) was seen by cardiology in the hospital. She has bad CHF. She was supposed to get the Metolazone PRN, not daily. If the medication is not given correctly, it can cause dehydration, low blood pressure, and feeling faint. If not treated, it could cause someone to pass out and become unresponsive."

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S9999	Continued From page 5 The facility's Medication on Admission, Readmission, and Discharge policy dated 12/13/23 showed, "Medication orders upon admission, readmission, and discharge in skilled nursing are to be entered by the admission nurse, verified by the physician, pharmacy and oncoming nurse for the next shift... The oncoming nurse for the next shift reviews the medication orders entered in the electronic medical record to prevent medication errors..." (B)	S9999		