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	IL6012991	A. BUILDING: _____ B. WING _____	06/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA HEALTH CARE EAST	100 MARIAN PARKWAY PO BOX 109 SHERMAN, IL 62684

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S 000	Initial Comments Annual Health Survey Ststement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1630c) 300.3220f) 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 300.1630 Administration of Medication c) Medications prescribed for one resident shall not be administered to another resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

These Regulations were not met as evidenced by:

Based on interview and record review the Facility failed to ensure medications are given to the right resident per physician's orders for one of nine residents (R71) reviewed for significant medication error in the sample of 41. This failure resulted in R71 receiving another resident's medication, resulting in R71 being hospitalized for 5 days.

Findings include:

On 6/18/19 at 2:57 PM, R71 stated she went to the hospital a couple of weeks ago because she was given the wrong medication. She stated, "I almost died. The nurse admitted she did it and said she was sorry. My daughter figured out what happened."

R71's Minimum Data Set (MDS) dated 5/31/19 documents, in part, a Brief Interview for Mental Status (BIMS) score of 13, indicating she is

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cognitively intact. This MDS also documents, under "Additional Active Diagnoses", the diagnosis of "Hypotension" (low blood pressure).

On 6/18/19 at 3:45 PM V2, Director of Nursing (DON) stated that R71 had been given another resident's medication in error on 5/13/19. She stated V20, Licensed Practical Nurse (LPN), the nurse who gave the wrong medication was new to the facility and mistakenly gave R71 blood pressure medications and insulin that was ordered for another resident. V2 stated she could not remember if she had gotten a statement from V20 during her investigation of the medication error. V2 stated the physician and R71's family were notified of the error.

On 6/21/19 at 9:00 AM V2 stated she expects the nurses to check the resident's pictures, which are kept updated on their Medication Administration Record (MAR) and ask the resident their name to confirm they have the right resident before administering medications to them. She stated V20 was a new employee to the facility and did not know the residents yet.

On 6/19/19 at 3:15 PM V2 stated that she did get a statement from V20, the nurse who made the medication error for R71, but she had mistakenly given the written statement back to that nurse, who will now take a picture of the statement and send it to the DON, who will then print it. No documentation of, or interview statement from V2 or V20 was received on 6/19/19.

On 6/20/19 at 2:25 PM, during a telephone interview, V21, R71's daughter and Healthcare Power of Attorney (HCPOA), stated a nurse from the Facility called her just before midnight on 5/13/19 and told her R71 was being sent out by

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ambulance to the Emergency Room (ER) because her blood pressure was too low. V21 stated the nurse who called her did not inform her that R71 had been given the wrong medication, and that no one had called her earlier in the evening to let her know. V21 stated she was informed of the medication error by the staff at the hospital emergency room. V21 stated someone from the facility called and informed her the next day and apologized for the error and told her the nurse who made the error was disciplined. V21 stated her mother went to the ER, and then was taken to the Intensive Care Unit. V21 stated, "She was in the hospital from Monday night until Saturday. Her (R71's) heart rate got all the way down to 39. It was very scary because she's 95 years old. It seems like she hasn't been the same since she got back to the Facility, not as alert, but I'm not sure if it is related to the medication mistake or her age."

On 6/20/19 at 3:15 PM, V30, the Facility's Medical Director, stated he would expect the nurses to follow the current Standards of Practice, including making sure they administer the right medication to the right resident.

On 6/21/19 at 12:00 PM during telephone interview, V20 stated she made a medication error on 5/13/19 during her 9:00 PM medication pass by giving R61's medication to R71. V20 stated she had left her medication cart with the Electronic Medication Administration Record (EMAR) on it up by the nurse's desk. She stated she had R61's medication in a cup in her hand and walked down the hall to give them to her but stopped and talked to another resident along the way. She stated she then went into the wrong room and gave R71 the medications she had for R61 and performed an accucheck on her. V20

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stated she forgot whose medication she was carrying. She stated she knew she was giving R71 the medications, and it did not register for her that R71 doesn't get an accucheck and insulin at night. V20 stated she had only worked that hall a few times since she started working at the Facility and didn't know just who got accuchecks and insulin on that hall. She stated she had to wake R71 up to do the accucheck and give her medications and R71 was groggy. When asked why she did not notify R71's daughter of the medication error, V20 stated, " I was not aware of the protocol when a medication error is made. I reported it to the charge nurse and followed her instructions. We documented everything on a piece of paper because the charge nurse told me not to document anything in the progress notes because she wasn't sure if we were supposed to document it there. The charge nurse reported the medication error to the Director of Nursing the next morning. " V20 stated she got a packet upon hire that had information about medication administration, and she knew she should identify the resident by their name and picture in their EMAR. V20 stated before she made the medication error she did not always take her medication cart and EMAR down the hall with her when she passed her medications. She stated she thinks she may not have made the medication error if she had not stopped to talk to another resident and if she had her medication cart and EMAR with her.

R71's Medication Administration Record dated May 2019 documents on 5/13/19, R71 had received her own scheduled anti-hypertensive medications as ordered on that day.

R71's Hospital Physician Discharge Summary dated 5/18/19 documents her admission

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diagnoses as Hypotension and Medication Overdose, and documents R71's Admission Condition was "Serious".

R71's Emergency Department Report dated 5/14/19 at 3:45 AM documents, in part, " Critical Care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: Circulatory Failure."

According to the ER report of filed vitals, dated 5/14/19 at 12:24 AM in the ER, R71's heart rate was low at 47 bpm (beats per minute), and lower at 2:42 AM, 40 bpm, and she was admitted to the ICU (Intensive Care Unit) because, " the hospitalist felt the patient would be unsafe on the floor as he could not do frequent enough files for monitoring."

R71's ER (Emergency Room) report, under ED (Emergency Department) Course, dated 5/14/19 at 3:45 AM, documents that ER staff spoke to charge nurse at the Facility at 1:03 AM, who reported that R71 had been given medication that were not hers this evening (5/13/19) and listed the medications she had been given in error.

R71's Hospitalist History and Physical dated 5/14/19 at 4:13 AM, documents R71's," Chief Complaint; Accidental medication administration that created hypotension and bradycardia at nursing home."

The Facility's "Medication Error Report" dated 5/13/19 documents, in part, that on 5/13/19 at 9:00 PM, R71 was given another resident's medication. The medications given in error to R71 included Cardura, an anti-hypertensive used to lower blood pressure, Clonidine, another medication to lower blood pressure and decrease

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the heart rate, Tarka, which is used to treat high blood pressure, and Humulin Insulin, used to manage blood glucose levels. It does not include documentation of notification of R71's daughter of the medication error.

The Facility's Final Report to Illinois Department of Public Health dated 5/15/19, untimed, documents, in part, that R71 did receive the wrong medication on 5/13/19 at 9:00 PM and that R71's physician and daughter were notified immediately of the error. The report also documents that her physician gave orders to monitor R71 for adverse effects by monitoring her vital signs every 15 minutes, which were stable up until 11:00 PM. According to this report, the physician and R71's daughter were notified and R71 was sent to the ER, and then admitted to monitor her blood pressure.

The Facility's Transfer/Discharge Report dated 5/14/19 documents, in part, under last vital signs, " 5/9/19- Blood Pressure 122/78 and Pulse 64. " No vital signs were documented for 5/13/19, the date the medication error occurred. On the same report, under "Chief Complaint " (reason for transfer), the area was left blank.

A Progress Note dated 5/14/19 at 7:05 AM documents, in part, "patient vitals wnl (within normal limits) this shift prior to 2300 (11:00 PM). Nurse called MD (Medical Doctor) at 2300 r/t (related to) hypotension 83/40 hr (heart rate) 48 rr (respiratory rate) 14 O2 (oxygen level) 92. MD ordered ok to send resident to ER to be evaluated and treated via EMS (Emergency Medical Service) at this time. Family emergency contact #1 notified at this time."

There were no progress notes documented on

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S9999	Continued From page 7 5/13/19 regarding R71 being given the wrong medication, notification of R71's physician or family when medication error was discovered, or documentation of monitoring R71 s for adverse effects after incorrect medication was given. On 6/20/19 at 8:10 AM V2 provided a hand written, unsigned report that she stated was V20's statement of R71's medication error on 5/13/19. The report was undated and untimed as to when it was written and by whom. The report included documentation of R71 receiving another resident's medication on 5/13/19 at 9:00 PM, the charge nurse being notified of the medication error, the MD's order that vital signs be checked every 15 minutes for the first hour then every 3 hours, and there was documentation of vital signs taken every 15 minutes for one hour and then every 30 minutes, and all these vital signs documented up to and including 10:30 PM, were within normal limits. At the end of the report, it documents, "I left the (facility) at 11 PM after (charge nurse) assured me she would continue checking vitals. Per (charge nurse) at 11:30 PM the resident's blood pressure was 83/40, resp (respirations) 14, 92%, pulse 49. (Charge nurse) said she called EMS and the doctor to send the resident to the hospital." The information provided along with this statement included a piece of paper, dated "May 13th", with hand written note, "Report called to (hospital) ED (Emergency Department) with the medications given, Clonidine 0.2 mg(milligrams), Cardura 1 mg, Tranclalapril-Verapamil 2/240, Humulin 70/30 10 u (units).) There was not documentation of reason for the medication error, or notification of R71's daughter of the medication error. This handwritten documentation did not identify who wrote it, what date or time it was written, and none of the information was found in R71's EMR.	S9999		

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S9999	Continued From page 8 The Facility's policy, "Medication Administration", dated 1/11/10, documents, in part, "It is the policy of this facility to accurately administer medication following physician's orders. 3. Try to avoid interruptions." The policy continued "16. Report known med errors as soon as possible. Notify physician of known medication error and follow orders received, Monitor resident and document interventions. Complete Medication Error Report and counsel and or in-service staff as needed." (A)	S9999		