Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013023	A. BUILDING: ______ B. WING ______	C 07/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI RESTORATIVE CARE	**1455 HOSPITAL ROAD SILVIS, IL 61282**

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S9999	Final Observations	S9999		

Statement of Licensure Violations

300.610a)
300.1630c)
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 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.

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

Attachment A
Statement of Licensure Violations

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by:

Based on interview and record review, the facility failed to verify the identity of a resident prior to medication administration for one of three residents (R1) reviewed for medication administration in the sample of three. As a result, R1 was administered R2's medications, causing R1 lethargy (drowsiness), hypotension (low blood pressure) and bradycardia (slow heart rate), subsequently requiring R1 to be hospitalized in the intensive care unit.

Findings include:

The facility's Patient Identification policy (Revised 11/7/14) documents the following: "Each patient will be properly identified throughout the course of his/her care...staff will identify the patient using name and date of birth and follow the practice...All departments will include name and date of birth in identification process. In some departments a third identifier may be required. All inpatients and applicable outpatients will have an ID band which will always be used to verify the name and date of birth before providing care. All supportive and direct care providers will identify each patient using two patient identifiers. Room number is never to be used to identify the patient. If the patient is unable to state their name and date of birth, the patient may be identified by checking their identification band and/or a family member when possible..."

R1's undated electronic Diagnoses documents R1's diagnoses include the diagnosis of Dementia. R1's electronic Care Plan dated 6/2/15 documents that R1 is alert and disoriented at times. R1's electronic progress notes dated 6/2/15 through 6/10/15 document the following:

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S9999	Continued From page 2 "(R1) is alert but forgetful and sometimes confused...alert but confused at times...alert with periods of forgetfulness..." R1's electronic progress note dated 6/10/15 documents the following: "(E4, Occupational Therapy Assistant) was pushing (R1) in the hallway and stopped to ask (E3, Registered Nurse) if (R1) needed medications before they went to the therapy room. (E3) stated, 'Who is the patient?' (E4) stated, '(R2).' (E3) administered pills for (R2). Immediately after administration, (E3) noticed (R2) moving (in R2's bed). (E3) stated to (E4), '(R2) is in bed.' (E4) then stated, 'Oh! I (E4) have (R1)!'...All morning medications held for (R1)..." R1's Initial Event Debriefing Tool dated 6/10/15 documents, "(R1) was wheeled out to the medication cart in the hall by (E4, Occupational Therapy Assistant), where (E3, Registered Nurse), was passing medications. (E4) asked (E3) if (E3) wanted to give (R1) his medications. (E4) stated, 'I (E4) asked (E3) if (E3) wanted to give (R1) his medications before I (E4) took (R1) to therapy.' (E3) then stopped (E3's) current medication pass and flipped to (R2's) Medication Administration Record and put all of the morning medications in a cup and gave (R1) the medications. Medications included: Lisinopril (Antihypertensive) 20 milligrams, Hydralazine (Antihypertensive) 25 milligrams, Gabapentin (Anti-convulsant) 600 milligrams, Plavix (blood thinner) 75 milligrams, Aspirin (Antithrombitic) 325 milligrams, Ranitidine (decreases stomach acid production) 150 milligrams, Omeprazole (decreases stomach acid production) 40 milligrams, and Miralax (laxative) 17 grams. (E3) then stated, 'I (E3) looked into (R1 and R2's) room, and noticed that R2 was sitting in the room	S9999		

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in bed 1. I (E3) then asked (E4) Are you sure you have (R2)?' And (E4) said (E4) actually had (R1).' This was after the medications were given...When (R1's) blood pressure started dropping, we (facility staff) called 911 and had (R1) transferred to (local emergency department)."

Z1's (R1's Physician) History and Physical for R1 dated 6/10/15 documents the following: "Incidentally (R1) was given multiple medications by mistake, instead mixed up with other patient. (R1) has received 1 dose of Aspirin 325 milligrams, 1 dose of Plavix 75 milligrams, 1 dose of Hydralazine 25 milligrams, 1 dose of Lisinopril 25 milligrams, 1 dose of Zantac 150 milligrams, 1 dose of Miralax 17 grams, 1 dose of Tylenol Arthritis, and 1 dose of Neurotin 600 milligrams. (R1) became hypotensive. (R1) was given an intravenous fluid bolus and decision was made to admit (R1) to the MICU (Medical Intensive Care Unit). I (Z1) arrived shortly after (R1) arrived to MICU. (R1's) blood pressure was 80/40...Admitting Diagnoses...Hypotension (could be secondary to blood pressure medication was given by mistake which include lisinopril and hydralazine...)"

On 7/6/15 at 12:51 p.m., Z1, R1's Physician, stated that R1 received another resident's medications by mistake and was hospitalized for close monitoring due to low blood pressure. Z1 then stated that R1 receiving the blood pressure medications, Lisinopril and Hydralazine, could have been one cause of R1's low blood pressure.

Z2's (R1's Cardiologist) Consultation Report dated 6/10/15 documents the following: "(R1)...was transferred from (local nursing home) to the intensive care unit because of low blood

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S9999	Continued From page 4 pressure and bradycardia. (R1) apparently received medications that did not belong to R1...When I (Z2) came to see (R1), (R1) was very lethargic, only opening (R1's) eyes when painful stimuli were given...(R1) has bradycardia on the monitor...(R1's) blood pressure is about 85 systolic..." On 7/6/15 at 1:59 p.m., Z2, R1's Cardiologist, verified that R1 was hospitalized for hypotension and bradycardia, and these symptoms could have been a result of R1 receiving the wrong medications. Z2 then stated that R1 was very sleepy initially and only responded to painful stimuli, which may have been from the Neurontin (Anti-convulsant) R1 mistakenly received. R1's local hospital Shift Report notes for R1 document the following: "Admitted from emergency department with hypotension and bradycardia after wrong medication administered (at nursing home)...Blood pressure remains low...with bradycardia..." According to the Mayo Clinic, "A blood pressure reading of 90 mm hg (millimeters of mercury) or less systolic blood pressure (the top number in a blood pressure reading) or 60 mm hg or less diastolic blood pressure (the bottom number) is generally considered low blood pressure." (http://www.mayoclinic.org/diseases-conditions/low-blood-pressure/basics/definition/com-20032298). According to the American Heart Association, "Bradycardia equals too slow. A heart rate of 60 bpm (beats per minute) is called bradycardia." (http://www.heart.org/HEATRORG/Conditions/Arrhythmia/AboutArrhythmia/Bradycardia-Slow-Heart-Rate_UCM_Article.jsp)	S9999		

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R1's local hospital's Vital Signs Flowsheet dated 6/10/15 - 6/13/15 document the following blood pressure readings: 71/31 mm hg, 89/60 mm hg, 81/39 mm hg, 77/38 mm hg, 85/34 mm hg, 71/33 mm hg, 77/39 mm hg, 80/40 mm hg, 80/39 mm hg, 78/38 mm hg, 84/37 mm hg, 83/45 mm hg, 77/43 mm hg, 89/44 mm hg, 90/46 mm hg, 85/41 mm hg, 83/37 mm hg, 83/40 mm hg, and 81/45 mm hg. This same form documents the following Heart Rate readings for R1: 43 bpm, 46 bpm, 49 bpm, 48 bpm, 45 bpm, 40 bpm, and 42 bpm.

On 7/6/15 at 11:48 a.m., E2, Director of Nursing, verified that R1 was given R2's medications the morning of 6/10/15. E2 stated, "We (facility staff) checked (R1's) blood pressure frequently. It started registering low...we layed (R1) down and called 911..." On this same date at 3:00 p.m., E2 stated the facility does not use identification bands for any of the residents, and therefore staff cannot verify a resident's identity or date of birth from an identification band. E2 then stated, "We are supposed to have the resident's picture in the front of their Medication Administration Record to assist in verifying their identity. (E3, Registered Nurse) said (R2's) picture wasn't there."

On 7/6/15 at 12:09 p.m., E3, Registered Nurse, verified that E3 administered R2's medications to R1 on 6/10/15 at approximately 7:15 a.m. E3 then stated, "I (E3) was working a hall that I (E3) had not worked in over a year and I (E3) was not familiar with the patients over there..."

On 7/6/15 at 1:36 p.m., E4, Occupational Therapy Assistant, verified that E3 administered R2's medications to R1 on the morning of 6/10/15.

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