STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014401	A. BUILDING: _____ B. WING _____	C 05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING OF EDWARDSVILLE	6277 CENTER GROVE ROAD EDWARDSVILLE, IL. 62025

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S 000	Initial Comments Complaint Investigation: 2143461/IL134046	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)1) 300.3240a) 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 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. Section 300.3240 Abuse and Neglect	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to administer medications as ordered by the physician for 1 (R4) of 3 residents reviewed for medication administration in the sample of 9. This failure resulted in R4 receiving three extra doses of chemotherapy medication, and subsequently being sent to the Emergency Department (ED) for evaluation of redness and facial swelling. Findings include: 1. R4's Minimum Data Set (MDS) dated 04/02/21 documents he is moderately cognitively impaired and requires limited assistance with Activities of daily living (ADL). R4's Electronic medical record documents diagnoses which include: Malignant Neoplasm of Sigmoid colon, Secondary Malignant Neoplasm of liver and intrahepatic bile duct, indicating that R4 has cancer. R4's Oncology Report dated, 04/02/21 documents V15 (Oncologist) ordered Regorafenib, also known as Stivarga (A chemotherapy drug) 80 (milligrams) mg daily, days 1-21 every 28 days. R4's Physician's Order Sheet (POS) dated, 05/13/21 at 10:38 AM, documents an order for Regorafenib (Stivarga) tablet (tab) 40 mg two tabs twice daily for 21 days on and 7 days off for	S9999		

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S9999	Continued From page 2 colon cancer until 06/09/21. R4's Physician's order sheet dated, 05/13/21 at 10:51 AM documents an order for Regorafenib (Stivarga) tab 40 mg two tabs twice daily for 21 days on and 7 days off for colon cancer until 06/10/21. R4's Medication Administration Record (MAR) documents the following medication errors. 05/14/21: Regorafenib was given twice on that date when it should have only been given once. 05/15/21: Regorafenib was given twice on that date when it should have only been given once. 05/16/21: Regorafenib was given twice on that date when it should have only been given once. R4 received three extra doses of Regorafenib from 05/14/21 through 05/16/21. On 5/20/21 at 2:01 PM, V6 (Licensed Practical Nurse/LPN), stated, "(R4) had a medication error with his chemotherapy medication. The medication was started on Friday and (V9), Registered Nurse (RN), found the error on Monday (5/17/21). The computer said to give it 2 times a day but that was incorrect. (R4) had swelling to the left side of his face and was sent to the ER (Emergency Room) and they put him on antibiotics." On 5/24/21 at 11:30 AM, V2 (Director of Nursing/DON) stated, "(R4) was sent to the hospital on 5/17/21 because of a medication error that occurred and (R4) had some facial swelling to the left side of his face. V15 recommended that (R4) go to the hospital for evaluation and treatment." On 05/24/21 at 12:05 PM, V9 (Registered	S9999		

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S9999	Continued From page 3 Nurse/RN) stated that when she arrived to 600 hallway on the morning of 05/17/21, the Certified Nursing Assistant (CNA) came to her and reported that R4 stated that his face felt weird. V9 stated that she went and completed a physical assessment of R4. V9 stated that the left side of R4's face was swollen and red and that R4's left eye was almost swollen shut. V9 stated that R4 denied any pain. V9 stated that she checked to see if R4 had started on any new medications and found that Regorafenib (Stivarga) was recently started. V9 stated that she held R4's Regorafenib that morning. V9 stated that V12 (Nurse Practitioner/NP) was at the facility and examined R4. V9 stated that she called V15's office and explained what was going on with R4. V15 asked V9 what dose did the facility have ordered for the Regorafenib. V9 stated that the order the facility has documented was that R4 was to get Regorafenib 80 mg twice daily. V15 stated that the order the facility has in the computer was incorrect, and that R4 was receiving too many doses. V15 stated that the order was for Regorafenib 40 mg two tabs daily and not twice a day. V9 stated that V15's office said to hold the AM dose of Regorafenib. V9 stated that after she had talked with V15, she went to report the medication error to V2. V9 stated that V2 was not in her office, so V9 left a note on V2's desk to please come and talk with her when she got the message. V9 stated that V2 finally came to talk with her and V2 told her that she had talked to V15 and that they wanted R4 sent to the hospital for evaluation and treatment. V9 stated that V2 told her not to worry about charting on the incident. V9 stated that V2 said she would document it under risk management. R4's Emergency Room Visit Note dated 5/17/21 documents, "Patient presents to the emergency	S9999		

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S9999	Continued From page 4 department from ECF (Extended Care Facility) for a medication administration error. The patient is currently on Stivarga for colon cancer and is followed by (V15). Per the ECF, the patient is supposed to be receiving 80 mg daily but for the past 3 days has been given 160 mg daily." It continues, "Clinical Impression: Impetigo, Medication administered in error." It further documents, "Prescriptions: New: Clindamycin HCL 300 mg Q (Every) 6 hours times 7 days." R4's Medication Incident Report, dated 5/17/21 documents, "Incident Description: Nursing Description: Regorafenib 40 mg 2 tabs PO (By mouth) daily for 21 days off 7 days and follow up with oncologist. The entered order in computer was incorrect. It was entered at twice daily rather than once daily. Resident received 3 days of med. incorrectly, was started on Friday given sat, and sun. Noticed facial swelling, med held Monday and reported, order was verified as daily. Oncologist was notified of error." Resident was sent to hospital for evaluation. Resident Description: Resident stated his face felt swollen. Immediate action taken: Description: Med was held. Order was corrected in eMAR (Electronic medication administration record). Reported to oncologist. His recommendation was to send resident to hospital for evaluation. NP present and agreed to send for evaluation. Resident taken to hospital? Y (Yes)." On 5/25/21 at 1:48 PM, V15 stated, "There have been 3 incidents of medication errors of two different cancer medications prescribed to (R4) in the past 4-5 months. I would expect the orders to be followed. The Stavarga was ordered to take 2 tablets once daily for 3 weeks. The nursing home contacted our facility and said the patient developed facial swelling and redness. They also	S9999		

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S9999	Continued From page 5 said that he was getting the 2 tablets of the medication twice a day, instead of once a day. I do believe that lead to the development of the symptoms and therefore I sent him to the ER, to be sure the swelling didn't get worse. I do think it was a significant medication error and caused harm to the resident. The concerning thing is also that it has happened now with two different medications. I start that medication out as a low dose because the potential for the side effect of swelling." Standards and Guidelines: Medication Errors revised date, 03/27/21 states: Standard: It will be standard of this facility that the staff and practitioner shall try to prevent medication errors and adverse medication consequences, and shall strive to identify and manage them appropriately when they occur. Guidelines: 1. The staff and practitioner shall strive to minimize adverse consequences by: A. Following relevant clinical guidelines and manufactures specifications for use, dose, administration, duration, and monitoring of the medication. "A"	S9999		