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S 000	Initial Comments Facility Reported Incident IL143837 of 2/12/22	S 000		
S9999	Final Observations Statement of Licensure Violations: 200.610a) 300.1210b) 300.1210d)1) 300.1210d)2) 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 300.1210 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	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 2) All treatments and procedures shall be administered as ordered by the physician. 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 requirements are not met as evidenced by: Based on interview and record review the facility failed to ensure a resident's physician ordered antihypertensive medication was correctly transcribed and ordered for one of three residents (R1) reviewed for medications in the sample of three. This failure resulted in R1 receiving triple the dose of an antihypertensive medication at three different times. R1 became dizzy and hypotensive with altered level of consciousness. R1 required emergent transfer via ambulance to the local area hospital in which R1 received five doses of a reversal agent intravenously and was admitted to the Intensive Care Unit on blood	S9999		

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S9999	Continued From page 2 pressure support medication. Findings include: The facility's "Receiving and Transcribing Orders Physician Orders" policy, reviewed 5/28/21, states, " Policy Statement: Orders for medications and treatments will be consistent with principles of safe and effective order writing. All orders will be transcribed and followed as directed...The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. 2. A current list of orders must be maintained in the clinical record of each resident." The facility's Admissions, Transfers and Discharges" policy, revised 4/26/21, "Admission Assessment and Follow Up: Role of the Nurse. Steps in the Procedure: 5. Reconcile the list of medications from the medication history, admitting orders, the previous MAR/Medication Administration Record (if available) and the discharge summary from the previous institution, according to established procedures." The facility's "Administering Medication" policy, revised 5/26/21, states, "Policy Statement: Medication shall be administered in a safe and timely manner and as prescribed. The community shall provide residents with necessary medication(s) when they leave the community temporarily. 2. Medications must be administered in accordance with the orders, including any required time frame. 4. If a dosage is believed to be inappropriate or excessive for a resident, or medication has been identified as having potential adverse consequences for the resident, the person preparing or administering the medication shall contact the resident's physician	S9999		

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S9999	Continued From page 3 to discuss the concerns." The facility's "Reconciliation of Medication" policy, revised 4/26/21, states, "The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medication, route, and dosage upon admission or readmission to the community and transfers between levels of care. Preparation: 1. Gather the information needed to reconcile the medication list: a. Discharge Summary from referring hospital, MAR from other transferring facility. b. Admission Order Sheet c. All prescription and supplement information obtained from the resident/family during the medication history. d. Most recent MAR is there is a readmission. Steps in the Procedure: 1. Obtain a medication history from the resident and/or representative. 2. The information from the medication history should include: e. Dosage, route, frequency and last dose taken for all items 3. Review the list carefully to determine if there are any discrepancies/conflicts. 4. If there is a discrepancy or conflict in medication, dosage, route or frequency, contact the physician within 24 hours and document." The facility's "(Name of Pharmacy) Remote Order Entry Process, not dated, states, "(Name of facility Pharmacy) Remote Date Entry (RDE) Team will enter orders into (name of facility's electronic charting system) from the hospital discharge orders for medications and from (name of facility organization) Order Sets for additional orders. The community will fax the orders for the residents to the RDE Team for input. All orders will be put into (name of facility's electronic charting system) in DRAFT status so that once completed, the nurse can review, verify the orders, and then change to ACTIVE status in	S9999		

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S9999	Continued From page 4 (name of facility's electronic charting system). Once the order is made active the order needs to be sent to (name of facility Pharmacy) electronically." R1's "Adverse Event Documentation" form, completed by V2 (Director of Nursing) on 2/14/22, documents the type of adverse event as "Medication Event." The date and time of the event is documented as 2/13/22 at 3:00 P.M. The "Brief Description of Medication Event (describe medications involved and any immediate actions taken)" states, "(R1) returned from LOA (Leave of Absence) post surgery. All medications were discontinued in the EMR (Electronic Medical Record) as (R1) was out of the facility for greater than 24 hours. (R1) arrived and AVS (After Visit Summary) was sent to (name of facility pharmacy). (Name of facility pharmacy) entered the medications into the EMR. Clonidine was transcribed at 0.3 (milligram) TID (three times a day) and should have been 0.1 mg TID. The RN (Registered Nurse/V4) then moved them to active and was an oversight in the 0.1 mg vs (versus) 0.3 mg during the review for medications for accuracy. One LPN (Licensed Practical Nurse/V10) did adjust the times (1700/5:00 P.M.-2000/8:00 P.M.) of administration but did not adjust the dosage. The medication (Clonidine 0.3 mg) was given (to R1) on 2/12/22 x (times) 1(one) dose and then on 2/13/22 x 2 (two) doses. (R1) c/o (complained of) dizziness and not feeling well. BP (Blood Pressure) noted 68/(no bottom number documented). Orders received to send (R1) to the ED (Emergency Department) for evaluation and possible treatment." This form documents the contributing factor as "AVS reentry process." The facility's "Serious Injury Incident Report" to	S9999		

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the local state agency on 2/14/22 documents the involved resident is R1, and the time of the incident is documented as 2/12/22-2/13/22. The Incident Category is marked as "Other-Medication Error with Hospital Evaluation/Treatment." The Incident Description documents R1 was assessed by V3 (Licensed Practical Nurse) and V4 (Registered Nurse Supervisor) on 2/13/22 at 2:15 P.M. and R1 was sent to the local area hospital Emergency Room and admitted with a diagnosis of "Clonidine Overdose". The Detailed Incident Summary states, "R1 returned from inpatient hospital on 2/12/22 status post inguinal hernia repair. R1 began to complain of not feeling herself and dizziness the afternoon of 2/13/22. Vital signs obtained and R1 noted to be hypotensive (low blood pressure)...R1 sent to (local area hospital) for evaluation and treatment if indicated. Through the course of the report to the hospital it was noted that R1 had been discharged on Clonidine 0.1 mg (milligrams) TID (three times a day) but transcribed as 0.3 mg (three times a day). R1's change in condition attributed to low blood pressure secondary to the dose of Clonidine."

R1's Emergency Services Report documents EMS (Emergency Medical Service) were dispatched to R1's skilled nursing facility on 2/13/22 at 3:13 P.M. for breathing problems. R1's Vital Signs at 3:25 P.M. are documented as BP 74/60, Pulse 57, Respirations 14 with an oxygen saturation of 97% (percent) on room air. R1's Vital Signs at 3:56 P.M. are documented as BP 72/46, Pulse 59, Respirations 14 with an oxygen saturation of 96% on room air. The "Narrative" of this report states, "Medic 22 was dispatched to (name and city of skilled nursing facility) for a (age and sex of R1) with complaints of respiratory distress after returning from the hospital after

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having hernia surgery and was having tachypneic respirations and was reported as being pale in color. RN (unknown facility nurse) related that (R1) had returned from having hernia surgery the previous day and upon (R1's) family coming to visit (R1) was found to be extremely lethargic and altered. RN related obtaining a manual blood pressure of hypotension and contacted her PCP (Primary Care Physician) who advised for transport to the hospital for a medical evaluation. RN related that she followed (R1's) daily care and noted that (R1) was not behaving per (R1's) norm...RN and (R1's) family related that they (facility staff) discovered that PTA (prior to arrival) of EMS that (R1's) prescription for Clonidine had been changed since discharge from the hernia surgery after reviewing (R1's) records. RN related that (R1) had been given three times the prescribed dosage for Clonidine within 24 hours..."

R1's "Critical Care History and Physical" signed and dated 2/13/22 by V8 (R1's Hospital Physician) documents R1 presented to the Emergency Department from the skilled nursing facility for generalized weakness, lethargy, and hypotension (low blood pressure). Per the Nursing Home supervisor, (R1) was given three times her regular dose of Clonidine. This same form report states, "Additional information received from nursing facility, (V9/R1's Family Member), and V6 (R1's Primary Care Physician) via phone. (R1) was recently admitted to (local area hospital) for urgent hernia repair. (V6) directly admitted (R1) herself for that admission. No medication changes were to be made during that hospitalization as they were not indicated. However, per nursing facility records, Clonidine has been administered at 0.3 mg (milligram) TID (three times a day) since discharge from (the

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local area hospital). Dosing prior to hospitalization was 0.1 mg TID. In the Emergency Department/ED, (R1) received 2 mg of Narcan (reversal agent) x 5 doses. (R1) was also given 2 L (liter) fluid boluses. Initially started on Levophed (blood pressure support medication) for hypotension which was discontinued while in ED due to BP response to Narcan and fluids. Initially given Vancomycin and Zosyn due to concern for septic shock. Discontinued after one time dose."

R1's Progress Note signed and dated by V6 on 2/15/22 states, "(R1) was admitted yesterday in the morning due to significant hypotension. It appears that when she was discharged from (local area hospital) on Saturday, February 12th following a left inguinal hernia repair on February 10th, she was discharged on her usual dose of Clonidine 0.1 mg TID. The nurse at (name of skilled nursing facility) where (R1) resides transferred the orders to the computer from the hospital discharge papers. She put in Clonidine at 0.3 mg 3 x daily, though the discharge med list has Clonidine 0.1 mg TID. (R1) received three doses of this incorrect dose of Clonidine after her discharge and then became hypotensive. (R1's) blood pressure dropped to 60/40. (R1) was transferred to the ED. (R1's) blood pressure was still very low. She was admitted to the ICU (Intensive Care Unit) due to her hypotension, placed on fluids and pressors, and this did bring (R1's) blood pressure back to normal. (R1) was there overnight and came to the floor (general) today where I saw her. She suffered no acute injury to her vital organs as a result of the hypotension." This same note states, "Impression: Significant hypotension secondary to Clonidine overdose."

R1's Nursing Notes signed by V3 (Licensed

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Practical Nurse) on 2/12/22 at 7:15 P.M. documents R1 returned to the facility with family at 2:00 P.M. and R1's medications were verified and sent to the pharmacy.

R1's Nursing Notes signed by V3 on 2/13/22 at 6:28 P.M., states, (R1) c/o (complained of) being dizzy and lightheaded, vitals taken, (R1) blood pressure very low, 60/46. Supervisor notified, family notified, attempt to notify (V6/R1's Physician) x 2. (R1) sent to (local area hospital) for eval (evaluation) and treat."

R1's current Census Report documents R1 was discharged from the facility on 2/9/22 and readmitted back to the facility on 2/12/22 following an inpatient hospital stay. This same report documents R1 was again discharged from the facility on 2/13/22 on a hospital leave.

R1's "Diagnoses/Surgical Procedures" report documents R1 with diagnoses to include but not limited to: essential hypertension, hypotension due to drugs and poisoning by other antihypertensive drugs (accidental).

R1's Brief Interview for Mental Status (BIMS) on 10/21/21 and 2/18/22 documents R1 as cognitively intact without memory impairments.

R1's current Care Plan documents Cardiovascular: R1 has potential for complications related to R1's diagnosis of Hypertension with an intervention of "Administer medications as ordered and monitor for side effects and effectiveness (see current physician orders and MAR/Medication Administration Record)."

R1's Discharge After Visit Summary (AVS) from

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the local area hospital on 2/11/22 documents an order for "Clonidine 0.1 mg (milligram) tablet, commonly known as Catapres, Take one tablet by mouth 3 (three) times daily."

R1's Fax Transmittal Sheet to the facility's Pharmacy for Remote Data Entry (RDE), dated 2/12/22, documents R1's AVS with the above Clonidine order was faxed to the facility pharmacy for entry.

R1's Pharmacy Transaction History documents a "new order" for Clonidine HCL (Hydrochloride) 0.3 mg tablet on 2/12/22 at 9:01 P.M. This order documents Clonidine HCL 0.3 mg tablets were "dispensed as written" from the facility's pharmacy and that this order was approved by V4 (Registered Nurse Supervisor).

The facility's Pharmacy Delivery Manifest, dated 2/12/22, documents the facility received 12 tablets of Clonidine HCL 0.3 mg tablets for R1.

R1's "February 2022 Physician Order Sheet" documents an order for Clonidine HCL 0.3 mg tablet (one tablet) three times daily for Essential Hypertension. This order has a start date of 2/12/22 and is documented as a telephone order read back by V4 (Registered Nurse Supervisor).

R1's Medication Administration Record for 2/1/22-2/28/22 documents an order for Clonidine HCL 0.3 mg tablet oral (one tablet) three times daily with an order date of 2/12/22. This same MAR documents R1 received one dose of the Clonidine 0.3 mg tablets on 2/12/22 and received two doses on 2/13/22, totaling three doses.

R1's Fax Cover Sheet documents R1's Medication Administration History was faxed to

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V8 (R1's Hospital Physician) at the local area hospital on 2/13/22 at 7:03 P.M. This Medication Administration History Form documents R1 received the Clonidine HCL 0.3 mg tablets on 2/12/22 at 9:29 P.M., on 2/13/22 at 9:19 A.M., and on 2/13/22 at 11:40 A.M. Handwritten vital signs are noted on the front of the fax cover sheet which V1 (Administrator) verified are R1's vital signs prior to R1 leaving for the hospital on 2/13/22. R1's vital signs are as follows: BP 68/42, Pulse 54, Respirations 24 and a Temperature of 97 Degrees Fahrenheit.

On 2/22/22 at 9:50 A.M. R1 stated, "I was recently in the hospital after hernia surgery. I came out and my meds were all mixed up. I usually take Clonidine 0.1 mg TID, and they gave me the wrong dose of 0.3 mg TID. My nurse in the morning (V3/Licensed Practical Nurse) had said she wanted to talk about my meds because some had increased. I was requesting Norco after my surgery and there was some problem with my prescription. It all got straightened out but (V3) seemed more worried about my Norco than my other meds. I don't get told what meds they are giving me. She gave me some pills before breakfast and then some more after. My son and daughter-in-law were here, and I couldn't stay awake...(V5/Certified Nursing Assistant) said she thought something was wrong, so she checked my blood pressure. (V5) kept trying to wake me up and couldn't. I was in the hospital for a day and a half. They gave me 10 mg of Narcan to wake me up and to get my blood pressure up. I don't remember much else until I was awake."

On 2/22/22 at 9:20 A.M., V1 (Administrator) and V2 (Director of Nursing) verified the Discharge After Visit Summary from the discharging facility is what current orders will resume once a resident

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S9999	Continued From page 11 arrives to the facility. On 2/22/22 at 12:00 P.M. V4 (RN/Registered Nurse Supervisor) stated, "I was the RN supervisor when (R1) came back from the hospital (on 2/12/22). We faxed (R1's) orders to the pharmacy for entry. The pharmacy puts the orders in and the nurse reviews what was entered and then makes the order active. I don't know how I did it. It was a transcription error. I am charge nurse; I normally don't do the med check, but we got two admits within 30 minutes of each other on the same hall. This new way of Pharmacy entering the medications is a brand new process. If it had been caught prior, I would have changed the order to what the AVS (After Visit Summary) said. I caught a bunch of other discrepancies; I don't know how I missed this one. I was with V3 when we checked on R1. I did a manual blood pressure, and it was 60/40's. I said to (V3), what kind of blood pressure meds did you give her? When looking at it, we realized the Clonidine was 0.3 mg vs 0.1 mg (TID). At the time, I thought it was a dose increase from the hospital, I did not realize right away that it was a transcription error." On 2/22/22 at 3:22 P.M., V7 (Pharmacy Remote Data Entry Supervisor) stated that the medications are only dispensed after the facility nurse approves the "draft" entered by the Pharmacy Technician by changing the orders to "active." V7 verified R1's Clonidine order was transcribed incorrectly by the Pharmacy Technician and that also the facility nurse (V4) missed the transcription error and approved the Clonidine 0.3 mg TID order erroneously. On 2/22/22 at 2:13 P.M., V6 (R1's Primary Care Physician) stated, "I admitted (R1) myself for her	S9999		

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LUTHERAN HOME, THE	6901 NORTH GALENA ROAD PEORIA, IL 61614

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S9999	Continued From page 12 hernia surgery and I saw her in the hospital before she left. I didn't discharge her on 0.3 mg (milligrams TID). She was on Clonidine 0.1 mg TID and the nurse approved an order for Clonidine 0.3 mg TID. Her blood pressure was stable on the 0.1 mg dose. I did not order any changes. It was an error. (R1's) hospitalization (on 2/13/22) was related to the error in the Clonidine dose." (A)	S9999		