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
	IL6013171	A. BUILDING: ______ B. WING ______	C 06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTGOMERY PLACE	5550 SOUTH SHORE DRIVE CHICAGO, IL 60637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2384495/IL160427	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1620f) 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 resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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Section 300.1620 Compliance with Licensed Prescriber's Orders

f) The licensed prescriber shall approve the release of any medications to the resident, or person responsible for the resident's care, at the time of discharge or when the resident is going to be temporarily out of the facility at medication time. Disposition of the medications shall be noted in the resident's clinical record.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to provide R2 with the correct medication at discharge. This failure resulted in R2 being discharged with another resident's medication, ingesting the incorrect medication, resulting in urinary retention and hospitalization for urinary catheterization. This affected one(R2) of three residents reviewed for discharge.

Findings Include:

Facility Final Investigation Report (dated 06/01/2023) regarding R2 documents in part: R2 was admitted to facility on April 27, 2023, for short-term rehabilitation, and was discharged on May 18,2023. He was alert and oriented x4. R2 had teaching completed upon discharge by agency nurse, patient verbalized understanding. We were notified by physician on June 01,2023 of a medication error with R2 after discharge from our SNF unit. Doctor had some communication with R2's primary care physician at hospital. Information was passed on that R2 received his medication upon discharge, but also two medication cards for another patient. The other

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medications were Oxybutynin 5mg and Atorvastatin 20mg. R2 took one dose of 5mg Oxybutynin the evening of May 18th. This medication error triggered urinary retention with R2, and he had to be catheterized in the hospital.

R2's Face Sheet documents resident is a 71-year-old with diagnoses including but not limited to: Cerebral infarction, unspecified, Hemiplegia and Hemiparesis following unspecified Cerebrovascular disease affecting left dominant side, Essential (Primary) Hypertension, Unspecified lack of expected normal physiological development in childhood, Cerebral Infarction due to unspecified occlusion or stenosis of right middle cerebral artery, Muscle Weakness (Generalized).

On 06/14/2023 at 10:32am V3 (Director of Nursing/DON) stated, "When R2 discharged from the facility on 05/18/2023, it was an agency nurse who did the discharge education with R2. V4 (agency nurse) is the one who did the medication teaching upon R2's discharge. V4 is the one who packed R2's medications and sent it home with R2 on the day of discharge. From my understanding, R2 was sent home with 2 wrong medications, and was taking the wrong medication at home. R2 was sent home with medication for urinary retention, and R2 did not have anything wrong with his bladder. We had no knowledge that R2 went home with the wrong medication. The facility had no knowledge that this medication error transpired upon discharge from the facility. The facility was notified by R2's physician of this medication error 2 to 3 weeks after R2's discharge from the facility. R2 was sent home with Oxybutynin and Atorvastatin by error. Oxybutynin is for an overactive bladder, and if taken when not needed, can cause urinary

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S9999	Continued From page 3 retention. The medication, Oxybutynin, causes the bladder to relax, and when taken by error, it can cause urinary retention. When a resident is discharged from the facility, the nurse does the medication reconciliation with the doctor prior to discharge. Then the nurse goes over the medication with the resident, and the nurse sends the resident's medication home with the resident. R2 was sent home with 2 incorrect medications, and from what was reported to us by R2's physician, the medication caused R2 to have urinary retention, and R2 had to go to the hospital, where R2 was catheterized. Since the error occurred upon R2's discharge, I have done in-service, as well as I implemented a new patient discharge form. The form assists the nurse with educating the resident/care giver about discharge medication and follow up appointments. The resident/care giver must sign the form on the bottom, indicating understanding." On 06/14/2023 at 12:01pm V6 (Licensed Practical Nurse) stated, "I have done a discharge with a resident in the facility. When a resident is discharged, the nurse will do a medication reconciliation with the physician. Once the medication reconciliation is done, the nurse will do a medication education with the resident and/or the family. During a discharge, the nurse will educate the resident/family on the medication name and what the mediation is for and what time the medication should be taken. After the medication education is complete, the nurse will pack the medication into a bag and the medication is sent home with the resident. Narcotics are not sent home with the resident. Upon discharge, the nurse has to review the reconciled medication list and compare it to the medication bingo cards on hand to make sure that the correct medication is being sent home	S9999		

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with the resident who is discharging from the facility. I go over the appointments that the resident needs to follow up on once the resident is discharged. I answer all the resident's and family questions, and make sure that the instructions and the medications are understood. I make sure that the resident and family understands how and when the medication is supposed to be taken."

On 06/15/2023 at 1:55pm V9 (Physician/Medical Director) stated, "R2 was given the wrong medication in error. The correct medication was sent to the pharmacy for R2. The wrong medication was given to R2 in bingo cards at the time R2 was being discharged from the facility. Medication bingo cards for a different patient were sent home with R2, that is the error that occurred. R2 was sent home with Oxybutynin, which were for another resident at the facility. Oxybutynin can cause urinary retention and constipation; all types of anticholinergic symptoms can occur, and this medication was not intended for this patient. R2 was in the hospital emergency room and had to be catheterized with a foley catheter. R2 has prostate enlargement and that can already slow down urine output, and on top of that R2 received Oxybutynin. With R2 having an enlarged prostate and receiving Oxybutynin, this medication blocked urine output and he was not supposed to receive this medication it was given to him in error. R2 was never supposed to be on this medication."

On 06/14/2023 at 1:54pm, V1 (Administrator) informed surveyor that V4 (agency nurse) was out of the country, therefore, not available for an interview.

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S9999	Continued From page 5 R2's Progress Note (dated 05/18/2023) documents, "Resident alert and oriented x4, discharged home with meds around 10:30am. Patient teaching completed with clear understanding. Stable upon discharge. DON made aware." Review of R2's Medication Administration Record (dated 05/01/2023 to 05/18/2023) documents that R2 was receiving Atorvastatin Calcium Oral Tablet 80mg 1 tablet at bedtime. The medication administration record indicated that Oxybutynin 5mg was not being administered to R2 while R2 resided at the facility. Medications-Leave of Absence, Discharge Policy (undated) states: Drugs which have been dispensed for individual resident use and are labeled in accordance with State and Federal law may be furnished to a resident upon his or her discharge provided that: The charge nurse is responsible for documenting medications provided upon discharge in the resident's medical record. Prevention of Medication Error In-service (dated 06/09/2023) states: Review and verify each medication for correct patient, correct medication, correct dosage, correct route, and correct time against the transfer orders, or medication listed on the transfer documents. "B"	S9999		