STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003636	A. BUILDING: _____ B. WING _____	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN GOOD SHEPHERD HOME	101 PRAIRIE MILLS ROAD GOLDEN, IL 62339

(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 Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) 300.1630c) 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		

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S9999	Continued From page 1	S9999		

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 300.1630 Administration of Medication

c) Medications prescribed for one resident shall not be administered to another resident.

These Regulations are not met as evidenced by:

Based on record review and interview the facility failed to ensure a resident was free of significant medication errors for one of one resident (R4) reviewed for significant medication errors in the sample of 28. These failures resulted in R4 ingesting a toxic amount of medication, experiencing increased lethargy, arrhythmia, sedation, and respiratory depression resulting in R4 requiring emergency department services and intravenous fluids.

Findings include:

R4's Progress Notes dated 10-16-24 at 5:25 PM and signed by V2 (Director of Nursing) documents, "(R4) received the wrong medication this evening. Doctor and family notified. Vitals obtained and will be monitored closely through the night, (R4) is alert and orientated. No need to go the ER (Emergency Room) at this time. Continue to monitor."

R4's Progress Notes dated 10-16-24 at 10:08 PM

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document, "(R4's) O2 (Oxygen Saturation) noted to be 82 percent. At 9:30 PM on-call (physician) returned call and asked for updated O2 which was 72 percent on two liters (oxygen) per minute. Order received to send to ER. Call placed to 911. Resident has been loaded into the ambulance and left (the) facility at this time."

R4's Emergency Department (ED) Notes dated 10-26-24 at 10:38 PM document, "(R4) is a 76-year-old who presents to the emergency department with complaints (c/o) accidental ingestion of medication at 5:00 PM today. (R4) had been inadvertently given medication meant for another patient. (R4) appears to be somnolent at point of examination hence history was obtained by EMS (Emergency Medical Staff). Life-threatening and function threatening differential diagnoses considered on ED evaluation include toxic ingestion, arrhythmia, sedation, respiratory depression, or other metabolic causes of sedation. 12:04 AM reassessment of (R4) shows (R4) to be in stable condition. (R4) shows improvement after the following was given in the ED: Sodium Chloride 0.9% (percent) 1000 milliliters intravenous."

R4's Emergency Department Clinical Care Summary dated 10-17-24 documents, "You (R4) were seen in the emergency department on 10-17-24 with the chief complaint of overdose."

R4's Progress Notes dated 10-17-24 at 7:06 AM document, "(R4) returned from the ER. (R4) remains lethargic and hard to arouse. Respirations are even and non-labored. Transporter reports, "It was a mess. It took five people to get (R4) in the wheelchair, (R4) is out of it."

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R4's Progress Notes dated 10-17-24 at 11:02 PM documents R4 continues to be lethargic.

R4's Progress Notes dated 10-17-24 at 8:49 AM documents, "This nurse fed (R4) for breakfast. (R4) asked, "What is wrong with me?" This nurse explained. (R4) stated, "Oh wow. I guess that's why I feel this way." (R4) stated he was full and would like to go back to sleep."

R4's Progress Notes dated 10-17-24 at 12:46 PM and 11:02 PM document R4 remained lethargic and remained in bed throughout the day.

On 11/25/24 at 11:30 AM V2 (Director of Nursing) provided a list of R31's medications that were administered by V12 (RN/Registered Nurse) to the wrong resident (R4) on 10-16-24 at 5:00 PM. That list included the following medications: Mirtazapine 30 mg (milligrams) one tablet, Atorvastatin 80 mg one tablet, Tamsulosin 0.4 mg one tablet, Clonazepam 0.25 mg one tablet, Colace 100 mg one tablet, Gabapentin 200 mg one tablet, Levetiracetam 500 mg one tablet, Memantine 10 mg one tablet, Senna 8.6 mg one tablet, and Vitamin C 500 mg one tablet.

On 11-26-24 at 11:30 AM R4 stated, "When I was given someone else's medications I was worried. I did not feel well and was having a hard time breathing. It scared me. I was tired for several days after that and stayed in bed most of the time."

On 11/25/24 at 12:05 PM V2 (Director of Nursing) stated, "Both (R4) and (R31) have the same first name. (V12) had given (R4) the other resident's (R31's) medications by accident. (V12) realized what she had did after it was too late."

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S9999	Continued From page 4 On 11-25-24 at 12:20 PM V12 stated, "On 10-16-24 at around 5:00 PM I was giving medications and I realized I had given (R4) a different resident (R31's) medications. I only asked (R4) his first name and not his last name before giving (R4) his medications. I reported it to (V2) and then called the physician and was told to monitor (R4) and if (R4) had a change in condition to send (R4) to the emergency room. I know after I left my shift, (R4) had a condition change and had to be sent to the emergency room." The Adverse Consequences and Medication Error policy dated 11/2024 documents "The interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects." Policy Interpretation and Implementation "1. An "adverse consequence" refers to an unwanted, uncomfortable, or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include a. Adverse drug/medication reaction; b. Side effect; c. Medication-medication interaction; or d. Medication-food interaction. 2. The staff and practitioner strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturers specifications for use, dose, administration, duration, and monitoring of the medication." Medication errors "1. A "medication error" is defined as the preparation of administration of drugs for biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services." 2. Examples of medication errors include b.	S9999		

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S9999	Continued From page 5 Unauthorized drug-a drug is administered without a physician's order; f. Wrong drug (e.g. (example), vibramycin ordered, vancomycin given). 3. A "significant medication-related error" is defined as: b. Requiring hospitalization or extending a hospitalization. e. Resulting in cognitive deterioration or impairment. f. Life threatening. Procedures "3. Evaluate the resident for possible medication-related adverse consequences when the resident has clinically significant change in condition/status, including a. Unexplained decline in function, cognition, or behavior. b. Worsening of an existing problem or condition. 4. Monitor the resident for medication related adverse consequences when there is a (an): f. Medication error, e.g., wrong or expired medication." The Administration of Medication policy dated 11/2024 documents "Medications are administered in a safe and timely manner, and as prescribed." " 9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include a. checking identification band; b. checking photograph attached to medical record; and c. if necessary, verifying resident identification with other facility personnel. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication." (B)	S9999		