STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001028	A. BUILDING: _____ B. WING _____	C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	1623 29 WEST DELMAR GODFREY, IL 62035

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S 000	Initial Comments Complaint Investigation 2543442/IL190558	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)1) 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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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.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to prevent a significant medication error in 1 of 6 residents (R3) when reviewed for medication administration in the sample of 6. This failure resulted in R3 being admitted to the hospital with a principal problem of Accidental Drug Overdose.

Findings Include:

R3's Progress Note, dated 4/17/25 at 6:59 PM, documents the following: "This Nurse recognized that I administered a wrong medication to the resident. Res. (Resident) has NKA (No Known Allergies). Res sent to ER (Emergency Room) for evaluation. NP (Nurse Practitioner, Administrator, and D.O.N (Director of Nurses) all made aware. ER MD (Medical Doctor) aware."

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R3's Progress Note, dated 4/18/25 at 5:50 PM, documents the following: "Update resident admitted with hypoglycemia and medication error. Resident stable and alert at this time."

R3's Progress Note, dated 4/20/25 15:02 PM, documents the following: "Resident returned to facility via ambulance at 14:55 (2:55 PM)."

R3's Medication Error Report, dated, 4/17/25, documents the following: Occurred on 4/17/25 at 6:50 PM, discovered 4/21/25 at 6:50 PM by V8, RN (Registered Nurse). Medication Involved: Clozaril (Clonzipine) 150 mg (milligrams). Description: resident came to nurse requesting meds while nurse was preparing meds for another resident and accidentally gave R3 the other resident's (R5) medication. Medication Error Type: wrong resident, wrong drug. Contributing factors: lack of staff concentration. Symptoms experienced: lethargy, sent to ER and admitted for observation. MD, pharmacy and family notified. Results of investigation: Sent to ER for further evaluation. ER admitted for 24 hours and returned to facility with no other adverse effects. Interventions: DON completed medication administration competency with V8, RN, and completed medication administration in-services with the nurses.

R3's ED (Emergency Department: Provider Notes, dated 4/17/25, document the following: "Patient here for lethargy, somnolence, history of diabetes. Nursing home called and said he was given a medication in error at 4:30 PM, 150 mg of Clozaril. Nursing home staff gave 22 units for his sugar of 330. Final diagnosis: Accidental drug overdose, Hypoglycemia, AMS (Altered Mental Status). Critical care was necessary to treat or

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prevent imminent or life-threatening deterioration of the following conditions: Hypo/Hyper Glycemic Control, Acute Ingestion. Poison control was contacted, unfortunately there is no reversal agent, recommended supportive measures, monitor for dystonia and seizures (control with benzos if needed), treat Hypotension with fluids and pressors as needed to protect the airway and admit for observation. R3's blood sugar in the emergency room was 85."

R3's Post-Acute Transfer Report, dated 4/20/25, document R3's Principal Problem was an accidental drug overdose.

R3's Physician Order Sheets (POS) were reviewed with no orders for Clozaril.

R5's POS was reviewed with an order for Clozapine (Clozaril) 100 mg, give 1.5 tablets by mouth twice daily.

On 4/22/25 at 1:23 PM, V8, RN, stated she was at the medication cart, getting medications ready for another resident (R5) when R3 came up to her and asked for his medication, and she accidentally gave R3 R5's medication, Clozaril, and about 15 - 20 minutes later, she realized what she had done. V8 stated R3 was very lethargic, the Nurse Practitioner was notified, and R3 was sent to the hospital. V8 stated R3 was admitted to the hospital for a few days.

On 4/22/25 at 1:30 PM, V10, Pharmacist, stated she reviewed R3's medication, and there were none of his medications that would have interacted with the Clozaril/Clozapine. V10 stated receiving one dose of this medication, would not have made R3 fatigued or lethargic. V10 stated when it is given regularly some common side

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effects can be lethargy, blurred vision, etc. from it building in their system with multiple doses, it would not normally be caused by just one dose.

On 4/22/25 at 2:45 PM, V2, DON, stated she was not here when the medication error with R3 took place, she was called at home by V8, RN, and V8 had already notified R3's physician and called EMS, and R3 was sent to the hospital. R2 stated, "(R3) did not have any adverse reaction from the medication; he is a severe brittle diabetic, his blood sugars quickly go high to low." V2 stated she was told by the hospital R3 was hypoglycemic upon arrival to the ER and was admitted. V2 stated prior to R3 going to the hospital, R3's blood sugar was 300 and he was given 22 units of insulin, and depending on when the insulin was given and he ate, could have caused his blood sugar to drop quickly, which is normal for R3. V2 stated they have changed his insulin and accu-check times to make sure when he is high and needs insulin, that he eats right then and doesn't wait. V2 stated R3 knows when his blood sugar is low and will get peanut butter cups and juice. V2 stated she is a diabetic and hypoglycemia can cause lethargy. V2 stated when a nurse is administering medications, she would expect them to follow the rights of medication administration, right medication, right person, right time, right frequency, etc.

On 4/22/25 at 2:55 PM, R3 stated he doesn't remember anything about the incident on 4/17/25, or for a couple of days after. R3 stated he woke up in the hospital and was told they thought he had been given the wrong medication, but that is all he was told. R3 stated his blood sugar goes up and down quickly, and now he doesn't take his insulin until he eats so it won't drop. R3 stated he knows when his blood sugar is low and he will get

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S9999	Continued From page 5 some candy to raise it. R3 stated when his blood sugar is low, he feels bad and sometimes will black out. The Clozaril Information from Drugs.com documents the following: It is an anti-psychotic used to treat Schizophrenia after other treatments have failed, works by changing chemical reactions in the brain. Also used for reduce the risk of suicidal behavior in adults with Schizophrenia or similar disorders. Clozaril can affect your immune system, can cause seizures when given in high doses, cause heart problems. Overdose symptoms may include drowsiness, confusion, fast heartbeats, feeling light-headed, weak or shallow breathing, drooling, choking, or seizure. The Medication Administration Policy, dated 6/2015, documents the following: All medications are administered safely and appropriately to aid in residents to overcome illness, relieve and prevent symptoms, and help in diagnosis. Check medication administration record prior to administering medication for the right medication, dose, route, patient/resident, and time. (B)	S9999		