STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016133	A. BUILDING: _____ B. WING _____	C 08/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR COURT OF FREEPORT	2170 WEST NAVAJO DRIVE FREEPORT, IL 61032

(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 Facility Reported Incident of 8/4/2019/IL114701 Investigation	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)1) 300.1630c) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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 300.1630 Administration of Medication

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

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidence by:

Based on interview and record review the facility failed to assure a resident was given the correct medications for one of three residents (R1) reviewed for medications in the sample of 3. This failure resulted in R1 being transferred to the local hospital intensive care unit for two days.

The findings include:

R1's facility face sheet shows R1 to be 100 years

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old and has diagnoses of dementia, obstructive uropathy, hypothyroidism, depression and atherosclerotic disease. R1's facility assessment shows R1 to have moderate cognitive impairment and requires extensive assist with care.

The facility incident report dated 8/4/2019 shows R1 received the medications of another resident (R2) in addition to R1's own medications that morning. V3 RN (Registered Nurse) was preparing the medications for R2 when R1 began to get up from the table. V3 went to help R1 sit back down and then proceeded to give R1 the pills meant for R2. The report shows R1 received R1's own medications which consisted of Tylenol 500mg, calcium, stool softner, probiotic, multi vitamin, cranberry, lasix 60mg (water pill), an eye vitamin and miralax. In addition, R1 also received an additional does of tylenol 650 mg , multi vitamin and calcium, two blood pressure medications, two anti-diabetic medications, and an additional 60 mg of lasix.

On 8/13/2019 at 9:35AM, V4 (R1's POA) said her (parent) was admitted to the intensive care unit at the hospital after receiving the wrong medications. V4 said her (Parent's) heart rate kept dropping very low and they were monitoring R1's blood pressure and blood sugars as well. V4 said this is not the first time her (parent) has received the wrong medications while at the facility.

On 8/13/2019 at 9:42 AM, V3 RN said she was the nurse that gave R1 the medications of R2. V3 said she became distracted while passing medications to the residents on the dementia unit. V3 said R1 was getting up alone and she went over to assist R1 and gave R1 the medications she had crushed up for R2.

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On 8/13/2019 at 10:45AM and 2:30PM, V1 Director of Nursing said V3 has had medication errors before and has been moved off the dementia unit due to her getting distracted. V1 said she moved V3 to a unit with more independent residents because they are able to say who they are and can identify their medications better. V1 said if V3 had not realized the error she had made and reported it, R1 could have easily died. V1 said she expects all nurses to follow the 5 Right's of administering medications which are: right medication, right patient, right dosage, right route and right time.

On 8/13/2019 at 2:00 PM, V2 Nurse Practioner said R1 had to be hospitalized after the medication error.

On 8/14/2019 at 10:40 AM, V8 pharmacist said the medications R1 received by mistake on top of R1's medications could have caused a drop in blood pressure, a drop in heart rate, an increase in urination,nausea, dizziness and if left untreated could lead to seizures and loss of conciousness.

The hospital records for R1 show the diagnoses of accidental overdose, hypoglycemia related to poisoning of anti-diabetic medications and bradycardia (low heart rate). The records show low blood sugars as low as 64 (normal is 74-106) and unstable heart rate as low as 30. (Normal heart rate is 80) The records show R1 was treated with intravenous fluids. The records also show the daughter reporting to hospital staff that this was the second time her (parent) has been given the wrong medications while at the facility.

The facility employee disciplinary action record dated 8/4/19 shows V3 was given a written

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warning for failure to administer medications following the 5 rights of medication administration resulting in a medication error.

The facility policy with a revision date of 02/04 shows the objective is to provide the resident with those medications deemed necessary by the physician to improve and/or stabilize a specified diagnosis of the resident. The teaching tool provided by the facility shows the "7 rights" of medication administration with number 2 showing the right patient is given the medications.

(A)