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	IL6004352	A. BUILDING: _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY NURSING PAVILION	9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457

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S 000	Initial Comments Annual licensure and certification Facility reported incident of 10/04/2019/IL116632	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)1)6) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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 follow the facility policy on identifying the right resident, administering medications as ordered by the physician, and safeguarding resident from receiving another resident's

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S9999	Continued From page 2	S9999		

medications. These failures resulted in R23 complaining of dizziness, weakness, heart pounding, and trouble breathing. R23 was sent emergently to the local hospital and diagnosed with Opioid overdose.

Findings Include:

R23 is 40 years old with Diagnoses of Major depressive disorder, Wernicke's encephalopathy, Deficiency of other specified B group vitamins, Hepatic Failure unspecified without coma, Pain specified, Gastro-esophageal Reflux Disease with Esophagitis. Minimum Data Set Section C, Cognitive Patterns (dated 9/12/19) indicate R23 has intact condition.

On 12/9/19 at 10:59 am, R23 was asked if she had ever been given wrong medication. R23 answered," Yes. The person who gave me the wrong medicine was V20 a new person. I was asleep and V20 woke me up. When V20 gave me the patch, I thought the doctor changed my medications. I don't think she asked me my name, because I would have said I am not that person. I was really scared when I got sick. I got sick because I only take Tylenol for pain. I got really dizzy, throwing up, pretty bad, and my body started tingling. I couldn't stand up right. My legs were weak. I was totally dizzy. Almost fainting. Fentanyl was so strong. Everything was going numb, I almost passed out. I couldn't catch my breath and my heart was pounding. I was sleeping and V20 woke me up. I trusted the staff to give me the right medication. V20 told me here's your meds, put the patch on and gave me pills. I woke up sick and went to the nursing station and I asked, "what is this on my arm" and they were shocked. It was probably around 8-9am. They gave me a pill, they called the

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S9999	Continued From page 3	S9999		

ambulance and I went to the hospital."

Progress Notes dated 10/4/19 03:00pm authored by V2 (Director of Nursing) documented that R23 was trembling and needing assistance by 2 staff members to sit. Skin was warm, face, chest and arms were flushed. Fentanyl Patch was in place on the resident left upper arm. Record was reviewed and R23 had no order for Fentanyl Patch. Facility called Nurse Practitioner and ordered Benadryl with no immediate relief. R23 showed increased mental confusion and restlessness. Vital signs were: Blood pressure: 86/54 mmHg, Pulse rate: 100 bpm, Respiratory rate: 22 shallow. 911 was called, they arrived 2 minutes after call was placed to take resident to nearest hospital.

R23's last set of vital signs prior to incident taken 9/10/2019 documented as: Blood pressure: 130/70 mmHg, Pulse: 70 bpm, Respiration: 20 rpm, Temperature: 98.6F, Weight: 209 lbs. Vital signs taken on 10/6/19 (two days post incident) were: Blood pressure: 124/82 mmHg, R: 18, P: 81 bpm, T97.9

On 12/9/19 at 12:01 pm, V20 (Licensed Practical Nurse) stated, I was orienting with another nurse. I looked at the MAR (medication administration record) at the nurses' station, and then I went to the room, I asked "Are you (R265's first name), she said "yes". V20 said "I will give you your meds and she said yes". She was lying on the bed, when I knocked on the door, and said (R265's first name), the lady in the first bed, sat up, and she answered to (R265's first name). I asked her 3x if she was (R265's first name) and she said "yeah". When she sat up from the bed, she said "yes", I told her who I was, I said "I will give you your meds". I walked out from the room

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S9999	Continued From page 4	S9999		

and went to the MAR and prepared the medications. I went back to the room, and said "I got your meds", she said "ok", I gave oral medication and put the patch on. When I gave her the patch, I asked her where you wanted me to put your patch, she said, "That's new, I never had that before" so "I said I will put it on you". I went to nursing station and told V24 (LPN) that (mentioned R265's first name) said "she never gets a patch", and V24 in the nursing station said, "She has been getting that for years". V20 was asked when she learned that there was a medication error, she stated "When the DON (Director of Nursing) called me. She asked me if I put a patch on somebody. I shouldn't have been passing medication because I was on orientation. I really didn't know the people. Only one nurse was working with me. I was giving medication by myself. That was my first time to pass medication in that building (Facility). V20 was asked if she asked R23's last name, V20 answered, "No"; and if she asked R23's birthday, V20 answered "No."

On 12/11/19 at 3:30pm, V2 said V24 was the preceptor, and V24 was at the nursing station passing medications. V2 also said, V20 was by herself when she administered the medications, and it was V20's first time to pass medication in the facility but, V20 has been a nurse for ten years.

On 12/9/19 at 11:53am, V2 said, on October 4, 2019 R23 received 6:00 am medications ordered for R263. R263's October 4, 2019 Medication Administration Record documented, Norco 7.5mg tablet, Alprazolam 0.5mg tablet, Levothyroxine 88mcg tablet, Fentanyl 25mcg/hr transdermal patch, was signed out by V20.

R23's Physician Order activity Detail Report dated

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S9999	Continued From page 5 October 10/1/2019- 10/31/19. No orders for Fentanyl, Norco, Xanax or Levothyroxine. R265's Physician order, documented Fentanyl 25mcg/hr transdermal patch apply 1 patch by transdermal route every 3 days at 6:00am, Norco 7.5mg-325mg 1 tablet by oral route every 8 hours, Alprazolam 0.5 mg by oral route, and Levothyroxine 88mcg tablet by oral route once daily. Progress Notes dated 10/4/19 6:03pm, authored by V22 Nurse Practitioner documented, R23 was administered a Fentanyl Patch 25mg (referring to mcg), Norco 7.5/325mg and Xanax 0.5mg. Assessment and Plan Opioid overdose: patient incorrectly given wrong medication. Patient rushed to ED, and received Narcan. On 12/10/19 at 10:07am, interview with V22, was asked the question, Do you think the administration of these medication may have contributed to R23's symptoms? V22 stated, "The patch was strong for a person who only takes Tylenol. The mixture of the 3 medications together was strong and I was concerned of respiratory distress, and they don't have Narcan, and I want it available as needed, so I wanted her to go the hospital to be able to better manage the resident." On 12/10/19 at 3:09pm V22 (Nurse Practitioner) was asked to clarify if an opiate overdose is a life threatening situation? V22 answered "Yes it is." V22 was also asked what the potential harm was to R23, and what would be the concern? V22 answered "Respiratory distress, that's why she was sent out to be able to manage appropriately in a timely fashion."	S9999		

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S9999	Continued From page 6	S9999		

Emergency Medical Services Narrative: In summary crew arrived to find pt. AO (Alert Oriented) x2 complaining of nausea. Staff related to crew that pt was given the wrong drugs. Norco, Fentanyl, Levothyroxine, Alprazolam. Pt was taken to ambulance for continued ALS (Advance Life Support) care. Crew administered 4 mg Narcan. R23 AO x3 upon arrival at local hospital. Pt care transferred over at nurse's station.

Local Fire Department (Paramedics) Vital Signs on 10/4/19 at 09:01 am: 130 (bpm) Pulse rhythm, Respiratory rate 18, Blood Pressure 142/70 mmHg

Emergency Room's Final Diagnosis: Poisoning by other Synthetic Narcotics Accidental (Unintentional), Poisoning by Benzodiazepines Accidental (Unintentional), Poisoning by 4-aminophenol derivatives.

On 12/9/19, V7 Registered Nurse (RN) (at 11:37) and V10 RN (at 2:17pm) were interviewed regarding medication pass. Per the facility medication policy, both nurses stated the correct way to administer medication to residents.

Facility's Incident/Accident Final Report Dated October 7, 2019, Documented, "Resident was accidentally given her roommate's medication. She was taken to Local Hospital via EMS for evaluation and treatment. She received Narcan in route to Hospital (D/T (due to) Ingestion of Narcotic analgesic (Fentanyl/Norco) and antianxiety medication (Xanax)."

Facility's Policy titled; Specific Medication and Administration Procedures dated July 2018 states in part; to administer medications in a safe and effective manner. Identify resident using two

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S9999	Continued From page 7 identification methods before administering medication (e. g photo plus verbal confirmation of last name, photo and confirmation by family member, etc.) Facility's Medication Errors policy states in part; a medication error is defined as a dose of medication that deviates from the physician's order as written in the medical record. Unauthorized drug- Administration to the resident of medication not authorized/ordered. (A)	S9999		