STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 06/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

(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 #1963742/IL112450	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 2)All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. (Section 2-107 of the Act) These requirements were not met evidencded by: Based on record review, and interview, the facility	S9999		

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S9999	Continued From page 2 failed to ensure that a resident received the correct physician ordered medications. This failure resulted in R1 receiving another residents' medications, R1 being sent to the hospital for anti-coagulant poisoning and hypotension, then being admitted to the intensive care unit. This failure affects two (R1, R5) of three residents reviewed for medications in the sample of five. Findings include: R1's facility Face Sheet (current) includes the following diagnoses: Cerebral Aneurysm, Vascular Dementia, Chronic Obstructive Pulmonary Disease and Abnormal Weight Loss. R1's Nursing Notes dated 3/21/18 document "Medication error noted. Administrator and MD (Medical Doctor) notified right away. Initial B/P (blood pressure) was 95/75. Wife was here and notified. Resident was put in wheelchair and brought to the nurse's desk to be closely monitored. Blood pressure was monitored every 15 minutes. Given (drink) per MD, PT/INR (Pro-Time/International Normalized Ratio) scheduled for 3/24 also per MD, to send to ED (Emergency Department) if B/P drops. B/P retook at (6:50 pm) 110/68. B/P 79/54 at (7:45 pm), 79/49 at (8:00 pm). LOC (Level of Consciousness) started to decrease. Medix called immediately. Wife agreed with decision. Medix arrived around (8:30 pm). Called ER (Emergency Room) at (11:00 pm) for update, admitted to ICU (Intensive Care Unit) with accidental overdose and anemia."	S9999		

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S9999	Continued From page 3	S9999		

Hospital Records dated 3/21/18 document R1 being seen in the ER for Poisoning by anti-coagulants, and Hypotension due to drugs. ER Notes document R1 brought in from (facility) after (R1) was given wrong medications. Records document "(R1) was accidentally given medication of another patient at the (facility) and was found to have low blood pressure subsequently. (R1) was given the wrong medications of Clonidine 0.3 milligrams (mg), Coreg 25 mg, Losartin 100 mg, Hydralazine 50 mg and Coumadin 8 mg. R1 is lethargic. Poison Control was contacted and recommends admission for monitoring. R1 admitted to ICU (Intensive Care Unit)." Hospital Note is signed by V24, Emergency Room Physician.

On 5/16/19, the facility was not able to provide any information on what medications R1 received in error on 3/21/18. In addition, the facility was not able to provide a Medication Error Report or facility Incident Report for the above event/medication error of 3/21/18, causing R1 to be hospitalized.

R1's Medication Administration Record (MAR) dated 3/21/18 documents R1 receiving R1's physician ordered medication. There is no documentation on the above MAR of R1 receiving any other medications other than R1's own.

Nursing Notes dated 3/26/18 document R1's readmission to the facility 5 days later from the hospital.

On 6/5/19 at 11:35 am, V1 Administrator confirmed that V20, Licensed Practical Nurse gave R1 another resident's (R5's) medication on the evening of 3/21/18. V1 stated there was no Medication Error Report or Incident Report

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S9999	Continued From page 4	S9999		

generated documenting this event. V1 stated V1 was able to piece together from statements made by V19, Certified Nurse Assistant/Resident Coordinator and V21, Admissions Director that V20 did give R5's 4:00 pm medications to R1 in error causing R1 to be hospitalized.

On 6/5/19 at 12:30 pm, V20 confirmed that V20 gave all of R5's 4:00 pm medications to R1 in error.

R5's Physician Order Sheet dated 3/21/18 documents the following medications scheduled for 4:00 pm: Clonidine 0.3 mg, Coreg 25 mg, Losartin 100 mg, Hydralazine 50 mg, (all anti-hypertensive medications) Coumadin 8 mg (anti-coagulant), Nepro 1 capsule, Vitamin C 500 mg, Phosio 667 tab and Calcium Carbonate with Vitamin D3 500/125 mg.

A facility policy titled "Guidelines for the Identification and Classification of Medication Errors" and undated documents the following: A significant error is one which creates discomfort for the resident or compromises the resident's health and safety.

(A)