FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED C IL6014328 B. WING 07/25/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST EUCLID AVENUE DIMENSIONS LIVING PROSPECT HTS PROSPECT HEIGHTS, IL 60070 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) **Initial Comments** S 000 Complaint Investigation: 2193922/ IL134675- No Findings Facility Report Incident (FRI) Investigation of 6/04/2021 /IL135165 330.1510)4 S9999 Final Observations S9999 Statement of Licensure Violations: 330.1510)4) Section 330.1510 Medication Policies 4) If the facility elects to administer medications to some residents for control purposes, the medications shall be administered by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Medications shall not be recorded as having been administered prior to their actual administration to the resident. This Requirement was not met as evidenced by: Based on observation, interview and record review, the facility failed to administer a cognitive-enhancer medication in a manner to prevent an adverse side effect. This applies 1 of 3 (R1) residents reviewed for medication administration. Attachment A The findings include: Statement of Licensure Violations The Face Sheet showed that R1, an 83 year old,

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BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: IL6014328 B. WING 07/25/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST EUCLID AVENUE **DIMENSIONS LIVING PROSPECT HTS** PROSPECT HEIGHTS, IL 60070 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) S9999 Continued From page 1 \$9999 was admitted to the facility 2/28/2020 with diagnoses that included restlessness, agitation, dementia without behavioral disturbance, anemia and hypertension. On 7/23/2021 at 11:30 A.M. and on 7/24/2021, R1 was observed to be ambulating around the hallway, founge area and her room in the Memory Care Section, Shelter Unit of the facility. R1 was pleasant, verbally responsive but confused. The facility's significant medication error incident report dated 6/16/2021 showed: -"On 6/4/2021 at around 4:30 P.M., (R1) had a change in condition, and was sent to the hospital Emergency Room. (R's daughter alleges that (R1) while at the hospital was found to have 2 patches of Rivastigmine 9.5 mg. patches on. (R1's) daughter alleges that (R1's) change in condition was due to this medication error. - Per Emergency Room Physician Documentation, (R1's) nausea and vomiting is partially due to having 2 patches of Rivastigmine 9.5 mg, patches on. - (R1) was treated in the Emergency Room and returned to the facility on 6/5/2021 without any residual nausea and vomiting. - (V5,nurse) was assigned on 6/4/2021 to (R1) had applied a new patch of Rivastigmine 9.5 mg. without thoroughly doing a body check and the Rivastigmine patch applied on 6/3/2021 was not removed. - (V5) was issued a final warning discipline and was reeducated on proper administration and removal of the Rivastigmine patch. (V5) was also was counseled on taking (R1) to her room to do a complete upper body assessment before applying the patch."

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The hospital emergency room record dated

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_ COMPLETED IL6014328 **B. WING** 07/25/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST EUCLID AVENUE **DIMENSIONS LIVING PROSPECT HTS** PROSPECT HEIGHTS, IL 60070 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 6/4/2021 showed that R1 was assessed with " Multiple Rivastigmine patches in place to anterior chest and back dated 6/3 AND 6/4. Diagnosis management comments: 83 year old woman with history of dementia who presents with complaint of nausea and vomiting since 4:00 P.M. today. On exam, she was actively retching. Noted multiple Rivastigmine patches in place, one dated from yesterday morning and one from today morning. Per chart review, these are to remain only 24 hours. The out of date patch was removed. Based on review of this medication. suspect (R1's symptoms are at least partially due to overmedication from extra patches being in place ....At 11:40 P.M., (R1) with no vomiting. Appropriate for discharge..." On 7/23/2021 at 1:30 P.M., V2 (Director of Nursing), stated that (V5) had not checked thoroughly R1's body to ensure that the old patch of Rivastigmine that was applied on 6/3/2021 was remove prior to applying a new one on 6/4/2021. V2 also added that R1 was sent out to the hospital due to nausea and vomiting and per report received from the hospital's physician and (R1's) daughter, this had caused the nausea and vomiting as an ill effects from the 2 patches of Rivasgtigmine. On 7/23/2021 at 1:45 P.M.,, V3 (Acting Director of Nursing in The Shelter Unit of the Facility) stated that V5 had not removed the 6/3/2021 Rivastigmine patch prior to application of the new patch on 6/4/2021 of the Rivastigmine 9.5 mg/24 hours, medication. On 7/23/2021 at 2:00 P.M. V4 (Human Resource Manager) stated that she investigated the medication error report. V4 stated that V5 had not thoroughly checked R1's body and ensured that

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Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** (X3) DATE SURVEY A. BUILDING: \_ COMPLETED C IL6014328 **B. WING** 07/25/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST EUCLID AVENUE **DIMENSIONS LIVING PROSPECT HTS** PROSPECT HEIGHTS, IL 60070 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REFIX PREFIX (X5)(EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 3 S9999 the old patch was removed prior to applying a new patch on 6/4/2021. On 7/23/2021 at 2:49 P.M., V5 (Nurse) stated that she had applied R1's new patch of Rivastigmine 9.5 mg. on 6/4/2021. V5 also added that she had signed the MAR (Medication Adminstration Record) that the old patch dated 6/3/2021 was removed and signed that the new patch was applied. V5 further added that she just signed the MAR without removing the old patch. V5 said that she was so busy so she had really no time to look thoroughly for the old patch and had signed the MAR as "removed" even if it was not. The POS (Physician Order Sheet) for the month of July 2021 showed a physician order dated 2/27/2020 for "Rivastigmine Patch 24 Hour 9.5 mg. /24 hour. Apply 1 patch transdermal one time a day related to Dementia and remove the patch per schedule. The MAR (Medication Administration Record) for the month of June and July July of 2021 showed that the schedule for Rivastigmine patch administration was to remove daily the old patch at 8:59 A.M. and apply a new one at 9:00 A.M. . The MAR dated 6/4/2021 showed that V5 (Nurse) had recorded and signed that she had removed the old patch applied 6/3/2021 and applied a new patch for 6/4/2021. This showed that V5 had signed the medication that it was given prior to administration. On 7/24/2021 at 8:55 A.M., V6 (Nurse) was observed for Rivastigmine administration to R1. V6 checked R1's upper body, removed the 7/23/2021 Rivastigmine patch from R1' left upper chest and then applied a new patch to the right

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• 3	explained that the MAR will prompt you to remove the old patch prior to applying a new one. The MAR will also show the site of the previously applied patch. V6 also stated that a nurse can also sign as removed and replaced prior to administration if the documentation happened to be on the scheduled time.				, H	3440	
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