STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007041	A. BUILDING: _____ B. WING _____	C 12/02/2021

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PA PETERSON AT THE CITADEL	1311 PARKVIEW AVENUE ROCKFORD, IL 61107

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S 000	Initial Comments Complaint Investigation 2118844/IL140762	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)1) 300.1210d)2) 300.1620a) 300.1630c) 300.3210o) 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. 2) All treatments and procedures shall be administered as ordered by the physician.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Section 300.1630 Administration of Medication c) Medications prescribed for one resident shall not be administered to another resident. Section 300.3210 General o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise. These requirements are not met as evidenced by: Based on interview and record review the facility failed to ensure a resident (R1) was properly identified prior to administering medication to prevent a significant medication error. This failure contributed to R1 developing hypoxia requiring	S9999		

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S9999	Continued From page 2	S9999		

emergency medical intervention and hospitalization. This applies to 1 of 3 residents (R1) reviewed for medication errors in the sample of 7.

The findings include:

R1's face sheet shows he is a 52-year-old male and was admitted to the facility on 11/20/2021 with diagnoses including: end stage renal disease (esrd), dependence on renal dialysis, acute on chronic combined systolic and diastolic congestive heart failure, and type 2 diabetes.

A nursing progress written on 11/20/2021 by V6 (Licensed Practical Nurse/LPN) shows that R1 is alert and oriented to person, place, time, and situation.

R1's physician order summary dated 11/1/2021-11/30/2021 shows R1 has an order for Norco tablet 10-325 milligrams (mg.) (Hydrocodone-Acetaminophen) Give 10 mg by mouth every 4 hours as needed for pain with an initial start date of 11/23/2021. The same order summary shows there is a second order for the same dosage of Norco as needed for moderate to severe pain 6-10 with a start date of 11/24/2021. There is no physician order for R1 for Morphine.

R1's nursing progress notes written by V6 (LPN) on 11/26/2021 at 3:42 PM, show, "R1 returned from dialysis stating he feels lightheaded asking for something to eat. Graham crackers and a peanut butter and jelly was given. Approx. 15 minutes later "R1" became unresponsive and limp. Was able to get a response with much verbal and tactile stimuli. "R1" had a medium green emesis and the NP (Nurse Practitioner)

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S9999	Continued From page 3	S9999		

"V3" was called and gave orders to watch the resident, and call with any new signs or symptoms." At 4:09 PM, V6 documented in the nursing progress notes that R1 was feeling very warm, a cold cloth was applied to his head and neck. The next note by V6 at 4:15 PM states, "Resident unresponsive again. Large emesis. Unable to get a response to any stimuli, color gray. 911 called, taken to a (local community hospital) sister "V8" informed." A nursing progress note written by V2 (Director of Nursing/DON) on 11/26/2021 at 10:13 PM, shows that "R1" was admitted for hypoxia.

A Nursing Home to Hospital Transfer Form completed by V2 (DON) on 11/26/2021 at 4:15 PM, shows that R1's usual mental status is alert and oriented and able to follow instructions.

R1's hospital records from a local community hospital say, on 11/26/2021 "R1" was brought to the emergency department for a syncope vs. possible opioid overdose due to decreased clearing due to esrd and possible given wrong medication at rehab facility. The same hospital records also state, "This patient's current admission to an acute care setting is essential for the treatment of hypoxic hypercapnic respiratory failure, opiate overdose. The Patient is at risk for developing further complications of hypoxic hypercapnic respiratory failure, opiate overdose if not treated in an acute care setting." The records give R1's diagnosis as hypoxic hypercapnic respiratory failure secondary to unintentional opiate overdose. The same hospital records show that "R1" reported taking 2 tablets of "Norco" on 11/26/2021 instead of 1, and believes it was given by the facility in error. The records show during the course of the hospitalization R1 has had periods of being unstable requiring

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S9999	Continued From page 4 immediate rapid responses, non- mechanical ventilator support and continued treatments of a Narcan infusion to reverse opioid overdose. A medication error reported dated 11/30/2021 and completed by V2 (DON) shows that on 11/26/2021 at approximately 5:30 AM, R1 received the wrong medication and was given Morphine instead of his prescribed Norco. On 11/30/2021 at 9:00 AM, V2 (DON) said she was just informed by V3 (Nurse Practitioner/NP) that R1 did have a medication error over the weekend, (which was later identified to be the morning of 11/26/2021). V2 said this is the first time she was notified of this medication error. On 11/30/2021 at 10:00 AM, V2 said the facility has each residents picture in their electronic record and that should be double checked along with the 5 rights (right patient, right dose, right route, right time, right medication) prior to administering medication to residents. On 11/30/2021 at 11:15 AM, V5 (agency Registered Nurse/RN) said that she did in fact make a medication error on the morning of 11/26/2021, just before the 6:00 AM shift change. V5 said she went to give another resident from the assisted living hall (R101) his scheduled morphine. She gave him only 1- 100 mg. tablet and when she was signing it out in the narcotic sheet, she realized she was supposed to give him a total of 4- 100 mg. tablets of morphine. V5 said she went and got 3 more of the 100 mg. morphine tablets (for a total of 300mg) and instead of taking them to R101 she took them to R1 because they have similar names and she got it confused. V5 said she realized soon after she had made this mistake, she felt terrible and called V2 (DON) and V3 (NP) and informed them both.	S9999		

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S9999	Continued From page 5 V5 (RN) said V3 (NP) gave orders for her to monitor R1 and call with any changes. On 11/30/2021 at 11:30 AM, V3 (NP) said she was informed about R1's medication error the morning of 11/26/2021. She said she received a text from V5 (RN) saying she switched 2 patients up, was rushing around and made a medication error. V3 (NP) said this was a significant medication error. On 11/30/2021 at 11:51 AM, V6 (LPN) said she was aware that R1 had received a medication error on the morning of 11/26/2021. V6 said after R1 returned from dialysis he became unresponsive, lethargic, and hot, his head was dropped to the side and she had to do sternal rubs to get him to become responsive. V6 said R1 had episodes of vomiting and reported not feeling right. V6 said she wasn't even thinking it could be from the medication error she attributed it to dialysis. V6 said she did notify V8 (R1's POA) of the incident when he was unresponsive and then again when he was sent out to the hospital via 911. On 11/30/2021 at 1:55 PM, V8 said she is the POA for R1 who is her brother. V8 said she had just visited R1 on 11/25/2021 and he was doing well and excited to get physical therapy and return home. V8 said she was notified by "V6" (LPN) on 11/26/2021 that R1 had "Coded" and needed to be sent to the hospital. She said she was never notified that R1 had received morphine by mistake, she said the hospital and herself were both under the assumption that R1 was maybe given too much of his prescribed Norco by mistake. V8 also said R1 is not doing well in the hospital and she is not sure if he is going to survive.	S9999		

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S9999	Continued From page 6 On 11/30/2021 at 2:50 PM, V4 (Pharmacist) said signs of an opiate overdose include loss of consciousness, lethargic, nausea and vomiting. V4 said there is a risk for death with any opiate overdose. On 11/30/2021 at 3:15 PM, V9 (Nephrologist) said he is familiar with R1 and was not aware of the medication error R1 had on 11/26/2021. V9 explained that morphine should not be given to residents with poor kidney function, who are receiving dialysis due to the fact it has large volume of distribution and is hard to be dialyzed out of the body. V9 said it makes sense that R1 was okay for hours after the medication error because it takes a while for the medication to build up and break down. He said while R1 was receiving dialysis it was helping his system, but once the dialysis was done the metabolites from the morphine would build right back up. V9 stated, "One would think 300 mg. of morphine for anyone on dialysis would be a huge problem. "It is not only possible it is probable that this medication error was the cause of "R1" needing hospitalization." V9 also went on to say R1 being treated with Narcan and responding temporarily, makes sense for an opiate overdose. V9 said an Opiate has the potential to be fatal if a person quits breathing. There was no documentation in R1's medical record of the significant medication error prior to 11/30/2021. The facility policy titled Adverse Consequences and Medication Errors revised in April 2018 states, "A medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with	S9999		

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S9999	Continued From page 7 physician's orders, manufacturer specifications, or accepted professional standards and principals of the professional(s) providing services. Examples of medication errors include: a. omission-a drug that is not administered, b. unauthorized drug-a drug is administered without a physician's order, c. wrong dose, d. wrong route of administration, e. wrong dosage form, f. wrong drug, g. wrong time and/or h. failure to follow manufacturer instructions ... In the event of a significant medication -related error or adverse consequences, immediate action is taken, as necessary, to protect the resident's safety and welfare. Significant is defined as: a. requiring medication discontinuation or dose modification, b. requiring hospitalization, or extending a hospitalization, c. requiring in disability, d. requiring treatment with a prescription medication, e. resulting in cognitive deterioration or impairment, f. life threatening: and/or resulting in death ... The following information is documented in an incident report and in the resident's clinical record: a. factual description of the error or adverse consequences, b. name and time the physician was notified. c. physician's subsequent orders. D. resident condition for 24 to 72 hours or as directed ..." (A)	S9999		