STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012413	A. BUILDING: _____ B. WING _____	C 07/08/2022

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S 000	Initial Comments Facility Reported Incident Investigation of 6/25/22/IL148714	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c)1) 300.1210d)6) 300.3220f) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 following and shall be practiced on a 24-hour, seven-day-a-week basis: 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 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 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 Regulations were not met as evidenced by: Based on interviews and record review the facility failed to ensure that a resident's narcotic medication (Methadone Hydrochloride) was administered as ordered by the physician. This applies to 1 resident (R1) reviewed for narcotic medications. This failure resulted in R1 being hospitalized with	S9999		

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S9999	Continued From page 2 diagnosis of Methadone poisoning. The findings include: R1 was admitted to the facility on June 24, 2022, from home under hospice care with multiple diagnoses which included idiopathic pulmonary fibrosis, interstitial pulmonary disease, COPD (chronic obstructive pulmonary disease), chronic respiratory failure with hypoxia, fibromyalgia, and chronic pain syndrome, based on the face sheet. R1's admission baseline care plan dated June 24, 2022, showed under summary that the resident was alert and oriented x 3 and was receiving hospice care. The same admission baseline care plan summary showed in-part, "She is here for respite care x 5 days." R1's progress notes dated June 24, 2022 (12:00 PM) created by V4 (Nurse) showed in-part, "All orders from hospice verified with MD/NP (Medical Doctor/Nurse Practitioner), with no new orders. All medications and treatment to be continued. All admission procedures completed." R1's progress notes dated June 25, 2022 (2:39 PM) created by V5 (Nurse) showed in-part, "with complaints of pain 7/10, vital signs stable. 8 AM pain meds administered as ordered. Husband noticed patient easily arousable but easily goes back to sleep. Patient stated she feels warm, sweating, and flushed face. Encouraged fluids, patient able to consume 1 liter of ice water, ice pack placed on patient's armpit and groins. Upon checking the order, patient had overdosage of pain meds. Informed husband, hospice, and MD regarding the medication overdose. 11:45 AM patient picked up by ambulance transportation and transferred to (hospital) ER (emergency	S9999		

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S9999	Continued From page 3 room)." R1's progress notes dated June 25, 2022 (8:48 PM) showed, "Pt admitted at (hospital) due to methadone poisoning per (hospital) ED (emergency department) staff." R1's incident report submitted to the State Agency on June 25, 2022, as the initial and final report showed in-part, "On June 25, 2022 at 11 AM resident is usually alert and oriented x 3 and was noted to be sleepy but arousable and able to respond to name. Resident with order for Methadone 30 mg TID (three times a day). Medication error noted. Resident medication was entered in the system as 30 ml. Family, MD and hospice were notified." Review of R1's medication profile sent to the facility by the hospice company on June 24, 2022, at (1:37 PM) showed multiple medication orders which included, "Methadone Hydrochloride 10 mg/ml (milligrams/milliliter) oral concentrate; Administer 30 milligrams oral 3 times a day; (3 ml); pain management." R1's facility electronic order summary report showed an order dated June 24, 2022, "Methadone HCl (hydrochloride) Concentrate 10 mg/ml, give 30 ml by mouth three times a day for Pain Management." R1's MAR (medication administration record) for the month of June 2022 showed that in the evening of June 24, 2022, V6 (Nurse) administered Methadone HCL Concentrate 10 mg/ml, 30 ml by mouth to the resident and in the morning of June 25, 2022, V5 (Nurse) administered Methadone HCL Concentrate 10 mg/ml, 30 ml by mouth to the resident.	S9999		

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S9999	Continued From page 4 Based on the hospice medication profile order, facility electronic order summary and MAR, R1 received 30 ml of the Methadone Hydrochloride medication, which was equivalent to 300 mg, instead of the ordered 3 ml which was equivalent to 30 mg. Along with the prescribed amount, R1 received an additional nine dosages in a single medication administration on two separate occasions. On July 6, 2022, at 1:44 PM, V3 (Assistant Director of Nursing) stated that during admission of a resident, the facility follows an admission check list which included medication verification and reconciliation to make sure that all orders transcribed in the electronic system are correct and accurate. According to V3, on June 24, 2022, when R1 was admitted to the facility, R1's admission check list was not fully completed because only the admitting nurse (V4) documented her initials that the medications were reconciled and that all the orders were correct. However, there was a second step which was for the night nursing supervisor to initial that everything in the admission check list, including medication reconciliation of all ordered medications, are properly transcribed in the electronic system to ensure correctness. According to V3, the second step of double checking the transcribed medication orders in the electronic system was not completed because the night shift nursing supervisor was off that day and when the said night shift nursing supervisor came to work the next day (June 25, 2022), R1 was already at the hospital due to overdose of the Methadone medication. Review of R1's admission check list, dated June 24, 2022, showed that V4 (Nurse) had initialed the said check list indicating that she completed	S9999		

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S9999	Continued From page 5 multiple admission tasks which included, medication reconciliation and "all correct orders into [electronic system]." However, the column which indicated "Double Check," was blank. On July 6, 2022, at 3:04 PM, V4 (Nurse) stated that she was the nurse who admitted R1 on June 24, 2022. According to V4, when R1 was admitted at the facility, the hospice nurse (does not know the name) who was present at the time of admission had the hospice company faxed R1's medication profile to the facility. The same hospice nurse who was present called their hospice Nurse Practitioner to verify the orders and the hospice Nurse Practitioner gave the order to continue all the orders written on the hospice medication profile, including the Methadone Hydrochloride which she had placed a check mark on the medication profile list. According to V4, R1's facility physician was also notified of R1's admission at the facility including the hospice medication profile orders to which the physician agreed. V4 stated that she then faxed a copy of the hospice medication profile orders to the facility pharmacy who would input the orders into the electronic system. According to V4 after the pharmacy puts in the orders, the orders would remain inactive or pending until the nurse activates the specific order. V4 stated that after seeing that all of R1's medication orders were in the electronic system, she individually activated each ordered medication one at a time based on the hospice medication profile orders. However, V4 admitted that she made a mistake and that she was not familiar with the Methadone Hydrochloride medication and the dosage. V4 stated that she got confused and activated the 30 ml Methadone Hydrochloride order that was put in by the pharmacy, instead of correcting it to 30 mg as ordered (by the hospice Nurse Practitioner	S9999		

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S9999	Continued From page 6 with the approval of the facility Physician) and written on the medication profile orders. V4 added that she followed the resident's (R1) admission check list and initialed that she completed the medication reconciliation and had verified that all orders entered in the electronic system were correct. However, V4 stated that another nurse was supposed to double check R1's admission check list, including the medication reconciliation and verify that the orders in the electronic system are correct. On July 6, 2022, at 3:43 PM, V6 (Nurse) stated that she was the nurse who gave R1 Methadone Hydrochloride 30 ml on June 24, 2022 sometime after dinner. V6 stated that she was not familiar with the said medication and its normal/usual dosage. V6 added, since the order in the electronic system was to give Methadone Hydrochloride 30 ml, "I followed the order, and I gave the 30 ml." On July 7, 2022, at 10:20 AM, V5 (Nurse) stated that she was the nurse who gave R1 Methadone Hydrochloride 30 ml on June 25, 2022 during the morning medication pass between 8:30 AM and 9:00 AM. V5 stated that she was not familiar with the said medication and its usual dosage because she has never given this medication before. According to V5, "I trusted that the nurse who activated the Methadone order had verified that it was the correct order including the correct dosage." V5 stated that on June 25, 2022, at approximately 9:15 AM, R1's husband came to visit the resident. R1's husband asked, what medications were given to the resident because according to the husband, R1 was sleepy and was not her usual self. According to V5 she told R1's husband what medications were given to the resident and per R1's husband, "she is taking the	S9999		

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S9999	Continued From page 6	S9999		

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On July 7, 2022, at 10:20 AM, V5 (Nurse) stated that she was the nurse who gave R1 Methadone Hydrochloride 30 ml on June 25, 2022 during the morning medication pass between 8:30 AM and 9:00 AM. V5 stated that she was not familiar with the said medication and its usual dosage because she has never given this medication before. According to V5, "I trusted that the nurse who activated the Methadone order had verified that it was the correct order including the correct dosage." V5 stated that on June 25, 2022, at approximately 9:15 AM, R1's husband came to visit the resident. R1's husband asked, what medications were given to the resident because according to the husband, R1 was sleepy and was not her usual self. According to V5 she told R1's husband what medications were given to the resident and per R1's husband, "she is taking the

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S9999	Continued From page 7	S9999		

same medications, but she never felt so sleepy, warm, sweaty and flushed before." V5 stated that she went to check on R1 and noticed that the resident felt hot, sweaty, and flushed as described by the husband. According to V5, R1 had an ongoing continuous oxygen and the resident's vital signs were within normal limits, including the temperature when she checked R1. V5 stated that she offered R1 ice water and encouraged the resident to drink. V5 stated that because of R1's change in condition she located the hospice medication profile orders and compared it with the orders in the facility's electronic system. It was only during this time that she discovered that R1 had overdosed on the Methadone Hydrochloride because the order on the hospice medication profile was to give 30 mg and not 30 ml. According to V5 the available Methadone Hydrochloride for R1 was 10 mg/ml and only 30 mg should be given to R1 which was equivalent to 3 ml. V5 stated that she immediately informed R1's husband, the Director of Nursing, hospice and the Physician about the medication error. The hospice ordered to send R1 to the emergency room for evaluation and treatment and V7 (Physician) agreed with the hospice.

On July 7, 2022, at 11:45 AM, V8 (Hospice Clinical Director) stated that R1 has been receiving hospice care at home since July 3, 2021. R1's admitting diagnosis to hospice is idiopathic pulmonary fibrosis. V8 stated that R1 was ordered to receive 3 ml of Methadone Hydrochloride 10 mg/ml, since June 16, 2022, for management of generalized pain. According to V8, based on the hospice physician notes dated June 16, 2022, R1 has chronic pain syndrome and was no longer tolerating the "IV (intravenous) Hydromorphone (narcotic)" which was why the

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S9999	Continued From page 8 Methadone Hydrochloride was started. V8 stated that the facility should follow and administer R1's medications as written and verified in the resident's medication profile which was also approved by the resident's Physician. On July 7, 2022, at 11:00 AM, V7 (Physician) stated that since R1 was admitted at the facility for respite stay under the hospice care she agreed for the resident to continue all her medications from home, including the Methadone Hydrochloride. V7 stated that she agreed for R1 to receive 3 ml and not 30 ml of the Methadone medication. According to V7 she was informed on June 25, 2022, around noon that R1 was given overdosages of the Methadone Hydrochloride and ordered to send R1 to the hospital for evaluation and treatment as long as the hospice agreed. V7 stated that she expects the facility to follow the resident's medication orders and for the facility to ensure that all the orders are transcribed correctly. V7 stated that she followed R1's care at the hospital after the resident was sent to the ER (emergency room). According to V7, she spoke to the ER physician and was informed that R1 was "hypertensive, confused, very flushed, with breath sounds diminished on both sides and with temperature of 36.9 (equivalent to 98.42 degrees Fahrenheit)" when assessed at the ER. V7 stated that Methadone Hydrochloride suppresses respiration and because of the significant overdose of the medication, R1 "could have gone into respiratory coma and die." (A)	S9999		