| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6010136 | A. BUILDING: _____ B. WING _____ | C 01/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CROSSROADS CARE CTR WOODSTOCK | 309 MCHENRY AVENUE WOODSTOCK, IL 60098 |

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| S 000 | Initial Comments<br><br>Facility Reported Incident of December 10, 2022/IL154763 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.1210d)1)<br>300.1630c)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>care needs of the resident.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br><br>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.<br><br>Section 300.1630 Administration of Medication<br><br>c) Medications prescribed for one resident shall not be administered to another resident.<br><br>These requirements were not met as evidenced by:<br><br>Based on interview and record review the facility failed to ensure a resident (R1) was properly identified prior to administering medications to prevent a significant medication error. This failure resulted in R1 receiving another resident's (R2) antihypertensive (high blood pressure) medications in which R1 subsequently required emergency medical intervention and hospitalization. This past noncompliance occurred from December 10, 2022 to December 13, 2022. This failure applies to 1 of 5 residents (R1) reviewed for medication errors in the sample of 9. | S9999 | | |

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| S9999 | Continued From page 2<br><br>The findings include:<br><br>R1's current care plan showed R1 had diagnoses including Down Syndrome, congestive heart failure, encephalopathy, and seizures. The care plan showed R1 had no diagnosis of hypertension. The care plan showed R1 was severely cognitively impaired.<br><br>R1's Medication Incident report dated December 10, 2022 showed R1 was, "inadvertently given three medications that would lower blood pressure around 8:00 AM." The report showed R1 was administered three antihypertensive medications, metoprolol, hydrochlorothiazide, and lisinopril that were prescribed to/for R2. The report showed, "Approximately 9:30 AM, Patient was visibly lethargic...Blood pressure was 92/58. RN (registered nurse) called Emergency Services to transport out...Approximately 9:40 AM, Emergency Services arrived at facility..."<br><br>R1's hospital records dated December 10, 2022 showed R1 was admitted to the hospital with a diagnosis of "hypotension (low blood pressure) secondary to incorrect administration of antihypertensive medication." The records showed R1 was discharged back to the facility on December 12, 2022.<br><br>On January 3, 2023 at 10:48 AM, V5 Agency Nurse stated, "It was my first day working in that facility (12/10/22). I didn't realize there were two residents (R1/R2) on that wing with the same first name. Around 8:00 AM, I gave (R1) all of (R2's) morning medications which included metoprolol, hydrochlorothiazide, and lisinopril. I didn't know the residents. Around 8:20 AM, I realized I gave (R1) the wrong medications. I didn't verify the | S9999 | | |

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| S9999 | Continued From page 3 | S9999 | | |

right medication for the right resident... By 9:20 AM, (R1's) blood pressure was dropping. By 9:30 AM, (R1) was more lethargic. His blood pressure and pulse were dropping so I called 911..."

On January 3, 2023 at 12:10 PM, V6 Nurse Practitioner stated V5 Agency Nurse notified her of the medication error involving R1 on December 10, 2022. V6 Nurse Practitioner stated, "(R1) has a history of low blood pressure, not high blood pressure, so his blood pressures tend to run lower...Giving those three medications (metoprolol, hydrochlorothiazide, lisinopril) can be detrimental to a person. They could cause a person's blood pressure and heart rate to drop which could cause that person to pass out and become unresponsive..."

On January 3, 2023 at 10:15 AM, V2 Acting Administrator stated the medication error involving R1 was caused by V5 Agency Nurse not verifying she was giving the right medication to the right patient.

The facility's Medication Administration-General Guidelines policy dated December 2019 showed, "Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication is put away...8) Residents are identified before medication is administered using (two) methods of identification. Methods of identification include: a. Checking photograph attached to medical record. b. Calling resident by name (except in residents

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| S9999 | Continued From page 4<br>with cognitive impairment). c. Having resident verify his/her name. d. If necessary, verifying resident identification with other facility personnel..."<br><br>Prior to the survey date of 1/3/23, the facility took the following actions to correct the noncompliance on 12/13/22:<br><br>1. Moved (R1) to a different hall.<br>2. Conducted a root cause analysis.<br>3. Performed a QAPI meeting to discuss plan of action.<br>4. In-serviced nursing regarding medication administration.<br>5. Conducted audits of resident profiles and updated EMAR (electronic medical records) resident pictures.<br>6. Facility called Agency (nursing) and requested they do not send V5 Agency Nurse back to the facility.<br>7. Med pass observations conducted.<br>8. The facility enhanced the orientation of the facility for Agency Nurses.<br>9. The facility will try not to have residents with the same first name on the same hall. ,<br>(B) | S9999 | | |