STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016158	A. BUILDING: _____ B. WING _____	C 01/04/2023

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PRAIRIEVIEW AT THE GARLANDS	6000 GARLANDS LANE BARRINGTON, IL 60010

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S 000	Initial Comments Facility Reported Incident of 12/16/22/IL154815	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) 300.1210d)2) 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 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** Statement of Licensure Violations	

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S9999	Continued From page 1 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. These requirements are not met as evidenced by: Based on interview and record review the facility failed to ensure a resident (R1) received the correct dosages of physician prescribed medication. This failure resulted in R1 receiving 17 additional doses of an anti-depressant medication which contributed to R1 being hospitalized for a mental status change. The findings include: R1's nursing progress notes show she was admitted to the skilled unit of the facility on 11/17/22. Her face sheet shows she had diagnoses including: major depression, anxiety, and a history of falls. R1's nursing progress note for 12/11/22 at 6:15 PM, shows R1 was having increased confusion and poor balance and gait. R1's progress note written and signed by V5 (Nurse Practitioner) on 12/12/22 states, "Patient {R1} is being seen because she is more confused her balance is off/Hx TIA and MI. Referred to see patient by RN secondary to increased confusion,	S9999		

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S9999	Continued From page 2 and unsteady gait over her stay at the skilled facility...Patient has been treated for a UTI (Urinary Tract Infection). Patient's husband is requesting patient to be seen by neurology." R1's nursing progress notes for 12/15/22 at 12:11 PM, states, "Member noted with altered mental status, unable to follow commands and increased confusion noted. POA (V9- R1's Power of Attorney/spouse) agreed to send member out to {local community hospital} for further evaluation." R1's Neurology consult report from a local community hospital show that R1 presented to the emergency room on 12/15/22 for complaints of altered mental status and generalized weakness that began a couple days prior to presentation. R1's nursing progress note dated 12/16/22 at 8:05 AM, shows that the facility was contacted by V10 (R1's daughter) while she was in the hospital to clarify the correct dosage of R1's Wellbutrin. R1's nursing progress note on 12/16/22 at 1:07 PM, written by V4 (Registered Nurse/RN) shows R1 was admitted to the hospital and V7 was contacted by her regarding R1's Wellbutrin order. R1's 12/21/22 physician progress note written by V11 (R1's primary physician) states, "Patient was seen secondary to follow-up hospital admission patient was sent secondary to some neurologic symptoms of unbalance. Patient "excellently" (sic) did take extra Wellbutrin. That was decreased in the hospital. Patient's back to normal self." R1's 12/7/22 nursing progress note signed by (V3 Registered Nurse/RN) at 3:00 PM, shows R1 went to a psychiatry appointment on 12/7/22 and	S9999		

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S9999	Continued From page 3	S9999		

returned with an order for Wellbutrin (anti-depressant) 300 MG (milligrams) PO (by mouth) BID (two times a day).
A Physician Progress note, and prescription written by V7 (Psychiatrist) for R1 on 12/7/22 states, "Wellbutrin 300 mg Xl #30 take 1 tab po daily. In V7's progress note there was an arrow pointing up, in front of the medication change, meaning to increase the dose to 300 mg.
That order was then incorrectly transcribed and entered into R1's 12/1/22-12/31/22- Medication Administration Record (MAR) on 12/7/22 as the following: Wellbutrin XL 300 mg tablet Give 1 tablet BID at 7:00 AM and 7:00 PM. R1 had an active order for buproprion 200 mg (generic medication for Wellbutrin) to be given at 8:00 PM prior to the medication increase, and that order was not discontinued when the new order was received. R1's MAR shows she ultimately received 500 mg more per day of the Wellbutrin/buproprion from 12/8/22 until 12/15/22 when she was sent to the hospital for increased confusion.

R1 received a total of 8 extra doses of the bupropion 200 mg. and 7 extra doses of the Wellbutrin 300 mg which was verified on 1/3/23 with V2 (Director of Nursing)

On 1/3/23 at 8:45 AM, V4 (RN) said she was made aware of the medication error for R1 while R1 was in the hospital. She said the facility was contacted by V10 to clarify the medication dosage for R1's Wellbutrin. When the facility began reviewing R1's physician orders it was discovered, and she then contacted V7 to report the medication error. V4 said R1 was experiencing more confusion but it was assumed to be from a urinary infection that R1 was treated for.

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S9999	Continued From page 4 On 1/3/23 at 9:00 AM, V5 (Nurse Practitioner) said she was made aware of R1's Wellbutrin medication error. She said the high end range of Wellbutrin is 450 mg per day and an overdose or too much of this medication can cause seizures and lethargy. V5 said she does not understand why the medication error was not caught sooner. On 1/3/23 at 11:00 AM V2 (Director of Nursing) said V3 incorrectly transcribed R1's Wellbutrin and as a result R1 received an extra 500 mg of the medication per day for 8 days. On 1/3/23 at 11:21 AM, V1 (Administrator) said we understand the importance of what has occurred, and disciplinary actions are being taken against V3. On 1/3/23 at 3:00 PM, V7 (Psychiatrist) said he did see R1 and prescribed her Wellbutrin 300 mg per day. He was notified by a nurse at the facility of the medication error when R1 was in the hospital. V7 said the maximum dose of Wellbutrin XL is 450 mg and by R1 receiving 800 mg a day (almost triple) his prescribed amount, with the other medications she was at an extreme risk of having a seizure. He said this was a very significant error to occur because of the risk to her. V7 said he never got a straight answer on how this error could have occurred and why it wasn't caught for 8 days by anyone from the facility or pharmacy. He said he feels this was a very significant medication error and had it went on longer the chances are high that R1 would have had a seizure. He also said he believes this was a major contributing factor as to why R1 became so confused and weak. On 1/4/23 at 8:16 AM, (V9/R1's spouse and POA)	S9999		

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S9999	Continued From page 5	S9999		

said that his wife has had urinary tract infections in the past and it has never caused her as much confusion as her saw in her after she started receiving the increased Wellbutrin. V9 said, "I am not a doctor and can't say for sure that the extra medication is what caused her increased confusion, but I have never seen her like that from a UTI." V9 said the family was told by the psychiatrist that this amount of medication was almost 3 times what he prescribed and could have caused a seizure.

On 1/4/23 at 8:23 AM, V10 (R1's daughter) said she learned about the medication error when her mom (R1) was in the hospital. She said when the nurses at the hospital were reviewing R1's medication orders they discovered then the Wellbutrin was a high dose. She said the hospital decided to hold the medication and slowly bring it back down to the correct dosage. V10 said she had some concerns about her mom's confusion at the facility after the Wellbutrin order was changed, but when she tried to discuss it with staff it was dismissed as she has good days, and she has bad days. She said she does not believe that was entirely accurate and she feels R1's confusion and weakness became far worse after she started receiving the wrong dose of the Wellbutrin.

The facility's Illinois Department of Public Health-Initial and Final Report completed by V1 (Administrator) shows it was identified on 12/16/22 that R1 had sustained a medication error at the facility, and she received Wellbutrin 300 mg bid and Wellbutrin 200 mg instead of the prescribed order being Wellbutrin 300 mg daily.

The facility provided Administering Medication policy revised on 12/6/22 states, "Administering

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S9999	Continued From page 6 Medications Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with the Prescriber orders, including any required time frame. (A)	S9999		