Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008726	A. BUILDING: ______ B. WING ______	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LAWN SHELTERED CARE	512 SOUTH FRANKLIN BUNKER HILL, IL 62014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey Complaint Investigation 2346196/IL162496	S 000		
S9999	Final Observations Statement of Licensure Violations 330.780 a) 330.780 b) 330.780 c) Section 330.780 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 330.785, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1	S9999		

notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

This Requirement is NOT MET as evidence by:

Based on interview and record review, the facility failed to provide a file for a medication error, notify the Department of the medication error which sent R11 to the local hospital, and failed to notify the Department within 24 hours of the incident of the medication error for 1 of 1 (R11) resident reviewed for incidents, accidents and medications in a sample of 11.

Findings include.

On 8/1/2023 at 8:00 AM, V1, Owner, stated R11 was accidentally given the wrong medications by V6, Nurse Assistant (NA), on 7/30/2023, but she (V6) called her, and they sent R2 out to the hospital. V1 continued to state she should have reported it to IDPH (Illinois Department of Public Health), but she has had so much going on. V1 stated R2 is now on a ventilator at a Regional Hospital, but they admitted her there with an Aortic Aneurysm; she doesn't think the wrong medication caused R11 to be on a ventilator. V1 stated she did not have a written report of the incident.

On 8/1/2023 at 8:15 AM, V6, Nurse Assistant, stated on Sunday 7/30/23, around 4:15 PM to 4:30 PM, R11 was late coming in from smoking outside. Some of the residents were being disruptive. She stated she thought she had R11's medication package, but must have taken R9's pill package out but mistake. V6 stated R11

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knows her medications, and would have told her it was wrong. V6 continued to state she opened R11's package for her and put them in a cup because she didn't want the pills to fly out of the package. V6 stated some residents alerted her about 30 minutes later that something was wrong with R11, who was sitting in the dining room. So, she went and checked on her; she was slumped over in her chair still breathing and drooling. V6 said she checked her eyes and they flinched. She continued to state she called 911, and the police and ambulance came and took her to the hospital. When the ambulance was her checking her out, they said her vital signs were good. V6 stated she accidentally gave her Gabapentin and Clozapine.

On 8/10/2023 at 2:00 PM, V6, NA, stated V7, R11's Physician, was notified today, 8/1/2023, of the incident that happened on 7/29/23. V6 also stated she did an incident report for R11 from 7/29/23, but she was still writing it.

R11's Progress note, dated 7/29/2023, V6, Nurse Assistant, documented, " ...(V6) passed meds to all but (R11 and R9). (V6) had opened (R11's) pills and put them in a cup. (V6) pushed them back on the care. Wrote (R11's) name." It continues, "(R11) came inside about 4:15 (PM) made her way to the med room. (R3) was back as well. (V6) reached for (R11's) pills but got (R9's) pills. (R11) took the pills, when (V6) realized there were pills sitting on the cart (V6) immediately traced that pills and saw they were (R11's)" It continues, "(V7) notified 8/1/2023."

R11's Local Hospital notes, dated 7/30/2023 at 6:10 PM, documented, " History of present illness. HPI narrative: 83 year old presenting unresponsive. Per EMS (Emergency Medical

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S9999	Continued From page 3 Services), the patient may have been administered another patient's medications at her living facility. She reportedly received gabapentin and clozapine. She presents minimally responsive to painful stimuli. Medications administered approximately 2 hours ago." It continues, "Medical Decision-Making narrative: Differential diagnosis includes but not limited to air and drug administration versus medication overdose versus alcohol intoxication versus intracranial pathology. Will evaluate with labs and imaging. Patient was intubated for airway protection. Unremarkable workup. My interpretation of imaging an official read are without acute pathological findings. No emergent laboratory derangements. Unknown etiology of her presenting unresponsiveness but could be related to the accident administration of 300 mg gabapentin and 100 mg of clozapine. Patient was also hypertensive when she arrived. To be hypertensive encephalopathy. She does have a history of hypertension. Blood pressure has come down and is currently 170/97." It continues, "Lab Data ...Ethyl Alcohol <3. Range/units 0-6 mg/dl." R11's Physicians order sheet, dated 8/1/2023, documented diagnoses of Hypertension and Psychotic Disorders. The facility was unable to provide a policy, nor were they able to provide an incident report. (B)	S9999		