STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002091	A. BUILDING: _____ B. WING _____	08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWMAN REHAB & HEALTH CARE CTR	418 SOUTH MEMORIAL PARK DRIVE NEWMAN, IL 61942

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.610a)
300.1210b)
300.1210d)1)

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

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. These requirements are not met as evidenced: Based on record review and interview the facility failed to administer the accurate dose of a liquid concentration, of the physician ordered, Oxycodone (narcotic analgesic) medication. Subsequently, R90 was administered an excessive dose of Oxycodone, twenty times greater than prescribed. The significant medication administration error resulted in R90 experiencing depressed respirations, prolonged apnea episodes, unresponsiveness, and lethargy. R90 is one of one resident reviewed for Hospice/Pain management on the sample list of 20. Findings include: R90's Physician Order Sheet (POS) dated 7/17/23- 7/31/23 documents R90 was admitted on 7/17/23 on Hospice (care services for terminally ill). R90's same POS documents the following medication order dated 7/17/23: Oxycodone one milligram (mg) per one milliliter (ml), (concentration) oral solution, take five ml (equals five milligrams) by mouth every three hours as needed for pain (PRN). R90's same POS documents for the above	S9999		

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S9999	Continued From page 2	S9999		

medication, one mg per one ml, liquid solution Oxycodone order, was crossed through, and had a triangle shape, with an apostrophe d, to indicate the order had been changed.

R90's same POS documents a new physician order was received on 7/24/23, with an increase concentration strength of Oxycodone liquid solution. The new order for R90's Oxycodone documents the more concentrate liquid medication of 20 mg per one (1) ml, give 0.25 (one quarter of a ml) ml (equals five mg), every three hours, PRN.

The facility pharmacy receipt/narcotic count supply sheet documents R90's liquid solutions of Oxycodone 100 mg per five ml (equals 20 mg per one ml as noted above 7/24/23 physician order), 30 milliliter bottle was dispensed by pharmacy. The Oxycodone directions for administration documents: 0.25 ml (5 mg, same as the previous dose, at the lesser concentration) by mouth, every three hours as needed for pain.

R90's same Oxycodone pharmacy receipt/ narcotic count supply sheet documents on 7/24/23 at 6:40 pm, V18, Licensed Practical Nurse (LPN) signed, and removed five ml (equals 100 mg) of the newly dispensed, 30 ml bottle of R90's higher concentrated liquid Oxycodone.

R90's Medication Administration Record (MAR) PRN sheet, dated 7/17/23- 7/31/23 documents the following: Oxycodone 20 mg per ml, give 0.25 ml (equals 5 mg) by mouth every three hours (PRN).

On the back of the same PRN, MAR documented by V18's initials to indicate R90 was administered Oxycodone five ml (equal to 100 mg, not 0.25 ml,

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S9999	Continued From page 3 that equals 5 mg in the higher concentration ordered) on 7/24/23 at 6:40 pm, the same time the Oxycodone concentrated dose was removed from R90's Oxycodone narcotic count supply, as noted above. R90's Oxycodone pharmacy bottle label documents the increased strength of 100 mg per 5 ml and directs nurses to administer 0.25 ml by mouth every 3 hours for pain. The facility "Medication Discrepancy Report dated 7/24/23 at 7:57 pm, signed by V2, Director of Nursing, documents the following: V17, LPN and V18, LPN completed the narcotic count at shift change. V17, LPN and V18, LPN discovered the discrepancy. V18, LPN had administered five ml (100 mg) of R90's new concentrated Oxycodone in error, instead of the 0.25 ml (5 mg) ordered. The same "Medication Discrepancy Report" documents the previous order for the lower concentration Oxycodone liquid was five ml (equals five mg). The new higher concentration of Oxycodone liquid was 0.25 ml (equals five mg). Five ml (100 mg) of the concentrated Oxycodone was administered to R90 in error. The same "Medication Discrepancy Report" also documents: "Possible effects to the resident (R90), shallow breathing, confusion, unresponsiveness, possible death." The same "Medication Discrepancy Report" also documents at the time of the report on 7/24/23: "The actual effects to the resident (R90), shallow breathing, unresponsiveness, vitals (measurement of pulse, respirations, blood pressure and body temperature) stable, aroused at 5:15 am (7/25/23, by progress note)."	S9999		

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S9999	Continued From page 4 R90's "Nurse's Notes" dated 7/24/23 at 7:57 pm signed by V18, LPN documents V18, LPN had given R90 the wrong dose of Oxycodone. The same note documents R90's vital signs were measured and R90's blood oxygen was 86 percent on room air. Supplemental oxygen was administered via mask at four liters per minute. "(R90) with periods of apnea (stopped breathing, duration was not documented)." The same Nurses Note documents R90's blood oxygen level, after supplemental oxygen was provided, was at a saturation level of 95 percent. The same note documents R90's unidentified family members declined Narcan medication administration (Narcan is used for the treatment of an opioid overdose emergency, with signs of breathing problems and severe sleepiness, or not being able to respond). R90's Nurses Notes throughout the evening 7/24/23, overnight into the morning of 7/25/23 document R90 continued to be monitored approximately every 15 to 20 minutes, with Hospice (staff unidentified) and family members (unidentified) at bedside intermittently overnight. R90's nurses note dated 7/24/23 at 10:55 pm documents R90's respirations were measured at six per minute with two episodes of apnea, that lasted 10 seconds, and 23 seconds without breathing. The Nurses Notes on 7/25/23 at 12:20 am documents R90's respirations dropped to two breathes per one minute with apnea episodes that lasted 36 seconds and 23 seconds without breathing. The nurses note dated 7/25/23 at 1:20 am documents R90 was repositioned and unresponsive to care. The Nurses Notes continued to document respirations between 4 and 7 per minute overnight. The Nurses Note dated 7/25/23 at 5:15 am documents R90	S9999		

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spontaneously opened her eyes, responded to contact stimulation, but remained lethargic. Nurses note at 6:30 am documents R90 is lethargic and stated to the nurse she feels sleepy. Nurses note at 8:30 am documents stated her head felt weird, and R90 refused to continue with oxygen. Family member at bedside.

On 8/9/23 at 1:30 V13, Regional Nurse, Clinical Director reviewed R90's medical records and confirmed a significant medication error occurred. R90 was given 100 mg (five ml), instead of five mg (0.25 ml) of Oxycodone.

On 8/9/23 at 1:35 pm V2, Director of Nursing confirmed R90 received a dose of 100 mg Oxycodone liquid solution instead of the five mg ordered on 7/24/23.

On 8/9/23 at 2:37 pm V15, Pharmacist who filled R90's second Oxycodone prescription on 7/24/23, stated he was aware the wrong dose of Oxycodone was administered to R90. V15 confirmed the wrong dose of Oxycodone was administered and stated R90 was supposed to be administered Oxycodone, (liquid concentration of 20 milligrams per milliliter), 0.25 ml which equals five milligrams. V15 stated R90 was administered five milliliters equal 100 milligrams, 20 times the dose prescribed. V15 also stated "The most serious potential for harm is death. An excessive dose of Oxycodone can cause Hypoxia (loss of oxygen to the brain, coma, brain damage, and neurological issues. Normally, a resident is very sedated. If a patient remains alert, it would likely be because they had a tolerance for opioid (narcotic) use." V15 Pharmacist then stated "(R90's) Oxycodone bottle was labeled correctly. The error should have never occurred."

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S9999	Continued From page 6 The facility policy "ADVERSE DRUG REACTIONS AND MEDICATION DISCREPANCY" dated October 2006, documents the following: "Policy: Adverse drug reactions and drug errors are to be reported to the resident's physician, documented in the nursing notes, and documented on an Adverse Drug Reaction or Medication Discrepancy Report. These reports are to be completed in coordination with the Director of Nursing and filed with the Administrator and reviewed by the Medical Director and Consultant Pharmacist. Responsibility: All Licensed Nurses monitored by the Director of Nursing. Procedure: 1. A medication discrepancy/error has been made when one of the following occurs: *Wrong medication administered. * Wrong dose administered. *Medication administered by wrong route. *Medication administered to the wrong resident. *Medication administered at the wrong time. *Medication not administered." (B)	S9999		