| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6013213 | A. BUILDING: _____ B. WING _____ | C 02/23/2023 |

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| S 000 | Initial Comments<br><br>Complaint Investigation 2391157/IL156285 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.1610a)1)<br>300.1620a)<br>300.1630b)<br>300.1640a)<br>300.1650a)<br><br>Section 300.1610 Medication Policies and Procedures<br><br>a) Development of Medication Policies<br><br>1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.<br><br>Section 300.1620 Compliance with Licensed Prescriber's Orders<br><br>a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.<br><br>Section 300.1630 Administration of Medication<br><br>b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available , a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility.<br><br>Section 300.1640 Labeling and Storage of Medications<br><br>a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage.<br><br>Section 300.1650 Control of Medications<br><br>a) The facility shall comply with all federal and State laws and State regulations relating to the procurement, storage, dispensing, administration, and disposal of medications. | S9999 | | |

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| S9999 | Continued From page 2<br><br>These requirements were not met as evidenced by:<br><br>Based on interview and record review, the facility failed to follow their Medication Administration policy and Narcotic/Controlled Medication Management policy, and physician orders. This affected 1 of 3 (R1) residents reviewed for physician orders and medication administration. This failure resulted in R1 received unscheduled opioid medication without doctor's order. R1 was transferred to local hospital due to hypotension and altered mental status in the wound clinic appointment. Hospital final diagnoses of Opioid overdose, accidental or unintentional, Anemia, Lupus, Antiphospholipid antibody positive and elevated BUN.<br><br>Findings Include:<br><br>R1 was admitted in the facility on 1/21/23 for pain management, physical therapy services and wound vacuum treatment on her right leg for post traumatic hematoma of right lower extremity and required embolization of anterior tibial artery at the time and required debridement of the wound.<br><br>R1 was admitted with pain medication in the facility on 1/21/23 such as: Acetaminophen 500mg three times a day and oxycodone 10mg every 4 hours as needed for maximum daily dose of 60mg. Oxycodone was changed on 1/24/23 to 10mg three times a day for 10 days.<br><br>On 2/2/23 R1 had a wound doctor appointment in wound clinic. Was seen by V4 (NP for pain management) and saw changes in condition, suggested to V2 (DON) for hospital evaluation. V4 stated on 2/21/23 at 11:15am "on February | S9999 | | |

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| S9999 | Continued From page 3<br>2nd, seen the resident there was a change of condition, mildly slow response, reviewed labs and may have contributed to that slow response, remembers seeing abnormal levels and suggested for resident to go to the hospital from there "I do not know what happened because the next thing I know, R1 was going for her wound doctor's appointment, and I guess my recommendation was not followed by the V2 (DON). All I heard was R1 diverted to the hospital that day".<br><br>R1's progress notes reviewed and noted on 2/2/23 at 2224 documented that a nurse placed a call to local hospital Emergency room and R1 is admitted with Anemia and opioid overdose.<br><br>Facility reported this incident to State Agency (SA) and initiated investigation on 2/2/23. Facility's investigation concluded that R1 admitted with medication order of oxycodone 10mg by mouth every 4 hours as need for pain with a maximum daily amount 60mg. Oxycodone was changed by pain management Nurse Practitioner (V4) on 1/24/23 from as needed to three times a day. Since the medication changed, R1 has not received more than the maximum recommended dose of 60mg per day. V2 reviewed narcotic records. In-service will take place with skilled licensed nursing staff.<br><br>Investigation documents reviewed and facility has an interview with V3 (Nurse) regarding administration of medication for R1. Written V3 stated she should have looked more thoroughly at the EMAR (Electronic Medication Administration Record) prior to administering medication. V1 (Administrator) and V2 explained the need to follow physician orders and if medication is not listed in PointClickCare (PCC, | S9999 | | |

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| S9999 | Continued From page 4<br>electronic charting), it cannot be administered. V3 expressed understanding and was very apologetic that V3 had missed it.<br><br>Narcotic opioid medication of R1 reviewed with V2. V2 showed the narcotic sheet count and the medication card, the count was right, however on 1/25/23 at 2am, 1/26/23 at 4am, and 1/27/23 at 2am, V3 administered oxycodone 10 mg to R1. Oxycodone was already changed from as needed to scheduled three times a day on 1/24/23. There is no noted change of order sticker on the medication card and on the count sheet.<br><br>On 2/16/23 at 1:45pm, Interviewed V3 (Nurse) and stated V3 stated R1 complained of pain those 3 nights that she worked and she gave pain medication without checking the EMAR of R1. V3 did not look at the EMAR for the order, V3 knows that R1 had a PRN oxycodone order and the medication is still in the cart so V3 assumed that there were no changes with R1's pain medication. V3 stated that facility practice they supposed to remove the medication out of the medication cart when it was discontinued to avoid medication error. V3 also stated that one of those days, the computer is not working but cannot recall which day, but still admit that she should have looked the EMAR. "We are not supposed to give medication without doctor's order, I should have checked first before giving R1 her medication". V3 also denied calling the doctor or NP to get an order and denied documenting anything in the progress notes of R1 for giving unscheduled medication at the time.<br><br>On 2/21/23 at 2:15pm V2 stated "Discontinued medication, they supposed to remove it from the cart because there is a change of order. If the medication is changed and keeping the | S9999 | | |

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medication, they will put the sticker to let other nurses know that there is a change while waiting for the new medication supply. No sticker was placed in R1's oxycodone medication. If the narcotic is remove they give it to me, and then I will destroy it. Nurses cannot give medication if there is no doctor's order.
If a resident is still in pain the nurse should call and follow up with the pain management or the physician and get a new order if needed. If there was a new order I still expect the nurses to put the new order and document that the new order was given".

Hospital record dated 2/2/23 shows that R1 was transferred to emergency department due to altered mental status and hypotension while in her wound clinic appointment. R1 receive 4mg of Narcan (known prescription medication used for treatment of a known or suspected opioid overdose) via IV and one dose via nebulizer treatment. R1 is more arouse after the narcan was given but still lethargic. Admitting diagnoses of Opioid overdose, accidental or unintentional, Anemia, Lupus, Antiphospholipid antibody positive and elevated BUN. R1 was assessed to be drowsy with pin point pupils and decreased respiratory effort in the ER.

On 2/21/23 at 11:15am, V4 also stated "I would expect nurses in the facility to follow the order, and not to give medication if it is not ordered. Narcan is use to reverse opioid overdose. I am not aware that extra oxycodone was given to R1".

On 2/21/23 at 11:45am, V5 (Nurse that discontinued the Narcotic medication of R1 on 1/24/23) stated "When medication is discontinued we remove it out the medication cart and if the medication is the same dose, we can keep the

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| S9999 | Continued From page 6<br>medication while waiting for the new one to come. There is a sticker that we put in the medication bingo card. I do not remember if I put a sticker at that time".<br><br>Facility policy for Medication Administration with last reviewed date of 7/12/22 reads in part: Medications shall be administered in a safe and timely manner and as prescribed. Only persons licensed or permitted by this State to prepare, administer and document the administrations of medication may do so. Medications must be administered in accordance with orders, including any requires time frame. The individual administering medications must verify the resident's identity before giving the resident his/her medications. The individual administering the medication must check the label three times to verify right medication, right dose, right time, and right method of administration before giving the medication. If drug is withheld, refused or given at a time other than scheduled time, the individual administering the medication shall indicate in PCC the appropriate/related code and also complete a progress note in the resident record.<br><br>Narcotic/Controlled Medication Management with last reviewed date of 6/20/22 reads in part: when a controlled substance medication is discontinued, left over controlled medication are not to be stock-pies in the medication cart.<br><br>(A) | S9999 | | |