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
	IL6007884	A. BUILDING: ______ B. WING ______	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTHAVE HOME-WHITESIDE COUNTY	408 MAPLE AVENUE MORRISON, IL 61270

(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 Facility Reported Incident of 3/22/23/IL158014	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) 300.1210d)2) 300.1630b) 300.1630c) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

care and personal care shall be provided to each resident to meet the total nursing and personal 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, rèctal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.1630 Administration of Medication

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.

c) Medications prescribed for one resident shall not be administered to another resident.

These requirements are not meet as evidenced by:

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Based on interview and record review the facility failed to administer the correct medications to a resident. This failure resulted in R1 having to be admitted to the hospital's intensive care unit for intravenous fluids and blood pressure support medications. This applies to one of four residents (R1) reviewed for medications.

The findings include:

The facility face sheet for R1 shows diagnoses to include atrial fibrillation, Alzheimer's disease and hypertension. The facility assessment dated 12/27/22 shows R1 to have severe cognitive impairment and require the assistance of one staff for care.

The facility medication error report dated 3/22/23 shows R1 received another residents medications at 6:30 AM. The medications R1 received in error included allopurinol (a uric acid reducer), aspirin (nonsteroidal anti-inflammatory and blood thinner), diltiazem (for high blood pressure), isosorbide (angina prevention), Jardiance (antidiabetic), lisinopril (antihypertensive), magnesium (dietary supplement), metoprolol (antihypertensive), vitamin B-12 (vitamin supplement), spironolactone (antihypertensive). These medications were meant for R10. The error report also shows a question that asked how could this error have been prevented and the nurse answered double checking resident with medications.

On 3/28/23 at 8:45 AM, V3 Licensed Practical Nurse (LPN) said she was the nurse that gave R1 the wrong medications. V3 said she was starting her medication pass early as she has a lot of residents to give medications to. V3 said she was standing outside R1's door with her

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medication cart but had R10's Medication Administration Record (MAR) open and was answering the COVID monitoring questions. V3 said she then prepared the medication from that MAR but gave the medications to R1 instead. V3 said she did not realize an error had been made at that time. V3 said later in the morning around 8AM, V1 began acting strange while sitting on the toilet with staff in the room. "He was having trouble sitting up." V3 said she got R1 back to bed and checked his blood pressure (B/P) which was 66/45. (Normal blood pressure is 120/80) V3 said R1's doctor was in the building, so she went and got him, and he instructed her to monitor the blood pressure, push fluids and keep R1 in bed with his feet elevated. V3 said she did not realize her error until she went to give R10 his medications after 8AM. V3 said she continued to monitor R1's B/P and when it was not coming back to normal, she contacted the doctor and R1 was sent to the emergency room. V3 said R1's B/P remained low and was 78/48 when he left the facility.

The hospital records dated 3/23/23 shows R1 was seen at the local hospital emergency room but was then transferred to a hospital with an intensive care unit for closer monitoring. R1 was given intravenous fluids and dopamine (a medication to treat symptoms of shock by improving blood flow). R1 was diagnosed with hypotension (low B/P) secondary to accidental overdose.

On 3/28/23 at 12:00PM, V4 LPN said when passing medications, it is important to double and triple check the medications to be given against the resident receiving the medications.

On 3/28/23 at 10:05 AM, V2 Director of Nursing

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S9999	Continued From page 4 said she expects the nurses to give the correct medications to the residents. The nurses should be checking the medications against the MARs numerous times and verifying they have the correct resident before giving any medication. On 3/28/23 at 1:10 PM, V9 Physician Assistant (on call for R1's regular Physician) said when nurses are administering medications to the residents, they need to verify the resident name by checking the MAR, checking name bands and looking at the picture. V9 said the medications R1 received could have caused severe low blood pressure, low blood sugar and heart arrhythmia. R1 required a stay at the hospital due to the accidental overdose of medications not prescribed for him. The nursing progress notes for R1 shows on 3/22/23 the wrong medications were given to R1. Later that same day a nursing note showing R1 was transferred to an intensive care unit due to low blood pressure. The facility policy dated 2/3/2019 for medication pass, right resident, right drug, right time, right route, right dose shows Medication administration: a.) all medications should be checked against the MAR prior to administration...b.) identify resident by picture, name c.) med pass should be completed within one hour before and after scheduled times. (A)	S9999		