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
	IL6015192	A. BUILDING: ________ B. WING ________	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SR LVG POPLAR CREEK	2150 WEST GOLF ROAD HOFFMAN ESTATES, IL 60194

(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 Complaint Investigation: 2319800/IL167051	S 000		
S9999	Final Observations Statement of Licensure Violations 330.1510a) Section 330.1510 Medication Policies a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to follow it's medication administration policy when a resident was given another resident's medications. This applies to 1 of 3 residents (R1) reviewed for medication administration in the sample of 3. The findings include: R1's Face Sheet showed diagnoses to include bladder cancer, depression, high blood pressure and high cholesterol (diabetes, vertigo/dizziness, and constipation are not listed). The facility's 11/23/23 Assisted Living and Shared Housing Incident and Accident Report showed R1	S9999	**Attachment A** **Statement of Licensure Violations**	

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was given another resident's medications. The medications were Aspirin 81 milligrams (mg), Empagliflozin 25 mg (a diabetes medication), Pioglitazone 45 mg (a diabetes medication), Metformin (a diabetes medication, dosage not listed), Meclizine (vertigo medication), Rosuvastatin (high cholesterol medication), Docusate (stool softener), daily vitamin, Vitamin B12, and Vitamin D3. The incident report showed R1 was sent to the hospital for evaluation, was admitted to the hospital for low blood sugar, then returned to the facility.

R1's Current Medication list (provided 11/30/23 at 12:48 PM) did not show he was ordered any of the medications in the incident report except for vitamin D3.

On 11/30/23 at 9:26 AM, R1 stated he recalled going to the hospital; however, he could not recall, without prompting, the reason he was sent to the hospital. R1 stated he had no side effects from receiving the incorrect medications.

On 11/30/23 at 11:00 AM, V3 Licensed Practical Nurse stated she had asked for R3 to be brought to the nurse's station for medication administration. V3 stated a resident was brought to the nurse's station who she believed was R3. (It was R1 that was brought not R3). V3 stated she called R1, R3's name and she was not corrected by R1. V3 stated there were no other staff in the area at that time. V3 stated she administered R1, R3's morning medications. V3 stated, "something didn't feel right" and as a caregiver walked by, she asked if this resident was R3. V3 said the caregiver said "No" that resident is R1. V3 stated she notified V2, R1's Power of Attorney, and R1's Physician. V3 stated she monitored R1's vitals and blood sugar. V3

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said when R1's Physician called back she was ordered to send R1 out for evaluation. V3 said she called 911 and within 30-60 minutes from giving the incorrect medication to R1, he was with the paramedics. V3 stated she should have verified R1's identity verbally or with another staff member that was more familiar with the residents.

On 11/30/23 at 11:58 AM, V6 Caregiver said she was the caregiver who delivered R1 to the nurse's station. V6 stated she was not aware V3 had requested R3 be brought to the nurse's station. V6 stated she was not at the nurse's station when V3 passed R1 the medications. V6 said when she returned to the nurse's station, V3 asked her if the resident was R3. V3 said "No" that is R1. V3 stated R1 did not want to go to the hospital and paramedics had to persuade him to go. V3 said R1 denied any symptoms.

On 11/30/23 at 12:21 PM, V2 Director of Nursing stated she was notified by V3 of the medication error. V2 stated V3 should have verified R1's identity verbally or with another staff member that is more familiar with the residents. V2 stated the concern with a resident, who is not diabetic, receiving diabetes medication is a low blood sugar.

The facility's Medication Administration policy (Revision 10/2021) showed, "Licensed nurse's or medication aides must refer to the Medication Administration Record (MAR) for each individual resident to assure medications are passed per 6 rights of medication administration and as per licensed medical provider order. (Correct name, correct medication, correct time, correct dosage, correct route of administration, and correct documentation.)

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