STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009120	A. BUILDING: ______ B. WING ______	C 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PAUL'S SENIOR COMMUNITY	1021 WEST E STREET BELLEVILLE, IL 62220

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S 000	Initial Comments Complaint Investigation: 2441626/IL170307	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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S9999	Continued From page 1	S9999		

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.

Section 300.1630 Administration of Medication

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

These Regulations are not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 6 residents (R2) reviewed for medication errors in the sample of 13. This failure resulted in R2 having a drop in blood pressure requiring hospitalization, intravenous fluids, and blood pressure support medication. This past non-compliance occurred on 2/26/24.

Findings include:

1-R2's Face Sheet documents R2 was admitted to the facility on 5/14/21 with diagnoses including Atrial Fibrillation, Supraventricular Tachycardia, Myocardial Infarction, Cognitive Communication Deficit, need for assistance with personal care, Hypertension, and Hypotension.

R2's Care Plan dated 11/28/23 documents, "(R2) has Hypertension." "Give anti-hypertensive medications as ordered. Monitor for side effects

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S9999	Continued From page 2 such as orthostatic hypotension and increased heart rate (tachycardia) and effectiveness." The Care Plan also documents, "(R2) is on diuretic therapy r/t (related to) hypertension." "Many other medications may interact with antihypertensives to potentiate their effect (Levodopa, Nitrates). Monitor for Interactions/Adverse Consequences." R2's Progress Note by V17, Licensed Practical Nurse (LPN), on 2/26/24 at 10:43 AM documents, "Resident is A&O (Alert and Oriented) x/times 4 able to make needs known. Nurse approached resident with medication, asked resident if his name was (R5), resident stated "yes". Nurse than {sic} gave resident medication. Nurse than {sic} noticed it was a mediation {sic} error. Resident received his roommate's medication. (V2) and (V18) contacted immediately. (V18) gave new orders for every 30 minutes blood pressure check and to monitor closely. VS (Vital Signs): BP (Blood Pressure): 109/86 P (Pulse): 82 O2 (Oxygen): 95 (Percent) RA (Room Air) T (Temperature): 97.2 (Degrees Fahrenheit). (V18) returned call at 1050 am with new orders to send resident to (Local Hospital). (Emergency Medical Services) contacted and transported resident to hospital. Family notified and hospital called for report." The Facility's 2/26/24 Hand-Written Statement by V17, LPN, documents, "Resident (R2) is A x O x 4 able to make needs known. Nurse approached resident with medication, asked resident if his name was "(R5)" resident stated "yes". Resident was given the medications. Nurse noticed resident was given his roommates {sic} medications. (V2), (V18) was contacted immediately. (V18) gave new orders every 30 min (minutes) blood pressure checks and to monitor closely. VS: BP: 109/86, P: 82, O2: 95 RA T:	S9999		

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97.2. (V18) contacted nurse back giving new orders to send resident to hospital. EMS contacted and resident was sent out to hospital family made aware. This nurse contacted hospital at 2PM. Hospital nurse stated that resident will be admitted to hospital r/t low blood pressure 83/47. Resident is alert and oriented, talking but lightheaded. (V2) and (V18) made aware."

On 3/7/24 at 8:17 AM, V17, LPN, stated "I went in and pulled the med, asked what I thought was (R5), and he said, "Yes, my name is (R5)." I went back to the med cart and heard another staff member call him (R2). I realized I had the wrong person and immediately notified (V1), (V2), (V18). We had a meeting and planned to monitor his vitals more closely, but he ended up being sent out (to the hospital)."

R2's Progress Note by V2, Director of Nursing (DON), on 2/26/24 at 11:38 AM documents, "(R2) was given another resident's medications in error. (V18) was notified and gave orders for BP (Blood Pressure) Q30 (every 30) minutes x2 hours and monitor closely. Returned call after talking to (V19) and requested resident be sent to (Local Hospital) for eval (evaluation) and treat."

R2's Progress Note dated 2/26/24 at 2:00 PM documents, "(Local Hospital) contacted r/t (related to) resident condition. Hospital nurse states that resident is admitted to hospital with BP (Blood Pressure): 83/47. Alert and oriented, talking but lightheaded. (V18) and (V2) made aware."

R2's Med Error Report dated 2/26/24 at 10:11 AM documents, "(V17) notified (V2) of (R2) being given another resident's medications by mistake. (V18) notified with orders to monitor closely, BP

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Q30 (every 30) minutes and report each one back for 2 hours. At 10:50 AM, (V18) returned call with orders to send to (Local Hospital) for eval and treat."

R2's Progress Note by V19, Physician, on 3/1/24 documents, "Received furosemide, carvedilol, isosorbide mononitrate, hydralazine, and tamsulosin that were intended for his SNF (Skilled Nursing Facility) roommate." The Progress Note also documents, "Had episode of SVT (Supraventricular Tachycardia) rate in the 190's (beats per minute) after having BM (bowel movement) on commode" and "Lightheaded".

On 3/5/24 at 3:30 PM, V11, Pharmacist, stated, "(R2) had an additional 4 items that lowered blood pressure. Furosemide is a duplication of his diuretic. Carvedilol duplicates (his) Metoprolol. Isosorbide Mononitrate and Hydralazine are pure extra blood pressure lowering medications. Tamsulosin can lower blood pressure, as well. I know it was an accident, but this is pretty major, and I can see how his blood pressure dropped. This is definitely significant since it caused (R2) to have to go to the hospital."

On 3/7/24 at 7:53 AM, V1, Administrator stated V17 was a new agency nurse and was not allowed to return to the facility due to this incident.

On 3/7/24 at 9:32 AM, V19, Physician, stated he was not here when this medication error occurred, but was told the resident's names were similar and V17 gave R2 the wrong medications. V19 stated he would expect the facility to give medications as ordered.

On 3/7/24 at 9:27 AM, V2, Director of Nursing (DON), stated this incident may not have

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happened if V17 had asked R2 to tell her his name. V2 stated she expects medication orders to be followed.

On 3/7/24 at 10:55 AM, V1, Administrator, stated he expects staff to follow all policies, including medication administration, and expects medications to be given as prescribed by the physician.

The Facility's "Administration of Medications" Policy dated 4/21 documents, "The nurse's station shall have necessary items and equipment available for proper administration of medications, and current standards of practice should be followed." "Nursing staff will report immediately to the attending physician any medication errors, or adverse drug reactions." "The pharmacy shall be informed, and a copy of all incident reports forwarded." "The facility shall check the Physician's Order Sheet and MAR against the current Physician's Orders, to assure proper administration of medications to each resident."

Prior to the survey date, the Facility took the following actions to correct the noncompliance.

Immediate Actions:

1-Director of Nursing, Assistant Director of Nursing, and/or Designee immediately in-serviced all nurses regarding the Five Rights of Medication Administration to include accurate identification of patient/resident prior to medication administration.

2-Director of Nursing, Assistant Director of Nursing, and/or Designee immediately initiated ongoing audits of medication administration per

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clinical managers to ensure that nurses are compliant with the Five Rights of Medication Administration to be immediately addressed upon identification and/or re-education provided three times per week for four weeks.

3-Facility pharmacy consultant and/or pharmacy nurses initiated ongoing audits of medication administration per clinical managers to ensure that nurses are compliant with the Five Rights of Medication Administration. Any variances will be immediately addressed upon identification and/or re-education provided.

4-Ad Hoc QAPI meeting was completed to review occurrence, immediate intervention, and plans for ongoing audits to ensure continued compliance.

Ongoing Actions:

1-Education will be provided to new employees prior to being allowed to work in the Facility.

2-Concerns will be addressed immediately and discussed during the monthly QAPI Committee for resolution.

(A)