STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145666	A. BUILDING _____ B. WING _____	C 05/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRALIA MANOR	**1910 EAST MCCORD RTE 161 EAST CENTRALIA, IL 62801**

(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) COMPLETION DATE
F 425	Continued From page 9 and inserviced on proper medication pass and pharmaceutical procedures and 5 rights of medication 2. Medication Administration Records (MAR) were reviewed to ensure resident photographs were in the MAR for resident identification (05/10/10). 3. Reviewed the facility's policy for Medication Administration on 05/18/10. 4. Facility will randomly audit medication passes to ensure proper medication administration and report to the Quality Assurance committee (05/18/10).	F 425		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)1) 300.1630c) 300.3240a) 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility. These written policies shall be followed in operating the facility. 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest	F9999		

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F9999	Continued From page 10 practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) 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. 300.1630 Adminstration of Medication c) Medications prescribed for one resident shall not be administered to another resident. 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered to the correct resident putting a compromised resident in a serious situation, and failed to administer prescribed medications in accordance with acceptable nursing practices and pharmacy policy for one resident (R1) of two resident records reviewed. This resulted in a hospitalization in an intensive care unit (R1). These practices involved five residents (R7, R8,	F9999		

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F9999	Continued From page 11 R9, R10, R11) with a potential to affect all 28 of the other residents living on West 400 and West 500 halls who received the 8:00 A.M. medications during this medication pass. Findings include: 1. R1 was admitted to the facility on 04/05/10 with diagnoses including, End Stage Renal disease, history of Atrial Fibrillation, Congestive Heart Failure, Cardiomyopathy and Parkinson's disease (History and Physical of 04/21/10). R1's physician's orders of 05/10 indicated R1 receives dialysis three times a week. R1's Minimum Data Set of 04/18/10 indicated R1 has no difficulty with cognition and has no problems with hearing. The nurse note of 05/08/10 at 8:20 A.M. stated, "While passing AM meds, res (resident) was given wrong medications." At 8:50 A.M., (nurse note) contact with the doctor indicated to "monitor BP (blood pressure) and BS (blood sugar)." The blood pressure (Vital Results form) was 112/74 at 10:30 A.M. and the 10:00 A.M. blood sugar was 92 (nurse note). At 2:00 P.M., the blood sugar was 79 (nurse note). At 4:45 P.M., R1's blood pressure was 110/60, the blood sugar was 53 (normal blood sugar range 70 to 125 hospital lab measurement) and the nurse note states, (R1) "can't catch my breath." Orange juice with four sugar packets was given. The blood sugar was rechecked with a result of 51. At 5:25 the physician visited (nurse note). The physician's progress note indicated R1's blood pressure was 110/54 and the blood sugar was 50. The physician ordered Glucagon 1 ampule IM to be given immediately (nurse note). Blood	F9999		

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F9999	Continued From page 12	F9999		

sugar was rechecked with a result of 116. At 8:45 P.M. the blood sugar was 72 and R1 was "not responding fully." The physician was called and ordered R1 sent to the hospital as a direct admit to the intensive care unit. At 10:10 P.M., R1 was alert and oriented (hospital admission note). At 11:20 P.M. R1's blood sugar was 45. The hospital nurse notes indicated R1 continued to receive food and Dextrose 10 at 50 milliliters per hour as well as Dextrose 50, 50 milliliters intravenous push. R1 was discharged back to the facility on 05/10/10 (nurse note).

In an interview with E1 (Administrator) on 05/17/10 at 11:00 A.M., E1 stated R1 received R2's medication during a morning medication pass on 05/08/10.

Review of R2's medications that R1 received included (R2's Physician Order sheet of 05/10/10): Zovirax 400 mg., Allopurinol 100 mg., Coreg 6.25 mg., Lexapro 10 mg., Hydralazine 50 mg. plus Hydralazine 25 mg., Imdur SR 30 mg., Cordarone 100 mg., Lasix 20 mg., and Glynase 3 mg. E3 (Registered Nurse) verified all scheduled 8:00 A.M. medications of R2 were given to R1 (interview on 05/17/10 at 1:30 P.M).

In an interview with E3 (Registered Nurse) on 05/17/10 at 1:30 P.M., E3 stated during the 8:00 A.M. medication pass on 05/08/10 in the dining room, E3 prepared medications for R2 and gave the medications to E4 (Licensed Practical Nurse) to give to R2. E3 stated he directed E4 to R2's table but did not observe E4 giving the medications to R1 to verify R1 was the correct resident. E3 stated this process of giving medications occurred for 5 residents (R7, R8, R9, R10, R11).

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F9999	Continued From page 13 In an interview with E4 on 05/17/10 at 1:40 P.M., E4 stated she was not familiar with R2. E4 stated E3 told her where R2 was sitting. E4 stated she took the medications to the dining table and asked R1 if he was R2. R1 replied "yes" and E4 set the medicine before R1 to take. E4 stated R1 took the medicine. E3 stated the medication error was not detected until E5 (Licensed Practical Nurse) prepared to give R1 his medications. R1 told E5 that he had already taken his medications. This was also verified by E5 on 05/24/10 at 9:30 A.M. E3 (interview of 05/17/10 at 1:30 P.M.) and E4 (interview on 05/17/10 at 1:40 P.M.) indicated medications are not to be passed with one nurse preparing the medication and another nurse administering the medication. E4 verified she failed to use the photo identification on the Medication Administration Record to assist with identification of R2. This medication error resulted in R1's admission to the intensive care unit on 05/08/10. The History and Physical of 05/08/10 indicated R1 was admitted for "Severe Hypoglycemia and Hypotension." In an interview with Z1 (Physician) on 05/18/10 at 1:00 P.M., Z1 stated the "incident was serious for this man...not just because he received the wrong meds but, Number One: dialysis, and Number Two: had depleted glycogen due to malnutrition, he wasn't eating. The error made it serious for him." Z1 stated R1's recall was good even though he could not remember the events leading to the hospitalization (also noted on the Discharge Summary of 05/10/10).	F9999		

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F9999	Continued From page 14 Review of R1's Minimum Data Set of 04/18/10 indicated no problems with cognition, hearing or vision. Interview with R1 on 05/18/10 at 12:50 P.M. indicated R1 recalled the medication error. R1 stated a nurse brought the medications to the table and "sat down a little cup and said here's your medication." R1 stated the nurse did not ask his name. R1 stated he took the medicine and in about 15 minutes E4 came back and said he was given the wrong medicine. The facility failed to follow their policy to identify residents prior to administering medications. Review of the facility's policy (pharmacy) titled Medication Administration dated 01/01/08, the policy states, "All residents should be identified prior to the administration of medications each time a medication is given. Residents should be identified by checking the arm band. If no arm band present, use two of the following means of identification: 1. Check photograph 2. Ask resident his/her name 3. Verify resident's identity with another facility employee familiar with the resident 4. Call resident by name" The facility's Medication Administration Record (MAR) contains photographs of each individual resident with their MAR (reviewed 05/17/10). (A)	F9999		