STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146016	A. BUILDING _____ B. WING _____	C 01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET REHABILITATION & HLTH C	**129 SOUTH 1ST AVENUE CANTON, IL 61520**

(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 000	INITIAL COMMENTS Facility Reported Incident of 1-14-21/IL130282	F 000		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident received their own Physician ordered medications for one of three residents (R1) reviewed for medication errors/discrepancies in the sample of three. This failure resulted in R1 receiving R3's medications along with R1's medications causing R1 to develop increased lethargy, an altered mental status, seizure activity, a critically low blood pressure and a low glucose level, which required R1 to be hospitalized in the ICU (Intensive Care Unit) for treatment. Findings include: The facility's Medication Administration Policy dated 11-18-17 documents, "The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container, verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and does given. Medications must be identified by using the seven rights of administration: Right resident, right drug, right dose, right consistency, right time, right route, and right documentation." R1's Minimum Data Set (MDS) Assessment	F 760	F1.F 760 1. The corrective action for the alleged deficient practice has been achieved by the following: A. R 1 was immediately monitored/assessed and sent to ER per primary care Physician orders. Date: 01/14/2021 B. The facility DON/designee immediately initiated an investigation and Notifications were made per the regulation. Date: 01/14/2021 C. V 4 was immediately suspended pending the investigation per facility Protocol. Date: 01/14/2021 Concerns with medications being administrator. 01/14/2021 E. DON/designee in-serviced nursing staff on the facility Medication Administration Policy, specifically addressing the seven rights of Administration and never to pre-set medication. Date:	2/12/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/12/2021

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F 760	Continued From page 1 dated 11-6-20 documents R1 is cognitively intact. This same MDS Assessment documents R1 has diagnoses of Seizure Disorder, Anxiety Disorder, Anoxic Brain Damage, Opioid Dependence, Muscle Spasms, and Depression. R1's Physician's Order Sheets (POS) and Medication Administration Records (MARs) dated 12-16-20 through 1-15-21 document R1 receives the following medications daily at 4:00 PM: Clonazepam (Anti-Convulsant medication) one mg (milligram) one tablet, Furosemide (Diuretic medication) 40 mg one tablet, Keppra (Anticonvulsant medication) 500 mg one tablet, Potassium Chloride (Potassium Supplement) 10 mEq (milliequivilents) one tablet, Topiramate (Anti-Convulsant medication) 100 mg one tablet, Hydrocodone-Acetaminophen (Opioid pain relieving medication) 5 mg-325 mg one tablet, and Baclofen (Muscle Relaxant) 10 mg one tablet. R3's POS and MARs dated 12-16-20 through 1-15-21 document R3 receives the following medications daily at 4:00 PM: Zyprexa (Anti-psychotic medication) 10 mg one tablet, Ferrous Sulfate (Iron supplement) 325 mg one tablet, Glipizide (Anti-Diabetic medication/blood sugar lowering medication) 10 mg one tablet, Potassium Chloride 20 mEq one tablet, Seroquel (Anti-psychotic medication) 50 mg one tablet, and Trajenta (Anti-Diabetic medication/blood sugar lowering medication) 5 mg one tablet. R1's Medication Discrepancy Report dated 1-14-21 at 4:20 PM documents, "Type of Discrepancy: Wrong resident (R1 received R3's 4:00 PM medications). Possible Effects to the resident: Decreased blood sugar and increased	F 760	2. This alleged deficiency could potentially affect all residents residing in the nursing home facility. However, with the implementation of the above and the quality assurance measures mentioned in this Plan of Corrections, the alleged deficient practice will not recur. 3. Systemic review of facility systems including current policy and procedure was accomplished. This review found all procedures in compliance with State and Federal Guidelines. No further changes are required to the policy/procedures. 4. The following measures will be carried out as part of the facilities ongoing Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and permanent: A. The DON/designee will complete random audits of medications administration to ensure that the nursing staff is following the seven rights of administration. B. The facility nurse management team will do 1 x a week for 6 weeks to audit medication cart with return demonstration to ensure that pre-set medication are not located in the medication carts. C. Newly hired nursing staff will be educated to the seven rights of administration and the medication administration policy during the SWAT education prior to first scheduled day of assignment. D. Concerns will be discussed at the	

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F 760	Continued From page 2 sedation. Actual effects to the resident: Hypoglycemia and altered mental status." R1's Nurse's Notes dated 1-14-21 at 4:37 PM and signed by V2 (Director of Nursing) document, "New order received to complete accuchecks (blood glucose monitoring) every four hours for 24 hours. If blood glucose below 60 call medical doctor. BMP (Basic Metabolic Profile) in morning. Monitor for lethargy." R1's Nurse's Notes dated 1-14-21 at 6:45 PM and signed by V2 document, "This nurse requested to address (R1) due to increased lethargy. Upon entering room (R1) noted to be sitting in a high back wheelchair with her eyes closed. (R1) unable to make eye contact when talked to. (R1's) pupils are pinpoint. Blood glucose reading 51. Blood pressure 79 systolic/55 diastolic. Pulse Oximetry 94 percent. Oxygen applied per nasal cannula at two liters. 7:05 PM Order received to send (R1) to the emergency department for evaluation and treatment. 9:00 PM admitted to Intensive Care Unit with the diagnoses of altered mental status, hypoglycemia (low blood sugar), hypokalemia (low potassium level), and adverse medication reaction." R1's Hospital History and Admission Physical Examination and Emergency Room Note Reports dated 1-14-21 document, "History of Present Illness: (R1) long-term resident at nursing home presents after accidentally being given another resident's medications. (R1) was given Zyprexa, Iron, Glipizide, Potassium, Seroquel, and Trajenta which were not (R1's) own. (R1) became less responsive so EMS (Emergency Medical Service) was called. (R1) presents with decreased responsiveness. (R1) was noted to be	F 760	Morning QA meetings as needed for immediate resolution to include further education and or disciplinary action per the facility Progressive Disciplinary Policy. This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that the Facility violated any federal or state regulation or failed to follow any applicable standard of care. The corrective action for the 760	

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F 760	Continued From page 3	F 760		

hypoglycemic initially and was given D50 (Dextrose/glucose 50 percent). (R1's) initial sugar went up but then began to decrease so (R1) was started on a dextrose drip. (R1's) blood pressure was extremely low. (R1) was given a total of two liters of normal saline in the emergency room and (R1's) blood sugar remained borderline low. (R1) has been started on Levophed (medication used to treat life-threatening low blood pressure). Very lethargic and drowsy."

R1's Hospital Discharge Summary dated 1-16-21 documents, "Discharge Diagnoses: Acute Seizures, Acute Hypoglycemia, Acute Medication Adverse Effect, Acute Altered Mental Status, Acute Hypotension, and Acute Chronic Pain Syndrome. (R1) was admitted to the ICU with close monitoring. (R1) was given dextrose fluids as well as pressors (blood pressure raising medications) to keep (R1's) blood pressure up. (R1) slowly improved and her mental status came back to normal."

V4's (Licensed Practical Nurse/LPN) Notice of Termination dated 1-19-21 and signed by V2 (Director of Nursing/DON) and V1 (Administrator) documents, "Substandard nursing care leading to medication discrepancy and hospitalization of resident (R1)."

On 1-20-21 at 9:00 AM, R1 was sitting up in her high back wheelchair and her left eye was twitching. R1 stated, "(V4) gave me the wrong pills on (1-14-21). (V4) gave me (R3's) pills. I got a low blood pressure, low pulse Oximetry, and low blood sugar. I had to be admitted to the hospital. I passed out and woke up at the hospital. I could not remember anything. I was p***ed off because getting the wrong medications

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F 760	Continued From page 4	F 760		

took my health backwards and caused me to have more seizures, low blood sugar, and low blood pressure. I felt like s**t for days and have been so tired. I hated having to be admitted to the hospital and having to get IV's (Intravenous Medications). If I could, I would sue (V4) for what she did to me."

On 1-20-21 at 1:40 PM V4 (LPN) stated, "On 1-14-21 I had pulled up (R1's) 4:00 PM medications around 3:15 PM. I went to give (R1) her medications and she was in bed. (R1) is at risk for choking, so I told the Certified Nursing Assistants (CNAs) to get her up out of bed so I could give (R1) her medications. I put (R1's) cup of medications in the top drawer of the medication cart. Around 4:00 PM, the CNAs parked (R1) right by my medication cart. I had two or three other residents at my medication cart at the time trying to talk to me and I had pulled up (R3's) 4:00 PM medications. (R1) is very demanding and wanted her medications right now. I put pudding in with (R3's) medications and gave the medications to (R1). I then realized that I gave (R1) the wrong medications (R3's medications) and told (R1) to spit them out. (R1) had already swallowed the wrong medications. I then gave (R1) her 4:00 medications. I told (V5/Minimum Data Set Coordinator) that I gave (R1) the wrong medications. (V2/Director of Nursing) and (V3/Assistant Director of Nursing) then approached me and said that I was being suspended for three days for giving (R1) the wrong medications. (V2) stated that they had called and informed (V6/R1's Physician) that I gave the wrong medications, and (V6) told (V2) that I needed to be suspended. I was then told to come in on Tuesday (1-19-21). On 1-19-21 (V2) told me that (R1's) potassium was high and blood

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F 760	Continued From page 5 sugar dropped requiring (R1) to be hospitalized. (V2) told me that (R1) could have died from me giving (R1) the wrong medications. (V1 and V2) then terminated me due to (R1's) medication error." On 1-20-21 at 11:05 AM V2 (Director of Nursing) stated, "I took over caring for (R1) on 1-14-21 after she received the wrong medications. (R1) was lethargic and not acting herself. I took (R1's) blood glucose level and it was 51. (R1) could not hold her head up and her blood pressure was extremely low. (R1's) blood glucose level dropped to 30. (R1) was sent to the hospital and admitted to the ICU unit with hypoglycemia, hypokalemia, altered mental status, and an adverse drug reaction. (R1) returned to the facility on 1-16-21. (R1) still was not acting herself and could not hold her head up. (R1) has been twitching more than normal since receiving the wrong medications. (R1) receiving (R3's) medications was definitely a significant medication error." On 1-22-21 at 12:40 PM V6 (R1's Physician) stated, "(R1) receiving the wrong medications caused (R1) to be hospitalized on 1-14-21 with an altered mental status, extremely low blood pressure, and a low blood glucose. (R1) had to be treated in the ICU (Intensive Care Unit)."	F 760		