STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145678	A. BUILDING _____ B. WING _____	C 04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON OF SCHAUMBURG	675 SOUTH ROSELLE ROAD SCHAUMBURG, IL 60193

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F 000	INITIAL COMMENTS Complaint Investigation 1591655/IL76043 - No deficiency 1591626/IL76013 - F281; F333 Incident Report Investigation IRI of 3/26/15 - IL76140 - F312	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to correctly measure and administered a liquid narcotic pain reliever (morphine) according to the manufacturer's recommendation and physician's order. The failure applies to one of three residents (R1) reviewed for narcotic use in a sample of six residents. Findings includes: According to a face sheet, R1 is a 75 year old resident with diagnoses of Atrial Fibrillation, Congestive Heart Failure, Acute Renal Failure, Metastatic Cancer of the Bladder and Dementia. R1 was admitted to palliative care on 3/27/15. Physician's Order Sheet (POS) dated 3/28/15 shows an order for Morphine Sulfate 20 mg/ml (milligrams per milliliters) and 10 milligrams to be given as needed (PRN) every two hours. E4's (Nurse) nursing notes dated 3/29/15 states R1 complained of pain and morphine was administered. After administration of the	F 281		

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

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F 281	Continued From page 1	F 281		

morphine, E4 realized the amount given was an overdose. R1 was sent to the emergency room.

On 4/2/15 at 11:20am E4 stated, the morphine oral solution was in a multi-dose vial and her conversion of the dose was off. E4 stated she intended to administer 10 milligrams (0.5 milliliters) and instead gave 5 milliliters (100 milligrams). E4 further stated that there was no calibrator (syringe) in the box and she used a medicine cup to measure the dose.

Controlled substance use worksheet dated 3/29/15 shows E4 documented 0.25 millimeters of morphine administered to R1. On 4/2/15 at 3:30pm E5 (Nurse) stated during the narcotic use reconciliation with E4 on 3/29/15, she noted a discrepancy in the volume of morphine remaining and volume documented by E4 after last dose was given. E5 stated she asked E4 about the discrepancy and E4 responded that she may have given a greater volume that documented.

E1 (Administrator) presented the medication vial used to administer R1's morphine which was observed to be a multi-dose vial labeled 20mg/ml oral solution, and labeled with R1's name and administration dose of 10 milligrams every 2 hours as needed. There was a syringe calibrator in the box that contained the vial. E1 stated if at the time of administration there was no syringe in the box, there is an ample supply of syringes on the unit accessible for use.
Manufacturer's recommendation for use of morphine sulfate oral solution states "always use the enclosed calibrated oral syringe when administering to ensure the dose is measured and administrated accurately.

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F 281	Continued From page 2 Facility's policy, General Dose Preparation and Medication Administration dated 12/1/07 does not address the administration of narcotics. The policy does state "Facility staff should use an oral dose syringe for measuring small and/or fractioned volumes of liquid medications. Facility staff should verify that the medication name and dose are correct".	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to remove a loose fitting denture from a resident mouth after a meal for one of four residents (R4) reviewed for activities of daily living in a sample of six. As a result R4's loose fitting denture became lodged in his throat and R4 was sent to the emergency room. Findings include: R4 is a 90 year old resident with diagnoses which includes Dementia, Dysphasia,, Congestive Heart Failure. Minimum Data Set (MDS) assessment dated 3/24/15 shows R4 is alert and oriented and requires extensive assist with activities of daily living.	F 312		

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Nurses notes dated 3/24/15 shows E8 (MDS coordinator) documented that R4 complained of dentures to be loose fitting and having occasional trouble with chewing. This note states a dental referral will be initiated.

On 4/9/15 at 2:45pm E8 stated during routine quarterly assessment on 3/24/15, R4 stated that his dentures are occasionally loose and causes difficulty chewing. E8 did not assess R4's denture fitness because, according to E8, R4 is alert and oriented and for this same reason she did not report this complaint to the direct care staff. E8 said she was not aware of how loose the dentures were. R4 had no issues with loose dentures prior to this.

Nurses notes dated 3/26/15, 9:21pm, states R4 accidentally swallowed his lower denture, and upon assessment R4 was able to talk, drooling, no shortness of breath, noted with metal part of his denture stuck on his throat with slight bleeding. R4 was transferred to the hospital.

On 4/8/15 at 11:45am. R4 was sitting in a specialized wheel chair in the dining room R4 was not wearing his dentures. R4 stated he would put adhesive on the loose fitting dentures. R4 stated he feels safe without the dentures although he would like to be able to wear them. According to R4, staff took his dentures away and he was told he needs to see a dentist but he cannot afford one. R4 stated he was putting adhesive on the dentures just before meals and the adhesive does not last very long. R4 stated that on the day of the incident he was sleeping in the wheel chair in the dining room with his head bent forward. R4 woke up, swallowed, and the denture went down. R4 stated he was able to speak and hollered for

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F 312	Continued From page 4 the staff who came immediately and he was sent to the hospital. On 4/8/15 at approximately 12:15pm E3 (Nurse Unit manager) stated before each meal staff would apply the adhesive and remove the denture after meals. Staff were supposed to go back to R4 after meals to make sure denture was removed and someone failed to do this. When asked if there is a written plan of care for denture removal after meals, E3 stated there is none. On 4/8/15 at approximately 12:50pm E7 (Certified Nurses Aid - CNA) stated he takes care of R4 on a regular basis. E7 stated that R4's denture sometimes become loose. E7 stated "we put glue and put them in (dentures) before meals. After he's done with meal denture to be taken off and placed at bedside. R4 does not wear his dentures between meals". MDS dated 3/24/15 shows R4 triggered for loose fitting dentures however, the care plan was not initiated until 4/1/15, after R4's incident.	F 312		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that 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 is free of a significant medication error by administering the wrong dose of liquid morphine as prescribed for one of six residents (R1) in a	F 333		

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F 333	Continued From page 5	F 333		

sample of six. As a result, R1 received 10 times the prescribed dose on morphine causing R1's blood pressure to be reduce and put R1 at risk for respiratory and/or heart failure.

Findings include:

According to a face sheet, R1 is a 75 year old resident with diagnoses of Atrial Fibrillation, Congestive Heart Failure, Acute Renal Failure, Metastatic Cancer of the Bladder and Dementia. R1 was admitted to palliative care on 3/27/15. Physician's Order Sheet (POS) dated 3/28/15 shows an order for Morphine Sulfate 20 mg/ml (milligrams per milliliters) and 10 milligrams to be given as needed (PRN) every two hours.

E4's (Nurse) nursing notes dated 3/29/15 states R1 complained of pain and morphine was administered. After administration of the morphine, E4 realized the amount given was an overdose. R1 was sent to the emergency room.

On 4/2/15 at 11:20am E4 stated, the morphine oral solution was in a multi-dose vial and her conversion of the dose was off. E4 stated she intended to administer 10 milligrams (0.5 milliliters) and instead gave 5 milliliters (100 milligrams). E4 further stated that there was no calibrator (syringe) in the box and she used a medicine cup to measure the dose.

Controlled substance use worksheet dated 3/29/15 shows E4 documented 0.25 millimeters of morphine administered to R1. On 4/2/15 at 3:30pm E5 (Nurse) stated during the narcotic use reconciliation with E4 on 3/29/15, she noted a discrepancy in the volume of morphine remaining and volume documented by E4 after last dose

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F 333	Continued From page 6	F 333		

was given. E5 stated she asked E4 about the discrepancy and E4 responded that she may have given a greater volume that documented.

On 4/2/15 at 12:45pm E3 (Registered Nurse, Unit Manager) stated E4 notified her of the larger than ordered dose of morphine (5 milliliters) administered to R1. E3 stated she immediately assessed R1 who was breathing, sleeping and arousable with tactile stimulus. E3 administered emergency drug to reverse the effect of the morphine and R1 was transferred to the emergency room.

Hospital physician's record dated 3/29/15 had under physical assessment indicated R1 had no respiratory distress, R1 had irregular heart rate and normal sinus rhythm. Heart sounds were clear. R1 was admitted to the hospital with diagnosis of Hypotension (low blood pressure), Accidental Overdose and Accidental poisoning by unspecified drug.

On 4/8/15 at approximately 1pm Z1 (Attending Physician) stated that R1 remains in the hospital. Z1 stated that an overdose of morphine at this magnitude could cause respiratory distress and lead to cardiac arrest and death.

E1 (Administrator) presented the medication vial used to administer R1's morphine which was observed to be a multi-dose vial labeled 20mg/ml oral solution, and labeled with R1's name and administration dose of 10 milligrams every 2 hours as needed. There was a syringe calibrator in the box that contained the vial. E1 stated if at the time of administration there was no syringe in the box, there is an ample supply of syringes on the unit accessible for use.

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F 333	Continued From page 7 Manufacturer's recommendation for use of morphine sulfate oral solution states "always use the enclosed calibrated oral syringe when administering to ensure the dose is measured and administrated accurately. Facility's policy, General Dose Preparation and Medication Administration dated 12/1/07 does not address the administration of narcotics. E6 (Nurse Consultant) stated on 3/31/15 at approximately 10am that the facility does not have a policy that addresses the administration of narcotics.	F 333		