STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145563	A. BUILDING _____ B. WING _____	C 02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVENA ST ANNE CENTER	**4405 HIGHCREST ROAD ROCKFORD, IL 61107**

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F 431	Continued From page 8 On 2/7/08 at 11:11 AM E6 (LPN) said that on the on the morning of 1/31/08 she noticed that the numbers on the seals did not match. E6 then inspected the contents of the box and found that two vials of Dilaudid were missing. It was determined that the vials of Dilaudid were used on 1/29/08 instead of Morphine.	F 431		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b)1)2) 300.1620a) 300.1630e) Section 300.1210 General Requirements for Nursing and Personal Care 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. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in	F9999		

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F9999	Continued From page 9 accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Section 300.1630 Administration of Medication e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report. These REGULATIONS are not met as evidenced by: Based on interview and record review, the facility failed to ensure that a nurse administered the correct medication to a resident as ordered by the physician to prevent a significant medication error. This failure occurred when R1 received Dilaudid 4 mg subcutaneously instead of Morphine 4 mg subcutaneously on 1/29/08 at 11:00 AM. (Dilaudid is 6 times more potent than a relative dose of Morphine). On 1/29/08 at 1:45 PM, R1 developed short periods of apnea and became unresponsive. R1 was sent to the hospital via ambulance and was admitted with a diagnosis of altered mental status and hypercarbic respiratory failure.	F9999		

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F9999	Continued From page 10 Findings include: R1 has the following diagnoses: Diabetes, Coronary Artery Disease, Hypertension, Congestive Heart Failure, Obstructive Sleep Apnea, Peripheral Vascular Disease, Spinal Stenosis, and Asthma per the Hospital History and Physical dictated on 1/29/08. The Minimum Data Set of 2/1/08 documents that R1 has short term memory problems and has some difficulty making decisions in new situations. Physician Orders for R1 dated 1/29/08 state, "Morphine 4mg subcutaneously now, then Morphine Elixir 20mg/ml 5mg every 4 hours PRN (As Needed)." On 2/7/08 at 11:30 AM, E3 (LPN) said that on 1/29/08 she gave Dilaudid 4mg subcutaneously instead of Morphine. "I made the medication error around 11:00 AM on 1/29/08. R1 became symptomatic around 1:00 PM." E3 confirmed that she did not become aware of the medication error until 1/31/08 during the morning drug count. This was approximately 44 hours after the medication error occurred. E3 said she was not sure if the hospital or physician were notified of the medication error. E3 said she reported the incident to her charge nurse and filled out a Medication Variance Report Form on 1/31/08. On 2/7/08 at 11:11 AM, E6 (LPN) confirmed that E3 asked her to check the syringe to ensure she had the correct medication and the right dose. E6 said that she did not verify the written order. E6 said that she checked E3's syringe along with the	F9999		

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F9999	Continued From page 11 vial and told E3 it was correct. E6 was asked if E3 told her at anytime during this conversation that she was giving Morphine and E6 replied, "Yes." R1's Medication Variance Report Form dated 1/31/08 was incomplete. The sections that document whether the physician was notified, the resident hospitalized, and the family/representative notified were blank. The facility's Policy and Procedure dated 4/17/02 entitled Medication Occurrence states, "Any time a medication occurrence is discovered, the physician must be notified immediately and appropriate orders obtained, if indicated." Nursing Notes dated 1/29/08 at 11:00 AM state, "Resident (R1) alert, but confused. Vital Signs (Temp) 97.8, (Pulse) 62, (Respirations) 16, and (Blood Pressure) 148/84. Oxygen saturation 87 percent on 3 liters per nasal canula. Was hallucinating, wanted to know where the cats went. Skin pale in color. Resident becomes very anxious with any bedside care. Staff informed R1 that it was time to get up out of bed and resident had a panic attack. Oxygen saturation (O2 Sat) fell to 64 percent, nebulizer treatment and Ativan given, some relief. After 20 minutes O2 Sat was at 86 percent....Physician here to see R1 and ordered to give Morphine 4mg subq (subcutaneously) now. R1 became lethargic after given Morphine, but easily aroused. At 1:45 PM resident (R1) became unresponsive, lungs congested and resident is having episodes of apnea....Physician called back with orders to call 911 and have R1 sent to the emergency room....At 2:00 PM ambulance here to take R1 to ER (Emergency Room)."	F9999		

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F9999	Continued From page 12 The Emergency Medical Services (EMS) Run Sheet dated 1/29/08 documents that the ambulance arrived at the facility at 1:59 PM. The initial assessment done by the EMS crew while at the facility shows that R1 was unconscious, pale, diaphoretic with rales in both lungs. The EMS Run Sheet Narrative states, "Upon our arrival, patient was in bed with the head of the bed up and the patient was being administered a nebulizer treatment. Patents's head was being held up by staff and patient was very diaphoretic, unresponsive with very moist audible rales....Patient remained unresponsive with labored breathing....Patient arrived at the hospital Emergency Department at 2:14 PM." The Emergency Department Narrative dictated 1/29/08 at 5:37 PM states, "The patient (R1) is non-verbal. She is unresponsive to both verbal and painful stimuli. She does not withdraw to pain. Pupils initially are pinpoint....At this point the patient was given Narcan although her nursing home medication list does not have any evidence of narcotic prescriptions and following a total dose of 8mg of Narcan, the patient's mentation and arousal began to improve. She began moaning, intermittently opening her eyes and also moving her upper extremities. With respect to the patient's hypercarbic respiratory failure and respiratory acidosis makes a multifactorial etiology including possible respiratory causes as well as narcotic overdose...At this point it does appear that the patient has improved with Narcan administration and her respiratory failure may be secondary to a concomitant narcotic use as well as a history of obstructive sleep apnea." On 2/13/08 at 2:30 PM, Z1 (Physician) said that	F9999		

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F9999	Continued From page 13 he was not made aware of R1's medication error until approximately 8 days after the error occurred. "This could have had a very negative outcome she could have died from this." On 2/13/08 at 12:40 PM, Z2 (Hospital Physician) said she was not aware that R1 received Dilaudid 4mg instead of Morphine 4mg while at the facility. "If we had known that R1 received Dilaudid instead of Morphine her treatment would have been different. We would have given Narcan right away to counter the effects of the narcotic." On 2/14/08 at 11:30 AM, Z4 (Pharmacist) said that Dilaudid administered subcutaneously is 6 times more potent than the equivalent dose of Morphine. Z4 confirmed that this information came from the Manual of Medical Therapeutics 28th Edition (The Washington Manual). The facility's Policy and Procedure dated 2/12/02 entitled Medication Administration General Guidelines states, "Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so....Prior to administration, the medication and dosage schedule on the resident's MAR (Medication Administration Record) is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule." (A)	F9999		