

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145384	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/23/2013
NAME OF PROVIDER OR SUPPLIER EDEN VILLAGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 SOUTH STATION ROAD GLEN CARBON, IL 62034		
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F 431	Continued From page 13 container." The facility's policy and procedure entitled, 'Storage and Maintenance of Medication' documents, in part, "All medications, except those requiring refrigeration, shall be kept in locked medication carts and cabinets. Medications must be checked regularly for expiration dates and deterioration. Expired medications are removed from use and returned to (Pharmacy). Medications no longer in use are returned to (Pharmacy) and are destroyed or credited, where applicable, in accordance with State and Federal regulations." The facility's policy and procedure, 'Labeling of Medication' documents, in part, "1) The labeling of all medications will meet the requirements of the State Board of Pharmacy. The definition of labeling in Illinois includes affixing of the appropriate label to the appropriate container of medication. This process in Illinois may only be performed by a registered pharmacist or a pharmacy technician within a licensed pharmacy. Therefore, when directions for use of medication change, pharmacy cannot send out new labels for use of that product. 2) Labeling for non-unit dose medications must be typed or printed and clearly indicate resident's full name, prescription number, name and strength of the drug, route, quantity of drug, date opened, date dispensed, expiration date of all time dated drugs. Medication labels are to be clean and legible and may not be defaced, altered or revised. 14) It is not permitted by the State Board regulation for the Pharmacy to re-label any medication supplied by an outsider provider pharmacy."	F 431			
F9999	FINAL OBSERVATIONS	F9999			

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F9999	Continued From page 14 Licensure Violations 300.1210b) 300.1210d)1) 300.1210d)2) 300.1220b) 300.1220b)1) 300.1220b)2) 300.1630c)e) 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 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. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:	F9999			

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F9999	Continued From page 15 1) Assigning and directing the activities of nursing service personnel. 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.1630 Administration of Medication c) Medications prescribed for one resident shall not be administered to another resident. 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 requirements are not met as evidenced by: Based on record review and interview, the facility failed to administer the correct medications to the correct resident as ordered by the physician, resulting in a significant medication error for one of five residents (R3) monitored for medication errors in the sample of five. This failure resulted in R5's blood pressure dropping rapidly and being sent to the hospital for emergency treatment. Findings include: On 4/22/13, at 10:00 AM, the Incident Summary	F9999			

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F9999	<p>Continued From page 16</p> <p>Report for medication errors dated 1/22/13 to 4/22/13 were reviewed. The Incident Report Detail for R3, dated 3/22/13, documents, in part, "Most recent caregiver-(E3, LPN) (Licensed Practical Nurse), She (R3) received the wrong medications. She got the medications that belonged to another resident. Additional Information; Hydralazine 50 mg (milligrams), Lyrica 50 mg, Tricor 145 mg, Docusate 100 mg, Metoprolol 50 mg. No ill effects noted." The measures to prevent reoccurrence documented are "More carefully identify residents using assistance of more experienced staff."</p> <p>On 4/22/13, at 3:48 PM, R3 was interviewed related to the medication error of 3/22/13. "The first medication error, they gave me pills. I said I was sick to my stomach. I threw up and threw up. I don't remember who gave it to me. I was kind of dazed. My son and husband came to the hospital and were praying. My husband talked to the doctor and nurse in the ER (emergency room). He got mad. My blood sugar must have gone out of whack. I didn't remember. The hospital told me they gave me the wrong medication."</p> <p>On 4/22/13, at 3:30 PM, E3, LPN was interviewed related to the medication error of 3/22/13 for R3. E3 reported she was orienting a new nurse, E6, Registered Nurse (RN). E3 reported R3 had already received her morning medication, including insulin. E3 reported she prepared medication for R5, including an insulin injection and asked E6 if she felt comfortable giving the medication to R5 and E6 agreed. E3 stated, "I told (E6) (R5's) (glucometer blood sugar level) and how much insulin to give her per sliding</p>	F9999			

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F9999	<p>Continued From page 17</p> <p>scale. She (E6) took everything and came back and told me about (R3). She kept calling her (R3) ""the new lady"", and didn't know her name. I called Z1, Physician, got R3 out of bed and gave her some food. I took her vital signs every 15 minutes. Her blood pressure started to drop. She had no loss of consciousness. R3 got nauseous and puked a little bit. I call 911 (emergency number) and had her sent out." E3 reported she was sent by ambulance to the local hospital. E3 stated, "She (R3) had received extra insulin and a bunch of meds (medication)." During the interview E3 was asked how to identify a resident for a medication pass. E3 replied, "By their name on the door and ask another staff. Their picture is on the MAR (Medication Administration Record), TAR (Treatment Administration Record) and a picture in their chart. Their picture is taken on admission."</p> <p>On 4/22/13, at 2:16 PM, E6, RN was interviewed. E6 reported she had been orientating with E3 on 3/22/13. E6 reported she became employed at the facility on 3/11/13. E6 stated, "She (E3) had popped out some pills and drawn up insulin and said take it down to the new lady, (R3). She (R3) had been moved from room 510 to 507 that AM. I walked in and said to (R3), ""Here's your meds."" I guess in retrospect I should have asked her name. I assessed her right arm. I took the insulin and pills to R3 about 8:30 AM. I went back and told E3 about assessing R3's right arm and then she (E3) knew I gave her (R5's). I was afraid her (R3) blood sugar would drop and she was given extra (liquid food supplement) and encouraged to eat a breakfast tray. I rechecked her blood sugar. It had gone up over 400 (normal fasting=70 to 110 mg per deciliter). We checked</p>	F9999			

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F9999	<p>Continued From page 18</p> <p>her blood pressure every 15 minutes. The doctor was called and said send her to the hospital. Her blood pressure began to drop, 70/40 something. She was still in her wheelchair and alert. She went to the hospital around 9:30 AM and was back at 1:00 PM. The resident's don't wear arm bands. The only way to identify is their name on the door, a picture on the MAR divider. They (residents) often don't look like their picture. Also, after she ate breakfast she said she was going to be sick and vomited. I now double and triple check medications. E3 documented the nurses notes at that time."</p> <p>On 4/22/13, at 10:15 AM, E2, Director of Nursing (DON) was interviewed about the medication errors for R3. E2 reported the medication error occurred while E3 was orientating a new nurse, E6. E2 stated, "There were two different stories. E6 said E3 told her to give the meds to the new lady, R3. E3 said she told her to give them to (R5). E6 gave R3 R5's medication during morning med pass, insulin and pills. Her blood pressure was running high. R3 is also diabetic, but not on insulin. The insulin didn't hurt her. Her blood pressure started going down. She did have an emesis and was sent to the ER and sent back in 2 or 3 hours. E6 realized what happened and was devastated. Both (E3 and E6) are experienced nurses. They should have gone back and looked and they didn't."</p> <p>In an interview on 4/22/13, at 2:43 PM, E2 reported, "I am well aware of a medication error problem." E2 reported the errors in the facility for 2013 have been related to improperly identifying the correct resident and failing to follow the facility's medication administration policy and procedures.</p>	F9999			

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F9999	<p>Continued From page 19</p> <p>On 4/23/13, at 11:50 AM Z1, Physician was interviewed related to the medication error for R3 on 3/22/13. Z1 reported he was aware of the medication error and considered this to be a significant medication error. Z1 stated, "They gave the wrong medication. The patient could have died. The patient could have been allergic and or had a severe reaction to too much blood pressure medication and too much insulin. Thank God she threw up." Z1 reported he is aware of a medication error problem at the facility.</p> <p>On 4/22/13 R3's MAR for 3/2013 was reviewed. The MAR for 3/13 documents E3 administered the following medication to R3 for her scheduled 8:30 AM medication pass; Hydralazine 50 mg, Pepcid 20 mg, the blood pressure medications of Hydrochlorothiazide 25 mg, and Norvasc 2.5 mg, and Aspirin 325 mg. The MAR documents R3's blood sugar level at 6:30 AM, on 3/22/13 was 289, and R3 was administered 6 units of Novolog insulin per sliding scale at that time.</p> <p>The Incident Report Detail for R3, dated 3/22/13, at 8:30 AM, was documented by E4, Assistant Director of Nursing (ADON). The Report documents on 3/22/13, at 8:30 AM, "(R3) received the wrong medications. She got the medications that belonged to another resident. Additional info (information)-Hydralazine 50 mg, Lyrica 50 mg, Tricor 145 mg, Docusate 100 mg, and Metoprolol 50 mg (an antihypertensive medication). Measures to prevent/ When training new nurses, the training nurse should say the resident's name and room number, and she should go with the orientating nurse. Send to ER for decreased BP (blood pressure)."</p>	F9999			

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F9999	<p>Continued From page 20</p> <p>The Physician's Order, dated 3/22/13, documents, "Send to (local) hospital by ambulance for monitoring related to wrong meds and wrong insulin."</p> <p>E3's Nurses Note for R3, dated 3/22/13 at 5:08 PM, documented, in part, "IR (incident report) med error. Resident was given another resident meds and insulin, communication error between nurses. (Z1) paged and called cell phone, exchange and both Friday offices, did not receive call back for one hour. Resident got up in wheelchair and taken to dining room so we could observe her, early breakfast tray gotten and 120 cc (cubic centimeters) of (liquid food supplement). Nurse got vs (vital signs) every 15 minutes for first hour and (glucometer) checks. At 8:25 AM (BP) 117/56, (pulse) 70, (respirations) 24, (temperature) 97.2, (glucometer) check-319, at 8:40 AM, BP-107/58, 94-(pulse), (respirations) -24, (glucometer) check 424, at 9:00 AM, BP-78/46, 88, 16, resident also complains of nausea and moderate amount of emesis, undigested food, At this time 911 called and here within minutes. (Z1) notified. Family and POA (Power of Attorney) and son notified resident sent to hospital for further observation. Resident returned at 1:00 PM, some confusion noted and not recalling earlier events."</p> <p>The Physician's Orders and Progress Note from the hospital, dated 3/22/13, documents, in part, "Diagnosis: Accidental OD (overdose) of insulin." The ER physician documentation addendum notes, dated 3/22/13, at 18:46 (6:46 PM) documents, in part, "Patient (R3) felt better after throwing up. Patient's glucose was 400. Patient</p>	F9999			

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F9999	<p>Continued From page 21</p> <p>received excess of 40 units long acting insulin. IMPRESSION: Accidental excess of insulin and medication. Pt (patient) present to ED (emergency department) with nausea and vomiting. Pt states symptoms began this morning after being given too much insulin. Pt was given wrong medications this AM, instead of pt's medications, pt was given: Apresoline 50 mg, Lyrica 50 mg, Norvasc 10 mg, Dulcolax 5 mg, Wellbutrin XL 150 mg, Zyrtec 5 mg, Lexapro 20 mg, Lasix 20 mg, Iron 150 mg, Lamictal 100 mg, Pravachol 40 mg, Colace 100 mg, Lopressor 50 mg, Novolin (insulin) N 50 units, Novolog (insulin) 8 units.</p> <p>On 4/23/13, the clinical record for R5 was reviewed. The POS and MAR for R5 in 3/13 documents R5 is to receive during morning medication pass the following medication; Hydralazine 50 mg, Lyrica 50 mg, Docusate 100 mg, Metoprolol 50 mg, Furosemide (Lasix) 20 mg, Iron Complex 150 mg, Pravastatin (Pravachol) 40 mg, Lamotrigine (Lamictal) 100 mg, Amlodipine (Norvasc) 10 mg, Aspirin 325 mg, Dulcolax 10 mg, Wellbutrin XL 150 mg, Zyrtec 5 mg, Lexapro 20 mg, Novolin N 50 units, and Novolog 8 units.</p> <p>The facility's policy and procedure entitled, 'General Medication Administration Procedures' documents, in part, "Medications are to be poured, administered and charted by the same licensed person in that order. Open the unit dose package only when you are administering medication directly to the resident. Removing the medication from its unit dose packaging in advance lessens the ability to positively identify the medication and increased the chance of drug</p>	F9999			

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F9999	Continued From page 22 administration errors. Before administering the dose, the nurse must make certain to correctly identify the resident to whom the medication is being administered. After the resident has been identified, administer the medication, watch the patient consume the medication until gone and immediately chart doses administered on the medication administration record." (B)	F9999			