| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145811 | A. Building<br>B. Wing | 09/21/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Aperion Care Peoria Heights | 1629 East Gardner Lane<br>Peoria Heights, IL 61616 |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34131<br><br>Based on observation, interview and record review the facility failed to enter admission medication orders under the correct resident, failed to give the correct medications to the correct resident per physician orders, and failed to identify a change in residents condition until R1 was seen by V8 Physician Assistant during his routine new admission visits ([DATE]) resulting in a R1 being transported to the hospital. On [DATE] R1 was admitted to the hospital with the primary diagnosis of Altered Mental Status, palliative care, and severe malnutrition. Extensive failures in the admission process resulted in R1 staying in the hospital from , d+[DATE]-[DATE]. R1 was admitted on hospice on [DATE] and expired on [DATE]. The facility also failed to enter R2's admission medication orders until three days after admit and failed to enter admission medication orders correctly per physician orders for R2 resulting in R2 missing three days of required medications (, d+[DATE]-[DATE]). R1-R8 do not have admission photos and are new admits. Further non-compliance could result in additional deaths.<br><br>These failures resulted in an immediate jeopardy.<br><br>While the immediacy was removed on [DATE], the facility remains out of compliance at a severity Level II as the facility continues to educated staff on the admission process for admission/re-admission of residents, implement a monitoring process for admission/re-admission residents accuracy and completion of orders, audit all resident records for complete identification (photos) and accuracy of orders, and educate nurses on proper identification of each resident as they are arriving at the facility.<br><br>Findings include:<br><br>The Immediate Jeopardy was identified on [DATE] at 12:49 pm. The Immediate Jeopardy began on [DATE] at 7:30am when the facility failed to order and administer the correct medications to the correct resident.<br><br>V1 Administrator was notified of the Immediate Jeopardy on [DATE] at 9:12 am.<br><br>Facility Admission of Resident, undated, documents Obtain an admission photo and distribute to the nursing department for MAR/Medication Administration Record identification needs. Explain the physician's orders and scheduled care of activities.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Facility Provider Pharmacy Requirements, undated, documents Regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications. Accurately dispensing prescriptions based on authorized prescriber orders. Screening each new medication order for an appropriate indication or diagnosis; for duplication of therapy with other drugs in the same therapeutic class ordered for the resident.<br><br>Facility Ordering and Receiving Non-Controlled Medications, undated, documents Medication orders are entered into the facility's EHR (electronic health record) and transmitted to the pharmacy. The medication order includes Date ordered, residents name and at least one other identifying information, medication name and strength, indication for use, and directions for use, if a new order. New Admissions/Re-admission Orders: When sending electronically medication orders for a newly admitted resident, the pharmacy is also given all allergies, and diagnoses to facilitate generation of a patient profile and permit initial medication use assessment. Receiving Medications from the pharmacy: A licensed nurse verifies medications received and directions for use with the medication order form.<br><br>Facility Medication Errors and Adverse Drug Reaction, revised [DATE], documents To safeguard the resident. To identify causes and prevent future errors. The residents receiving incorrect medication should be observed as needed.<br><br>Facility Medication Administration General Guidelines, undated, documents Medications are administered as prescribed. Five Rights- right resident, right drug, right dose, right route, and right time, are applied for each medication being administered.<br><br>Facility Administration Procedures for all Medications, undated, documents To administer medications in a safe and effective manner. Prior to removing the medication package/container from the cart/drawer check the order, identify the resident before administering medication (photo, verbal confirmation of last name, monitor for side effects or adverse reactions immediately after administration and throughout each shift.<br><br>Facility Physician-Family Notification- Change in Condition, revised [DATE], documents To ensure that medical care problems are communicated in a timely, efficient, and effective manner. A significant change in the resident's physical, mental, or psychosocial status (deterioration in health, mental, or psychosocial status).<br><br>Facility Registered Nurse/RN and Licensed Practical Nurse/LPN job description, dated [DATE], documents The RN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities. Complete and file required record keeping forms/charts upon the resident's admission, transfer and/or discharge. Prepare and administer medications as ordered by the physician.<br><br>Facility Resident Rights for People in Long-term Care Facilities, revised ,d+[DATE], documents You have the right to safety and good care.<br><br>Facility Resident Rights Federal, undated, documents These resident rights policies and procedures ensure that each resident admitted to the facility: has a right to dignified existence. Each resident has the right to be free from Psychoactive drug administration not required to treat the resident's medical symptoms.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Online American College of Physicians, Internal Medicine Encephalopathy, copyright 2015, documents Acute Encephalopathy may be referred to as toxic. Toxic Encephalopathy describes acute mental status alteration due to medications, or toxic chemicals. Causes of acute toxic encephalopathy include acute organ failure such as hepatic (liver) and renal (kidney), dehydration, medications.<br><br>Facility Daily Assignment Sheet, dated [DATE], documents V5 staff RN/Registered nurse on day shift (6am-6pm) and V7 Agency LPN/Licensed Practical Nurse for 6pm-6am.<br><br>1. R1's local hospital note, dated [DATE] by V24 (R1's MD/Medical Doctor ED/Emergency Department) documents (R1) has a past medical history of alcohol use disorder, liver disease, presenting with a chief complaint of lower extremity weakness. States he is trying to quit drinking and stopped drinking 1.5 days ago.<br><br>R1's EHR (electronic health record) documents R1 was admitted to the nursing home on [DATE], from , d+[DATE]-[DATE] in the hospital, and [DATE] at the facility.<br><br>R1's EHR from the facility documents the following: Diagnoses- Fatty Liver, Unspecified Psychosis, Anxiety, ETOH withdrawal, BPH/Benign Prostate Hypertrophy, Atrial Fibrillation, Anemia, Metabolic Encephalopathy, Alcohol dependence, and elevated liver enzymes.<br><br>R1's hospital After Visit Summary/AVS from a local hospital, dated ,d+[DATE]-[DATE], documents the following: Diagnosis of Alcohol Withdrawal. Discharge Medications: Tylenol 325mg/milligrams (2 tablets) po/by mouth every four hours as needed for pain; Calcium Carbonate 500mg chew take two tablets by mouth every eight hours as needed for heartburn or indigestion; Depakote 500mg by mouth two times daily; Folic Acid 1mg po daily; I-Vite 1 tablet by mouth daily; Ativan 1 tablet by mouth three times daily for five days, then 0.5mg tablets three times daily for five days, then 0.5mg tablets two times daily for five days, then 0.5mg tablets daily after breakfast for five days; Flomax 0.8mg po daily; and Thiamine 100mg po daily.<br><br>R1's head cat scan at local hospital, dated [DATE], documents No acute intracranial abnormality.<br><br>R1 was admitted to the facility on [DATE] and already had admission orders in his record.<br><br>R1's Facility Incident Report reported to (state agency), dated [DATE], documents the following: On [DATE] at 4:54pm, (R1) with the diagnoses of 'Toxic encephalopathy, psychoses not due to known physiological condition, anxiety, alcohol dependence with withdrawal, and fatty liver' received hospital updates for resident due to inpatient status. Upon reviewing hospital updates it was noted there are medications that are on his EMAR (Electronic Medication Administration Record) that are not his medications. Incorrect orders were entered into the residents EMAR. On [DATE], (V7) Agency LPN/Licensed Practical Nurse was asked if she could recall the events of the night of [DATE]. (V7) stated she was looking at (R1's) chart, two residents were trying to exit seek, staff were conducting a 'code pink', grabbed (R2's) medication orders to enter them into (online charting system). (V7) stated 'I did not mean to enter the wrong orders into (R1's) chart. It was crazy that night. I should have double checked I was on the correct person before I continued entering orders. I am horribly sorry for the medication error'.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R1's EHR Order Recap Report from the facility, dated ,d+[DATE]-[DATE], documents the following: Order date [DATE] and [DATE] documents I have reviewed and concur with the plan of care, allergies, and diagnoses signed by V20 (R1's Medical Doctor/MD) at the nursing home.<br><br>R1's [DATE] nursing home orders include the following: Occupational Therapy/OT evaluation and treatment; Tylenol 325mg/milligrams (2 tablets) po/by mouth every four hours as needed for pain; Calcium Carbonate 500mg chew take two tablets by mouth every eight hours as needed for heartburn; Depakote 500mg by mouth two times daily/BID; Folic Acid 1mg po daily; I-Vite 1 tablet by mouth daily; Ativan 1 tablet by mouth three times daily/TID for five days (R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]), then 0.5mg tablets three times daily for five days (R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]), then 0.5mg tablets two times daily for five days, then 0.5mg tablets daily after breakfast for five days (unspecified diagnosis); Ativan 1 tablet by mouth three times a day for anxiety (on top of the tapering Ativan listed prior with no order, R2's order) R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; Flomax 0.8mg daily for BPH; and Thiamine 100mg po daily.<br><br>R1's [DATE] orders include the following: Physical Therapy/PT and Speech Therapy/ST evaluation and treatment as indicated; full code; and PT evaluation and treatment for ,d+[DATE] weeks for four weeks.<br><br>R1's facility note, dated [DATE], documents (R1) arrived around 5:45pm, full code, regular diet, alert, 1 assist with gait belt and cares, and incontinent at times.<br><br>R1's facility note, dated [DATE], documents (R1) admitted on [DATE] for skilled nursing/rehab after being hospitalized for alcohol abuse and withdrawal. Previously lived independently in his home prior to his hospitalization .<br><br>R1's activities interview, dated [DATE], documents R1 was able to answer all the questions on his daily preferences and activity preferences.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R1's [DATE] medical record has orders that include the following (These were R2's orders): Abilify 2mg po BID for depression (no diagnosis of depression, no order, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; Ascorbic Acid 500mg by mouth BID (no orders, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; Cogentin 1mg po BID for Parkinson's (no diagnosis of Parkinson's, no order, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication , d+[DATE]-[DATE]; Biktarvy tablet [DATE]mg by mouth daily for HIV (no diagnosis of HIV, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; Vitamin D 2000 unit by mouth daily (no orders, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; Doxazosin 4mg daily for antihypertensive (no diagnosis of hypertension, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; Ferrous Sulfate 325mg by mouth daily (no order, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; Lisinopril 5mg daily for antihypertensive (no diagnosis of hypertension, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; Lasix 40mg BID for fluid retention (no diagnosis of fluid retention, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; Ativan 1 tablet by mouth three times a day for anxiety (on top of the tapering Ativan listed prior for R1 with no order, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; Nicotine Gum 4mg 1 gum by mouth every hour for nicotine cessation (no order, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; Nystatin Powder apply to abdominal folds every day and night shift (no order, and R2's order); Miralax powder 17mg/grams 1 scoop by out one time a day for constipation (no order, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; and Ritonavir 100mg one time a day for HIV (no order, no diagnosis, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication , d+[DATE]-[DATE].<br><br>R1's [DATE] orders include the following: OT and treatment for one week; and ST evaluation and treatment for ,d+[DATE] weeks for four weeks.<br><br>The wrong orders entered into R1's nursing home medical record for Miralax and Lasix resulted in R1 having multiple bowel movements a day including incontinent episodes. R1's Bowel and Bladder Elimination record for bowel continence, dated [DATE] documents one incontinent and one continent, [DATE] one incontinent, and [DATE] one incontinent bowel episode.<br><br>R1's [DATE] nursing home orders include the following: regular texture and consistency diet.<br><br>R1's physician progress note, dated [DATE] at 6pm by V8 (R1's PAC/Physician Assistant Certified) documents (R1) currently sleeping in bed and not easily aroused. Send to ER/emergency room for evaluation.<br><br>R1's facility note, dated [DATE] at 7:31pm and 9:57pm, documents (R1) sent to hospital because of changes in his level of consciousness for the past two days. (R1) has been sleeping throughout this shift.<br><br>R1's communication form and progress note from the facility, dated [DATE], documents (R1's) situation has gotten worse, mental status is unresponsiveness, functional status needs more assistance, and neurological is decreased level of consciousness.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R1's EHR documents R1 went to the hospital on [DATE], and on [DATE] returned to the facility.<br><br>R1's local hospital notes, dated [DATE]-[DATE], documents R1 was ordered and received the above medications during his hospital stay which were R2's admission orders from [DATE] along with R1's admission orders from [DATE].<br><br>R1's local hospital notes, dated [DATE] by V26 (Registered Nurse Emergency Department), documents (R1) has no history of dementia but alcoholism. (R1) will not answer any questions, just screams when touched, and unable to obtain oral temp.<br><br>R1's local hospital notes, dated [DATE] by V27 (Resident Doctor ED) documents I spoke to the nurse at (facility) and learned the following: (R1) was sent in to the hospital for increased lethargy and altered mental status. On [DATE] (V1) R1's PA at the nursing home evaluated (R1) and thought he had decreased level of consciousness. Other nursing notes in the last two days mentioned acute concerns from the patient and stable vital signs. They mentioned he has decreased appetite and thirst. (R1's) communication and mental status limits this history. Physical exam: [NAME] crusting in oropharynx, very dry. Neurological: Challenges communicating. Patient is arousable. History was somewhat difficult to obtain from the patient due to difficult to understand speech. Patient was initially somnolent but was arousable and able to answer questions.<br><br>R1's local hospital notes, dated [DATE] by V28 (R1's case manager) documents (V9/R1's POA/power of attorney) is aware of (R1's) condition worsening.<br><br>R1's local hospital notes, dated [DATE], documents (R1) has been very drowsy for most of the day.<br><br>R1's note from a local hospital, dated ,d+[DATE]-[DATE], documents R1 has the following diagnoses: [DATE] Altered Mental Status and [DATE] Palliative Care by Specialist. This form further documents discharge medication orders: [DATE] orders include the following: Abilify 2mg po BID (R2's admit order and no order for R1); Ascorbic Acid 500mg by mouth BID (R2's admit order and no order for R1). R1's MAR/Medication Administration record documents R1 got this medication [DATE]; Cogentin 1mg po BID (R2's admit order and no order for R1); Calcium Carbonate 500mg chew take two tablets by mouth every eight hours as needed for heartburn; Depakote 500mg by mouth two times daily; Ferrous Sulfate 325mg by mouth daily (R2's admit order and no order for R1); Flomax 0.8mg daily for BPH; Folic Acid 1mg po daily; Nystatin Powder apply to abdominal folds every day and night shift (R2's admit order and no order for R1). R1's MAR/Medication Administration record documents R1 got this medication ,d+[DATE]-[DATE]; Miralax (Glycolax) powder 17mg/grams 1 scoop by out one time a day for constipation (R2's admit order and no order for R1); Thiamine 100mg po daily; Vitamin D 2000 unit by mouth daily (R2's admit order and no order for R1); Zyprexa 2.5mg by mouth daily; and Foley Catheter and bag change as needed, and foley catheter care every shift as needed.<br><br>R1's facility's notes, dated [DATE], documents Resident arrived around 4pm by stretcher, lethargic, catheter draining dark urine, pureed diet, (mechanical) lift for transfers, incontinent of bowel, and medication concerns.<br><br>R1's [DATE] facility orders include the following: I-Vite 1 tablet by mouth daily; pureed texture and regular consistency diet; may crush acceptable medications; (name of hospice) to evaluate and treat stat (immediately) for 'Toxic Encephalopathy' (Brain dysfunction cause by toxic exposure); Do Not Resuscitate/DNR; and admit to hospice.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | R1's facility notes, dated [DATE] at 2:20am, documents (R1) is totally dependent on one to two staff for activities of daily living including bed mobility, transfers, eating, toileting, dressing, personal hygiene, walking, and bathing.<br><br>R1's facility notes, dated [DATE] at 2:33am, documents Resident open eyes to name only. Nonverbal at this time. (Catheter) patent and intact, draining dark amber urine.<br><br>R1's nursing home notes, dated [DATE] at 5:33am, documents Resident expired on [DATE] at 4:55am.<br><br>R1's [DATE] facility orders include the following: Discontinue medications due to death.<br><br>On [DATE] at 9:40am, R1 was in bed, fidgeting/twitching, mouth open, does not respond to my voice, does not respond to his name, eyes closed, and catheter on his right side draining amber urine. R1 is white (Caucasian), tall, and skinny.<br><br>2. R2's EHR documents R2 was admitted to the facility on [DATE]<br><br>R2 was admitted on [DATE] and R2's admission orders were entered on R1's electronic medication orders.<br><br>R2's hospital record from a local hospital, dated ,d+[DATE]-[DATE], documents the following: Why you were in the hospital: schizoaffective disorder, bipolar type; HIV; hypertension, and peripheral edema. Discharge Medications: Albuterol 108mcg/act 2 puffs Q6 PRN; Abilify 5mg po daily; Ascorbic Acid 500mg po BID; Cogentin 1mg po BID; Biktarvy [DATE]mg po daily; Calcium Carbonate Vit D3 ,d+[DATE]mg po daily; Prezista (Darunavir) 800mg po daily; Cardura 4mg po daily; Ferrous Sulfate 325mg po daily; Lasix 40mg po BID; Lisinopril 5mg po daily; Lorazepam 1mg po TID PRN; Multivitamin 1 tablet po daily; Nicotine gum Q1 hour PRN; Glycolax 17 gm po Q12 hours PRN; Ritonavir 100mg po daily; and Zoloft 25mg po daily.<br><br>R2's Discharge Summary from (local) hospital, dated [DATE], documents (R2's) medical history significant for HIV AIDS currently on retroviral therapy, and schizoaffective disorder/bipolar disorder.<br><br>R2's nursing home orders include the following order dates: Ascorbic Acid 500mg po BID ordered [DATE] (R2's MAR/Medication Administration record documents R2 got this medication [DATE]); Cogentin 1mg po BID ordered [DATE]; Biktarvy [DATE]mg po daily ordered [DATE] (R2's MAR/Medication Administration record documents R2 started getting this medication [DATE]); Calcium Carbonate Vit D3 ,d+[DATE]mg po daily order date [DATE]; Prezista (Darunavir) 800mg po daily order date [DATE] (R2's MAR/Medication Administration record documents R2 stated getting this medication [DATE]); Cardura 4mg po daily order date [DATE]; Ferrous Sulfate 325mg po daily order date [DATE]; Lasix 40mg po BID order date [DATE]; Lisinopril 5mg po daily order date [DATE]; Multivitamin 1 tablet po daily order date [DATE]; Nicotine gum Q1 hour PRN ordered [DATE] and R2's MAR documents R2 was given this hourly on ,d+[DATE]-[DATE] per entered ordered Q1 hour scheduled and not PRN per order; Glycolax/Miralax 17 gm po Q12 hours PRN order date [DATE] and per R2's MAR was given this on [DATE] one dose; and then ,d+[DATE]-[DATE] given two doses a day (not ordered PRN it was scheduled; and order on [DATE] this was changed to PRN; Ritonavir 100mg po daily ordered [DATE]; and Zoloft 25mg po daily ordered [DATE].<br><br>R2's Lorazepam 1mg po TID PRN was never entered into R2's nursing home medication orders.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The wrong orders entered into R2's nursing home medical record for Miralax resulted in R2 having multiple bowel movements a day including incontinent episodes. R2's Bowel and Bladder Elimination record for bowel continence, dated [DATE], documents: ,d+[DATE]/ continent; [DATE] continent, [DATE] continent; [DATE] continent; [DATE] two continent; [DATE] one continent and two incontinent; [DATE] two incontinent; [DATE] one incontinent; [DATE] one continent and one incontinent; [DATE] one incontinent; [DATE] two continent; and [DATE] two incontinent bowel episodes<br><br>On [DATE] at 10:50am, R2 was in a manual wheelchair, stated he got the facility in August, unsure if he has had his picture taken, alert, and states he goes outside and around the facility in his wheelchair during the day. R2 is overweight/obese, and in a manual wheelchair.<br><br>On [DATE] at 9:30am, V3 and V4 (both CNAs/Certified Nurse Assistants) stated (R1) could walk but he was unsteady and would use the wheelchair to self-propel himself thru the home. Before his last hospitalization he could feed himself but now we have to feed him, and he won't open his eyes. Before this last hospitalization we had to remind him to eat at times, but he fed himself. Now he can't walk or move, and he needs a (brand name of chair) or hi-back wheelchair for safety. (R1) came back yesterday ([DATE]) about four or five pm and he is not the same. He was at the hospital about two weeks.<br><br>On [DATE] at 10:00am, V5 (staff Registered Nurse/RN) stated I work 6am to 6pm and have worked with (R1) frequently. Before (R1) went to the hospital last, he could stand, sit in the wheelchair, walk the hallways, and answer yes/no questions. Verified R1 had a catheter now. He (R1) was new, came from the hospital and was here five or six days before sent to the hospital again after getting the wrong medications. He (R1) fell a few times when he first got here, he was a person that needed a one to one and now he is not a one to one. He (R1) wore briefs before. (R1) got (R2's) medications for a few days. I was here working when (R2) was admitted ([DATE]) and performed his admission assessment, he came at change of shift, and the oncoming nurse (V7 agency LPN/Licensed Practical Nurse) put the orders in the computer. (V7) was to put the orders in for (R2) under (R2's) name but put (R2's) orders in the computer under (R1's) name. The orders go directly to pharmacy then for them to fill. When we put the orders in the computer, they are the orders for the residents. I gave (V7) R2's admission summary paperwork because I was the off going nurse and (V7) was the oncoming nurse and we help one another out. I probably should have stayed and finished the orders so we would not have had this happen. I was off work the next day ([DATE]) and came back on [DATE] and asked staff/management where (R2's) medications were in (online charting system). I spoke to V6 (Interim DON/Director of Nursing) about (R2's) missing medications in (online charting system). I knew (R2) had medications he needed to be given because I had started his admission on [DATE] and (V7) was to put the orders in. I left (R2's) admission packet on the desk for (V7) to complete. I did (R2's) admission assessment and the other nurse was supposed to put the orders in for (R2). We have a re-admit checklist we go by with each admission.<br><br>On [DATE] at 9:30am, V4 (CNA) stated Our prior (V11) DON used to keep (R1) in his office as a one-to-one observation, or he would walk with (R1). We also used to keep (R1) up at the desk for close observation. He would go in his wheelchair and push himself around, he was really unsteady when walking. He did fall a few times when he was first here which is why he was on increased observation. He would ask for alcohol and clothes. He would disrobe himself at times. He did use the toilet but wore briefs(incontinent briefs) because he did have incontinent episodes.<br><br>(continued on next page) |

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| | 145811 | A. Building<br>B. Wing | 09/21/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Aperion Care Peoria Heights | 1629 East Gardner Lane<br>Peoria Heights, IL 61616 |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at 12:00pm, V6 (DON) stated I have been DON for about three weeks until someone gets hired. The nurse (V7 LPN) must have been under (R1's online charting system) access and put (R2's) orders under (R1's) name. (V7) did come to me to find where (R2's) orders were and we could not find any orders in (online charting system) for (R2). (R2) needed his medications so we re-entered them under (R2's) name so he could get his medications. [DATE] (R2's) medication orders were put in. When we put orders in (online charting system) it goes to pharmacy automatically so they can fill his medication orders. When (R1) was sent to the hospital on [DATE] (local hospital) called and wanted to know why (R1) was on medications without a diagnosis. I and V2 (RN Regional Nurse Consultant/RNC) both emailed and discovered (R2) was on the same medications so we called the hospital and gave the full list of medications (R1) should not have been on. (R1) is still on some medications from the hospital that he should not be on from his admission. I did call the doctor for clarification and verified these medications he was not on at admission ([DATE]).<br><br>On [DATE] at 12:20pm, V2 stated (V11) was the DON until [DATE], and V8 (R1's PAC) was here [DATE]. (R1) was more lethargic and he was sent to the hospital per (V8's) request. The nurses did not identify (R1) had a change in condition until (V8) pointed it out. (V8) asked the nurse about Ativan which was held ([DATE]) but (V8) felt (R1) was more lethargic from the week prior and sent him to the hospital. I was notified the hospital had concerns about the medications (R1) was on. I looked at (online) orders and (admission sheet) and compared and saw HIV medications (R1) was not on but was on now. It was determined (R1) got (R2's) medications and orders were put in under (R1's) name. V7 (Agency LPN) stated she put (R2's) orders in (online charting) under (R1) and did not check to make sure she was in the correct chart which should have been (R2's). (R1) got (R2's) medications for five days (,d+[DATE]-[DATE]). New admission pictures should be in (online charting) within 24 hours of admit. Activities or social services take the residents pictures for admission.<br><br>On [DATE] at 1:07pm, V7 (Agency LPN) stated I worked [DATE] and I took care of (R1) and (R2). (R2) was a new admit. I was going to put his orders in (online charting system) but at the time of putting in orders we had a 'code pink' (elopement) so I had to go take care of that. I was looking at (R1's) chart prior to the 'code pink', and when I got back from the 'code pink' I just entered (R2's) orders without verifying I was on (R2's) chart. I entered (R2's) orders on (R1's) record on accident. I had a lot of distractions going on, call lights, 'code pink', and residents very busy and demanding. I should have double checked the resident's records. I worked the next night and couldn't find the orders for (R2) I had entered. I know I put them in. I asked V6 (Interim DON) (who was the wound nurse at the time) to help me find them, she and I both looked, she notified V2 (RN RNC/Regional Nurse Consultant), (V11) prior DON (who was the DON at the time). It was a mistake, there were no pictures in the online record for (R1) or (R2). I work for agency.<br><br>On [DATE] at 4:48pm, V9 (R1's brother and POA) stated My wife was there to take (R1) to smoke and then a few days later he was trying to die. He could carry on a conversation and hold his cigarette and smoke by himself before he got the wrong medications. Now he can't open his eyes and he is not eating. My wife noticed from his (local hospital) my chart he was on the wrong medications. My wife is at the nursing home now talking with them about putting (R1) on hospice. He was getting HIV medications, blood pressure and (diuretic) medications at the nursing home which he has never taken before. He has low blood pressure so he shouldn't be getting a medication for high blood pressure. On [DATE] we thought he was going to die.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at 5:48pm, V10 (R1's family) stated (R1) was in the hospital for alcohol abuse. When he was at the nursing home he recognized me, ate, and I took him outside to smoke cigarettes. He was sent to the hospital on [DATE] and he was out of his mind. He could not communicate or talk, he did not recognize me, and he moaned and groaned. He did have a fall at the nursing home where he had a cat scan done which was negative. I checked his (local hospital) my chart and noticed he was on abilify, (diuretic), high blood pressure, and HIV medications. I told the hospital he did not have HIV and they called the nursing home. He got the wrong medications at the nursing home and hospital. He was at the nursing home for alcohol abuse and rehab. He lived in a two-story home by himself which he took care of prior to going to the nursing home. He was at the nursing home to dry out from alcohol, get some rehab since his legs were weak, and when he was physically able to, he was to go back home to live independently as he did before.<br><br>On [DATE] at 9:,d+[DATE]:37am, V8 (PA-C/Physician Assistant Certified) for R1 at the facility stated (R1) has been lethargic, the last day I saw him for his evaluation ([DATE]) he was very lethargic and I sent him in for an evaluation at the hospital. Abilify can cause falls, drowsiness, restlessness, and somnolence. Ativan can sedate, affect ambulation, and increase your risk for falls. If you are on Ativan double your usually dose it can sedate, absolutely, we give 2mg IV in ER for status epilepticus so 2.5mg of Ativan TID would 'snow' (R1) for sure. Benztropine (Cogentin) can cause drowsiness, sedation, dizziness and nervousness; Biktarvy can cause liver and kidney problems; Doxazosin can cause hypotension and sedation; Lasix can dehydrate, cause confusion and kidney failure; Miralax can cause diarrhea and dehydration, Lisinopril can cause lightheadedness and hypotension; and Ritonavir can cause drowsiness, loss of appetite, and cause severe liver failure. Taking medications that are not prescribed for you can harm your kidneys, liver can be harmed especially since most medications are metabolized in the liver and (R1's) liver was already compromised due to his alcoholism, so these medications can cause increased liver toxicity. When (R1) was sent to the hospital for falls he had a cat scan, and it showed no subarachnoid or traumatic brain injury, so I don't believe that was the cause of his change in condition on [DATE].<br><br>On [DATE] at 1:55pm, V13 (R1's attending physician at local hospital) fro[TRUNCATED] |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34131<br><br>Based on observation, interview and record review, the facility failed to educate staff and agency nurses that there was Narcan in their building, facility failed to educate staff and agency nurses on the medication dispensary machine, failed to give staff and agency nurses access codes and privileges to the medication dispensary machine, and failed to provide training to V6 (Interim DON/Director of Nursing). Further non-compliance could result in serious health issues and possibly death.<br><br>These failures resulted in an immediate jeopardy.<br><br>While the immediacy was removed on 9/20/22, the facility remains out of compliance at a severity Level II as the facility continues to in-service all staff and agency nurses on where the Narcan is stored in the facility, educate, and provide access to all their nurses on their emergency medications and medication dispensary machine locations and contents, and in-service the DON on her job duties.<br><br>Findings include:<br><br>The Immediate Jeopardy was identified 9/16/22 at 1:28 PM. The Immediate Jeopardy began on 9/15/22 at 2:15am when the facility failed to educate and provide access to all their nurses on their emergency medications and medication dispensary machine locations and contents.<br><br>V1 (Administrator) was notified of the Immediate Jeopardy on 9/20/22 at 12:58 PM.<br><br>Facility Emergency Pharmacy and Emergency Kits, undated, documents Emergency pharmacy service is available on a 24-hour basis. The pharmacy supplies emergency medications in limited quantities in portable, sealed containers.<br><br>Facility provided a document titled Department Head List, undated, documenting V6 (Interim DON/Director of Nursing/Wound Nurse).<br><br>Facility First Dose Machine and (Brand name), revised 8/2015, documents The supply of medications will be referred to as the Automated Dispensing System (ADS) unit. The purpose of the emergency supply of medication is to ensure the residents will have access to pharmaceutical care in a manner that provides for the appropriate initiation and continuation of drug therapy. Each person who accesses the ADS will have his/her own individual electronic, biometric, or other authentication credentials permitting access. Access to the First Dose System will be limited to designated licensed nurses. The DON/Director of Nursing will be responsible for developing and maintaining a confidential system for assigning access codes and system privileges for nursing personnel. This information will be maintained current and easily retrievable by the DON.<br><br>Facility pharmacy emergency kit content, emailed 9/20/22, documents Naloxone 0.4mg (milligram)/ml (milliliter) vial (1ml) (Narcan) with a quantity of one.<br><br>Facility pharmacy ADS medication list inventory, emailed 9/20/22, documents Naloxone 0.4mg (milligram)/ml (milliliter) vial (1ml) (Narcan) with a quantity of two.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 9/20/22 at 12:48 PM, V22 (Pharmacy Director) emailed the following: Number (how many) of Emergency Kits provided to (nursing home) 3 kits (locations: Hillside unit, Riverside Unit, and one additional to be kept in nursing office for emergency), and Number (how many) (electronic medication dispensary) at (facility) 1 machine.<br><br>Facility Director of Nursing/DON, dated 5/2/17, documents The primary purpose of the DON is to plan, organize, develop and direct the overall operation of our Nursing Department to ensure that the highest degree of quality care is maintained at all times. Make written and oral reports concerning the operation of the nursing services department. Develops methods for coordination of nursing services with other resident services to ensure the continuity of the residents' total regimen of care. Must have as a minimum three years of experience as a supervisor. Must be knowledgeable of nursing and medical practices and procedures as well as laws regulations and guidelines that pertain to nursing care facilities.<br><br>Facility Registered Nurse/RN and Licensed Practical Nurse/LPN job description, dated 5/2/17, documents The RN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities. Complete and file required record keeping forms/charts upon the resident's admission, transfer and/or discharge. Prepare and administer medications as ordered by the physician.<br><br>V1 (Administrator in training/AIT) provided the training for all the facility nurses and the training did not include any training for the medication dispensary machine, or convenience/emergency medication location/use, machine access, or contents. The provided training for V6 (Interim DON/Wound Nurse) did not include any training for the DON position.<br><br>Facility was unable to provide any training the facility has done/provided to the agency nurses.<br><br>Facility was unable to provide any DON training for V6 (Interim DON RN/Registered Nurse.)<br><br>Facility staffing sheet dated 9/14/22-9/15/22 6pm-6am documents V15 (agency) and V16 (staff LPNs/Licensed Practical Nurses) were the only nurses scheduled to work in the building.<br><br>R9's electronic nurses notes, dated 9/15/22 at 2:15am by V15 (agency LPN) documents the following: Writer alerted by staff that (R9) noted lying on his back on the floor at the foot of the bed. Resident lethargic, unable to respond to commands, pupils blown, respirations shallow with periods of apnea noted, and pulse weak/thready. 911 called. Narcan 4mg (milligrams) administered in each nostril and resident began to respond appropriately to commands. He denies taking anything. (R9) taken to (hospital) for evaluation and treatment. All responsible parties notified.<br><br>On 9/16/22 at 9:50am, V1 (AIT) stated the facility uses (Name of pharmacy) for their medications and they manage the medication dispensary machine. I started Tues 9/6/22 as the AIT. I do not know what agency gets for education. I do not know what we do for educating them to our building. We use a lot of agency nurses, have a lot of new staff, and only have a few of our own staff. Yes, there will be time when only agency may be in the building because we have three nurses on from 6am-6pm, and two nurses from 6pm-6am.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 9/16/22 at 10:30am, V6 (Interim DON/RN) stated We suspected drug overdose for (R9). (R9) went unresponsive. (R9) is normally alert and oriented to person and place. He possibly got drugs from the people he hangs out with on the patio. (R9) went unresponsive, was given Narcan x2 doses at the nursing home, and then sent to the hospital. I am only helping out in the DON position until they hire someone.<br><br>On 9/16/22 at 11:46am, V16 (staff LPN) stated I am new, started [DATE]th or 8th, 2022. I worked 9/14-9/15/22 from 6pm-6am. I am not entirely sure what happened with (R9). (R9) goes to bed late sometimes, goes to dialysis Tues, Thurs, and Saturdays, is a bilateral amputee, and self -propels his wheelchair around the nursing home. At midnight or 1am (9/15/22) the CNAs reported to me that (R9) was on the floor and unresponsive. I checked his vital signs, he was breathing shallow, he was asked what he took but did not respond, Narcan was given x2 (V15), two doses in his nose, he started to arouse by taking deeper breaths and move his arms and head, I called 911 and sent him to the hospital. I am new and did not know we had Narcan in the building. I am not sure where (V15) got the Narcan.<br><br>On 9/16/22 at 12pm, V15 (agency LPN) stated One of the CNAs found (R9) unresponsive, staff got me, pupils were dilated, periods of apnea, the nursing home has had some issues with people overdosing on drugs, and residents know which residents get drugs and go their rooms for drugs. I went to my car and got Narcan that I had on hand. I gave Narcan x2 in his nose, they are single use doses, so I had to use two to get him to respond. I have seen overdoses before, so I had Narcan on hand and figured that is what he did, and after the Narcan he started to come to. I don't know if Narcan is in the building. I think the emergency medications are located in the ADS, and agency nurses do not have access to the ADS. I work on Hillside hall.<br><br>On 9/16/22 at 11:30am, V17 (staff LPN) was in the building on Riverside hall and stated I work PRN/as needed and can't get in the (ADS). The C-Box/Narcotic box are located on Hillside in the (ADS). I do not have Narcan on my cart, the convenience-box has Narcan but it is in the (ADS) and I can't get into the (ADS) system. At that same time surveyor and nurse walked to Hillside hallway and entered the medication room where the ADS system was located. In the med room V17 was unable to find the Narcan or access the ADS system where she believed the Narcan was located. Upon surveyor looking around the med room with V17, surveyor found two sealed red medication tackle boxes from pharmacy located on a shelving unit on the bottom shelf. At that same time, V17 verified there were two separate red medication boxes that were secured with zip ties from the pharmacy, and one dose of Narcan was in each medication box for a total of two doses in the building. V17 stated I did not know Narcan was in the red box. At that same time, the nurse (V5 RN) working on Hillside was on lunch break and V6 (Interim RN DON/wound nurse) was out of the building on lunch. No ADON is employed or listed on the management roster. No other nurses not on break were working in the building besides V17 and V18.<br><br>On 9/16/22 at 12pm, V18 (agency RN) was in the building on Riverside and stated I can't get in the (ADS). I am an agency nurse. the Narcan is located in the (ADS), and I don't have Narcan on my medication cart.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 9/19/22 at 11:57am, V6 (Interim DON/RN) stated I don't want the DON position permanently. I have worked as DON before at another place, but it has been a long time ago. I will have worked here two years in October 2022. I became the interim DON about four weeks ago. When (V11) prior DON left (8/19/22) we had no DON for one week and then I went into the Interim DON position (about 8/29/22). I did not get training as DON here, and when things come up, I call corporate nurse for guidance. I was supposed to be Interim DON for two weeks only. They hired a DON to start on 9/26/22 but I heard they are not coming now. I work during the week Monday thru Friday where I do the wound treatments first thing in the morning on Monday and Tuesday only, and then the rest of the day I spend as Interim DON.<br><br>The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy:<br><br>1.All nurses educated on e-box. Location, content usage of contents. Education completed by V2 RN/RNC (Registered Nurse/Regional Nurse Consultant). 9/20/22.<br><br>2.Corporate DON assigned to facility V30 (RN/DON). 9/20/22<br><br>3.All nurses educated by V2 (RN/RNC) on pharmacy electronic medication dispensary machines- locations, gaining access and content. 9/20/22.<br><br>4.List of all emergency medications available in e-box as well as medication dispensary machine posted in all med rooms. 9/20/22.<br><br>5.All agency staff will be educated on location/content of emergency medications prior to next shift worked by V30 (RN/DON). 9/20/22.<br><br>6.All nurses will receive education on medication dispensary machine and convenient box during orientation. Education completed by V30 (RN/DON). Initiated 9/20/22 on going.<br><br>7. All nurses educated on location of Narcan and how and when to administer Narcan. Education completed by V2 (RN/RNC). Initiated 9/20/22 will be completed by 9/21/22.<br><br>8.New orders for naloxone for all residents who currently receive narcotics or have a history or substance abuse. 9/20/22.<br><br>9. V20 (MD/Medical director) notified of incident on 9/20/22 and reviewed the facility's immediate action plan. V20 was in agreement with immediate action plan. 9/20/22.<br><br>10. QAPI review with V20 (MD/Medical Director) to review emergency medication boxes including content/administration/location. 9/20/22. |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34131<br><br>Based on observation, interview, and record review the facility failed to enter admission medication orders under the correct resident, and failed to give the correct medications to the correct resident per physician orders which included HIV, antihypertensive's, antipsychotic, diuretic, anti-tremor, depression, and sedative medications for two (R1 and R2) of three residents reviewed for medications in a sample of nine. These failures resulted in R1 having a change in condition with a hospital stay from 8/23-9/12/22, and R2 missing three days of required medications from 8/18-8/20/22.<br><br>Findings include:<br><br>Facility Medication Errors and Adverse Drug Reaction, revised 1/4/2, documents To safeguard the resident. To identify causes and prevent future errors. To provide guidelines for reporting and recording. All medication, treatment errors, and drug reactions must be reported promptly. The residents receiving incorrect medication should be observed as needed.<br><br>Facility Registered Nurse/RN and Licensed Practical Nurse/LPN job description, dated 5/2/17, documents The RN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities. Complete and file required record keeping forms/charts upon the resident's admission, transfer and/or discharge. Prepare and administer medications as ordered by the physician.<br><br>Facility Medication Administration General Guidelines, undated, documents Medications are administered as prescribed. Five Rights- right resident, right drug, right dose, right route, and right time, are applied for each medication being administered.<br><br>Facility Resident Rights Federal, undated, documents These resident rights policies and procedures ensure that each resident admitted to the facility: has a right to dignified existence. Each resident has the right to be free from Psychoactive drug administration not required to treat the resident's medical symptoms.<br><br>Facility Resident Rights for People in Long-term Care Facilities, revised 3/2011, documents You have the right to safety and good care.<br><br>1. R2's EHR/electronic health record documents R2 was admitted to the facility on [DATE] and R2's admission orders were not entered into R2's electronic medication orders until 8/20/22.<br><br>R2's hospital AVS/after visit summary from a local hospital, dated 7/21-8/17/22, documents the following: Why you were in the hospital: schizoaffective disorder, bipolar type; HIV; hypertension, and peripheral edema.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145811 | A. Building<br>B. Wing | 09/21/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aperion Care Peoria Heights | 1629 East Gardner Lane<br>Peoria Heights, IL 61616 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R2's AVS Discharge Medications, dated 7/21-8/17/22, documents the following significant medications: Abilify (antipsychotic) 5mg/milligrams po daily; Cogentin (anti-tremor) 1mg po BID; Biktarvy (HIV) 50-200-25mg po daily; Prezista (Darunavir) (HIV) 800mg po daily; Cardura (antihypertensive) 4mg po daily; Lasix (diuretic) 40mg po BID; Lisinopril (antihypertensive) 5mg po daily; Lorazepam (sedative) 1mg po TID/three times a day PRN/as needed; Ritonavir (HIV) 100mg po daily; and Zoloft (depression) 25mg po daily.<br><br>R2's nursing home orders include the following order dates: Cogentin 1mg po BID ordered 8/20/22; Biktarvy 50-200-25mg po daily ordered 8/20/22 (R2's MAR/Medication Administration record documents R2 started getting this medication 8/21/22); Prezista (Darunavir) 800mg po daily order date 8/20/22 (R2's MAR/Medication Administration record documents R2 stated getting this medication 8/21/22); Cardura 4mg po daily order date 8/20/22; Lasix 40mg po BID order date 8/20/22; Lisinopril 5mg po daily order date 8/21/22; Ritonavir 100mg po daily ordered 8/20/22; and Zoloft 25mg po daily ordered 8/20/22.<br><br>R2's Lorazepam 1mg po TID PRN was never entered into R2's nursing home medication orders.<br><br>2. R1's was admitted to the nursing home on 8/15/22 and already had admission orders in his record.<br><br>R1's Facility Incident Report reported to (state agency), dated 9/3/22, documents the following: On 8/29/22 at 4:54pm, (R1) with the diagnoses of 'Toxic encephalopathy, psychoses not due to known physiological condition, anxiety, alcohol dependence with withdrawal, and fatty liver' received hospital updates for resident due to inpatient status. Upon reviewing hospital updates it was noted there are medications that are on his EMAR (Electronic Medication Administration Record) that are not his medications. Incorrect orders were entered into the residents EMAR. On 8/30/22, V7 (Agency LPN/Licensed Practical Nurse) was asked if she could recall the events of the night of 8/17/22. (V7) stated she was looking at (R1's) chart, two residents were trying to exit seek, staff were conducting a 'code pink', grabbed (R2's) medication orders to enter them into (online charting system). (V7) stated 'I did not mean to enter the wrong orders into (R1's) chart. It was crazy that night. I should have double checked I was on the correct person before I continued entering orders. I am horribly sorry for the medication error'.<br><br>R1's 8/17/22 nursing home medical record has orders that include the following (These were R2's orders): Abilify 2mg po BID for depression (no diagnosis of depression, no order, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication 8/18-8/22/22; Cogentin 1mg po BID for Parkinson's (no diagnosis of Parkinson's, no order, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication 8/18-8/22/22; Biktarvy tablet 50-200-25mg by mouth daily for HIV (no diagnosis of HIV, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication 8/18-8/22/22; Doxazosin 4mg daily for antihypertensive (no diagnosis of hypertension, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication 8/18-8/22/22; Lisinopril 5mg daily for antihypertensive (no diagnosis of hypertension, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication 8/18-8/22/22; Lasix 40mg BID for fluid retention (no diagnosis of fluid retention, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication 8/18-8/22/22; Ativan 1 tablet by mouth three times a day for anxiety (on top of the tapering Ativan listed prior for R1 with no order, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication 8/18-8/22/22; and Ritonavir 100mg one time a day for HIV (no order, no diagnosis, and R2's order). R1's MAR/Medication Administration record documents R1 got this medication 8/18-8/22/22.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R1's EHR documents R1 was admitted to the facility on [DATE], 8/22-9/12/22 in the hospital, and 9/12/22 at the facility.<br><br>On 9/13/22 at 12:00pm, V6 (DON) stated The nurse (V7 LPN) must have been under (R1's online charting system) access and put (R2's) orders under (R1's) name. 8/20/22 (R2's) medication orders were put in, but he was admitted on [DATE]. When we put orders in (online charting system) it goes to pharmacy automatically so they can fill his medication orders. When (R1) was sent to the hospital on 8/22/22 (local hospital) called and wanted to know why (R1) was on medications without a diagnosis.<br><br>On 9/15/22 at 9:20-9:37am, V8 (PA-C/Physician Assistant Certified) for R1 at the facility stated (R1) has been lethargic, the last day I saw him for his evaluation (8/22/22) he was very lethargic and I sent him in for an evaluation at the hospital. Abilify can cause falls, drowsiness, restlessness, and somnolence. Ativan can sedate, affect ambulation, and increase your risk for falls. If you are on Ativan double your usually dose it can sedate, absolutely, we give 2mg IV in ER for status epilepticus so 2.5mg of Ativan TID would 'snow' (R1) for sure. Benztropine (Cogentin) can cause drowsiness, sedation, dizziness and nervousness; Biktarvy can cause liver and kidney problems; Doxazosin can cause hypotension and sedation; Lasix can dehydrate, cause confusion and kidney failure; Miralax can cause diarrhea and dehydration, Lisinopril can cause lightheadedness and hypotension; and Ritonavir can cause drowsiness, loss of appetite, and cause severe liver failure. Taking medications that are not prescribed for you can harm your kidneys, liver can be harmed especially since most medications are metabolized in the liver and (R1's) liver was already compromised due to his alcoholism, so these medications can cause increased liver toxicity. When (R1) was sent to the hospital for falls he had a CT scan, and it showed no subarachnoid or traumatic brain injury, so I don't believe that was the cause of his change in condition on 8/22/22.<br><br>On 9/16/22 at 1:55pm, V13 (R1's attending physician at local hospital) from 8/24-8/29/22 stated If (R1) got medications for the heart, blood pressure, Parkinson's disease, HIV, an antipsychotic, and a diuretic medication, and he was not prior prescribed these medications they could contribute to his encephalopathy. If (R1) was dehydrated with these medications on board it could contribute to his co-morbidities and overall decline in health. This was very unfortunate for him. |