STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145480	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mattoon Rehab & Hcc	2121 South Ninth Mattoon, IL 61938

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on interview and record review the facility failed to ensure that residents were administered medications as prescribed per phyisican orders for (R1, R2, R3 & R4) of four residents reviewed for medication administration. This failure resulted in R1 being administered medications prescribed for another resident, to include a large dose of Morphine (Opiod Narcotic medication), resulting in R1 experiencing side effects for multiple days after and also requiring the administration of Narcan (Opiod Reversal Agent). Findings include: 1.) R1's Medication Error Report dated 2/25/25 documents that R1 was administered R2's 4:00PM medications, erroneously. R2's February 25, 2025 medication administration record documents the following scheduled medication tablets for 4:00PM administration: Amoxicillin/Clavulanate 875mg/125mg (antibiotic), Colace 100mg (stool softener), Naproxen 500mg (nonsteroidal anti-inflammatory), Primodone 50mg (anti-seizure), Senna 8.6 (laxative), Vitamin C 500mg (vitamin), and Morphine Extended Release 90mg (opioid). R1's progress notes document on 2/25/25 at 4:57PM R1 was administered R2's 4:00PM medications. R1's Medication Administration Record dated 2/25/25 at 5:00PM documents 2mg of Nalaxone given intramuscularly for opioid reversal. R1's progress notes dated 2/26/25 at 9:45AM document that R1 was having several episodes of vomiting. Resident was given 8mg of Zofran (antiemetic) and continued to have episodes of emesis. V13 Medical Doctor was notified and recommended sending R1 to the hospital for evaluation and treatment. Resident refused to go out to hospital. Resident states he wants left alone. R1's progress notes dated 2/26/2025 at 9:27PM document that R1 is being monitored for being given morphine and began dry heaving after receiving his medication. Zofran (antiemetic) was given and effective. R1 did not eat dinner and states that he feels hungover. R1's progress notes dated 2/27/2025 at 10:52 document that R1 has not presented with any vomiting episodes thus far this shift. R1 stated that he was still feeling as drowsy, did not each breakfast and is still slightly lethargic. (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 0760 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 2/27/2025 at 21:05 documents that R1 arouses more easily, was able to speak more clearly but is still feeling tired. R1 did not eat dinner. Zofran given for nausea and vomiting and it was effective with urinary output better than yesterday, but not a lot better. R1's February Medication Administration Record dated 2/26/25 documents Zofran (antiemetic) given at 9:14AM and 6:01PM. R1's progress notes dated 2/28/2025 at 1:30AM document that Zofran was given for nausea (3/1/25). R1's progress notes dated 2/28/2025 at 12:53PM document that R1 states that he still doesn't feel well. Resident refused meals today. R1's Minimum Data Set, dated dated dated [DATE] documents R1 is cognitively intact. On 4/3/25 at 10:15AM R1 stated that he took the pills that were given to him except for the Lactulose. When I told (V6) that (the lactulose) wasn't my medication, (V6 Agency Licensed Practical Nurse) asked me if I was (R2) and I told him that (R2) was my roommate. I wouldn't have told him that my name is (R2). I just remember that they gave me something after that and I felt awful for a few days afterward. I was nauseous and vomited and they wanted me to go to the hospital, but I just wanted to be left alone. On 4/3/25 at 9:17AM, V2 Director of Nursing (DON) stated that on 2/25/25 R1 received R2's 4:00PM medications including 90 milligrams of extended release morphine by an agency nurse who was working his first shift in the facility. V2 stated that the error was identified when R1 would not take the lactulose and said that it wasn't his medication; however he had already swallowed the pills. Upon identification of the error, V2 DON called V13 Medical Doctor and received instructions to reverse the Morphine with Narcan, which was done. R1 then began vomiting the next day, continuing for days. On 4/3/25 at 10:33AM, V6 Agency Licensed Practical Nurse stated that he entered R1's room and asked if R1 was R2's first name and R1 responded in the affirmative. After R1 refused the lactulose, V6 stated that he asked R1 again if he was R2 and R1 said, No, that's my roommate. V6 stated that he immediately went out and found the charge nurse, told her of the error and then contacted the doctor for a Narcan order (opioid reversal agent). When asked how V6 identified R1 he stated, I looked at their pictures, but they look a lot alike. So I asked R1 if he was R2 and he said yes. V6 then stated, In that building, the beds are opposite in their numbering compared to all of the other facility's that I work. Bed one is usually by the door and bed two is usually by the window. On 4/7/25 at 9:01AM, V13 Medical Doctor stated that he was notified immediately of the error and that it was treated with Narcan (an opioid reversal agent). V13 also stated that this error could have resulted in respiratory depression and severe harm to R1. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The package insert for Morphine Sulfate, dated Revised, January 2012 documents: .---INDICATIONS AND USAGE-- Morphine sulfate is an opioid agonist indicated for the relief of moderate to severe acute and chronic pain where an opioid analgesic is appropriate. (1) --DOSAGE AND ADMINISTRATION-- Morphine Sulfate Tablets: 15 to 30 mg every 4 hours as needed. 5.1 Respiratory Depression Respiratory depression is the primary risk of morphine sulfate. Respiratory depression occurs more frequently in elderly or debilitated patients and in those suffering from conditions accompanied by hypoxia, hypercapnia, or upper airway obstruction, in whom even moderate therapeutic doses may significantly decrease pulmonary ventilation. Use morphine sulfate with extreme caution in patients with chronic obstructive pulmonary disease or cor pulmonale and in patients having a substantially decreased respiratory reserve (e.g., severe kyphoscoliosis), hypoxia, hypercapnia, or pre-existing respiratory depression. In such patients, even usual therapeutic doses of morphine sulfate may increase airway resistance and decrease respiratory drive to the point of apnea. Consider alternative non-opioid analgesics, and use morphine sulfate only under careful medical supervision at the lowest effective dose in such patients. 6 ADVERSE REACTIONS Serious adverse reactions associated with morphine sulfate use include: respiratory depression, apnea, and to a lesser degree, circulatory depression, respiratory arrest, shock and cardiac arrest. The common adverse reactions seen on initiation of therapy with morphine sulfate are dose-dependent and are typical opioid-related side effects. The most frequent of these include constipation, nausea, and somnolence. Other commonly observed adverse reactions include: lightheadedness, dizziness, sedation, vomiting, and sweating. The frequency of these events depends upon several factors including clinical setting, the patient ' s level of opioid tolerance, and host factors specific to the individual. Anticipate and manage these events as part of opioid analgesia therapy. https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/022207s004lbl.pdf 2.) R3's Medication Error Report dated 3/26/25 documents that at approximately 12:00PM, R3 was given 250 milligrams (mg) of Trazodone (antidepressant), instead of the 150 mg that was ordered. R3's Minimum Data Set, dated dated dated [DATE] documents R3 as cognitively intact. R3's progress notes dated 3/26/24 document that R3's Trazodone order was increased to 150mg, however the old order of 100mg was not discontinued resulting in R3 erroneously receiving 250mg instead of the ordered 150mg. On 4/3/25 at 3:00PM, R3 stated that she was told when the medication error occurred and other than sleeping really well, she felt no ill effects from the error. 3.) R4's Medication Error Report dated 3/26/25 at 5:00PM, documents that R4 was given 5 units of Novolog Insulin and 5 units of Aspart Insulin. The order was documented to give 5 units of Novolog Insulin with meals, only, but the order was documented incorrectly, resulting in the error. R4's Minimum Data Set, dated dated dated [DATE] documents that R4 is cognitively intact. On 4/3/25 at 3:05PM, R4 stated that she was told that she received the wrong amount of insulin the other day, but that her sugars had been running high, so she did not have any issues when it was given. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 4/7/25 at 2:55PM V15 Clinical Director stated that two resident identifiers should be used any time medication is being administered including date of birth and asking the full name. V15 stated, Further inservicing and education needs to be completed to insure the issue of the right patient and right order are followed for all residents by all staff.