STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145636	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charleston Rehab & Health CC	716 Eighteenth Street Charleston, IL 61920

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 20892 Based on interview and record review the facility failed to correctly identify a resident prior to administering medications resulting in a resident receiving another resident's medications. This failure affects one of 12 residents reviewed for medication administration in the sample list of 14. Findings include: The Physician Order Sheet dated October 2024 documents R1's primary diagnoses as Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure, Acute Respiratory Failure with Hypoxia, and Sepsis and R1's Hospice diagnoses as Chronic Ischemic Heart Disease, Heart Failure, and Unspecified Atrial Fibrillation. R1's BIMS (Brief Interview for Mental Status) for R1's annual assessment in October 2024 documents R1 as severely impaired with decision making skills. R1's MDS (Minimum Data Set) dated October 2024 documents R1 requires a mechanical lift for transfers to his special design wheelchair and R1 requires all activities of daily living to be completed by staff to including feeding. On 10/29/24 at 8:15 AM, the facility report titled MED ERROR was completed by V5 Registered Nurse (RN) documenting Agency nurse (V5) mistakenly gave resident (R1) medication meant for another resident (R2). The report continues to state Immediate Action taken: Vital signs were checked routinely, blood pressure dropped. Called hospice and did not hear back. Called Medical Director (V8) to explain incident and Medical Director (V8) gave order for normal saline given at 100 ml (millimeters)/hour until BP (Blood Pressure) normalized. Daughter/POA (Power of Attorney) notified as well. The report continues to state under other information: Agency Nurse (V5), second day in the facility. Two male residents with the same last name. Incident occurred in the dining room. The Section titled Statements includes a statement from V9 CNA (Certified Nursing Assistant) on 10/30/24 no time given, that documents I was in the dining room assisting with feeding residents and the Agency RN (V5) was noted to be giving (R1) thin liquids when (R1) is to receive thickened liquids. I said something to (V5) who continued to give thin liquids with medication and then (V5) stated he thought he was the other resident (R2). (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order Sheet dated October 2024 documents R2's morning medications (which were administered to R1 on 10/29/24) as Amiodarone HCL 200 mg (milligram) (Antiarrhythmic), Clopidogrel Bisulfate 75 mg (Anticoagulant), Ferrous sulfate 324mg (Iron Supplement), Hydralazine HCL 50 mg (Antihypertensive), Isosorbide Mononitrate ER 60 mg (Diuretic), Lorazepam 1 mg (Antianxiety), Pantoprazole Sodium 40 mg (Anti-reflux), Potassium Chloride ER 20 meq (milliequivalent)(Supplement), Terazosin HCL 5 mg (Antihypertensive), Valsartan 160 mg (Antihypertensive), Vancomycin 125 mg (Antibiotic) and Vitamin B12 1000 mcg (microgram). V4, RN stated in interview on 11/13/24 at 10:48 AM (R1) did not receive his own medication for 8AM (on 10/29/24). (V9, CNA) reported to me that she saw the nurse (V5) give (R1) his medications with thin liquids and (R1) is on thickened liquids. The event took place in the dining room around 8:30 AM the residents were eating their breakfast. This was (V5's) second day working at the facility. The facility has a binder that explains everything to new employees and to Agency personnel working here. This binder is located at the nurse's stations, we ask the agency staff nurses to come in early about 15 minutes to 1/2 hour before their shift starts so we can orientate them to the facility and the binder. The binder contains the policies and procedures the nurses need to follow to pass medication to the residents. All of the resident's pictures are on the Medication Administration Record so they can see who they are giving medication to. (V5) did not follow the rules for medication rights, according to our policy. R1's Electronic Blood Pressure and Pulse Summary documents on 9/15/24 R1's Blood Pressure was 110/62 millimeters of mercury (mmHg) with a Heart Rate was 52 beats per minute (BPM). The Electronic Blood Pressure and Pulse Summary documents on 10/29/24 (the day of the medication error) R1's blood pressure was 110/62 mmHg with a heart rate of 42 BPM at 8:29 AM and at 10:16 am (after the medication error) R1's blood pressure was 82/64 mmHg with a heart rate of 90 BPM. V4, RN stated in her interview on 11/13/24 at 10:48 AM, Yes R1's BP (Blood Pressure) did go down and he was also taking BP medication but it was different than what R2 was receiving. V7, Registered Pharmacist stated on 11/7/24 at 2:17 PM the medications R1 received can lower blood pressure and R1 was receiving other medications that can also lower blood pressure. V8, Medical Director confirmed on 11/7/24 at 3:40 PM the medications R1 received can lower blood pressure. V2, Director of Nurses (DON) stated on 11/6/24 at 2:30 PM Yes we realize we have a significant medication error. V1, Administrator confirmed V2's statement on 11/6/24 at 2:40 PM and said they are doing random checks to ensure the problem will not happen again. The facility Medical Errors & Adverse Events policy reviewed date 09/2022 states When medical errors or adverse resident events are identified, the facility will: Analyze the cause, implement corrective actions to prevent future events and Conduct monitoring to ensure desired outcomes are achieved and sustained. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated medication policy titled Medication Administration Policy for Senior Living states: Adherence to this Medication Administration policy is essential to ensure the well-being and safety of our residents. All staff members are expected to follow these guidelines strictly and to report any issues or deviations from the policy. Continuous improvement and open communication are encouraged to uphold best practices in medication administration. The Section of the policy titled Medication Administration documents 3. Medications should be administered according to the five rights of medication use: right resident, right drug, right time, right dose and the right route.