STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella at Clifton	1190 E 2900 North Road Clifton, IL 60927

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** 32853 Based on interview and record review the facility failed to ensure a resident's opioid pain medication was administered as prescribed to avoid a potential lethal dosage for one of three residents (R1) reviewed for significant medication errors in the sample list of three. This failure resulted in R1 receiving a dose of Narcan (opioid reversal medication) and being transported by ambulance to the emergency room for evaluation. Findings include: The facility's Medication Administration Policy with a Revised date of [DATE] documents, Medications must be administered in accordance with a physician's order, e.g. (example), the right resident, right medication, right dosage, right route and right time. Do not administer a medication if you note a change in its color, consistency, and/or odor. If a medication and/or treatment error occurs, the licensed nurse will: a. Immediately notify the attending physician, b. Describe the error and the resident's response in the Nurse's notes, c. Complete an Incident Report, d. Identify the error on the 24-Hour Report, and e. Monitor the resident's status. The facility's Medication Errors and Adverse Drug Reaction policy with a Revised date of [DATE] documents, 1. All medication, treatment errors, and drug reactions must be reported promptly. 2. The charge nurse will be responsible for generating the Medication Error report, describing the action taken. 3. A detailed account of the incident must be recorded in the resident's medical record. Documentation should be factual. R1's Medication Administration Record dated [DATE] through [DATE] documents diagnoses including Chronic Obstructive Pulmonary Disease, Dyspnea, Anxiety Disorder, Anorexia, Delirium due to known Physiological Condition, Dysphagia Oropharyngeal Phase and Dependence on Supplemental Oxygen. R1's 60-day Physician Recertification of Terminal Illness report dated [DATE] documents R1 had terminal diagnoses of Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure. This report documents R1 had worsening Dyspnea and progressing decline. This report documents R1 was certified for another six months of hospice care valid until [DATE]. The facility's Medication Error Report dated [DATE] and completed by V4 (Licensed Practical Nurse/LPN) documents on [DATE] at 4:45 AM, R1 was given 4 ml (milliliters) of Hydromorphone (Narcotic pain medication) 10 mg (milligrams)/ml instead of the 0.4 ml Hydromorphone that was ordered. As a result, R1 received 40 mg of Hydromorphone instead of 4 mg as prescribed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Actual harm Residents Affected - Few	R1's Medication Administration Record (MAR) dated [DATE] through [DATE] documents an order for Hydromorphone HCL (Hydrochloride) oral tablet 2 mg. Give 8 mg by mouth every 8 hours for pain/Dyspnea (shortness of breath) with a start date of [DATE] scheduled to be given at 12:00 AM, 8:00 AM and 4:00 PM. This MAR also documents an order for Hydromorphone HCL oral liquid 1 mg/ml, give 4 ml by mouth every four hours as needed for pain with a start date of [DATE]. R1's medical record contained a Physician's Order Form written by V12 (Hospice Registered Nurse/RN) dated [DATE] for Hydromorphone 10 mg/ml, 4 mg (0.4 ml) every four hours as needed for pain/Dyspnea. On [DATE] at 9:05 AM, V2 (Director of Nursing) confirmed there was a medication error on [DATE] for R1. V2 stated that R1 had been declining and had been receiving a large amount of Hydromorphone daily between the scheduled amount and the as needed amount. V2 stated that hospice increased the concentration of the Hydromorphone and that the night nurse was not aware that it had increased. V2 stated that they wanted to finish the previous bottle before starting the new bottle with new dose. V2 confirmed that the nurse did not look at the bottle and gave 4 mls of the 10 mg/ml Hydromorphone. V2 stated that she completed an investigation due to the medication error. V2 stated that R1 was in the hospital several days and was going to come back when he declined and passed away in the hospital. V2 stated that she completed several in-services with all of the nurses regarding the medication error and V4 received a one-day suspension. On [DATE] at 12:14 PM, V4 (LPN) stated that on [DATE] R1 had asked for a dose of his pain medication around 4:,d+[DATE]:45 AM. V4 stated that she had already given him the last dose from a bottle of Hydromorphone 1 mg/ml earlier that evening. V4 stated that she gave him 4 mls at that time and opened the new bottle this time and pulled the order up on the Electronic Medication Administration Record and it said to give 4 ml, so she automatically drew up 4 ml out of the new bottle of Hydromorphone and gave it to R1. V4 stated that when she administered it to R1 she noticed the color and mentioned that it was pink to R1 and V4 stated that R1 said that there was a change in the medication. V4 stated that V4 immediately went to look up the medication order and checked the medication bottle. V4 stated that the strength was not updated in the Electronic Medication Administration Record, but the bottle was 10 mg/ml. V4 stated she immediately notified hospice and the Physician (V5). V4 stated that hospice wanted her to monitor him. V4 stated that they started monitoring his vital signs. V4 stated that when she contacted V5 that he wanted her to give a dose of Narcan now and another in 30 minutes if needed and continue to monitor. V4 stated that V5 then decided he wanted R1 sent to the hospital to be evaluated. V4 stated that she gave R1 the Narcan and the ambulance was there before the next dose was due to be given. V4 stated that R1 remained conscious the entire time. V4 stated when the ambulance arrived R1's speech became slightly slurred but otherwise he was the same as he had been. V4 stated that she notified the Director of Nursing (V2) and then completed the Medication Error Report as directed. R1's Narcotic count sheet for the Hydromorphone 1 mg/ml is dated received on [DATE] and documents 120 mls received. The last dose documented as given was on [DATE] at 7:45 PM by V4 in the amount of 4 ml with zero doses left in the bottle. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	R1's Narcotic count sheet for the Hydromorphone 10 mg/ml is dated received on [DATE] and documents 30 mls was received. There is note written, New dose - give 0.4 mg (sic) to = (equal) 4 mg. The first and only dose given from this bottle is dated [DATE] at 4:45 AM with the amount given documented as 4 mls and 26 mls remaining in the bottle. This was signed by V4 (LPN). This resulted in R1 receiving 40 mg of Hydromorphone instead of 4 mg. On [DATE] at 10:22 AM, V13 (Hospice Director of Nursing) confirmed there was a change in the concentration of the Hydromorphone so that he did not have to take as much medication at one time. V13 stated that the hospice nurse wrote a new order for the Hydromorphone 10 mg/ml give 0.4 ml on [DATE] and stated that V12 (Hospice RN) gave the new order to the facility but did not document whom she gave the order to. V13 stated that R1 was alert and oriented at the hospital after the incident and the hospital had been working on getting him discharged back to the facility but then he declined. V13 confirmed that R1 was terminally ill, and death was an expected outcome. On [DATE] at 12:37 PM, V5 (On call Physician) on [DATE], stated that the facility nurse (V4) called hospice first and then called him. V5 stated he instructed the nurse to give R1 Narcan and to monitor his vital signs. V5 stated that he then decided they should send R1 to the emergency room for evaluation since it was such a high dose of Hydromorphone. V5 stated that R1 was stable when he spoke to the nurse the first time. V5 stated when he called the nurse back, he only told her to send R1 to the hospital, he did not get R1's condition report at that time. V5 stated that he did not have any immediate concerns with R1's condition but stated that could change rapidly. V5 stated that he could not say if the overdose of Hydromorphone contributed to R1's death. V5 stated that it was several days after the overdose before he passed away so he could not say that was the cause. On [DATE] at 2:03 PM, V10 (Hospice Pharmacist) stated that the concentration change was probably due to a condition change in the resident and with the increased concentration he would have to take less medication. V10 stated that he was probably closer to the end of life. V10 stated that as far as she could tell there was not alert placed on the bottle indicating the concentration change. V10 stated that it is up to the person preparing the medication and it is at their discretion to place an alert on the bottle. V10 stated that Hydromorphone has a fast half-life so if R1 would have died from the overdose it would have had to happen a lot sooner than it did. V10 stated that an overdose death is soon after the overdose. R1's hospital progress note dated [DATE] documents diagnosis of Acute on Chronic Hypoxic Hypercapnic Respiratory Failure Secondary to Severe Chronic Obstructive Pulmonary Disease (COPD) Exacerbation and documented R1 was currently on hospice. The hospital referral information documented possible discharge on [DATE]. R1's Death Certificate dated [DATE] documents the cause of death was Acute Hypoxic Respiratory Failure, COPD Exacerbation and Pneumonia.