STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145510	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYMPHONY OF LINCOLN PARK	**1366 WEST FULLERTON AVENUE CHICAGO, IL 60614**

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure correct administration of medications for two (R3, R5) of four residents reviewed for medication administration. This deficient practice resulted in R3's emergent transfer to a local hospital with cardiac implications that required hospitalization for close monitoring. Findings include: R3's Admission Record documents the following medical Diagnoses: [REDACTED]. R3's [DIAGNOSES REDACTED]. R3's MDS (Minimum Data Set) dated 1/15/2020 documents that R3 is severely cognitively impaired. R3 could not be interviewed. The Census List documents that R3 was admitted to the facility as 11/27/17 and indicates that R3 was transferred to a local hospital on [DATE]. R3's Progress Note dated 6/28/19 at 1:15 am and authored by V7 (Licensed Practical Nurse) reads: Resident received medication other than the medications prescribed by MD (Medical Doctor). This note documents that V8 (Physician) was called with an order to transfer resident to a local hospital for medical evaluation. A facility incident report subtitled Medication Error and dated 6/27/19 reiterates that R3 was administered the wrong medication. R3's Physician order [REDACTED]. Instead, R3 received medications that were not ordered by V8. R3's Hospital Record dated 6/28/19 documents a note authored by V12 (Hospital Cardiologist) that reads: Allergic Reaction: patient sent from NH (nursing home) due to her being given a [MED] tab around 2100 (9:00pm) which was not for her, she has a history of ([MEDICATION NAME]) allergy. This note continues to document that R3 mistakenly received [MED] 500 mg, [MEDICATION NAME]-[MEDICATION NAME] (20 mg/10 mg) and one dose of [MEDICATION NAME] 100 mg. The note reads: Brought to ER (emergency room) and admitted to telemetry for observation given the potential for QT prolongation. Concern was raised about the interaction between the [MEDICATION NAME] and the [MEDICATION NAME]. R3's hospital note documented: EKG's were suggestive of significant prolongation of the QT interval. For this reason a cardiology consultation was obtained and (R3) was observed an extra day. According to R3's history, the EKG from 6/28/19 had changes when compared to an EKG dated 10/17/2012. The hospital plan was to continue cardiac management, monitor blood pressure closely, continue telemetry monitoring and repeat EKG's every six hours. It was noted that the [MEDICATION NAME]/[MEDICATION NAME] and [MED] medications that were mistakenly given to R3 were ordered to be administered to R5. R5's POS documented an order dated 12/21/18 which read, Give [MED] 500 mg every 12 hours indefinitely for suppression due to infected prosthesis. This POS also documents [REDACTED]. V8 (Medical Doctor/R3's Primary Doctor) was not available for interview. On 3/10/2020 at 11:10am, V9 (Cardiologist) stated, The combination of [MEDICATION NAME] and [MEDICATION NAME] ([MEDICATION NAME]/[MEDICATION NAME]), especially when given with antibiotics, can cause QT wave to be prolonged. It is an adverse reaction. It requires monitoring of the QT wave by EKG. If QT prolonged, it can lead to an arrhythmia or an abnormal heart rhythm. On 3/11/2020 at 1:26 pm, V13 (Pharmacy Manager) stated, Cardiac implication with [MEDICATION NAME] and [MEDICATION NAME] and [MED] when given in combination. QT prolongation between [MEDICATION NAME] and [MEDICATION NAME] can cause a severe interaction. If this is a brand new combination (of medications) for a resident, it would put a resident at a higher risk versus someone that's been on the medications for number of years. Also if brand new meds for patient, would let facility know to monitor QT status. A facility policy dated May 27, 2011 and titled, 8 rights of medication administration documents: 1. Right patient - Check the name on the order and the patient. Use 2 identifiers. Ask patient to identify himself/herself. 2. Right medication - Check the medication label. Check the order 3. Right dose A facility policy dated 7/14 and titled, Medication Administration documents: GENERAL: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. GUIDELINE: 1. An order is required for administration of all medications. 5. Check Medication Administration Record [REDACTED]. 15. Identify resident using two resident identifiers.

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

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.