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	ASL510324	A. BUILDING: _____ B. WING _____	C 08/22/2025

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AUBERGE AT NAPERVILLE	1936 BROOKDALE ROAD NAPERVILLE, IL 60563

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A 000	Initial Comment Facility Reported Incident Survey Conducted: #IL196958 Type 1 Violation: Section 295.6000 a) 5) Resident Rights	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes. This requirement is not met as evidenced by: Based on interview, and record review, the establishment failed to ensure measures are in place to prevent an incorrect dosage of medication from being given to a resident. They also failed to ensure their licensed professionals/nurses follow their Medication Service Plan regarding administering medication	A6000		

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as ordered by the physician. This failure creates a substantial probability of severe harm to a resident or residents.

These failures contributed to a resident (R1) being given an excessive dosage of a prescribed medication (Vitamin D3) for a period of time. This resulted in the resident's lethargic condition, and hospitalization with diagnosis of Vitamin D toxicity at 228.8 ng/ml level.

This applies to 1 (R1) resident reviewed for facility reported incident of Medication Administration error.

The findings include:

R1 is an 89-year-old female resident admitted to the establishment on April 26, 2025 with diagnoses of essential (primary) HTN; presence of cardiac pacemaker; dementia in other diseases classified elsewhere, unspecified severity; major depressive disorder, recurrent, mild; past medical history of Alzheimer's dementia, breast cancer, atrial fibrillation, anxiety, hypertension, complete heart block s/p PPM.

On August 22, 2025 at 10:00 AM, E1 (Executive Director-ED) said R1 has been a resident in this memory care unit since April of this year. E1 confirmed a medication error happened this month involving R1. E1 explained the error was discovered by their nurse. The nurse noticed the medicine was in a different color. She noticed it because she is also taking the same medicine the resident has been taking. E1 added the establishment underwent a pharmacy change under their new management company. The mistake happened under the new pharmacy. The

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wrong dose of Vitamin D3 was given at 50,000 units daily instead of 5,000 units daily because the wrong dose of Vitamin D3 was sent in the medicine packet that came from the pharmacy. E1 explained the resident's daughter noticed her to be more lethargic the past days prior to her hospitalization. However, due to her current medical condition of having cognitive issues, they could not really determine if her lethargy was just part of her disease process and natural decline.

During a tour of the establishment with E1 (ED) on August 22, 2025 at 10:36 AM, R1 was observed asleep in her room. She was able to answer questions even with her eyes closed. E1 reminded her she will be picked up by her family to have lunch out. R1 was already dressed and looked ready for the excursion. R1 expressed agreement and delight with the idea. E1 explained R1 will usually take a nap after breakfast and wakes up to get ready for lunch.

Around lunchtime, R1 was up and waiting to be picked up for her lunch out with her family. She was sitting in her wheelchair waiting by the area near the information counter. R1 looked awake, alert, and in great spirit. She was responsive and answered the usual questions and pleasantries with enthusiasm.

The establishment's Incident Report to the Department dated August 12, 2025 showed, "The morning nurse noted that the usual dosage for the Vitamin D3 was different from the previous dosage. MD was immediately notified of the medication error and ordered to discontinue the Vitamin D3 immediately and to have blood drawn for CBC, CMP, TSH, and Vit D level. On August 13, 2025, the phlebotomist came early morning, and results were received around 10AM. Vitamin

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D level was 228.8. MD was in the building to assess the resident. Upon consultation with an endocrinologist, MD ordered to send resident to ER for Vitamin D toxicity and to have IV fluids, EKG, and have blood drawn every 6 hours. On August 14, 2025, the resident was cleared by the kidney doctor and was discharged after one night stay at the hospital. Vitamin D level on discharge was 205.5. PCP ordered CMP and Vitamin D level check for August 18, 2025, but lab technician comes into the building on Wednesday and Saturday only. On August 15, 2025, pharmacy consultant came to the community to check inventory of all current medication orders. On August 20, 2025, blood was drawn, and the Vitamin D level was 206.6 Other order was BMP on August 27, 2025, vitamin D level x2 weeks. Resident was visited by the APN. The resident continued to ambulate independently with a rollator to the dining room for all meals. No weakness or discomfort reported at this time."

The establishment's Progress Notes for R1 corroborated the details in the incident report related to the medication error.

MD ordered Vitamin D discontinued on August 12, 2025.

The establishment's record of R1's Vitamin D result (prior to the incident) collected and verified May 3, 2025 was at 93.4 level (Reference range 30.0 - 100.0 ng/ml).

The establishment's record of R1's Vitamin D result (after the incident) collected and verified August 13, 2025 was 228.8 level (reference range 30.0 - 100.0 ng/ml).

The establishment's Physician Assessment Form

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for R1 signed and dated April 2, 2025 and used as part of her admission documents showed and listed an order of Natural Vitamin D3 125 mcg (5,000 UT) oral tab under her Current Outpatient Medication list. The order showed take 1 tablet (5,000 units total) by mouth daily.

The establishment's Service Plan for R1 signed and dated July 7, 2025 showed, "Medication category - Goal: Resident will maintain and/or maximize current level of functioning with medication; Action: Partial Assist; Licensed nurse will administer all medication as prescribed."

The hospital's History and Physical dated August 13, 2025 under History of Present Illness showed, "(Patient) is an 89-year-old female with past medical history of Alzheimer's dementia, breast cancer, a-fib, anxiety, hypertension, complete heart block s/p PPM who presents ED for abnormal labs. Patient has had decreased appetite, constipation, weakness, nausea, worsening confusion compared to baseline dementia. Patient's daughter reports she noticed that patient was getting wrong dose of Vitamin D since June 18. She was supposed to take 5000 units daily, but pharmacy gave her 50,000 units daily. Patient's PCP sent lab work and patient's vitamin D level came back elevated at 228.8 She was told to come to ER for further evaluation."

The hospital's initial encounter diagnosis was Poisoning by Vitamin D, accidental or unintentional.

On August 22, 2025 at 2:00 PM, E2 (Health Services Director-HSD) said they did an in-service and training for all nurses as a corrective action to prevent this incident from happening again. E2 explained they identified the

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breakdown in the system. Although this is a pharmacy error, the nursing staff members would have been able to help prevent the wrong dosage from being given to the resident by double checking the delivered medicines, not just against the medication profiled in Yardi, but also against the actual medication order from the physician. The medication should have been verified in all three areas (delivered medicine, Yardi profile, and actual physician order). E2 (HSD) added they changed/updated the system of verification after this incident. E2 acknowledged the wrong dosage of medication was discovered after 55 days of administration. Upon their investigation of the physician order review, Vitamin D3 5,000 units was ordered. However, pharmacy profiled the order under a different drug name (Daily Vite with Vitamin D3 50,000 units) instead of Vitamin D3 5,000 units. The prevention measure coming from the nursing side is the verification aspect of the medication delivery.

The establishment's In-Service document dated August 12, 2025 showed, "Verification: All new medication orders shall be written in 24H report and charted on the day it was received, preferably immediately, as soon as you receive the order. When verifying a medication, refer to the 24H report making sure you approve the right dosage and the right medication. For the day shift, check your dashboard to see if there is a new medication that needs verification. Verify before you leave your shift. If the order is not available before the end of your shift, make sure the nurse taking over is aware of following up and verify the new orders when they become available ...Match the drug name, strength, frequency, form, and instructions with the original order as written on the POS. The pharmacy does not accept telephone orders. The prescriber e-scripts the

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A6000	Continued From page 6 order directly to the pharmacy. However, the nurse receiving the order will write the order to the POS (Provider by PharMerica) and place it on the prescriber's binder for signature during weekly visits."	A6000		