STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

PINE TERRACE — Facility Name

0043299 — I.D. Number

2017 NORTH PINE STREET, WAUKEGAN, IL 60085 — Address

Date of Survey: 07/01/2004

Incident Report Investigation of APRIL 7, 2004

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

350.1210b) The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:
Nursing services to provide immediate supervision of the health needs of each resident by a registered nurse or a licensed practical nurse, or the equivalent.

350.1220j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety, or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.

350.1230c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel.

These REGULATIONS are not met as evidenced by:

Based on interviews, record review, and review of the hospital record, the facility neglected to provide health care services in accordance with his needs to one individual (R1) who required emergency hospitalization (04/01/04) and expired (04/07/04) after exhibiting signs and symptoms of serious illness for more than two weeks.

The facility failed to:

1. Verify, monitor, document, and notify medical personnel when R1 reported he was having pain, difficulty swallowing, and vomiting.

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2. Provide non-medical staff with training to assist them in recognizing information contained in incident reports and laboratory (lab) results, for example, that should be referred to medical personnel in a timely fashion.

3. Have a system in place with the lab that services them that clarifies to both facility and lab:

a. The method of notification, and who specifically will be notified, of lab work results.

b. The process for prompt notification of "panic" (highly abnormal) labs that require immediate medical intervention and/or notification of medical personnel.

c. The method to be used for identifying lab work that has been completed as ordered versus that which has only been partially completed.

Findings include:

(*Note: Increased thirst, increased urination, and unexplained weight loss are often seen as early signs and symptoms of diabetes per MOSBY'S clinical nursing 3rd edition -1993)

According to his Individual Program Plan (IPP) of 10/16/03:
R1 was a 31-year old male diagnosed as having mild mental retardation, Klippel Feil Syndrome, allergic rhinitis, and bipolar disorder. (Additionally, his Physician's Order Sheet [POS] of 02/26/04 to 03/24/04 includes the diagnosis of hypertension). R1 was ambulatory and verbal ("communicates in easily understood language"). R1 was described as "...very high functioning in his ADL's (activities of daily living)...capable of managing money, can cook and clean...(and) learning advanced work skills..." The IPP states that the nurse found him to be obese, that he had gained 16 pounds in the past year on a "no seconds diet", and in need of exercise." He was monitored for sexual inappropriateness, verbal aggression, and false complaints.. He took "...Depakene for anxiety and depression." He was also taking Buspar 30 mg. daily. An allergy to Trileptal is indicated. His parents are listed as his legal guardians.

According to information faxed by the facility to the surveyor on 06/24/04, during the 6 month period of 10/03 - 03/04, R1 had a total of 6 documented incidents of making false complaints. The information reads as follows: Oct. '03-1 incident; Nov. '03-1 incident; Dec. '03-0 making false complaints indicated; Jan. '04 - 3 incidents; Feb. '04 - 1 incident; and Mar. '04 - "no documented targeted behaviors."

Per review of accident/incident reports, on April 1, 2004 at approximately 5:00 P.M., R1 was taken via ambulance to a local hospital due to vomiting, incoherence, and being unresponsive to staff. R1 was admitted to the hospital with a "very high" blood sugar ..."suffering from Diabetes." A written notification of April 8, 2004 to the Illinois Department of Public Health (IDPH) Regional Office states that R1 expired at the hospital on April 7, 2004. The cause of death is stated as being acute pancreatitis, acute diabetes and renal failure.

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1. The facility failed to verify, monitor, document, and report to medical personnel claims made by R1 that he was having pain, difficulty swallowing, and vomiting. A review of 03/04 and 04/04 employee schedules revealed E3 (direct care staff) was working the afternoon shift on 04/01/04. Per interview of E3 on 06/03/04, she verified that she was working (3:30 P.M.- 11:30 P.M.) at the facility when R1 was transferred by ambulance to a local hospital on 04/01/04. She stated that facility staff had picked him up from the local workshop he attended as he had reportedly missed the van that generally brings him and others back to the facility from the workshop. E3 said that R1 returned home at about 4:05 P.M., sat down, and said he was not feeling good. He said he was vomiting, and she observed him to vomit twice (brown in color) after he got home. E3 said she paged Z1; then paged her again about 30 minutes later as she had not responded to the first page. After speaking with the nurse, E3 stated she walked R1 to the facility van to take him to the hospital, but R1 said he couldn't lift his leg (to get in). "He kept saying he didn't feel good." E4, direct care staff, who was also working at the time, called "911". When the paramedics arrived, E4 went with R1 in the ambulance to the hospital. E3 went on to say that R1 had complained about having a loose bowel movement and vomiting for about the last week of March. There is no documented evidence that the facility contacted the nurse/physician regarding this. As to how R1 appeared to her on 04/01/04, E3 stated he "may have been walking a little slower, looked in his eyes like he was not feeling good."

E5, direct care staff, was interviewed on 06/03/04. He said he had received a phone call from Z2 around "noon-ish" on 04/01/04. E5 said that initially Z2 "sounded like she couldn't find him" (R1) at the workshop; like he was missing. E5 said Z2 told him that R1"didn't want to move, couldn't walk." E5 stated he thought "it was probably his (R1) knee"; saying that he had complained about that before. E5 said that Z2 "definitely" mentioned "no symptoms" that R1 was having such as forced coughing, vomiting, or diarrhea .

E5 accompanied R1 to the physician's appointments in 3/04. During the interview, E5 stated that R1 had complained of back pain off and on since early or mid-March. E5 said he remembered taking R1 to his physician's office in March due to this complaint and also because R1 "kept urinating on himself; couldn't control it." E5 said that R1's being incontinent of his urine was "new." E5 went on to say that the physician took a urine specimen, ordered some urine tests, and told R1 that he couldn't see any problem. He did tell R1 that "a lot was due to his weight" that he needed to lose. E5 said he had observed R1 from about 6:15 or
6:30 A.M. until about 8:30 A.M. on 04/01/04 as he had worked the night shift. He said R1 ate breakfast that morning. When asked if R1 had complained of vomiting the morning of 04/01/04, E5 said R1 reported vomiting more to the 2nd shift (evenings).

Per an interview with Z8 on 06/18/04, she stated R2 told her that on the morning of 04/01/04, "they (staff) had to keep waking him (R1) up."

File review revealed R1 had been seen at his physician's office twice in March--on 03/08/04 and 03/23/04. E5 was again interviewed on 06/16/04. He said he believed he had taken R1 to both of these 03/04 physician appointments. When asked if he had reported any vomiting, diarrhea, or pain that R1 had been experiencing or complaining about to the physician, E5 stated that he was "positive" R1 had told the physician of not feeling

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so well, that he couldn't swallow, and that his food keeps coming back up. As to notifying E1 (Qualified Mental Retardation Professional - QMRP), he said he "thinks" he told E1. As to notifying Z1, E5 stated he "might have, pretty sure..." As to any complaints R1 may have had the morning of 04/01/04, E5 stated "not to my knowledge."

File review of progress notes reveals two dates in March, 2004 (03/29/04 and 03/31/04) when documentation by direct care staff was made regarding R1. A progress note dated 03/29/04 bearing the initials of E5 reads that during breakfast that day, E5 observed R1 "...eating peculiarly." The note states that "(R1) was taking bites of food, holding it in his mouth, while drinking large amounts of fluids (milk) then (trying) to swallow them both without chewing, thus (purposely) making himself gag. He ran to the washroom and began to throw-up knowing that he doesn't know I saw him. I asked him what was wrong, he replied, "I was just sitting here, I took a bite of the bread (toast) and all of a sudden I had to throw-up." The two progress notes dated 03/31/04 bear the initials of E4. The first reads, "At 3:30 P.M. (R1) was walking from the kitchen and he turned to his right and threw-up in the garbage can." The second reads, "@ 8:45 (R1) threw-up again (there) was no (mucous) (visible). None of these three progress notes document that notification was made to E1, the nurse consultant, the physician, or E2 (assistant administrator). No other documentation by direct care staff was noted in R1's file for the month of March, 2004.

Per file review, E1's monthly QMRP note for R1 for March 2004 is dated 04/04/04. In this report, E1 states that, "(R1) was not able to tell the doctor why he was continuing to throw up..." He also writes that, "(R1) seemed to have trouble keeping food down during this month and had made two visits to his doctor. Staff tried to substitute foods for him that would ease his swallowing and digestion processes. Staff continue to monitor the types of foods that are making (R1) vomit and relay that information to the doctor." E1 also writes that, "There were reports by staff at home and at DT (day training) that he was (R1) telling staff that he had vomited; but when staff went to observe the discharge in the toilets, (R1) had responded that he had flushed the toilet." E1 notes, "It had been reported by the DT that (R1) was having some behavioral issues regarding forcing himself to vomit. (R1) did indicate that he was having problems with vomiting at the workshop as well." Regarding activities, E1 indicates that "(R1) participated in and enjoyed in as many activities as he felt capable of taking part in this month but, due to him not feeling well, his participation was limited."

There is no documentation by the QMRP of any instructions given to staff in monitoring R1's alleged vomiting to verify whether R1's vomiting is due to medical or behavioral reasons.

E1 was interviewed on 06/16/04. During this interview, E1 stated that during the last two weeks or month of R1's life, he complained about throwing up; "talked about it all the time. "When asked if he had informed the nurse consultant about the vomiting, he stated, "I'm sure we (the nurse and I) would have talked about this when she came in." As to documenting that notification, E1 said he did not write it down if he did speak with the nurse about the vomiting. As to notification to the physician, E1 stated that, "(R1) was not one to hold back. He would have told the doctor." E1 added that he thought R1 saw the doctor twice in March 2004.

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Per file review, the nurse consultant wrote two progress notes in March regarding R1--on 03/08/04 and on 03/23/04. The note of 03/08/04 speaks of the physician visit due to R1's "constant urination, incontinence (incontinence)." The entry of 03/23/04 refers to abnormal labs from 03/19/04 being faxed to the physician. Neither entry documents notification to the physician about R1's complaints of vomiting, difficulty swallowing, and/or pain.

Z1 was interviewed on 06/03/04, 06/16/04, and 06/17/04. She stated on 06/16/04 that she does recall R1 seeing the doctor because of vomiting. She said she was unable to remember exactly when that was, but she believes he was diagnosed as having gastroenteritis. She said she recalls hearing that people at workshop thought he was "faking" the emesis. On 06/17/04, she said that the information she received about R1 possibly vomiting "was not reliable. There were no facts or evidence. It was a he said, she said "She stated R1 "sometimes lied or exaggerated." The facility had no documentation to show that R1's "vomiting" was verified whether it was medical or behavioral in nature. As to being notified that he actually did vomit, she said she was told by staff on 04/01/04 about his vomiting on 03/31/04 and 04/01/04.

E2 was interviewed on 06/17/04 and 06/21/04. He stated he does not recall anyone notifying him about R1 vomiting.

Z7 was interviewed on 06/16/04 and 06/24/04. During both interviews he stated that he "cannot remember" anyone reporting R1's vomiting to him prior to 04/01/04.

On the consultation report and/or medical history/physical exam form from R1's 03/08/04 appointment with the physician, no mention of vomiting or difficulty swallowing is noted. "Consistent back pain" is stated as part of the "reason for consultation" on the consultation report. "Constant urination, can't control bladder, and an increase in frequency" are documented on one or the other of these reports. The diagnosis is indicated as being "acute cystitis." The 03/23/04 appointment refers to R1 having a "sore throat & cough" and gives a diagnosis of "URI" (upper respiratory infection) on the medical history/physical exam. A notation of "see labs--attached" is stated on this same report. No consultation report was noted for 03/23/04. The nurse consultant said she was unable to find the report on 06/17/04.

Per interview with Z8 on 06/18/04, she said that R1 had complained of vomiting for about a week before his hospitalization on 04/01/04. She stated he told her he'd try to eat and throw up. She also said he had complained that his side (she could not recall whether it was his right or left) was "really hurting when he laid down." She said one staff (who is no longer working at the facility) told her that (R1) would come to her and cry and say, "I wish my side would quit hurting." Z8 said she had talked with Z7 "the Saturday before 04/01/04" (03/27/04) and told him (of the vomiting), and that (R1) "kept spitting up every time he went to eat or drink." She stated that Z7 told her to have the facility make an appointment for R1 to see him on Monday (03/29/04), and that she related that to facility staff (E5). There is no documented evidence that the facility followed up regarding this.

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The facility's monthly weight chart for R1 shows a 20 lb. weight loss from February to March 2004. The hospital emergency department's "initial data base" of 04/01/04 lists R1's chief complaint as "vomiting x 1 wk" (times 1 week), 30# wt. loss." This form also indicates R1's complaining of weakness, (increased) thirst, and (increased) urination. The hospital record (04/01/04 - 04/07/04) reveals a consultation with Z5 on 04/02/04 which shows R1 to have been admitted, in part, due to a blood sugar of 1,440 (reference range: 65-110).

2. The facility failed to provide training to non-medical staff in identifying information received in reports that may necessitate immediate medical attention.

Incident reports pertaining to R1 were reviewed at the facility and at the work and training center (DT) he attended. Five incidents were noted to have occurred at DT during March, 2004. On 06/16/04, E1 was interviewed regarding these incidents:

Per incident report of :

03/09/04 @ 12:30 P.M.-R1 reported chest pain. R1 said he was much better at 12:55 P.M. E1 was notified in person at 1:05 P.M., followed by a "copy" at 2:30 P.M. E1 stated he "remembers going there about something like this." As to documenting this incident, he stated he "may have."

03/15/04 @ 12:55 P.M.-R1 "...vomited approximately 2 cups of chunky vomitus." E1 was notified by phone at 12:58 P.M., followed by a "copy" at 2:30 P.M. According to the report, "(E1) did not have available staff to come get (R1) as he was requesting to go home. (R1) was allowed to rest instead of engag(ing) in production." E1 stated he "does not really recall" this incident.

03/18/04 @ 12:20 P.M.-R1 was observed by DT staff to have "...red fluid on his chin, shirt and the floor in front of him [appeared about 3/4 cup]. There was also some on the pant leg of a female consumer sitting next to him. (R1) told me [I threw up]." The report indicates R1 returned to work. There is no documentation as to "persons notified." E1 said he "does not recall" the incident.

03/23/04 @ 12:15 P.M.-R1 was observed by DT staff, as the staff poured R1 a cup of water, that, "...in addition to his usual lunch, he had 4 boxes of apple juice and a bottle of (a liquid supplement)...(R1) chose to drink all of his juice anyway." E1 was notified by phone at 1:30 P.M., followed by a "copy" at 2:30 P.M. E1 stated he "kind of remembers about the (liquid supplement). Almost every day clients take juice in empty (liquid supplement) bottles."

03/30/04 @ 12:40 P.M.-R1 reported to DT staff that he had vomited in the mens' restroom. The report further states that "the vomit was a dark color and all liquid." It further reads that "this was the third time today he had vomited, he told staff. The times were 9:10 A.M., 10:00 A.M., and after lunch at 12:40 P.M." E1 was notified by phone at 2:00 P.M., followed by "mail" at 2:30 P.M. on 03/30/04. According to the report, R1 returned to work after each incident. E1 stated he "remembers getting faxes around this time from (DT) but not certain" about receiving this (particular) one.

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During the interview with E1 on 06/16/04, he described the usual procedure of receiving written incidents from DT as either being faxed or sent via a resident when they return from that DT at the end of the day.

(Per fax on 06/29/04, E1 confirmed the facility had received the aforementioned five incident reports from DT.) He went on to say that he does read the (workshop) incident reports and then places (them) in a binder. If (there was a) reoccurring problem, (he) would call the nurse or make a doctor appointment. He said, "Remember, (R1 was) sent to the doctor twice in March." He further stated "I'm sure we (Z1 and I) would have talked about this when she came in." As to documentation, E1 stated he did not write it down if he did speak with Z1. As previously mentioned, Z7 stated he "cannot remember" anyone telling him about R1 vomiting.. Z1 stated she was notified on 04/01/04 of R1 vomiting on 03/31/04 and 04/01/04.

Per review of R1's record, a laboratory report dated 03/19/04 was noted to have been faxed to the facility at "18:37" (6:37 P.M.). According to R1's POS of 02/26/04 - 03/24/04 and prior lab reports, a blood "glucose" should have been included in this report but was not. R1's alkaline phosphate was indicated as being high @ 175 (the expected range is given as 39 - 117). Also noticeably low were his sodium @ 119 (expected range 133 -149) and his chloride @ 76 (expected range 96 -113). Somewhat high were his potassium @ 5.4 (expected range 3.5 - 5.3) and his CO_2-Bicarb @ 33 (expected range 21 - 31).

When interviewed on 06/16/04, E1 said that he is the person who normally gets the faxes in the morning. He said he "scans them " (faxed lab results, for example) and calls Z1 if he "really notices highs or lows in the results." He added that he "would" call the nurse, but that he has not done that (called her) since he took over the RSD/QMRP position at this facility (sometime last fall). When asked if he had received training/in-servicing in what he should be looking for in the lab results, E1 said the he could not recall any formal training. He said that he and Z1 discussed some things. In response to the surveyor requesting to see "anything in writing" that would show that he and/or others have been trained, the facility faxed a response stating there was "no evidence of training regarding lab results present."

3. The facility failed to ensure they have a system in place that identifies who will receive laboratory (lab) reports, how prompt notification of abnormal results will be assured, and the method to be employed to identify lab results that are completed from those that have some results pending.

Per review of R1's record, as stated above, a laboratory report dated 03/19/04 was noted to have been faxed to the facility at "18:37" (6:37 P.M.). According to R1's POS of 02/26/04 - 03/24/04 and prior lab reports, a blood "glucose" should have been included in this report but was not. At the bottom left, this report was identified as being a "CHART copy." Some previous lab reports were noted to be a "CHART copy" while others were indicated to be a "FINAL CHART copy." An interview with Z4 on 06/15/04 clarified the difference. Z4 said that "FINAL CHART copy" indicates that ALL the results of lab tests ordered are being reported. "CHART copy" indicates that NOT ALL the results are being reported at the time (some results are pending). During this interview, Z4 stated that on 03/19/04 @ 8:21 P.M. the "FINAL CHART copy" was faxed to the facility with R1's glucose being High at "899" (expected range 60 - 115). Regarding further questions about this lab report, Z4 stated the surveyor would need to speak with Z3.

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Z3 was interviewed 3 times on 06/16/04. During these interviews, she stated that the "Final" was faxed to the facility on 03/19/04 at 8:21 P.M., and that it reported R1's glucose as being "899." Z3 said that this same report was re-faxed to E1 on 06/15/04 at 7:35 P.M. When asked about the lab's method of notification and to whom copies of the lab reports were sent, Z3 stated that the lab reports are faxed "just to the facility, not to the doctor." As to there being a "back-up system" to assure the facility has been notified of significant/abnormal lab results, Z3 said there is no such system in place. Z3 said that Z6 was the person who handled this lab report on 03/19/04. Z3 also told the surveyor that she does not have a copy of a contract with the facility.

Z6 was interviewed on 06/16/04 and 06/17/04. During these interviews she said that on 03/19/04, she called the facility "several times" but no one answered. She stated she had worked from 5:30 P.M. (03/19) until
2:00 A.M. (03/20/04). She also said she had trouble at first with faxing the lab results, but that at 8:21 P.M. the fax went through to the facility. When asked about verification of the fax being transmitted, she said she would "try to bring it up; but that (that information is usually deleted when the month ends). On 06/17/04, Z6 said she was unable to retrieve a fax verification. She stated that she recalls looking at the fax log and seeing that the transmission went through at 8:21 P.M. She said she would be willing to testify that the fax went through in a hearing or in court.

E1 was interviewed on 06/16/04, and said that the faxes from the lab come in on the machine located in his office. He said that his office is locked when he is not working (usually evenings, nights, and week-ends) and that E2, E9 (RSD/QMRP), and Z1 have keys to his office. When asked about faxes that may come in during his off-hours, he stated that they would be reviewed "the next morning" for example. He said that he is usually the one who receives the faxes. When asked about R1's lab report of 03/19/04 that showed his glucose to be "899," he said that he "can't say he remembers this specific one; so many come in." He did say that he was the one providing week-end coverage on 03/20 and 03/21/04 for the facility and for the other nearby three facilities. E1 said when he is providing week-end coverage that he usually begins his day at this facility, where his office is. He stated that sometimes things may be going on at one of the other houses, and it is possible that he may not visit each of the four homes. E1 said that it was his understanding that the physician gets a copy of lab results from the lab.

Z1, during interviews on 06/03/04, 06/16/04 and 06/17/04, stated that the physician gets a copy of the lab results from the lab. She also said she did not understand "Chart copy" to indicate that not all the results of the ordered lab tests are in, nor did she realize that "FINAL CHART copy" means that all the results have now been reported. She said that she did not receive the "FINAL CHART copy" of 03/19/04 for R1. She did not follow-up on the missing glucose.

(A)