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

CARDINAL HEALTH CARE — 0046672

Facility Name — I.D. Number

210 EAST COLLEGE, ENERGY, ILLINOIS 62933
Address

Date of Survey: 04/23/2004

ANNUAL FOLLOW-UP

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):

350.620a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

350.1210b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.

350.1230d)2)3 Direct care personnel shall be trained in, but are not limited to, the following:
Basic skills required to meet the health needs and problems of the residents.
First aid for accident or illness.

350.3240a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Sections 2-107 of the Act)

Based on observation, interview and file review, the facility has failed to provide each client with nursing services in accordance with their needs as evidenced by:

1) Nursing staff failed to notify the physician of a significant reduction in seizure medication; failed to contact the physician by phone or through his answering service after the client had a seizure lasting over three minutes; and failed to implement and train nursing and direct care staff on the facility's policies and procedures for seizure emergencies, for one client (R12) who expired at a local hospital on 02/02/04 from respiratory failure as a result of aspiration from complications related to seizure activity; and

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2) Nursing staff failed to notify the physician and dentist and seek additional treatment for relief of pain and infection for one client in the sample (R9) who was seen on 02/24/04 at an after hours clinic for swelling of the jaw due to a tooth infection and who was placed on an antibiotic and medication for pain. No further documented action was taken by the facility for the relief of R9's pain and infection until brought to the attention of staff by the surveyor on 04/06/04, even though R9 took the last dose of his antibiotic on 03/05/04 and had not had his infected tooth removed.

Findings include:

1) Per review of the State of Illinois Medical Certificate of Death, R12 was a 60-year-old male who died on 02/02/04 at 4:40 p.m. at a local hospital. The immediate cause of death was identified as "Respiratory Failure" due to, or as a consequence of "Aspiration". Other significant conditions identified were that of Mental Retardation and Seizure Disorder.

a) Nursing staff failed to notify the physician of a significant reduction in seizure medication.

Per file review, R12 was admitted to a local hospital on 01/31/04 due to continued seizure activity. Per review of R12's Nurse's Notes for January 2004, nursing documentation identified that R12 had an upper respiratory infection on 01/12/04. Continued documentation noted that on 01/14/04 at 10:20 a.m. R12 had a two and a half minute seizure. Documentation for this date noted complaints of chest pain(s) and general discomfort. R12 was sent to the emergency room via ambulance at 3:00 p.m. R12 returned from the emergency room with new orders for Dilantin (seizure medication) 200 milligrams twice daily, and orders for Levaquin (antibiotic) 50 mg., Tussinex Suspension 10 milligrams/5 cc (cubic centimeters)
1 teaspoon with Robitussin Plain two teaspoons PRN (as needed), and Xopenex 0.633 with Atrovent (nebulizer treatment) every six hours PRN (as needed). Review of R12's Physician Order Sheet dated January 2004, identified that R12's new Dilantin order (200 mg. BID) was a 200 milligram reduction (per day) from his previous orders for Dilantin 300 mg. BID. No documentation was noted within the Nurse's Notes to identify that R12's physician (Z1) was notified of the 200 mg. reduction of Dilantin.

Telephone interview with Z1 (Physician) on 04/09/04 at 9:23 a.m., Z1 stated that he was not aware of the
200 mg. reduction (per day) in R12's Dilantin dosage. Z1 stated that he does not receive the emergency room reports and would have expected the facility to notify him of the Dilantin reduction, as with any other changes in physician's orders. During this interview, Z1 confirmed that the 200 mg reduction in Dilantin medication (per day) was a "significant change" and would have had an impact on R12's medical condition.

Per telephone interview with Z3 (Facility's Pharmacist from a local pharmacy) on 04/20/04 at 9:20 a.m., Z3 confirmed that a 200 mg. reduction in Dilantin was "significant". Z3 stated that as based on the medication's half life, you generally would expect to see changes in the resident's condition within seven to ten days after the reduction in the Dilantin dosage. Per telephone interview with Z4 (Facility's Consultant Pharmacist) on 04/20/04 at 10:00 a.m., Z4 also confirmed that a 200 mg. reduction in Dilantin was significant and would have an impact on the resident's condition. During

this interview, the facility should have notified the physician of the significant reduction in R12's Dilantin dosage. Z4 stated that

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On 01/20/04, R12 had Dilantin levels drawn, with the result being 8.2 (therapeutic range is 10.0 - 20.0). The lab report was faxed to Z1 on 01/20/04 with nursing documentation that identified "Current Dilantin Dose
200 mg. BID". Z1 documented on the lab report, "Cont (continue) same with (symbol for "with" used) level in one (symbol for "one" used) mo (month). Per telephone interview with Z1 (Physician) on 04/08/04 at
2:30 p.m., Z1 stated that he was not aware that R12's Dilantin dosage had been reduced to 200 mg. BID. Z1 stated that when he reviewed the lab report of 01/20/04, he was under the impression that the 200 mg. BID was R12's regular dosage, unaware that the Dilantin dosage had been reduced from 300 mg. BID.

Review of the Nurse's Notes from 01/14/04 to 01/30/04 did not identify that additional monitoring systems were put into place to monitor R12 for any further seizure activity after the reduction of his Dilantin. Per record review, no nursing plan of care was developed after 01/14/04 to address R12's seizure activity.

b) Nursing staff failed to contact the physician by phone or through his answering service after the client had a seizure lasting over three minutes.

Further review of R12's Nurse's Notes identified that sixteen days after R12's Dilantin was reduced daily by 200 mg., R12 experienced another seizure on 01/30/04 which lasted over three minutes and fifteen seconds when discovered by direct care staff after R12 was heard crying in his room. Nursing documentation identified, "1:30 a.m. Res (resident) was heard by CNA (Certified Nursing Assistant) to be crying, CNA went into room and found resident having a seizure while lying in bed. Res HOB (head of bed) elevated (symbol for "elevated" used), seizure was 3 min. (minutes) 15 sec (seconds) long with (symbol for "with" used) tonic stiffening and jerking movements. Res facial expression had blank stare, skin hot, dry. Res was grunting and (symbol for "and" used) breathing heavy during seizure. Gagged x (times) 2 at end of seizure. No (symbol for "no" used) emesis. Res. was unable to answer questions 1 min. after seizure, Incontinent during seizure... Z1 faxed at 1:25 a.m. with (symbol for "with" used) info (information) regarding seizure. Notified ADON (E1) of situation." Further nursing entries were made at 2:10 a.m., 2:35 a.m., and 5:00 a.m. No documentation was found in the nursing notes that identified that the physician (Z1) had responded to the fax sent to his office at 1:25 a.m. No documentation was found that identified that nursing staff had attempted to re-contact the physician by telephone or through Z1's answering service after the physician did not respond.

Per telephone interview with Z1 (Physician) on 04/08/04 at 2:30 p.m., Z1 stated that there is no one at his office at 1:25 a.m. if the facility faxes any information to him at that time of the morning. Z1 stated that the facility should have called his answering service or called his home phone number to inform him on R12's seizure activity lasting over three minutes, rather than faxing his office.

Further review of nursing documentation for 01/30/04 identified that R12 had a one minute seizure at 1:00 p.m. E8 (LPN) notified the physician and orders were received for Dilantin 300 mg. stat and to start client on Dilantin 300 mg. BID. The last entry made by nursing staff for 01/30/04 was at 3:00 p.m. No further entries were made into R12's record until 5:00 a.m. on 01/31/04.

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Per review of the Nursing Schedule and as confirmed per interview with E8 (LPN) on 04/09/04 at 12:55 p.m., E8 stated that she had worked from 6 a.m. to 6 p.m. on 01/30/04 on B wing. E8 stated that when she works from 6 a.m. to 6 p.m., she leaves the keys with either the A wing or the C wing nurse when she leaves for the day. E8 stated that the next nurse for B wing does not come in until 10:00 p.m. E8 stated that one of the nurses from the other wing comes over and passes the 8:00 medication to the B wing clients. E8 confirmed during this interview that no nurse is present on B wing from 6:00 p.m. until the nurse comes to pass the 8:00 medication and, that after medications are passed, no nurse is present on B wing until 10:00 p.m. E2 (Director of Nursing) who was present at the Nurse's station during part of the interview, stated, "No" when asked by the surveyor if direct care staff had received training or had been inserviced on "Emergency Procedures-Seizures".

Further review of nursing documentation for 01/31/04 identified that R12 continued to experience seizure activity even after he received Dilantin 300mg. stat on 01/30/04 and after his Dilantin dosage was increased back to 300 mg. BID. At 11:40 a.m., R12 was transferred to the emergency room via ambulance. At
3:00 p.m., Nursing documentation identified, "Received call from (Name of Hospital identified) ER (Emergency Room) sending Res (resident) back. Was given 100 mg of Cerebyx Increase (symbol for "increase" used) Dilantin to 300 mg BID. F/U (Follow up) with Z1 in 3 days Check (symbol for "check" used) Dilantin Level in five days. Dilantin Level at (symbol for "at" used) (Name of Hospital identified) ER was 4.7."

Nursing documentation identified that R12 returned back to the facility at 3:15 p.m. At 4:50 p.m., R12 had a forty-five second seizure and at 5:00 p.m. had a one minute and ten-second seizure. At 5:10 p.m., R12 was again transferred to the Emergency room via ambulance. R12 was admitted to the hospital at 8:00 p.m. on 01/31/04.

Per telephone interview with Z1 (Physician) on 04/08/04 at 2:35 p.m., Z1 stated that it was his impression that R12 died from aspiration possibly during a seizure.

c) The facility failed to implement and train nursing staff on the facility's policies and procedures for seizure emergencies.

Per review of the facility's policies and procedures regarding "Emergency Procedures-Seizures" with a date of 9/96, the policy states that it is the responsibility of "all staff" to provide emergency care to residents in the event of a seizure. Procedures identified within the policy stated that after the seizure has ended the resident should be kept resting, positioned for drainage from the mouth to prevent possible aspiration. Additional procedures were noted to, "Notify the physician immediately" and that staff should "Transport resident to an appropriate medical facility...".

Per review of the facility's policies and procedures regarding "Physician Notification" with a date of 7/91, the policy included situations when the physician is to be notified. No specific procedures were noted within the policy as to how the physician would be notified by the facility.

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On 04/09/04, the facility provided the surveyor with revisions to their policies and procedures for "Emergency Procedures- Seizures" and for "Physician Notification of Resident Change in Condition" with dates of 04/08/04.

Per interview with E8 (Licensed Practical Nurse/LPN) on 04/09/04 at 12:55 p.m., E8 stated that she had never seen the facility's policy on "Emergency Procedures-Seizures" dated 9/96, nor the new Seizure policy that the facility had drafted during the survey process dated 04/08/04. E8 also stated that she notifies the physician of changes in the resident's conditions and/or regarding labs, or new orders by faxing the physician's office. E8 stated that after faxing the physician's office, if she has not heard from his office after 30 to 40 minutes, she then calls his office.

2) Nursing staff failed to notify the physician and dentist and seek additional treatment for relief of pain and infection.

Per review of the Physician's Order sheet, R9 is a 47-year-old male who functions at a profound level of mental retardation and has diagnosis of Impulse Control Disorder with Self Injurious Behaviors, Aphasia, and Vision Impairment.

R9 was observed sitting in his wheelchair in the dining room on the facility on 04/06/04 at 3:15 p.m. The right side of R9's jaw area was observed to be swollen. E9 (Direct Care Staff) was present in the dining room and informed the surveyor that R9 had an abscessed tooth and had gone to the dentist. E9 stated that the facility did not send a medical card with them and the dentist refused to see him. E11 (Direct Care Staff) who was also present in the dining room stated that it difficult to brush R9's teeth on the right side of his mouth because he bites down on the toothbrush when trying to brush his teeth.

Review of R9's record identified that R9 has gone to the dentist on 03/08/04. Nursing entry noted that at
3:30 p.m., R9 returned to the facility and was refused treatment related to no medical record. The nursing entry was signed by E11 (Licensed Practical Nurse/LPN). E11 and E2 (Director of Nursing) and were present at the nurse's station at the time the surveyor reviewed R9's record. E11 (LPN) stated that R9 had an infected/impacted tooth and needed medical treatment for removal. E11 stated that she had filled out forms for R9 that were sent by the dentist, but was unsure of where the forms were. E2 stated that she thought R9 had been seen. At approximately 3:30 p.m., (on 04/06/04) E3 (Assistant Administrator) informed the surveyor that the dentist would be at the facility on 04/21/04. Per review of the Nurse's Notes from 03/08/04 to 04/06/04, no further documentation was found to identify that nursing staff had notified the physician and or the dentist that R9 had not been seen by the dentist in regard to his infected tooth.

Further record review and as confirmed per telephone interview with E8 (LPN) on 04/21/04 at 2:10 p.m., R9 was seen on 02/24/04 at the after hours clinic for his swollen right jaw. Duricef (antibiotic) 250 mg two tablespoons twice daily for ten days was ordered for a possible tooth infection. R9 received his last dose of

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Duricef on 03/05/04. E8 also stated that R9 had received a Tylenol #3 on 02/27/04, 03/01/04 and on 04/07/04. R9 was sent to the dentist on 03/08/04 but was not treated for the infection. No further documented action was taken by the facility until brought to the attention of staff by the surveyor on 04/06/04.

On 04/07/04, R9 was seen by the dentist (Z2) at the facility. Z2 documented, "R9 has swollen maxillary right cheek. Visual exam shows mobile and decayed maxillary right wisdom tooth (#1). Recommended extraction of tooth #1 and (symbol for "and" used) possibly #2 after X-ray diagnosis. Mandibular teeth did not seem to be involved on visual. Pt.'s (Patient's) prescription for Duricef to be refilled and (symbol for "and" used) patient referred to dentist. He will need sedation or general anesthesia. Also he needs prescription for Tylenol #3 refilled. Prescribed Duricef 250 mg (milligram) tabs (tablets)... take 1 tab BID (twice daily).

Per continued record review and as confirmed per telephone interview with E8 (LPN) on 04/21/04 at 2:10 p.m., R9 was seen by the dentist on 04/12/04. E8 stated that the dentist could not remove R9's wisdom tooth until June 2004. E8 confirmed that R9 received his last dose of Duricef on 04/17/04. E8 also confirmed that the physician (Z1) and or the dentist (Z2) had not been contacted for further treatment orders since R9's infected tooth could not be removed until June 2004.

(A)