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

PINE LAWN MANOR **0045708**

Facility Name **I.D. Number**

200 POPLAR STREET, SUMNER, ILLINOIS 62466
Address

Date of Survey: 02/10/2004

Incident Report Investigation of December 26, 2003

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) 350.1230a) 350.1230b) 350.1450a) 350.3240a) **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.**

Each facility shall have a full-time director of nursing services (DON) who is a registered nurse (RN) and whose only responsibility is the immediate supervision of the facility's health services. This person shall be on duty a minimum of 36 hours, four days per week. At least 50 percent of this person's hours shall be regularly scheduled between 7 a.m. and 7 p.m.

Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:

Periodic re-evaluation of the type, extent, and programming.

The facility shall comply with all federal and State laws and State regulations relating to the procurement, storage, dispensing, administration, and disposal of medications.

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

1) Nursing staff failed to transcribe Physician Orders received on 12-26-03 for a urine analysis, Amoxicillin 250 mg. (milligrams)/5ml (milliliters) 10ml (milliliters) three times daily for 10 days and Tylenol 160/5cc (cubic centimeters) 5cc (cubic centimeters) qid (four times a day) PRN (as needed) and did not implement these orders until 12-29-03.

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Per review of Physician's Order Sheet, R13 is a 31-year-old male that functions at Moderate level of Mental Retardation. Other Diagnoses' include: Cerebral Palsy, Spastic Athetoid, Non Ulcer Dyspepsia, Gastro Esophageal Reflux Disease, Hypotension, Testicular Cancer, Pseudo membranous Colitis.

Per review of facility's "Incident Tracking Log", surveyor noted that on 12-26-03 there had been a medication transcription error involving R13. Scale of error is identified as A/C. On code at bottom of page, Scale A is identified as, "No Injury". Scale C is identified as, "Moderate". Moderate is also identified as, "Lacerations requiring sutures or emergency room evaluation".

Per review of incident report faxed to local public health office, on 12-30-03, states, "On 12-26-03 order was taken for R13 for Amoxicillin 250 mg. (milligrams)/5cc (cubic centimeters). 10 cc (cubic centimeters) TID (three times a day) X (times) 10 days R/T (related to) (increased) temp. (temperature) N/V (nausea and vomiting). Do UA (urinalysis) et (and) Tylenol 160cc (cubic centimeters)/5cc (cubic centimeters) 5cc (cubic centimeters) qid (four times a day) PRN (as needed). Due to transcription error U/A (urinalysis) was not completed or amoxicillin started until a.m. 12-29-03..." "...Resident temp. (temperature) was 99.9 et (and) was given Tylenol.@ (At) 11 A. temp. (temperature) 99.9. @ (At) approx. (approximately) noon resident noted to have nasal congestion c (with) dry cough which would start resident to gagging. Asked resident et (and) he nodded yes if gagging & (and) cough were caused by post nasal drainage. Dr. (doctor) notified et (and) order received for Clarinex 5 mg. (milligrams) daily X (times) 10 days R/T (related to) nasal congestion & (and) post nasal drainage. Later that evening resident temp. (temperature) 104.7 resp. (respirations) labored et (and) pulse elevated was sent to ER (emergency room) for evaluation et (and) was admitted c (with) diagnosis of pneumonia".

Per review of R13's Nurse's Notes, surveyor noted the on 12-24-03, at 9:00 p.m., nurse had documented that R13 had a temperature of 99.8 and was complaining of upset stomach. Lungs are documented as being clear.

On 12-25-03, at 6:00 a.m., R13 had a large emesis and was still complaining of upset stomach. At 8:00 a.m., on 12-25-03 R15 was given Reglan 10cc (cubic centimeters). Temperature at this time is documented as being 99.6.

On 12-25-03, at 1:00 p.m., temperature is documented as being 100.6. Tylenol was given at this time. At 9:00 p.m., temperature is documented as being 98.7, pulse 102, oximeter 95%.. Lungs are documented as being clear.

On 12-26-03, at 3:00 a.m., documentation states temperature is 98.8 and oximeter is 96%. Documentation also states that R13 continues to have upset stomach.

12-26-03, at 9:00 a.m., temperature is 100.7. Lungs are documented as being clear.

On 12-26-03, at 10:00 a.m., nurse called on-call physician and notified him of R13's increased temperature and occasional nausea and vomiting. Temperature at 1:00 p.m. is documented as being 98.9.

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On 12-26-03, R15's temperature is documented as being 98.9 both at 10:50 a.m. and 1:00 p.m. Temperature on 12-27-03, at 4:00 a.m. is 98.1. Temperature at 3:15 p.m. is 98.8 with oximeter being 96%.

12-27-03, 10:00 p.m., documentation states, "No resp. (respiratory) problems. No lung assessment nor vital signs are documented as to being done. 12-28-03 at 7:00 a.m. temperature is 97.9 and oximeter is 95%.

On 12-28-03, at 9:00 a.m., documentation states temperature is 98.6 and lungs are clear. No oximetry reading is recorded as being done. At 9:00 p.m., lungs are documented as being clear with temperature of 98.4 and oximeter of 94%.

Documentation for 12-29-03, 2:00 a.m. stated that R13's temperature is 101 and R13 had had emesis. Lungs are documented as being clear with oximeter reading of 94%.

Per continuing review of Nurse's Notes for R15, surveyor noted that on 12-29-03, (no time documented), documentation states, "Late entry for 12-26-03, (physician on call for facility) called c (with) order for U/A (urinalysis). Start Amoxicillin 250 mg. (milligrams)/5ml (milliliters) 10ml (milliliters) tid (three times a day) X (times) 10 days et (and) Tylenol 160/5cc (cubic centimeters) 5cc (cubic centimeters) qid (four times a day) PRN (as needed).

On 12-29-03, physician's office was contacted at 10:50 a.m. in regards to R13's nausea, vomiting and increased temperature.

Documentation states that at this time, the physician was also notified of order for Amoxicillin and Urinalysis on 12-26-03 that was not transcribed and therefore not started until 12-29-03 a.m. At 11:00 physician's office was again contacted and notified of R15's nasal congestion and increased temperature. An order was received for Clarinex 5 milligrams daily for 10 days.

On 12-29-03, at 11:00 a.m., temperature is documented as being 99.9, oximeter 95%. Nurse also documented, "Nasal congestion c (with) post nasal drainage noted et (and) produced non-prod (productive) cough which caused some gagging @ (at) times..." At this time two Tylenol were given.

On 12-29-03, at 1:00 p.m., temperature is documented as being 99.9. No pulmonary assessment is documented to have been completed at this time.

At 3:45 p.m., on 12-29-03, the physician was notified that R13 was complaining of chest pain, temperature was 104.7 (Apically), pulse 148, respirations 38 deep and labored, blood pressure was 125/75 and oximeter 94%. Physician ordered R13 to be sent to the local emergency room.

R13 was transferred to the local emergency room via ambulance at 3:30 p.m. on 12-29-03.

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Per review of R13's Emergency Room Record, dated 12-29-03, physical exam upon arrival to the hospital states that blood pressure was 98/58, pulse 154, respirations 36 and shallow, Oxygen was 95% and temperature was 103.7. Documentation also states, "...He has open mouth breathing. Mucous membranes are dry. He has some cracks on his lips. He has a lot of yellow-green nasal mucus..." "...Coarse upper respiratory sounds. There are coarse rhonchi scattered throughout all lung fields. He has a staccato cough". Heart rate was described as, "tachycardia". R13 was admitted to the hospital for Intravenous antibiotics. Physician's Plan at the time of admission states, "1. Rule out sepsis with all cultures...".

"2. Continue the IV (Intravenous) antibiotics and intravenous fluid. 3. Further work-up on this patient depends on the clinical progress.". "The long-term prognosis is poor.".

While admitted to the hospital, a urinalysis was obtained that showed, "a large amount of blood and moderate bacteria, moderate mucus, 50 - 100 red cells (normal range is negative for any red cells), protein 100 (normal range is negative for protein).

R13 remained in the local hospital until 01-05-04, when he was discharged back to the facility.

Discharge Diagnoses' on 01-05-04 are documented as being: 1. Pneumonitis, 2. COPD (Chronic obstructive pulmonary disease) exacerbation, 3. Mild heart failure, 4. Hypoxia. Oxygen dependent, 5. Hematuria,
6. Cerebral Palsy, 7. Leukocytosis, resolved, 8. Flexion contractures, 9. Testicular cancer by history, 10. Status post orchiectomy, 11. Status post chemotherapy, 12. Metastatic testicular cancer.

Per telephone interview with Z1 (Medical Director) on 02/09/04 at 11:30 a.m., Z1 confirmed that the facility should have started R13 on his medications and completed a urine analysis on the 26th of December as ordered. Z1 stated that the failure to start R13's medication on 12/26/03 "had an impact on R13's being hospitalized on 12/29/03."

2. Medicine error and lack of follow-up.

Per review of Physician's Order Sheet, R14 is a 53-year-old female that functions at a Severe level of Mental Retardation. Other diagnoses' include: Hypertension, Hyperlipidemia, Arteriosclerosis, Cerebral Palsy, Generalized Weakness Both Legs.

R14 is non-ambulatory and requires a wheelchair for all mobility needs.

Per review of Physician's Order Sheet, R15 is a 51-year-old female that functions at a Moderate level of Mental Retardation. Other diagnoses' include: Seizures, History of Schizophrenia and Agitation, Hypothyroidism.

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Per review of facility's incident log, surveyor noted that on 11-16-03, documentation states that a medication error occurred at 8:00 a.m., involving R14. Incident was coded as "C". Code at bottom of Incident Tracking Log identifies C as being "Moderate". C is also described as "Lacerations requiring sutures or emergency room evaluation".

Per review of R14's Nurses Notes, documentation on 11-16-03 states: "4:30 p.m., Res. (resident) was sent to E.R. (emergency room). She was transferred by (Local Ambulance). T. (temperature) 97.6, P. (pulse) 120, O2 (oxygen) 95%, R. (respirations) 20 B/P (blood pressure) 101/57. She has been acting very lethargic today, her speech became slurred and she was displaying facial drooping. She was also combative & (and) screaming. Res. (resident) normally stands c (with) transfers from w/c (wheelchair) to bed, bath, etc. She could not stand during assessment..."

Nurses Notes dated 11-16-03, at 6:00 p.m., states, "Nurse realized that she gave res. (resident) another res. (residents) meds (medications) in the a.m.. She realized the error at around 6 p.m. in the evening. Res. (resident) was not acting like herself, she was combative, drooling, and her speech was slurred & (and) unclear. Res. (resident) was sent to ER (emergency room) at 4:30 p.m. to rule out possible CVA (Cerebral Vascular Accident)/etc....". "...Res. (resident) returned from (local hospital) c (with) orders for enema, MOM (Milk of Magnesia), & (and) Miralax..."

Nurses Notes, dated 11-16-03, at 6:00 p.m., states, "Hosp. (hospital nurse) called..." "...Res. (resident) was to get MOM (Milk of Magnesia) 30cc (cubic centimeters) tonight, cleansing enema X (times)1 tonight & (and) Miralax 1 scoop q (every) d (day)..."

Per interview with E2, (Administrator), on 01-28-04, at 2:10 p.m., E2 stated that by looking at facility's Accident/Incident Report and facility's Incident Tracking Log, there was no way to determine which nurse administered R14's medications on 11-16-03, nor to determine what medications R14 received. E2 stated that she would have to look at the Medication Administration Record and see who had initialed that day's medication as given and what medication was administered. E2 also confirmed that there was no way to track medication errors in order to monitor which nurse was making errors, other than to look on Medication Administration Record.

Per interview with E2, on 01-29-04, at 8:00 a.m., E2 identified E4 as the nurse administering R14 the medication that belonged to R15. E2 was unable to determine what medications R14 received. E2 was also unable to say whether or not R15 received her medications on 11-16-03. E2 continued to say that E4 was a "fairly new nurse". E2 is unsure if the facility has a competency check off list for new nurses, prior to passing medications, but thinks it may just be verbal and observation. E2 confirmed that all medication errors and the medication given should be documented in the client's medical record.

Per interview with E2, on 01-29-04, at 11:50 a.m., E2 stated that she had called the Director of Nurse's and that the Director of Nurse's told E2 that there was no competency check list for newly hired nurses. The new nurses stay with another nurse until they feel comfortable on their own. E2 also stated that the Director of

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Nurse's said that there was no special tracking system to help monitor which nurse makes a medication error, that the tracking is done on the "Incident Tracking Log". E2 confirmed that the type of medication error and name of nurse making the medication error is not identified on the log. Per interview with E4, (Licensed Practical Nurse), E4 stated that she started working at this facility on 10-10-03 and that this was her first nursing job. E4 continued to say that there was no competency test or check list required prior to passing medications. E4 said that she was, "1 on 1 with another nurse for about 2 weeks, just watching her".

Per interview with E2, on 01-30-04, at 10:50 a.m., via telephone, E2 stated that she was still unable to determine whether R15 received her medications on 11-16-03 or not. E2 stated, "E4 thinks E8 (Licensed Practical Nurse) may have given them and I haven't had a chance to talk to E8 since I talked to E4 yesterday".

Per interview with E4, on 01-29-04, at 7:00 p.m., E4 stated that when she came to work on 11-16-03, the nurse going off duty informed her that three people had not yet received their 7:00 a.m. medications. R15 was one of the residents whom had not yet received their medications. E4 stated that she had prepared R15's medication. E4 then said that she saw R14 walk through the hall and she yelled at staff to bring her back to get her medicines. E4 said she administered the medications to R14. E4 continued to say that about 2 hours later, R14 began drooling, had left-sided weakness and slurred speech "almost like she was having a CVA (Cerebral Vascular Accident)". E4 said she thought about the medications all day, but it wasn't until she was driving home that evening, that she was sure that she had given R14 the medications that were intended for R15. E4 stated that R14 received all of R15's 7:00 a.m. medication. When asked if R15 received her medications on 11-16-03, E4 said that she wasn't sure but she thinks E8 gave them to her.

Medications scheduled for R15 to receive at 7:00 a.m., but were instead administered to R14 were: Clozapine 100 milligrams (for Schizophrenia), Depakote 500 milligrams (for seizures), Furosemide 20 milligrams, Vitamin E capsule, Certagen Tablet (nutritional supplement), Vitamin B6 100 milligrams (nutritional supplement), Vitamin C 500 milligrams (nutritional supplement).

Per telephone interview with Z1 (Medical Director) on 02/09/04 at 11:30 a.m., Z1 stated that he considered the medication error involving R14 that occurred on 11/16/03 a "significant medication error." Z1 further stated, "The Clozapine would have had a significant impact on R14's medication condition."

2. Not providing nurses with additional training after medication errors:

Per interview with E2, last documented training for nurses regarding medication errors occurred October 2003.

Per review of facility's "Incident Tracking Log", surveyor noted that there have been three documented medication errors since the training in October 2003, (2 of which, per facility's documentation, has resulted in hospital visits). Incidents are as listed:

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11-16-03 - R14 medication error (not identified as to what type of error or nurse administering).
12-17-03 - R32 medication error (not identified as to what type of error, or nurse administrating).
12-26-03 - R13 medication error (transcription error).

Per interview with Z3, (Consulting Pharmacist), on 01-30-04, at 1:15 p.m., Z3 stated that she conducts in-services for nurses and medication administration at this facility. Z3 said that her last in-service was October 2003. Z3 continued to say that she is there monthly and follows one nurse per month during medication pass. Z3 stated that she does not get copies of the facility's medication error reports, and that if she did, she would be able to identify problems and "repeat offenders". Z3 continued to say that she could then make different choices to re-train that particular staff, follow her more, and keep closer track to ensure less medication errors. When asked if incident of 11-16-03 would be considered a significant error? Z3 replied, "How could I not consider it a significant error, since we're talking about Clozapine and Lasix and they sent the client to the hospital thinking she was having a stroke".

3. Not following proper procedure for checking placement of feeding tubes prior to medication administration:

Per review of Physician's Order Sheet, R13 is a 31-year-old male that functions at Moderate level of Mental Retardation.

Other Diagnoses' include: Cerebral Palsy, Spastic Athetoid, Non Ulcer Dyspepsia, Gastro Esophageal Reflux Disease, Hypotension, Testicular Cancer, Pseudo membranous Colitis.

R13 has a feeding tube for all nutritional needs.

Per observation of the evening medication pass, on 01-29-04, at 6:19 p.m., E4, (Licensed Practical Nurse) was observed to enter R13's room to administer his 4:30 p.m. medications. Medications included: 1 can of Resource Plus, Baclofen 20 milligrams, and Zantac 10 cubic centimeters.

Surveyor noted E4 to wash her hands, apply gloves and obtain a 50cc (cubic centimeter) syringe from the bottom drawer of the medication cart. E4 pulled up R13's shirt and revealed the feeding tube. E4 proceeded to aspirate contents of the feeding tube. Approximately 5 to 10 cc's of white milky substance was aspirated from the feeding tube. The milky substance was returned into the feeding tube. E4 then administered 50cc of water into the tube. R13 began coughing and gagging. E4 asked if he was okay, and said that he does this every time. R13 stopped coughing and gagging. The baclofen and Zantac were poured into the same medicine cup and poured together into the feeding tube. After the medications were administered by gravity flow, E4 again administered 50 cc of water. Resource was administered and another 50cc of water was used to flush the tube.

Per interview with E4, on 01-29-04, at 7:00 p.m., when asked the procedure for checking placement of feeding tubes prior to administration of medications, E4 stated, "You check by pulling it out and making sure you get stomach contents".

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Per telephone interview with E2 (Administrator) on 01-30-04, at 10:50 a.m., when asked for proper procedure for checking placement for feeding tubes prior to medication administration? E2 stated, "I'm not really sure at this time, I haven't had a chance to get to the nurse's office and pull it". E2 stated that she would fax the procedure to surveyor.

Per fax, sent to surveyor, on 01-30-04, regarding facility's policy on confirming placement of feeding tubes, documentation was not complete as to what the actual procedure is.

Per interview with E2, on 02-04-04, at 2:30 p.m., E2 stated that the pages were out of order and that she could not find the rest of the procedure on confirming placement of the feeding tubes.

Per interview with Z3, (Consulting Pharmacist), on 01-30-04, at 1:15 p.m., when asked about checking placement of feeding tubes prior to medication administration, Z3, stated, "We recommend using a stethoscope and listening as you inject air, or just listening to bowel sounds". Z3 continued to say that aspiration of stomach contents is not adequate.

4. Nursing staff failed to properly dispose of expelled or refused medications.

During the 01-29-04 evening medication pass, occurring from 5:00 p.m. until 6:45 p.m., surveyor noted that when medications were spit out or refused, they were thrown into a trash bag attached to the side of the medication cart. Medications that were observed to be thrown into the bag were: Baclofen 20 milligram tablet, Potassium Chloride 10 mill equivalents, Sinemet 25/250 milligrams, Ferrous Sulfate 325 milligrams, Depakote Sprinkles 125 milligrams, (4 capsules opened and in pudding), Senokot 187 milligrams, and Remeron 15 milligrams.

Per interview with E4, on 01-29-04, at 7:00 p.m., regarding throwing the medications into the trash, E4 stated, "As long as it's not narcotics, we can throw them in there (trash bag) and then throw the bag away."

Per interview with E2 (Administrator), on 01-30-04, at 11:00 a.m., when asked if it was proper procedure to throw medications, including Remeron, into the trash bag attached to the medication cart, E2 stated that she would "Highly question" Remeron being thrown into the trash bag.

Per interview with Z3 (Consulting Pharmacist), on 01-30-04, at 1:15 p.m., Z3 confirmed that it was not proper procedure to throw any unused medications into the trash. Z3 continued to say that all medications that are thrown away should be documented as wasted and flushed in the presence of a witness. Z3 also said that she has a "Real problem" with Remeron being thrown into the trash.

5. No Director of Nurses Available:

Per interview with E2, (Administrator), on 01-28-04, at 11:10 a.m., E2 stated that the Director of Nurse's is on medical leave at this time.

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E2 stated that Director of Nurse's has been on medical leave since 01-13-04. E2 continued to say, "E21 (Registered Nurse) is doing paper work and trying to do part of (Director of Nurse's) duties".

Per interview with E21, on 01-28-04, at 11:20 a.m., E21 stated that she was not the Director of Nurse's or the Assistant Director of Nurse's. E21 also said that she was not doing any Director of Nurse's duties. E21 continued to say that she has been off work, due to a knee injury, since October, 2003 and just came back last week on 4 hour days. This is her first week back on full 8-hour days.

Per interview with E18, (Registered Nurse), on 01-28-04, at 11:35 a.m., E18 stated, "The DON (Director of Nurses is on medical leave and there is no central person to go to with concerns or problems. E2 is trying to do DON's job but has a lot on her shoulders. It makes it hard".