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

WARREN BARR PAVILION	**0046003**
Facility Name	**I.D. Number**

66 WEST OAK STREET,
CHICAGO, IL 60610

Date of Survey: 04/13/04

Annual Inspection and Complaint Investigation

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):

300.650f)1) **All new employees, including student interns, shall complete an orientation program covering, at**
300.1210a) **a minimum, the following: general facility and resident orientation; job orientation, emphasizing**
300.1210b)1) **allowable duties of the new employee; resident safety, including fire and disaster, emergency**
300.1610a)1) **care and basic resident safety; and understanding and communicating with the type of residents**
300.1630b) **being cared for in the facility. In addition, all new direct care staff, including student interns,**
300.1630c) **shall complete an orientation program covering the facility's policies and procedures for resident care services before being assigned to provide direct care to residents.**

The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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300.650f)1) **Medications including oral, rectal, hypodermic, intravenous, and intramuscular shall be properly**
300.1210a) **administered.**
300.1210b)1)
300.1610a)1) **Every facility shall adopt written policies and procedures for properly and promptly obtaining,**
300.1630b) **dispensing, administering, returning, and disposing of drugs and medications. These policies and**
300.1630c) **procedures shall be consistent with the Act and this Part and shall be followed by the facility.**
(Cont'd.)

The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification.

Medications prescribed for one resident shall not be administered to another resident.

These requirements are not met as evidenced by:

Based on resident and staff interview, review of facility policy on medication administration, incident report review, and record review, the facility failed to develop and implement facility policies and procedures to ensure that residents receive medications as prescribed by the physician; failed to have in place a orientation program for temporary nursing staff administering meds; and failed to address ongoing complaints from family and residents regarding ongoing medication errors.

All of these system wide failures resulted in 1 resident (R16) receiving the wrong medications and experiencing an avoidable medical crisis that required emergency hospitalization. The lack of policy and procedures, an orientation program for temporary nurses, and the failure to address continued complaints from residents and families on med pass problems, and failure to follow physician orders placed R16 and other residents in the facility at risk.

Findings include:

R16 is an 87 year old admitted to the facility on 3/12/04 with diagnoses that includes status post fractured right hip, congestive heart failure, deep vein thrombosis with IVC filter, and atrial fibrillation. MDS (Minimum Data Set) of 3/15/04 scores R16's cognitive status as "0", no deficits.

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300.1210a)
300.1210b)1)
300.1610a)1)
300.1630b)
300.1630c)
(Cont'd.)

Review of an incident report dated 3/15/04 states that R16 was experiencing low blood pressure (70/40), vomiting, and oxygen saturation levels of 79-84%. R16 was sent to the hospital and admitted for 23 hour observation for these acute medical changes.

Review of hospital records dated 3/15/04 confirm that R16 was experiencing low blood pressure and low heart rate upon admission and required hospital observation. Two different physician notes state that R16 "received an excessive dose of beta blockers " prior to admission causing the symptoms.

Review of the facility's investigation of the incident revealed that R16 received R49's (R16's roommate) medications on 3/15/04 during the morning medication pass.
R16 received Cardura 4mg, Zoloft 50mg, Atenolol 50mg p.o. Cardura and Atenolol are used to control blood pressure and heart rate; Zoloft is a antidepressant. All of these medications are prescribed for R49.

Further review of the incident report and the facility's investigation revealed that Z1(agency nurse) was on duty and assigned to pass R16's morning medications on 3/15/04. E9 (nurse manager for the 7th/8th floors) interviewed Z1 who at first denied making the error, and then admitted that she may have given R16 his roommate's (R49) medications. E9 and Z1 then went and reconciled the medications together and discovered the error. Z1's only statement on facility's "Medication Occurrence Report" was that the "Res answered yes when the roommate's name was called."

E9 then interviewed R16 on 3/15/04 who stated that Z1 had tried to administer insulin to him and he told her that he did not take insulin. Z1 then gave R16 three pills in a cup. R16 also stated that Z1 then returned with a second set of medications and informed him that these were also his as well. R16 reported that he took the second cup of medications and immediately stated to E9 that he "just does not feel well" since taking the last medications.

E9 was definite that he took meds two times that morning.

Z1 denied giving R16 a second cup of medications.

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300.650f)1) **In an interview with E11, Certified Nursing Assistant caring for R16 on 3/15/04 E11 stated that**
300.1210a) **she saw Z1 give R16 medications at two different times and also confirmed that Z1 tried to give**
300.1210b)1) **R16 insulin. R16 refused the insulin which alerted E11 to the incident with the wrong meds.**
300.1610a)1)
300.1630b) **On 4/8/04 at 9:20am, E2 (nursing director) was interviewed regarding the above incident. E2**
300.1630c) **stated she called E9 regarding a possible medication error. While E9 investigated the error, E2**
(Cont'd.) **called R16's physician, and the family. 911 was called because R16 began to decompensate and he was sent to the hospital.**

When asked about what type of orientation the temporary nurses are given to the facility, E2 replied that" there is no formal program, but that the temporary nurses are to read the floor communication book and sign it, and make rounds with the nurse going off duty to familiarize themselves with the residents."

Interview with E9 on 4/8/04 at 12:10a.m. confirmed that Z1 initially denied making the error but after checking the medications, determined that R16 had gotten R49's medications. E9 feels R16 is a credible witness because he is alert and oriented. R16 stated he did not feel well and E9 stated that the first blood pressure (B/P) taken was within normal limits, but a second taken 15-20 minutes later was 70/40 and the resident started vomiting. E9 started an IV and called 911. After a bolus of fluid, R16's B/P had improved.

Interview with E11(CNA) on 4/8/04 at 12:30p.m. confirms that Z1 gave medication to R16 on 3/15/04 but did not ask the resident his name or check his identification band to confirm proper identification. "Her first words to (R16) were' Take your pills ' and (Z1) gave (R16) the medications and some water." Approximately 20 minutes after the pills were given, R16

became pale and started complaining , and "did not look right."

E11 took R16's B/P and could only get 50/0 so she immediately notified the nurse (Z1).

Interview with R49 (roomate) on 4/8/04 at 12:15p.m. confirmed E9 and E11's interviews that R16 received his (R49's) medications, and that Z1 told R16 that morning that he had to take the medications . R49 states that sometime later R16 became pale and the nurse was called.

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(Cont'd.)

Interview with Z2 (attending physician) on 4/8/04 at 1:20p.m. revealed that she was on her way to the facility to see R16 when she received the page regarding the incident. Z2 had not yet examined R16 since he was just admitted to the facility on 3/12/04. Z2 talked with R16's son and explained the situation, she also spoke with Z1 who apologized for the error. Z2 has examined R16 since the incident and has found no further problems or side effects from the error.

Interview with R16 on 4/7/04 at 9:50a.m. confirmed that he felt he had received his roommates medications on that day (could not remember the exact date, but thought it was on a Monday) and that he had been sent to the hospital because of it. R16 believes that they were blood pressure medications. He realized that they might be the wrong medications when the nurse (Z1) tried to give him an insulin injection too and he told her he did not take insulin. R16 stated he started to feel weak and dizzy and vomited shortly after taking the pills.

Current facility policy and procedure on Medication Administration states: "3. Prior to Medication Administration:
3.1 Verify each time that the medication is the RIGHT DRUG, at the RIGHT DOSE, the RIGHT ROUTE, at the RIGHT RATE, at the RIGHT TIME, for the RIGHT CUSTOMER.
3.1.1 Confirm that MAR reflects the most recent medication order."

Random interviews with facility staff nurses E4, E8, E12, E13, E14, E15, E16, E17, E18, E19 on 4/8/04 revealed that they would check the residents identification bands, call the residents name, read the name on the door of the room or check the pictures in the MAR (Medication Administration Record) to identify residents. It was found that there was no consistent method used by nursing staff for checking resident identity prior to giving medications. Surveyors did a random check of residents on all floors on 04/08/04 to see if identification bands were in place, and found that not all residents were wearing them. The only floor found to have pictures on the MAR was the 6th floor, which is the dementia unit. The facility at the time of the survey had a census of 190 residents. Facility had a different identification procedure from floor to floor and staffing revealed continued use of registry nurses expected to pass meds which could further compromise resident safety since these nurses are not familiar with residents on the various floors.

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300.650f)1) **Group interview on 4/7/04 with 11 alert and oriented residents present revealed that temporary**
300.1210a) **nurses were often found trying to give wrong medications to residents, that the medications were**
300.1210b)1) **consistently given late or not at all, and sometimes you have to go ask for your meds yourself,**
300.1610a)1) **and that often they were called by the wrong name when medications were being given and that**
300.1630b) **they needed to correct the nurse before taking their pills. Surveyors already determined during**
300.1630c) **survey that MARs are not signed out properly and treatments are not always recorded as required**
(Cont'd.) **and to clearly indicate to other nurses the status of the med pass.**

Individual interviews of R4 and R15 during the survey of 4/6-4/8 also confirmed these same problems.

Interviews with Z3 and Z4 on the 6th floor on 4/7/04 revealed that they have had multiple complaints from family members about the residents not getting the right medications,

especially when a temporary nurse is involved responsible for the med pass.

Review of the Resident Council Minutes for March 2004 had documented complaints regarding medication administration. Residents stated that when the night time nurses come on duty they are not getting their night time medications timely or at all, and that staff are talking on their cell phones while handing out medication and that they are concerned for their safety while nurses are on the phone and not concentrating on passing the proper medications.

The Grievance Log entries show 5 incidents from 1/04 - 2/04 of residents or family's concern regarding medications not given, medications not given timely, or errors with medications. Although these incidents were followed up on by the facility, there was no evidence that a comprehensive plan was put in place to prevent med errors from occurring again.

(A)