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

DEARBORN COURT — Facility Name
0043208 — I.D. Number

520 SOUTH DEARBORN STREET, KANKAKEE, ILLINIOIS 60901 — Address

Reviewed By
11/4/04 — Date of Survey

COMPLAINT INVESTIGATION — Type of Survey
Surveyed By

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 of 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):

350.1060h — There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary suporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional.

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:

350.1230b)3)
350.1230d)1)2)
350.1230e) — 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.

350.3240a) — Direct care personnel shall be trained in, but are not limited to, the following:

First aid for accident or illness.

Direct care personnel shall be trained in, but are not limited to, the following:

Detecting signs of illness, dysfunctionor maladaptive behavior that warrant medical, nursing or psychosocial intervention.

Basic skills required to meet the health needs and problems of the residents.

DEARBORN COURT | 0043208
Facility Name | I.D. Number

Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activies.

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

These regulations were not met as evidenced by the following:

Based on observation, interview and record verification, the facility failed to provide nursing services in accordance with a client's needs when there was evidence of dehydration, failure to maintain nutrition, decreased urinary output, constipation, low blood sugar, high blood pressure, vomiting, numerous medication refusals, choking during a meal, increased lethargy and weakness for R2 with the potential to affect 3 of 3 other clients in the facility (R's 1, 3, and 4) when they:

1) Failed to develop and / or implement systems to monitor and ensure food and fluid intake and output to maintain health when they failed to consistently document nutrition, hydration and urinary output for R2 [who had decreased nutrition and fluid intake with episodes of vomiting for weeks] and when there was no easily retrievable way to evaluate R2's food / fluid intake or urinary output and failed to report vomiting, lack of fluid/food intake and decreased output to the physician.

2) Failed to have a plan in place to monitor R2's hypoglycemia [low blood sugar] as noted on physician order sheets and the Emergency Room record more frequently than every 2 months, and failed to ensure staff knew signs and symptoms of hypoglycemia.

3) Failed to ensure bowel health for R2 who had no recorded bowel movement for 12 days, refused, vomited or did not receive ordered laxative medication for his constipation, failed to accurately document results of laxatives and failed to notify the physician when additional PRN laxatives did not work.

4) Failed to monitor and report to the physician high blood pressure (BP) for R2 who had multiple high blood pressure readings (documented by direct care staff) for more than one month, with few documented nursing notes of elevated BP readings in nursing notes; and failed to have a mechanism in place to ensure BP's were documented in the client chart; and failed to report frequent elevated BP readings to the physician.

5) Failed to have evidence of nursing monitoring, documentation, follow-up or reporting to the physician when R2 had water blisters on his tongue and /or excoriated areas in his mouth; had an episode of choking at mealtime; and had no evidence of reporting the incidents of changes in health to the physician or guardian.

6) Failed to implement new physician orders for R2 who had physician orders [to address the mouth sores, hypertension, hypoglycemia, dehydration and constipation] that were not implemented for more than 20 hours after the orders were received.

7) Failed to monitor for potential side effects of a psychotropic medication after R2 was placed on a psychotropic medication, Risperdal, 9-2-04.

According to the client profile data in his chart, R2 is a 35 year old male with a diagnosis that includes Profound Mental Retardation (IQ - 9), Cerebral Palsy with Spastic Quadriplegia, Epilepsy / Seizure Disorder, Scoliosis with Corrective Surgery, History of Malnutrition, Cysts with dilation of the ventricles, D and D of cervical spine, contracture of right hand, right hemiparesis, Hypoglycemia - etiology unknown, history of fracture of the right hip.

R2's Individual Service Plan (ISP) dated July 18, 2004 showed that R2's functioning level is 1 year 2 months. The ISP was not printed at the time of the on site complaint investigation [from 10-12-04 to 10-15-04], and was faxed to the surveyor on 10-19-04.

.Per the ISP, the physician said R2's current "condition is good".
The Medical portion of the ISP stated his weight was 116 lbs and dietary wrote R2's weight was 120 lbs. The nurse wrote that R2's weight was down 15 pounds from the previous year. The ideal body weight, according to the ISP if 137 - 171 lbs. The dietary portion of the ISP stated R2 had a nutritional liquid supplement [identified by product brand name] BID, a snack TID and a multivitamin. The Dietician stated the diet should "allow for weight gain and insure adequate nutritional status...is on a mechanical soft diet."
Per the ISP, R2 can answer "yes / no" to questions and can say some words.

DEARBORN COURT
Facility Name

0043208
I.D. Number

The Vocational portion of the ISP showed that R2 stated one of R2's training programs was to feed himself 50% of his lunch at 50% completion. He had not met the previous year's objective to feed himself 50% with 100% completion.

The QMRP's monthly summary for 8-04 stated R2's health had deteriorated, he slept a lot of the time and his seizure medication was decreased.
The QMRP's monthly summary for 9-04 stated R2 was hospitalized from 8-2-04 to 8-16-04 due to his ammonia level having been increased and "he had his alertness decreased...had been...periods of sleeping and appeared lethargic." He was readmitted to the hospital 8-24-04 for 6 days due to his ammonia levels having been increased. R2's Depakote was discontinued due to the increased ammonia level. The QMRP review stated R2 experienced a loss of appetite, and was spitting up his medication. Lab results showed R2 had Dilantin toxicity and Hepatic Encephalopathy. The QMRP review did not state that R2 came home from his hospitalization on 9-2-04 with a new order for Risperdal 0.25 mg at bedtime, Ativan 0.5 mg by mouth every 6 hours as needed, Zonegran 400 mg daily. The review did not state a swallow study done 8-26-04 showed R2 had no aspiration when swallowing.
The review did not state that the neurologist consult note dated 9-29-04 "discussed with the techs that Zonegran can sometimes suppress the appetite. If he continues to have weight loss, we may need to consider reducing the Zonegran..."

Following R2's most recent return from the hospital on 9-2-04, R2 was taken to the Emergency Room [ER] on 10-5-04 when the laboratory was unable to draw blood for an ordered lab test. The ER report stated a facility staff member was with R2. Per interview with E2 on 10-13-04 at 4:15 PM, E2 said that she went to ER with R2 October 5th due to his respirations being shallow and down to 8 [per minute]. She said the ER did a CT scan of his head and drew blood for lab work but nothing was found. The ER record was not available at the facility.
Per the ER record obtained from the hospital during the survey, the record showed that the CT scan showed no bleeding in the brain and there was no evidence of a Cerebral Vascular Accident. R2's ammonia level was elevated, according to the ER report.

The dictated physician ER report stated that the care provider present with R2 [from the facility] stated R2 had been to his doctor for his "decreased appetite over the past several days and noted mental status changes today. He has been getting lactulose for high ammonia levels and that seems to be helping until today." The report states the facility care provider said R2 was at the ER to "get some labs" since "they were not able to obtain labs at the facility today." There is no evidence that E2 reported that R2 had been "in a daze" with "eyes unfocused" and had episodes of vomiting, decrease in food and fluid intake and intermittent episodes of high blood pressure as documented on progress by direct care staff on notes reviewed from 9-14-04 to the time of the 10-5-ER visit. There is no information related to R2's respirations being decreased to 8 per minute as told by E2 in interview on 10-13-04.

A second October ER visit was documented 10- 12-04.
A progress note written by E2 on 10-12-04 states that R2's father came to the facility and wanted to know why nothing was being done regarding R2 having no bowel movement (BM). E2 documented that R2's father wanted the ambulance called because he was taking him to the hospital. The progress note written by E2 states,"I gave him the phone and said all he had to do was call 911. He did!" The ambulance took R2 to the ER where a diagnosis of Hypoglycemia, Dehydration and Constipation was given. An ER record obtained during the survey showed that the blood glucose was below 69. The ER record said the father of R2 stated R2 had no BM for 8 days. R2 was given IV fluid, Glucose IV and given a prescription for a laxative and R2 was sent back to the facility.

1. Based on observation, interview and record verification, the facility failed to have an easily retrievable and consistent system to ensure / monitor food and fluid acceptance, emesis, urine output, bowel movements, weekly weights for R2.

R2 was observed at the facility and at the workshop on 10-13, 10-14, and 10-15. He was observed in a specially adapted wheelchair at the living and dining room 10-13-04 at intervals from 3:40 to 6:00 PM. He had very slow speech responses, held a sippy glass of fluid in his hand, but did not drink from the glass. He stared into space and at times looked at staff when they addressed him. At supper, he fed himself very slowly some cream soup.
On 10-14-04 R2 was observed holding a glass of what staff said was his nutrition drink. He made no attempt to bring the sippy glass to his mouth. When asked if he needed assistance to bring the glass to his mouth staff assisted him hand over hand to bring his drink to his mouth. R2 was very weak and did not resist staff's assistance to bring the glass to his mouth. However, he did not drink from the glass. He had yellow streaks at the roof and sides of his mouth. His lips were dry and very red.
On 10-15-04 R2 was observed at the day training site at lunch time at 12:30 PM. He was staring into space. Direct care staff, Z5, was attempting to feed him. Food put into his mouth was not chewed or swallowed. The food remained on R2's tongue. Z5 said in interview at the observation time, that R2 had no food or fluid intake on 10-14-04 or 10-15-04 at the workshop. Z5 said that on 10-14-04

R2 vomited after he took some food. Z5 said R2 was taken to the bathroom when he said "Pee Pee" but would sit on the toilet for 20 to 30 minutes without voiding.

Z5 said they did not measure intake, output, or document food acceptance. She said that the information is communicated verbally, when R2 is taken home, given to facility by written documentation or by telephone.
There was no documentation at the facility regarding R2's refusal of food and fluid at the workshop, emesis or lack of urinary output.
When asked if R2 has been eating at the workshop, Z5 said R2 has not eaten or taken fluids "for a while".

Review of R2's progress notes written by direct care staff showed that there was no consistent documentation of food acceptance, intake or output.

The following documentation was noted in the progress notes documented by the direct care staff. These notes were not transferred or documented in the nursing notes or did not become a part of R2's clinical record:

10-1-04: 65% of one meal for the day documented. No output for the day documented. No other liquid intake documented.

10-2-04: 50% of lunch documented at 1 PM. 100% of a shake was documented for the 3-11 shift. No other fluid intake for the day was documented. Only 1 output (large amount of dark urine) was documented at 11:30 AM.

10-3-04: Sips taken at 9:30 AM and 25% breakfast and 15% of supper eaten. No other intake documented for the day. Only one urine output documented for the day [large amount amber at 10:40 AM].

10-4-04: 75% breakfast, and 75% of supper and a shake was taken. No other fluid intake is documented for the day. No output is documented for the day. It was documented that R2 was crying.

10-5-04: 25% of breakfast and 3 ounces of a fluid was taken. 2 glasses of water was taken. No output for the day was documented at the facility. It was documented that R2 was crying. R2 went to the ER at 5:45 PM and had 300cc urine output per catheterization at the ER, per the facility progress notes.

10-6-04: No food intake documented for the day. 1/2 glass water and 10% of his liquid laxative [lactulose] was documented for the day. He had urine output documented at 4:10 and 8:30 PM. It was documented that R2 was crying.

10-7-04: 30% breakfast and 1% supper documented. An episode of vomiting [no time given] was documented. No other intake for the day was documented. One urine output at 5 PM was documented as dark amber. It was documented that R2 was crying.

10-8-04: 75% of supper, 100% of one milkshake and 2% of his supper was documented. No other intake was documented. One urine output of dark amber urine was documented on the evening shift. It was documented that R2 was crying.

10-9-94: 50% of breakfast and 90% lunch documented and 70% "of meal" documented as being given at 9:05 PM (after pain medication for the sores in his mouth was given). 1/2 glass of water documented for the day. No other fluid intake documented for the day. One episode of urinary incontinence documented.

10-10-04: 80% supper and 50% of a shake documented. One glass of water and no other fluid was documented for the day. He complained of his mouth hurting. One urine output for the day was documented. It was documented R2 was crying, complained of mouth pain and the pain medication was not effective.

10-11-04: 90% supper, 1/2 glass juice, two 1/2 glasses of water is documented. No other fluid intake was documented One urine output for the day [dark amber urine] was documented for the day. At 10 PM, R2 said he had to urinate, but was unable to void.

10-12-04: 100% food eaten (not identified as a meal) after workshop. No other intake documented for the day. One urine output [dark amber] documented for the day at 5 PM. At 5 PM R2 was taken to the emergency room at his father's request. He received IV fluids for dehydration.

10-13-04: 100% lunch and 90% supper, 100% shake, 1 glass of juice in the evening and 8 oz water with his laxative was documented. A urine output was documented 3 times for the day. R2 was observed at supper on this day. He was served a bowl of soup and a drink.

10-14-04: 50% of supper and 50% of his shake was documented for the day. No other food or fluid intake was documented. One urine output [dark color] was documented for the day.

10-15-04: No intake was documented for the day. No lunch or fluid intake was observed at the workshop for the day. This was verified by Z5. No output was documented for the day. R2 voided at the facility before he was taken to the emergency room at approximately 4:00 PM.

Per interview with E4, RN consultant, on 10-13-04 at 5:15 PM, there is no specific monitoring of intake and output for R2 and appetite / food acceptance is only documented in the hab tech progress notes. E4 said there is no easy way to track intake, output and food intake, other than to read through all of the progress notes. E4 said on 10-15-04 at 4:30 PM that she could not find a tracking sheet [for intake ant output] "for this company." The direct care staff progress notes are kept in a file at the facility and are not kept in the clients' charts. The recent progress notes are kept on a clip board in the medication room. The progress notes from several weeks ago (or longer) are kept in the office which is locked when the RSD is not in the building, so would not be accessible to review by direct care staff.

E5, direct care staff, said in interview 10-15-04 at 9:20 AM that there in no documentation sheet for intake, output, food intake. E5 said that she takes a cup of fluid to his mouth, but he lets the liquid run out of his mouth. She said when R2 has food or fluid in his mouth, he makes a frown - like it hurts "especially food". She said that it was not normal for R2 to vomit and felt he was deteriorating. E7, direct care staff, said in an interview on 10-14-04 at 5:45 PM that when R2 did not want to eat or drink, that they were to offer the food, drink, medication 3 times and document it (as a refusal). She said they were not told anything else to do when meals, medications and fluids were refused.

Per interview with Z2, physician on 10-14-04 at 5:10 PM, the physician was not aware that R2 continued to have poor food and fluid intake. He said that if R2 was not eating / drinking enough for several days, he should go to the emergency room. Interview with Z2 on 10-15-04 at 4:00 PM, he would be expected to be called anytime if R2 was not eating or drinking and would expect the facility to measure intake, output, appetite and bowel movements.

R2 has a physician order for a weekly weight on the September physician orders. Per the Individual Program Plan (IPP) in the record dated 7-03 as well as the current IPP dated 7-18-04 (that was not available at the on site survey), the nutrition report stated he weighed 120 lbs. His ideal body weight range is 137 - 171 lbs.

Only 1 weight was done in August, 2004 (on the 1st) - 116 lbs.
3 weights were done in September, 2004: 5th - 115 lbs; 18th - 118 lbs; 29th - 103 lbs
1 weight in October, 2004 (as of the 14th): 14th 114 1/2 lbs.
E4 said that she had told the QMRP that weekly weights were not being done. Since R2 was in a wheelchair, no arrangements had been made until 10-14-04 to make use a wheelchair scale of another facility. There is no evidence that the lack of weekly weights, the documented 15 lb loss in 11 days in September or resolution for the problem of obtaining a wheelchair weight was being addressed.

Per interview with E4, RN on 10-13-04 at 5:15 PM and on 10-15-04 at 4:30 PM, she said the RSD keeps the P-15's (direct care staff progress notes) and they are available (for review) and felt that the facility was monitoring these functions, but could not easily retrieve the information related to appetite, food and fluid intake and output, emesis and bowel movements.

The neurologist wrote a consult note on 9-24-04 for R2's visit of 9-19-04. The note said that since R2's Zonegran, given for seizures, can sometimes suppress appetite, that he may need to consider reducing the dosage of the Zonegran. It was noted that R2 also took two other medications for seizures. There is no evidence that the nurse reported the continued loss of appetite to the neurologist, after his dictated note was received, to discuss the possibility of Zonegran reduction with him.

2. Based on interview and record verification, the facility failed to have a plan in place to monitor R2's diagnosed hypoglycemia.

R2 was admitted to the ER on 10-12-04 and was given IV Glucose for hypoglycemia. The blood sugar documented on the ER record showed a blood sugar of 69. R2's facility record shows that he has a diagnosis of hypoglycemia. R2 has a routine order for a fasting blood sugar every 2 months. The facility fasting blood sugars done 9-16-04 was 63 (normal is 70-110). Based on hospitalizations and emergency room visits, the blood sugar fluctuates between hypoglycemia and hyperglycemia. A blood sugar done 10-13-04 was within normal range (83). There is no evidence the nurse contacted the physician to request more frequent blood sugars when the lab results showed low blood sugar.
There is no evidence the nurse checked R2's blood sugar when he showed lethargy or decreased appetite at the facility.

Per interview with the physician, Z2 on 10-14-04 at 5:00 PM, the blood sugar should be checked at the facility to monitor the blood sugar on a more frequent basis. The RN wrote a phone order dated 10-14-04 for R2 to have an accucheck BID (2 times per day). There was no equipment at the facility to check blood sugars until late afternoon of 10-15-04, when the nurse brought the equipment to the facility from the pharmacy.

There are not written instructions for the direct care staff to follow regarding symptoms to watch for regarding hypoglycemia. There is no evidence the direct care staff were trained to monitor for signs or symptoms of hypoglycemia (low blood sugar).

The discharge instructions from the emergency room on 10-12-04 included symptoms to monitor for diabetes / high or low blood sugar.

3. Based on interview and record verification, the facility failed to ensure bowel health for R2 who had no recorded bowel movement for 12 days, refused, vomited or did not receive ordered laxative medication for his constipation, failed to accurately document results of laxatives and failed to notify the physician when additional PRN laxatives did not work.

Per interview with E2, QMRP, on 10-13-04, R2 was taken to the hospital on 10-12-04 by his father for evaluation of having no bowel movements. Z1 said when he came to the facility on 10-12-04, he thought R2 was dead. Per Z1, he was sitting in his wheelchair, his eyes were glazed and he gave no response when he spoke to him. The ER record stated R2's father reported that R2 had no BM for 8 days. However, upon review of the direct care progress notes, R2's last documented BM was 10-3-04 , which was actually 9 days with no BM as of 10-12-04. The nurse was informed that R2 had no bowel movement for 6 days according to a progress note written by E2, QMRP dated 10-9-04 at 12 noon. The note states,"Spoke to [E4] nurse. [R2] has open sores on the roof of his mouth. He is to be given [name brand given for acetaminophen] every 6 hours for pain. [R2] also has not had a bowel movement in 6 days according to the logs. He will be given a laxative PRN [as needed] also."
Per R2's physician order sheet and medication administration record (MAR), R2 had Lactulose Solution, a laxative / stool softener, 45 cc ordered twice a day. Per the MAR, R2 refused or did not receive 10 of 22 doses of Lactulose from 10-1-04 to 10-12-04.
The MAR has documentation that Milk of Magnesia was given 10-10-04 at 1 PM, 10-11-04 at 9:10 PM and 10-12-04 at 4 PM. Although E8, direct care staff, documented an "E" [identified in the key as "effective"] for the Milk of Magnesia dose given 10-11-04, there is no narrative as to the effective results of the laxative. The MAR showed R2 received both the Milk of Magnesia and the Lactulose Solution.

At the surveyor's request, E4, RN, called E8 to ask what she meant by the documented "E", E8 said that R2 actually had no results (BM) from the laxative and the documented "E" was an error.

There is no evidence that the nurse notified the physician of repeated laxative refusals, lack of a bowel movement even with additional laxatives given 3 days in a row.

R2's ER diagnosis from 10-12-04 included constipation, Dehydration and Hypoglycemia. ER discharge orders included Miralax 1 heaping tablespoon in 8 ounces of water by mouth daily for 7 days. The medication was started at 7 AM on 10-13-04. As of 10-14-04 afternoon, R2 still had no bowel movement.

During this time, after 11 days with no BM, there is no reproducible evidence that the nurse assessed, evaluated R2's constipation and lack of a response to the laxatives or notified the physician of R2's lack of response to the Lactulose, Milk of Magnesia and Miralax.

Per phone interview with Z2 on 10-14-04 at 4:00 PM, Z2 said he had not been informed of R2's ongoing constipation.
Following Z2's interview, the nurse was given phone orders from Z2 for Dulcolax Suppositories every 3rd day if no BM.
The surveyor observed phone orders on 10-15-04 on R2's current physician order sheet. The phone orders were dated 10-14-04. There is no signature of who transcribed the order or the name of the prescribing doctor.
As of 10-15-04 at 10:00 AM, R2 had not received a Dulcolax Suppository.
Z6, pharmacy technician, said in 9 AM phone interview on 10-15-04 that the pharmacy had not received an order for the suppository. She said the nurse discussed a medication for high blood pressure for R2 on 10-14-04, that had been ordered but was not covered by Illinois Dept. of Public Aide. But Z6 said Dulcolax was not discussed. She said she leaves the pharmacy at 5:30 PM, but there is a pharmacy tech after hours.

E4 stated on 10-15-04 at 4:30 PM that the Dulcolax was not ordered from the pharmacy on 10-14-04 because E4 wanted to clarify the orders with the physician. She said that R2 was on Miralax and she did not know if the physician wanted the Dulcolax suppository given with the Miralax and Lactulose.

She brought the Dulcolax suppositories to the facility about 4 PM on 10-15-04. E4 said she picked up the medication ordered on 10-14-04 herself and that the pharmacy closed at 5 PM. she stated that she was not aware of available pharmacy service after closing hours. She said if emergency medication was needed, the client would be sent to the emergency room.
Z2, physician for R2, said in interview on 10-15-04 at 4 PM that he would have expected the Dulcolax suppository to have been given when it was ordered and that he could have been called at any time.

There is no evidence the nurse checked R2 for an impaction during the time R2 had no BM's

There is no documentation that the staff or the nurse called the doctor before or after the ER visit on 10-12-04 regarding the constipation.
There is no evidence the nurse developed a plan for direct staff to follow.

4. Based on interview and record verification, the facility failed to report R2's recurrent untreated high blood pressure to the physician or implement a system to follow-up with elevated blood pressures by informing nurse or retaking blood pressures / pulses when they were elevated.

Progress notes written by the direct care staff between 9-14-04 and 10-15-04, R2's blood pressure was elevated 25 times with elevated ranges from 138/90 to 148/109 and pulse of 92 to 111.
Additionally blood pressures at an ER visit on 10-5-04 was 126/93.

The physician order sheet states R2 was to have a monthly blood pressure [BP]. The Medication Administration Record reflects the monthly blood pressure. All other BP's were recorded in direct care staff progress notes (which are not a part of the client chart) nursing quarterlies or in a nursing note.

From 9-14-04, there were more frequent blood pressures documented by the direct care staff for 2 days. From direct care staff progress notes given to the surveyor from the QMRP's office showed that the last BP recorded on 9-16-04 at 9 PM by a direct care staff indicated R2 had a BP of 148/108 in the left arm with a pulse of 94 and a BP of 125/95 in the right arm with a pulse of 96. There is no further documentation of a BP until 9-25-04. The BP increased through the day from normal 114/76) in the morning to 143/104 at 7 PM.

No further blood pressures are documented until 10-1-04 (no time given - 135/95).
There is no evidence of nursing review or physician notification the multiple elevated blood pressures / pulse rates.

On 10-7-04 the first blood pressure checked since 10-6-04 was 143/102 pulse 93 at 4:15 PM. At 4:20 PM the BP was 149/102. Documentation by E8, direct care staff, stated the nurse was called and the "nurse said to give [R2] 2 aspirin. E4 said in an interview on 10-14-04 that she thought that R2 had pain from the sores in his mouth that was causing his BP to be elevated and if something was given for the pain, that his BP would decrease. None of this information is documented in the nursing notes by E4.

Per interview with E8 on 10-14-04 at 5:50 PM, the nurse, E4, told her to give the aspirin when she was called about R2's elevated BP. E8 said she was not given instructions as to retaking the blood pressure.

E8 said when she talked to the nurse a "couple of times" about R2's elevated BP, she was told to just "write it in the P-15's" [direct care staff progress notes].
A nursing quarterly report was written by E4 for R2 is dated 10-7-04 [the same day as the elevated readings taken by E8].

The nursing quarterly shows a BP of 136/80 pulse 85, Respirations 10. There is no mention made in the nursing quarterly regarding the frequent elevated blood pressure readings or the 2 reported elevated readings on 10-7 documented in the direct care staff progress notes by E8. The direct care staff progress notes which includes dates and times of changes in health status as well as other generalized and observed client status, are not in the active client record. The surveyor would not have been aware of R2's ongoing hypertension [documented in the direct care staff] had the direct care staff notes not been requested by the surveyor. The notes were found in various places at the facility (med room, in the RSD's office in various places).
E4, RN said in interview 10-14-04 at 12:50 PM that she had not specifically informed the physician of the elevated blood pressure, but he took the BP in his office and she took the BP at the facility. She said that she summarizes information from the direct care staff for her notes. There is no evidence that information related to the elevated blood pressures were reflected in the nursing monthly summaries or nursing quarterly notes.
Z2, physician said in interview on 10-14-04 at 5:10 PM that he had not been informed of R2's elevated blood pressure and that he could give medication for the elevated BP.
R2 had no diagnosis or treatment for hypertension as of 10-14-04.

5. Per observation, interview and record verification, the facility failed to:

a) Document, monitor, follow-up or report to the physician blisters or sores in R2's mouth or
b) R2's vomiting, or change in level of alertness

5-a. R2 had reported blisters and sores in his mouth from approximately 9-15-04 until at least 10-9-04 with no evidence this was monitored by the nurse, treated or reported to the physician.

Per interview with Z3, workshop staff, R2 cries and howls like he is in pain. Z3 said he did not cry and howl prior to 9-04. She said that on 9-15-04, R2 had large water blisters on his tongue, on the far back of his tongue and on his uvula. She said that this was communicated to the facility staff. This observation was verified by the workshop nurse.
Documentation from E4, RN 9-16-04 (no time given) was on a direct care staff progress note that read, " Nurse followed up for a red, excoriated palate area (roof) of mouth. Complained of soreness. PRN meds given for pain. Enc [encourage] staff to give cold liquids and no red colored fluids and will cont. [continue] to monitor."

There is no documentation regarding this in R2's chart / nursing note and there is no evidence of further follow-up or monitoring by the nurse.
E4 said that she thought R2 had a red soft drink type drink that may have caused the roof of his mouth to look excoriated.
An additional report completed by the day training 9-24 referred to blisters in R2's mouth.
On 10-9-04 a note written in with the direct care progress notes by E2 stated the nurse was called due to R2 having open sores in the roof of his mouth. The note by E2 said he was to be given [brand name for acetaminophen] every 6 hours for pain. A 10-10 note by direct care staff said R2 was crying with his mouth hurting and the acetaminophen was ineffective.

E4 said in an interview on 10-14-04 at 12:50 PM that the doctor had not specifically been informed of R2's mouth sores. There was documentation by E4 of the mouth sores / excoriation from 9-16-04.
There is no evidence the nurse assessed, monitored or further documented on the mouth sores that were being reported and documented by the direct care staff and the workshop.
R2's physician said in interview on 10-14-04 that he had not been informed of R2's mouth sores and that a mouth rinse or lidocaine rinse before food or fluid intake would probably help with the pain.

5-b. Vomiting, possible choking and repeated documentation of R2 being dazed with eyes unfocused and R2 being unresponsive were not monitored, documented by the nurse or reported to the doctor.

A progress note written by E7, direct care staff on 9-14-04 (no time) stated the day training staff called to report that R2 was sick, appeared to be in a daze, did not talk or acknowledge he was being spoken to, and advised he go to the hospital to be evaluated.
He began to vomit while getting on the bus to go home. The note said the administrator, E1, and nurse, E4, were notified.
A note written by E2, QMRP, stated E1 said not to take R2 to the hospital unless the nurse recommended he go [to the hospital]. The note said they were waiting for the nurse to call back (no time was documented.)
There is a note dated 9-14-04 by the nurse (no time given) that states "checked document, vital signs (B/P - P - R) ...of meal intake, urine output, BM's, emesis (color, liquid, food particles), Resident status (ex. calm, anxious, crying, cooperative) each shift, please report to oncoming shift. Will F/U [follow-up]."
This was written on the direct care staff progress note page. There is no note by the nurse in the nursing notes for this date. There is no documentation or evidence of assessment or evaluation of R2's vital signs, level of consciousness or general condition by the nurse on 9-14-04. There is no evidence the physician was notified of R2's condition.
There is no documentation as to why R2 was not sent to the hospital for an evaluation.

When R2 was taken to the emergency room by E2 on 10-5-04, there is no evidence the emergency room doctor was informed of R2's episodes of vomiting, increased lethargy, episodes of elevated blood pressure or recent history of elevated ammonia levels and dilantin toxicity.

The direct care staff documented on multiple days that R2 was in a daze with eyes unfocused.
On 9-15-04 direct care staff documented R2 gagged on a hot dog.
Per workshop notes (identified as Consumer Contact Sheet, actions corrected sheet and incident sheet), on 9-24-04 the workshop reported that R2 began gasping in air, he was choking, had a seizure, and had thick sputum at the back of his throat. The nurse at the workshop was able to sweep the sputum from his throat. Z4, RN at workshop said in 10-15-04 interview at 1:10 PM that she did not know if R2 had choked on food on 9-24, but he had "a lot of saliva." She said he was served a bologna sandwich, and big banana chunks on the day he choked and she had talked about a pureed diet being necessary.

On observation at the workshop 10-15-04 at 12:30 PM, R2 was observed in the dining room. He appeared to stare into space, did not respond to verbal stimuli, when food was put into his mouth, the food stayed on his tongue with no effort to swallow.
Z5, who was feeding him said he came from home to work that morning with food at the back of his mouth.

On 10-15-04 observation, R2's lunch at the workshop consisted of a whole bologna sandwich, sliced peaches. a banana cut into large chunks and corn curls. Z5 said he, as well as the other clients from the facility, all receive regular diets. She said at times raw carrots and other hard foods are sent. R2 has no teeth based on the nursing assessment and dietary assessment.
R2's diet order is for a mechanical soft diet with ground meat. Z5 said on 10-15-04 that R2 is never sent a mechanical soft diet with ground meat. Day staff at the facility said all 4 clients at the facility are on mechanical soft diets and should have ground meat and other foods on the mechanical soft menu.

Additional direct care staff notes state R2 vomited on 10-5 and 10-7.
There are direct care documentations for September and October of R2 being weak and unable to stand, frequent episodes of crying and appearing dazed or sleeping. These notations are not noted in the nursing notes. When asked about the documentation about R2 being dazed, the nurse said in 10-14-04 interview that she did not know what the staff meant by dazed - that if he were not responding normally, that was lethargic.

She said the vomiting was not reported to the physician because there were standing orders for PRN medications for vomiting. There is no documentation that the PRN (as needed) medications for vomiting were given.

6. R2 had orders phoned to the nurse from his physician on 10-14-04 after the surveyor discussed R2's health issues related to mouth sores, hypoglycemia, dehydration and lack of nutrition.
The orders recorded on the order sheet were dated 10-14-04 and were as follows:

Accu check BID. Call if below 70, Encourage 2000 cc per 24 hours, Increase [name of nutritional supplement] TID, Dulcolax suppositories every 3rd day if no BM.
As of 10-15-04 AM, the direct care staff had not been informed to measure fluid intake to ensure 2000cc, had not been informed to track bowel movements or increase supplement.
The Accucheck machine and suppositories were not brought to the facility until 10-15-04 about 4 PM. The nurse said she had to go to the pharmacy herself to pick up the supplies and medicine since the order had to be processed.
The physician had also left orders for medication for hypertension and for the mouth sores according to E4 on 10-15-04.

Per the nursing consult report (not a part of R2's active record) faxed to the surveyor in the regional Department office on 10-19-04, the nurse had also received an order for Norvasc 5 mg daily and hold if the blood pressure was below 100/65.

The consult report said the Norvasc was not covered by Medicaid and when the doctor office was called, the doctor was gone for the day and "noted office staff of plan to call the next day for orders." The consult report continues that a message was left with office staff for phone consult and orders were received at 1 PM on 10-15-04 for Procardia XL 30 mg daily, hold if B/P below 100/65. Lidocaine viscous swabbed to oral sores prior to eating.
The nurse consult report also stated the neurologist's office was called at 1:30 PM on 10-15-04 to report the poor nutritional intake and to request a decrease or discontinuance of Zonegran (as recommended if appetite did not improve per the 9-29-04 neurologist report). The neurologist left orders to gradually decrease and discontinue the Zonegran and call if R2's appetite did not improve.

The consult report states at 3:30 - 4 PM the medications and equipment and MAR forms were picked up from the pharmacy and stated none of the orders received were "as now or stat".
It was noted in the progress notes that only 1 blood pressure was checked on 10-13-04 (138/90 at 3:15 PM) and one taken on 10-15-04 (140/100 pulse 92). Although the medication was not ordered stat, there is no evidence in R2's file to justify waiting 24 hours to initiate medication for ongoing constipation and elevated blood pressure, or evidence that attempts were made to contact the physician or pharmacist before or after the close of normal business hours to clarify orders and begin ordered medication.

A progress note written by E4 on 10-16-04 indicated the hospital nurse stated R2's dilantin level was toxic (26) and dilantin was "on hold". A note written 10-18-04 stated R2 was still in the hospital and his ammonia level was elevated (66). These elevations have a possible effect of decreasing level of consciousness.
The note continued to say that an obstructive series showed there was no bowel obstruction, but there was a mild ileus (a decrease in movement of the intestine).
R2 remained in the hospital on 10-20-04.

7. The facility failed to obtain a written consent, justify and verify the purpose and monitor side effects for an antipsychotic medication, Risperdal 0.25 mg HS, that was ordered by a psychiatrist in the hospital and was started at the facility for R2 9-2-02.

R2, according to E2, QMRP was given the Risperdal when the hospital determined that R2' s refusals to eat were a result of a maladaptive behavior since a swallow study was negative (for aspiration).
E4, RN said that the physician ordered the medication and she does not ensure a medication consent is obtained - that the QMRP takes care of the consent.
There is no evidence R2 was evaluated for side effects of the Risperdal.
A DISCUS to monitor for Tardive Dyskinesia was done 7-04 and showed that R2 took no psychotropics.
Since starting on Risperdal, there has been no repeat DISCUS. A potential side effect of this drug is Tardive Dyskinesia.

No nursing care plan was initiated per interview with E5, direct care staff on 10-14-04 at 9 AM and E4.

E5 said the health issues are called to the nurse but felt his health care is not being addressed.
E7 and E8, direct care staff, said in interview 10-14-04 at 5:45 PM that the staff are not allowed to send a client to the emergency room unless the nurse approves.

Z1 said per 10-14-04 interview that he had not been notified of R2's many health problems (elevated blood pressure, hypoglycemia, vomiting) by the facility. He said he was approached about having a G-tube put into R2, but felt that all other measures should be tried first and evaluate if there was an underlying problem for R2's lack of appetite, such as mouth sores, or other medical issue.
He verified that he was told that if he wanted R2 to go to the hospital on 10-12-04, that E2 told him that was his right and was handed the phone to call 911.
Z1 felt the nurse and assistant administrator were not paying attention to R2's health.

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(Continuation Page)

DEARBORN COURT	10066
Facility Name	I.D. Number

STATE OF ILLINOIS
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STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)

Facility Name

I.D. Number

STATE OF ILLINOIS
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STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)

Facility Name

I.D. Number

STATE OF ILLINOIS
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STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)

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STATE OF ILLINOIS
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STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION
(Continuation Page)