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

ASTA CARE CENTER OF ROCKFORD	0041772
Facility Name	I.D. Number
707 WEST RIVERSIDE BOULEVARD, ROCKFORD, ILLINOIS 61103	
Address, City, State, Zip	
22344	APRIL 2, 2008
Reviewed By	Date of Survey
COMPLAINT 0811347/IL34176	21546, 21016
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.

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):

300.1210a)b)1)2)3) **Section 300.1210 General Requirements for Nursing and Personal Care**

a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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. Restorative measures shall include at a minimum the following procedures:

b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven days a week basis:

1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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Based on observation, interviews, and record review the facility failed to identify an adverse reaction to an Opiate (Morphine) in a resident who was found lethargic and unresponsive.

The facility failed to protect a resident from undue medication consequences by not discontinuing a medication (Fentanyl). The resident was found to have 2 Fentanyl patches on her body upon being admitted to the Emergency Department on 3/21/08. The 2 Fentanyl patches and the morphine 30mg twice daily caused a cumulative effect resulting in the residents' lethargy and unresponsiveness.

These failures resulted in R1 becoming difficult to arouse and required emergency transport on 3/21/08 at 6:15 AM to a local hospital. R1 required 2 doses of Intravenous Narcan (an Opiate reversal agent) to make her more responsive. The resident was admitted to the Progressive Care Unit of a local hospital with the diagnoses of Narcotic Overdose and Elevated Troponin T - Non ST Elevation Myocardial Infarction likely due to Coronary Hypoperfusion from Narcotic Overdose and Subsequent Hypotension.

The resident's Fentanyl was discontinued by physician order, but continued to be administered to R1. The resident was also receiving Morphine 30mg twice daily.

This applies to 1 resident (R1) who received discontinued, contraindicated Fentanyl and who received Morphine 30mg after being found lethargic and unresponsive on 3/21/08.

The examples include:

R1 is a 60 year old resident who has End Stage Renal Disease, Hemodialysis, Morbid Obesity, Gastric Esophageal Reflux Disease, Type II Diabetes Mellitus, Anemia, Hypertension, Congestive Heart Failure, Sleep Apnea, Peripheral Vascular Disease, Asthma, Orthostatic Hypertension, Chest Pain Abscess, Above the Knee Amputation, and Below the Knee Amputation, according to the March 2008 Physician Order Sheet (POS).

R1's March 1 through March 31, 2008 Physician Order Sheet shows that on 3/17/08 the resident's Fentanyl 25mcg/hour patch was discontinued. On 3/26/08 at 10:00 AM E2 (Director of Nursing) said that the resident's Fentanyl patch was discontinued because the pharmacy said that the medication was contraindicated and likely to cause a severe drug interaction with Zyvox (an Antibiotic), which the resident was on. E2 said that the Fentanyl patch was discontinued and the resident was placed on Morphine Sulfate 30mg twice daily.

The Journal of American Geriatric Society, June 2002, volume 50, No. 6, Supplement states that the duration of Fentanyl 25mcg/hour patches (change every 72 hours) is usually 3 days, but may range from 48 hours to 96 hours.

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Nursing Notes of 3/21/08 written at 5:15 AM by E4 (Licensed Practical Nurse) state, "Went to give resident medications and resident is very sleepy and lethargic. Hard to arouse. Finally she was awakened. When I gave her pills (to her) I had to tell her to drink water and swallow each pill. Oxygen Saturation 95 %...(Blood Pressure 90/50)...5:22 AM paged (E3 - physician) and he was advised of resident's condition. New order received to send resident to (Emergency Department) for further evaluation..."

The facility's Controlled Substances Proof of Use sheet shows that on 3/21/08 at 6:00 AM E4 signed out R1's AM dose of Morphine Sulfate 30mg. Next to her signature she writes that she wasted the medication. There was no co-signature witnessing the wasted narcotic. On 3/26/08 at 10:00 AM E1 and E2 (Administrator & Director of Nursing) said that that it is the facility's policy that any wasted narcotics is to be verified by 2 nurses. E1 said that E4 (LPN) had received a formal disciplinary write up for not following policy. The facility had no evidence to prove that R1 did not receive her Morphine on the morning of 3/21/08.

The ambulance report of 3/21/08 at 6:15 AM states, "called to the scene for a 60 year old female (R1) for a possible overdose on Morphine. Nursing staff stated the patient is given 30mg of Morphine in the morning and the evening. The staff thought maybe the patient had too much Morphine and now had a decreased mental status...Morphine was administered 1 hour prior to the call...1mg of Narcan administered via the IV. Patient became more responsive. Respiratory rate increased from 8 to 12 (respirations per minute). During transport patient started to vomit...patients' condition improved on arrival, increased respirations, more responsive".

Emergency Department (ED) notes for R1 (3/21/09 @ 6:43 AM) written by Z2 state, "The patient was placed on increased dose of oral Morphine this week and Fentanyl patches were discontinued but never removed by nursing home staff and the patient became unresponsive this AM and EMS called...". The ED notes under History of Present Illness state,"EMS states patient sent from nursing home for possible overdose on Morphine. States patient on 30mg Morphine in the AM and PM. Was given AM dose and patient became unresponsive with minimal respiratory effort. Upon arrival patient respiratory rate 8 (times per minute). Given 1 mg Narcan. Patient's respiratory rate (RR) increased to 12 and became more responsive. Upon arrival patient is oriented to person. RR16. Patient with emesis upon arrival. Incontinent of stool." The ED notes show that R1's primary diagnosis was Overdose - Opiates.

On 3/27/08 at 11:00 AM Z2 said that that R1 had 2 Fentanyl patches on when she arrived in the ED. Z2 said that one of the patches was dated 3/15/08 and the other was dated 3/17/08. Z2 said that the report they received was that the resident had received her AM dose of Morphine, and shortly after became unresponsive. Z2 said that the resident was given Narcan IV by the paramedics and the medication was repeated again in the ED. Z2

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said that the overdose was most likely due to an accumulative effect of the 2 Fentanyl patches and the Morphine. Z2 said it was definitely an Opiate overdose because after the Narcan was given R1 improved. Z2 said that the resident exhibited signs of withdrawal; Tachycardia (rapid heart rate), emesis, and incontinence, after the Narcan was given.

R1's Minimum Data Set of 1/28/08 shows that the resident's short and long term memory is intact and that she is independent in daily decision making. On 3/27/08 R1 said that she was admitted to the hospital because she was given too much Morphine. R1 stated that the morning she was transferred by ambulance to the hospital E4 (LPN) gave her the red Morphine. During the interview the resident was asked what year it was and who the president of the United States was. The resident was able to answer the questions correctly and without any hesitation.

On 3/28/08 at 7:15 AM E4 said that at about 5:00 AM on 3/21/08 she attempted to wake up R1 for her 6:00 AM medications. E4 said that the resident was very lethargic. She said that she was able to get the resident to take her medication, by giving them to her one by one and reminding her to swallow each time. E4 denied giving the Morphine 30mg tablet to the resident. E4 said that she did not get a witness when she wasted the narcotic because the other nurse was up on the 2nd floor of the facility. E4 said that after giving her the medications she returned approximately 30 minutes to check on the resident. She said that R1 was very sleepy and difficult to arouse so she called the doctor and received an order to transfer the resident to the hospital.

The Hospital list History and Physical (H & P) for 3/21/08 states, "...was doing fine up until this morning when she was discovered unresponsive by the nursing home staff...She was brought to the hospital Emergency Room where she was noted to be on multiple opiate based pain killer medication including MS Continue, Morphine Sulfate and Fentanyl Patch. In Fact it appears that she may have had several Fentanyl patches on her. All the narcotic medications were discontinued immediately, Fentanyl patches were removed and patient was given some Narcan after which she became much more alert and responsive...Cardiac markers however were slightly elevated..." Listed under the Impression section of the H & P were 10 diagnoses which include the first diagnoses to be Narcotic Overdose. The 3rd diagnosis is Elevated Troponin T - non-ST elevation myocardial infarction likely due to coronary hypoperfusion from narcotic overdose and subsequent hypotension.

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