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	145806	A. BUILDING _____ B. WING _____	C 06/18/2008

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F 490	Continued From page 20 Administrator, and Quality Assurance Committee. The Director of Nursing will monitor for overall compliance through her supervision of nursing staff and review of quality Assurance Reports. IV. Completion Date: 6/12/08	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)2) 300.3220f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care	F9999		

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F9999	Continued From page 21 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) These REGULATIONS are not met as evidenced by: Based on observation, staff interviews, and review of clinical records, the facility: 1. Failed to follow physician's orders for one resident in a sample of 4 (R2). 2. Failed to identify the correct resident scheduled for an invasive procedure.	F9999		

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F9999	Continued From page 22 3. Failed to follow the facility's policy and procedure for transfer forms. 4. Failed to follow the facility's Identification Policy of Resident Prior to Transfer. These failures resulted in: -- R2 being transported to Z7 (a local hospital) where he underwent a Bone Marrow Aspiration which was scheduled for a different resident (R3). --R2 not being informed of the need for such a procedure nor of the details involved in the procedure. --The Bone Marrow Aspiration altering the physical/mental well being of R2 due to no explanation being given for the procedure and the endurance of pain caused by the Invasive procedure (Bone Marrow Aspiration). Findings include: R2 is a 62 year old male with diagnosis which include Depressive Disorder, Panic Order, Anxiety State, and Regional Enteritis. Medications include Ferrous Sulfate and Vitamin C. MDS 2.0 quarterly dated 4/10/08 states cognition: Modified Independence with difficulty in new situations only, no concerns with speech or communication, memory or hearing. At approximately 7:00 AM on 3/28/08, R2 was sent to Z7 (a local facility) where he did underwent a Bone Marrow Aspiration (an invasive procedure also referred to as Bone Marrow Biopsy) which was not ordered for him. The test had been	F9999		

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F9999	Continued From page 23 ordered for R3. R3, a 33 year male with diagnosis to include Schizoaffective disorder, was being followed for new complications. R3 now has a diagnosis to include an enlarged spleen with decreasing white blood cells (WBC's). R3 is alert and oriented. Per the MDS 2.0 R3's cognition is modified independent. He is allowed out on passes to visit the home of his mother without escort. He was scheduled for an appointment with a hematologist/oncologist at Z7. R3 was not sent for the scheduled appointment set for 3/28/08. Instead R2 was sent. On 5/30/08 12:30 PM surveyor observed R2 having lunch in facility dining room. As surveyor entered the dining area, R2 looked up and immediately asked, "are you the lady from the State?, If so, I need to talk to you." R2 ambulated with a slow gait without assistive devices. R2 is alert and oriented times x 3, clear speech with the ability to state and sign name. R2 per interview 5/30/08 at 1:00 PM in room 104 stated, "they (this facility) sent me out for a test. I don't know why I needed that test. It hurt me so bad, It hurt so bad. They stuck a big needle in my thigh and it really hurt. I keep asking these nurses here why I had to have that test, and no one will answer me. I went to the hospital for the test by medical car, and I had an escort name (E3) with me. I need you to find out why this was done to me. It really hurt me bad for a long time. When the nurse told me I was going out for the test, I did not know what test it was. The nurse told me I was going to have a Bone Marrow done. I did not know what that was."	F9999		

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F9999	Continued From page 24 Interview with R3 on 5/30/08 at 12:00 PM: R3 informed surveyor, "I've had my room changed three times already. The first two times I asked for the change, but this time I didn't. They just moved me. I was on the first floor. I did not go for any Bone Marrow Testing, and I don't know that I need to go." 5/30/08 1:35 PM Interview with E3 (Certified Nurses Aide/CNA) who is assigned to rehab department and escorts residents to and from appointments: E3 stated, "On 3/28/08 I did escort R2 to an appointment. I was given papers for him in an envelope. I don't know what the papers or the appointment was for. I never read the papers. I gave the papers to the facility when I arrived they took the resident back. When they were finished with him I called the transportation to pick us up. The nurse on the first floor told me to take R2 (the sending nurse referred to R2 by name) to his appointment. When I arrived at the appointment, I just handed them the papers and they took R2 away. They never asked me who he was. They just took the papers." 6/3/08 1:30 PM Interview with Z4 (Medical Transportation): "I arrived at the nursing home at 7:00 AM. I asked for R2. The nurse handed me the papers and told me to take R2 for an appointment, and the escort would be accompanying him. Later I received a call from the facility. They were very angry, shouting at me saying I had taken the wrong resident. The facility called shouting at me saying that you were suppose to take R3." 5/30/08 3:10 PM Interview with Z5 (Registered	F9999		

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F9999	Continued From page 25 Nurse/Assistant for Z2): Z5 informed surveyor, "the error occurred when the nursing home sent the wrong patient. R3 was scheduled for the procedure. I'll fax you the order and all the documentation regarding this mix up." 5/30/08 2:30 PM Interview with Z3 (Director of Risk Management at Z7: "On 3/28/08 R2 arrived at our facility (Z7) at 9:00 AM. R2 had a Bone Marrow Aspiration performed on him. The physician here had made a reservation for R3 who was to have the biopsy done. R2 was able to sign his name on the consent for surgery form." 5/30/08 3:30 PM Interview with E1 (Assistant Administrator): "It is the responsibility of the night nurse to send the residents out for testing. The nurse looks in the appointment book, calls transportation, and makes the arrangements. There is no order for R3 to go for a Bone Marrow Biopsy. The residents are identified by asking their names. We also have pictures in the chart to help identify the resident. The request to send residents out for appointments are obtained by: 1. Resident goes out and comes back with an appointment and presents it to the nurse on the floor who takes it from there. 2. The physician calls the order in and gives it to the nurse who documents in the appropriate chart. The night nurse takes it from there. 3. The physician may fax us the request then the nurse does a mini order on the physician's order form. There never was an order for R2 to have the test. It was for R3." 6/02/08 1:15 PM Interview with Z2 (Hematologist/Oncologist): "I had briefly met R3, so when I was informed of the arrival of the patient for the procedure I went down to meet	F9999		

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F9999	Continued From page 26	F9999		

him for the procedure. I said, 'Hi John,' and he answered. I never asked a last name. I asked if he knew what he was here for, and he answered I am here for a Bone Marrow. I am very upset. After the procedure I received a call from the nursing facility stating the wrong resident had been sent, but I had already completed the procedure when it was found this was not R3. I am so sorry this happened. To notify the facilities of the need for testing, I fill out a request form, and my assistant notifies the facilities. The admissions department here notifies me when the patient arrives because I also sent notification to our admitting department. I never gave an order for R2. The order was faxed to the facility for R3. It's funny after the mistake was made, a couple of days later I received a request from the facility to do a consult for R2 for a Bone Marrow Aspiration. In all my 25 years in the business this has never happened to me."

6/11/08 2:00PM Interview with E5 (Licensed Practical Nurse): "I have resigned. E4 sent the wrong resident out. I was working on the 7-3 shift on 3/28/08 when this happened. When R2 came back, he was in so much pain. The pain was so bad everyone was coming to the floor to see him. I did not write any orders for R2. Even though after I was informed what had happened, the administration started to ask me to sign all kinds of papers, so I left. Every one in the facility started running around when they found out the wrong person had been sent out. Yes I do know the procedure for sending a person out. R2 did not have an order."

6/13/08 11:30 AM Interview with E4 (RN/Registered Nurse 11-7 shift): "I was the one that sent R2 out. I know there was no order. I

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F9999	Continued From page 27 checked the appointment book, and the one that was responsible for placing the appointments in the book and making the transportation arrangements had arranged transportation for R2. I checked the physician's order for R2, and there was no order written for R2 to go out. The man from the transportation asked for R2 by complete name stating the arrangements had been made. I did all the checking that I could. Even though there was no order for the procedure, I sent R2 out anyway." 6/18/08 10:00 AM Interview with E6 (CNA): "I did schedule an appointment for R2 for transportation to Z7. I received a piece of paper with the name of the resident scheduled to go out and the name of the place they are to go and the date they want to see the resident. On 3/27/08 I did arrange transportation and did document in my appointment book a trip for R2 to go to 9669 North Kenton in Chicago." Interview 5/30/08 1:00PM with Z1 (Attending for R2/R3 and Medical Director for the facility): "I never wrote an order nor gave an order for R2 or R3 to have a Bone Marrow Aspiration/Biopsy. I was not aware that R2 had one done." Clinical review of documentation: On 5/30/08 surveyor requested the nursing notes for R2 and R3 for 3/28/08. The facility could provide no documentation for the event. There was no incident report/investigation or acknowledgement that the incident had occurred. E1 (Assistant Administrator) stated, "I have an order for R2 to go out for testing. I do not have an order for R3 to go out. At this time I am not able to locate any nursing notes for 3/28/08 for R2 or R3."	F9999		

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F9999	Continued From page 28 On 6/3/08 E1 faxed this surveyor a nursing note entered as late entry documentation into the record of R2 stating, "facility received a call from Z7 stating a Bone Marrow Aspiration and Biopsy had been completed on the wrong resident." The notes surveyor obtained on 5/30/08 from record of R2 end with last note for March dated 3/7/08. There was no record of the incidents that had occurred up to this time. Clinical review also noted documentation of order written by E5 for Bone Marrow Biopsy dated 3/24/08 for R2 with a transportation pick-up form completed for R2 dated for 3/28/08. Further documentation for Bone Marrow Aspiration was documented on the Physician's Orders Form for R2 for Bone Marrow Aspiration as a Telephone Order from Z1 (Medical Director) signed by E5 although the order was denied as being given per interview with Z1. A Transfer form for R3 made on 3/27/08 by E7 in the social service department for transportation is for 3/28/08 8:00 AM to be seen by Z2 for a Bone Marrow Biopsy. Incident report for R2 was sent to IDPH due to surveyor prompting on 6/12/08 and had to be requested again on 6/13/08 as only the back page without the name of R2 was sent to surveyor. On 6/13/07 at 3:30 PM, E1 again had to be prompted by surveyor to report to IDPH the incident of 3/28/08, as there was no notification in the regional log books. R3 has been re-scheduled for Bone Marrow Aspiration per clinical review received on 6/12/08. Documentation provided by Z7 (local facility)	F9999		

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F9999	Continued From page 29 regarding the incident of 3/28/08 states: 1. A request for Bone Marrow called in to facility on 3/24/08 set for date of 3/28/08 for R3 with physician listed as Z2 for Pancytopenia. 2. A full statement of the incident from the legal department of Z3. 4. A consent from Z7 was obtained for the Bone Marrow Aspiration and Biopsy. R2 was given the procedure although the first name and not the last name was signed on the consent form. 5. Surveyor also received on 6/3/07 from Z3 at Z7: statement of no documentation of R3 having Bone Marrow Aspiration on 3/28/08. An incident report for R2 having the invasive procedure performed. 6. Documentation supplied by Z3 for R3 states, "You have an appointment for a Bone Marrow Biopsy on Friday 3/28/08 at 8:00AM diagnosis Pancytopenia" signed by Z3. A review was done of the facility's policies and procedures: By sending R2 for unscheduled invasive procedure the facility failed in: 1. Identification of Policy of Resident Prior to Transfer Policy and Procedure. Policy: It is the policy of this facility to provide complete and accurate information when residents are transferred... Procedure: 2. Identification of the resident being transferred should be verified by name band, picture, or asking resident to state name. 3. Nurse should verify order for transfer and verify transfer arrangements. 4. Nurse will complete a transfer form and forward with the resident. A review was done of the facility's policy and	F9999		

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F9999	Continued From page 30 procedure for Physician Orders: The facility failed to provide for R2 and R3: Procedure: All physicians' orders shall be recorded on the Physician's order Form for each resident and must be signed or initiated by the attending physician. Any orders for outside appointments are made by the nurse receiving the order. The transportation arrangements to the appointment are made by the nurse or person designated by the Director of Nurses. All appointments and transportation arrangements are recorded in the residents chart and in the transportation book. The original order must remain in the book at all times. Review of Transfer Forms-Policy and Procedure: Procedure: Should it be necessary to transfer a resident from the facility, a Transfer Form will be executed and forwarded with the resident. A copy of the transfer form will be filed in the resident's medical record. The transfer form will completed by nursing services and should include: Current medical findings, Diagnosis, Summary of course of treatment..... No form was noted in the records for R2 and R3. (A)	F9999		