STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING _____ B. WING _____	C 04/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 333	Continued From page 22 compliance to the quality assurance committee monthly until resolution. 4. Education will continue to be provided upon hire and quarterly for one year, then annually thereafter. Ongoing Monitoring The quality assurance committee will review the results of the Director of Nursing analysis of trends and compliance during the monthly meeting. The quality assurance committee will meet additionally on 4/1/10 at 2:30pm	F 333		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)1) 300.1610a)1) 300.1620a) 300.1630a) 300.1630c) 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.	F9999		

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F9999	Continued From page 23 b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Section 300.1630 Administration of Medication	F9999		

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F9999	Continued From page 24 a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. c) Medications prescribed for one resident shall not be administered to another resident. These regulations are not met, as evidenced by the folowing: Based on interview and record review the facility failed to follow their policy and facility practice by not fully identifying 1 of 3 sampled residents (R1), who was not a resident admitted to the facility. These failures resulted in R1's nurse signing the transportation form accepting R1 to the facility and R1 being placed in R2's bed on the nursing unit. The facility also failed to follow their policy by administering R1 medication without a physician order. The facility also failed to notify the physician of all medications administered to R1 during the incident at the facility. Findings includes: A review of the facility's medication discrepancy report dated 3/17/10 10:00pm noted that R1 was involved a medication error. Type of medication involved was noted as oral and intravenous. The report indicated that E3 (licensed practical nurse) was the nurse responsible for the error. The report described the medication error as medication administered to a resident that was	F9999		

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F9999	Continued From page 25 from another facility and was brought to the facility by accident. Medications identified as Lyrica 25mg oral, Evista 60mg oral, Multiple vitamin oral, colace 100mg oral, Lantis 23 units subcutaneous injection, and Azactam 1gram intravenous. On 3/25/10 at 11:55am E2 (director of nursing), said that R2, a facility resident currently residing in room 114, went to an outpatient appointment the morning of 3/17/10, and that R1 from facility #2, room 114 also went out to an outpatient appointment the morning of 3/17/10. E2 said that the outside transportation provider inadvertently returned R1 to the facility instead of taking R1 to facility #2 where R1 resides. E2 said that when the outside transportation provider arrived to the facility with R1, that E3 did not check R1's wrist band for her name, nor did E3 review the name on the outpatient transportation form acknowledging receipt of R1. A review of the outpatient transportation form dated 3/17/10 indicated in top right hand corner R1's name. The area on the form also noted by signing below, I certify that I am one of the following individuals, and that I am authorized to sign on the patient's behalf. The box was checked indicating a representative of institution that furnish care or other services to the patient. E3's signature was noted below, along with E3's printed name. Also during the interview with E2 on 3/25/10 at 11:55am, E2 said that after R1 was accepted into the facility that the outside transportation provider took R1 to room 114, and left. E2 said that E3 assessed R1, thinking it was R2. E2 said that E3 gave R1 the scheduled medications prescribed	F9999		

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	145734	A. BUILDING _____ B. WING _____	C 04/13/2010

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F9999	Continued From page 26	F9999		

and scheduled for R2. E2 said that the facility was not aware of R1 belonging to facility#2, until the outpatient transportation provider returned around midnight to transport R1 back to facility #2. E2 said that he provided facility #2 with a list of medications that were given to R1 while at the facility. E2 said that he did not notify any physician of the event because he gave the information to facility#2 staff, and thought they would follow up with R1's physician.

A review of R2's medication administration record indicated that E3 signed as administering Lyrica 25mg oral, Evista 60mg oral, Multiple vitamin oral, colace 100mg oral, Lantis 23 units subcutaneous injection, and Azactam 1gram intravenous at 9:00pm to R1.

On 3/25/10 during the daily status meeting both E1 (administrator) and E2 said the facility has no policy on identifying a resident returning to the facility after going out for an appointment or procedure if a nurse is not familiar with the resident. E1 said the nurse should use the same procedure as though the nurse was identifying a resident for medication administration. E2 said the facility practice would be to look at the arm/wrist bractlet with resident's name and facility name, or call the resident by name, and to look at any paperwork that arrived with the resident. E1 said that nurses experience residents going in and out of the facility during orientation with their preceptor.

On 3/25/10 at 12:50 in the conference room E3 (licensed practical nurse), said that she has been a nurse for 5 years, and has worked at the facility for 1 year. E3 said that she is currently in school and works part time at the facility. E3 said that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F9999	Continued From page 27 she worked a double shift on 3/17/10, first shift from 7:00am to 3:00pm and the second shift 3:00pm until 11:00pm. E3 said she was assigned to the 100 unit on both shifts, but R2 was not her resident on the first shift. E3 said that in report for her second shift she was made aware that R2 had gone out to an outpatient procedure, and was due to return later that evening. E3 said on 3/17/10 around 8:30pm she realized that R2 had yet to return from her outpatient procedure, E3 said she telephoned the supervisor E4 (licensed practical nurse) about R2's whereabouts. E3 said that E4 instructed her to call the hospital to see if she was admitted after her procedure. E3 said instead of calling right then she decided to pass her 9:00pm medications, to give R2 a little more time to return to the facility. E3 said as she was performing the 9:00pm medication pass she saw the outpatient transportation bringing a resident down the hall on a gurney. E3 said as they approached she asked the driver if the resident on the gurney was R2, and the driver said yes. E3 said the driver handed her a form and she signed it. E3 admitted that she did not look at the name on the form. E3 said she asked the driver if there was any additional paper work because R2 was coming from an outpatient procedure. E3 said the driver told her no additional paperwork accompanied the resident. E3 said the driver from the transportation provider took R1 to room 114-1 without her telling them where she belonged. E3 said she went into the room calling R1 by R2's name with no response. E3 said that she assessed R1 for any pain. E3 said that she called Z1 (physician) to get any orders since no paperwork accompanied R1 from the procedure. E3 said that Z1 told her to continue with same medication orders thinking the resident	F9999		

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F9999	Continued From page 28	F9999		

was R2. E3 said that it was her first time providing care for R2 and she did not know what she looked like. E3 said normally when she has a new resident she checks the wrist band for identification. E3 said that she did not check the wrist band when identifying R2. E3 said that she did not assess for resident's orientation upon meeting R1. E3 said that she proceeded with taking R1's vital signs (temperature 100.4, blood pressure 152/78, heart rate 89 beats per minute, respirations 20 breaths per minute, oxygen saturation 98%, and blood sugar 133.) E3 said that R1 displayed some anxiety talking about her husband. E3 said that after taking R1's blood sugar and vital signs she proceeded to administer the medications as scheduled for R2. E3 said that gave the oral medications (Lyrica 25mg, Evista 60mg, Multiple vitamin, colace 100mg) and gave the Lantus insulin 23 units subcutaneous injection as scheduled. E3 said she proceeded to administer Azactam 1gram intravenous (Antibiotic), E3 said she felt comfortable giving the insulin and the antibiotic because R1 had a slight increase in temperature and blood sugar was high. E3 said that after she prepared the antibiotic for administration she assessed R1's intravenous site which was located on R1's right upper chest wall with three lumens and clear occlusive dressing. E3 said that she never administered medication through a three lumen catheter in located on a resident's chest wall. E3 said she knew that the catheter was a central venous catheter and required a Registered Nurse (RN) to administer medication into it. E3 said that there were 2 RN's working on 3/17/10 during this 3:00pm to 11:00pm shift E5/E6 (Registered Nurses). E3 said that both E5/E6 was busy with other residents and she wanted to get the antibiotic completed before the

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F9999	Continued From page 29	F9999		

end of her shift. E3 said she administered the antibiotic from 9:30pm until 10:00pm. E3 said she did not want to wait for E5/E6 to complete their current task, to have one of them administer the antibiotic as required. E3 said it was the first time in her five years as a nurse administering medication in a central venous catheter in a clinical setting. E3 said she did not observe the name located on R1's wrist. E3 said that residents at the facility all wear identification wrist bands. E3 said she was aware of the five rights (right patient, right dose, right route, right time, and right medication).

On 3/26/10 at 10:45 at the nurses station Z1 (physician) said that she was the physician on-call for the physician group covering both facilities the night of 3/17/10 until the morning of 3/18/10. Z1 said that on 3/18/10 at 1:00am she was notified about R1 being inadvertently transported to the facility and medication was administered. Z1 said she had strong concerns regarding R1 may have some allergic reaction to the medication administered. Z1 said she was informed by facility#2 of the incident/medication error. Z1 reviewed the medications with surveyor and said that she was unaware of the Lantus insulin 23 unit being administered. Z1 said no one informed her of this medication, and had some concerns because it could be potentially life threatening if not monitored because R1 could have had an hypoglycemic reaction causing her blood sugar to drop below normal levels. Z1 said if informed she would have ordered facility#2 to monitor R1 blood sugar frequently. Z1 said the entire incident was concerning to her that the nursing staff did not verify R1 by checking the transportation paper work before accepting R1 into the facility, and

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F9999	Continued From page 30 that nursing did not follow protocol by identifying residents by checking the wrist band prior to administering medication On 3/25/10 at 3:30pm R1 was observed and assessed to be alert and oriented to name only. R1 was also observed with a raised identification bracelet located on her right wrist transparent with a green insert indicating R1's name, and facility of residence with telephone number. During the observation surveyor called out R2's name at R1 and R1 did not respond or look around. R1 only responded to her name when called by surveyor. R1 was also assessed to have a triple lumen central venous catheter located on her right chest wall and a double lumen cathter for dialysis located on her left chest wall. A review of R1's clinical record noted R1 was diagnosed with acute cerebral ischemia, and end-stage renal disease. R2 was assessed on 3/26/10 at 3:00pm in her room to be alert and oriented to person, place , and time. R2 was assessed to have a peripheral midline catheter with lumen located in upper right arm. A review of R2's clinical record nurses note 3/12/10 9:00pm, noted that R2 had a midline catheter placed by outside provider, and nurses note 3/14/10, 4:30pm notes that R2's midline located in the right arm was intact. R2 was also observed with a flat white identification bracelet located on her right wrist with R2's name, and facility of residence. Throughout the course of the survey all residents observed at the facility were wearing white flat bracelets on their wrist. A review of the procedure provided by the facility from the facility's outpatient pharmacy entitled, "The Role of the Nurse practicing Infusion	F9999		

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EVERGREEN HEALTH CARE CENTER	**10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805**

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F9999	Continued From page 31	F9999		

Therapy" notes the licensed nurse will practice infusion therapy within the scope of the state's Nurse Practice Act, according to rules and regulations promulgated by the state's Board of Nursing, facility policies and procedures, and practicing guidelines.

On 3/26/10 at 4:00pm, E2 said that licensed practical nurses are not allowed to administer antibiotic medication via central line catheter at the facility. E2 said that if a licensed practical nurse is assigned to a resident with a central venous catheter the licensed practical nurse is expected to obtain the assistance of a registered nurse to administer the medication through the central venous catheter.

A review of the E3's personnel file indicated that on 3/24/10 E3 signed the record of correction indicating that on 3/17/10 E3 administered medication to a resident who was improperly transported to the facility by the ambulance service. Medications included intravenous Antibiotic administered via central venous catheter which per scope of practice LPN's are not permitted to perform.

According to the Illinois Department of Financial and Professional Regulation, Division of Professional Regulations indicates that the licensed practical nurse who possesses the proper education, training and experience may in fact administer antibiotic medication through a peripheral intravenous line. The report also notes that a peripheral intravenous line is defined as a catheter inserted through the skin into a peripheral vein.

A review of the facility's policy "Intravenous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING _____ B. WING _____	C 04/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HEALTH CARE CENTER	**10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805**

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F9999	Continued From page 32 Therapy-LPNs" notes that the LPN (licensed practical nurse) may perform activities related to intravenous therapy under the supervision of a registered professional nurse. The policy also indicates that LPN may administer antibiotic medication through a peripheral intravenous line. The policy describes a peripheral intravenous line as a short catheter inserted through the skin into a peripheral vein. A review of the facility's policy Medication Administration notes the purpose of the policy is to ensure that the administration of medication is performed in a safe manner to prevent medication errors. The standard of the policy notes medications are administered according to state and federal law. The policy notes that the nurse use the five rights prior to medication administration:(right medication, right dose, right time, right route, and right resident). The policy notes that 2 means of identification will be use to determine the right resident (identification band, photo, verbal affirmation or birth date). (A) 300.1010h) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such	F9999		

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F9999	Continued From page 33 accident, injury or change in condition at the time of notification. Based on record review and interview the facility failed to notify the physician of a change of condition in an identified pressure sore for 1 of 3 sampled residents R3. Findings includes: A review of R3's clinical record admission face sheet dated 7/31/08 noted that R3 was admitted to the facility. The wound/skin condition identification and progress reporting record dated 7/31/08 indicates that R3 is identified with a pressure sore on the left buttocks assessed to be stage 2, and measured .5cm in length, and .5cm in width and .1cm in depth. R3's physician was notified of the pressure sore and treatment orders were given. A review of the wound/skin condition identification progress reporting record dated 8/5/08 indicates that the pressure sore has increased in size, length 4.2cm, width 3.5cm and depth not measured. A review of R3's clinical record nurses notes dated 8/5/08 no entry noted, informing the physician of the change in condition of the wound. A review of the physician orders sheet dated 8/5/08 noted no new treatment orders for the change in condition of the identified pressure sore. A review of the facility's policy "Change in condition" notes that notification of the physician should occur promptly when there is a change in the residents condition. The policy identifies a change in condition as a need to alter treatment (i,e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HEALTH CARE CENTER	**10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805**

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F9999	Continued From page 34 On 3/26/10 at 3:00pm E1 (administrator), and E2 (director of nursing), both said they were not employed at the facility at the time of the incident and were unable to comment about what happened in 2008. (B)	F9999		