STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING ______ B. WING ______	C 06/17/2010

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KENWOOD HEALTHCARE CENTER	6125 SOUTH KENWOOD CHICAGO, IL 60637

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F 000	INITIAL COMMENTS Complaint Investigation: 1082171/IL47734 An extended survey was conducted. Kenwood Healthcare Center is in compliance with 42 CFR Part 483 Requirements for Long Term Care facilities for this survey following the MPRO IDR.	F 000		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1210b)2) 300.1210b)3) 300.1220b)2) 300.3240a) 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. 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 psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided	F9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F9999	Continued From page 1 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. 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the faciltiy, including: 2) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observation, record review and interview, the facility failed to:	F9999		

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F9999	Continued From page 2	F9999		

- monitor and provide comprehensive assessments for a resident who was refusing Valproic acid level blood draws.
- provide appropriate services related to abnormal lab work.
- monitor abnormal levels in which dilantin level was <2.3 and valproic acid level was <13.
- provide updated behavior care plan for a resident non-compliant with therapy treatment.
- follow their change in condition policy and procedure.

This is for 1 of 8 residents (R3) in the sample.

R3 had a diagnosis of schizophrenia and he was non compliant and refusing the scheduled lab work draws for his Valproic acid levels. These levels were documented as low or high for approximately 5 months for the draws that were done.

These failures resulted in R3 having abnormal Valproic acid levels <13 and Dilantin <2.3. As a result, R3 had multiple seizures including one that lasted 45 minutes. R3 was intubated and admitted into Neurology Intensive Critical Care Unit with diagnosis of Grand Mal Seizures.

Findings Include:

R3 is a 61 year old male with diagnoses of Seizure Disorder, Schizo Affective Disorder, Hypertension and Hyperthyroidism. R3 was observed on 06/03/10 at 3:00 pm ambulating on the unit. R3 is alert and oriented X 3.

Minimum Data sets dated 03/23/10 denoted Section B. Cognitive Patterns. (4). Cognitive Skills For Daily Decision- Making - score 2 -

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F9999	Continued From page 3 Moderately Impaired - decision poor; cues/supervision required. The Nurses Notes denote: 03/25/10 at 7:00 pm - This writer received report that resident had some seizure activity in dining room. This writer observed activity lasting 2 minutes. Resident Vital signs blood pressure 146/68, Pulse 104 and Respiration 22. Medical Doctor paged. Telephone order given for resident to have Valproic Acid Level drawn in morning and 24 hour neurochecks. Will continue to monitor. 03/27/10 at 9:00 am - Labs results received - test not done due to resident refusal. 05/19/10 at 10:45 - Medical Doctor aware of Labs - received no new order. 05/20/10 at 1:20 pm - Resident seen by Z2. No new orders. 05/22/10 at 3:30 pm - Resident began to having seizures outside in front of Z7. Resident was accompanied and escorted by staff using a wheelchair to room. Vital signs blood pressure 140/120, Pulse 102, Respiration 28 and Temperature 96.9. Placed on 3 liters of oxygen. Resident's bed up in high Fowler. Telephone Medical Doctor to made aware of constant seizure activity. If resident has another seizure send to hospital. Also draw Depakote on 05/24/10. 05/22/10 at 5:30 pm - Resident began having another seizure . Ambulance services telephoned to send resident to hospital. Ambulance picked up resident at 5:45 pm. 05/22/10 at 6:00 pm - Ambulance services called stating that resident would be taken to hospital due to constant seizure activity. The physician orders dated 04/01/10 through 05/26/10 stated, " Depakote level monthly."	F9999		

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F9999	Continued From page 4 The Laboratory Report denoted: 11/17/09 - Phenytoin Total 2.5 CL (Reference Range 10-20 ug/ml) and Valproic Acid 47.9 L (Reference Range - 50 -100 ug/ml) were low. 11/25/09, 11/27/09 and 11/30/09 Patient refused. Rescheduled 12/04/09. 12/18/09 - Valproic Acid was low 38.6. 12/19/09 Stat Depakote 500 mg. Repeat in one week. 12/23/09 - Valproic Acid 30.2. 12/24/09, 12/28/09 and 12/29/09 - Patient refused. Medical Doctor rescheduled. 01/13/10, 01/15/10 and 01/18/10 - Patient refused 01/20/10 - Per E8 (Nurse) documented on lab report - rescheduled. 01/21/10, 01/22/10 - Patient refused - rescheduled (out of program. Valproic Acid and Phenytoin due every 28 days). 01/25/10, 01/26/10 and 01/27/10 - Patient refused. 01/29/10, 02/01/10 and 02/02/10 - Patient refused. 02/10/10 - Phenytoin 2.5 Low and Valproic Acid 103.0- High. 03/10/10 - Valproic Acid - 67.4. 03/30/10 - Valproic Acid 75.8. 04/07/10, 04/08/10 and 04/09/10 - patient refused. 04/14/10 - Valproic Acid 18.5 CL (Reference Range 50 -100). 05/12/10, 05/13/10 and 05/14/10 - patient refused. The Laboratory Report dated 04/14/10 stated, "Diagnosis recommended therapeutic range for Depakote as follows: 50 150 mcg/ml for psychiatric disorder and 50 - 100 mcg/ml for	F9999		

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F9999	Continued From page 5 seizure disorders." The hospital record dated 05/24/10 at 1:58 pm stated, "(R3) is a 61 year old male who presented to the hospital initially on 05/23/10 after being witnessed at his nursing home with a generalized tonic-clonic seizure lasting 45 minutes. The patient was brought into the emergency room at that time. In the emergency room, the patient was given 2.5 mg of Valium intravenous X 2 and then started having desaturation afterwards. The patient was intubated, and placed on a Fentanyl and Versed drip. Patient was monitored in the Intensive Care unit. He was admitted with a dilantin level low 2.5 and Valproic Acid level was 13. Patient was loaded with 1.5 gm Dilantin. The patient was continued on intravenous Depakote as well. Patient says that he has seizures when he misses his medications, and admits he hasn't taken them, but not sure how long it's been. He says that he does not have warning before the seizure, but will have some problems with incontinence. Dilantin up to 16 after load, currently 11." Z1 (Physician) on 06/03/10 at 11:30 am on the telephone stated, "61 year old male with Grand Mal Seizure. He was transferred from the nursing home with grand mal seizure for 45 minutes. There was no detectable medication in his system. In emergency room lab work drawn for Depakote level was undetectable and very very low labs level (13). The Dilantin level was 2.5. If he was not on Dilantin level should have been zero. The seizure lasting 45 minutes could have resulted in brain injury and death. Although he is a Schizophrenic his lab work must be done because of the possibility of death. He was admitted into the Intensive Care Unit. He was	F9999		

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F9999	Continued From page 6 sent back to the nursing home with medication Depakote and Dilantin. He is also to have follow up lab work weekly. This lab and medication must be done/ given. This is life threatening for (R3) if the medication is not given and lab work not done." E3 (Nurse) on 06/03/10 at 3:30 pm in the conference room stated, "When I came in to work I heard on the call system all nurses were needed downstairs. I came down the stairs. He was having a seizure. It was (R3). I put him in the wheelchair, placed oxygen 2 liters per nasal cannula and called the medical doctor. I put him to bed. He had another seizure. Then he went back into another seizure. I called the supervisor, did vital signs and called the doctor again. The physician order was if another seizure to send him out to the hospital." Surveyor ask E3 if R3 had another seizure beside the 3. E3 stated, "Yes, He had another seizure. After calling ambulance services. They said it would be 45 minutes. But ambulance services arrived in 50 minutes. He had back to back seizures. While he was coming upstairs, R3 had 2 -3 seizures. He was post activity when ambulance services came. He started to have a seizure in the room when the ambulance attendant came into the room. The ambulance attendant called me back and said the resident was unstable to go to (Z4) hospital. He was taken to the hospital. He was admitted with diagnosis Grand Mal Seizures." E5 (Certified Nurse Aide) on 06/03/10 at 3:55 pm in the conference room stated, "(R3) came upstairs. He was not looking right. He came in room sit on bed. I was talking to him. He started	F9999		

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F9999	Continued From page 7 to have a seizure. I called the nurse. He had another seizure when ambulance attendant came. I stayed the whole time. He was continuing to have seizures." Z2 (Physician) on 06/09/10 at 11:45 am by telephone stated, "He could have been non-compliant in taking his medication. He might not have been taking his Depakote medication. The Depakote level should not be low if he had taken medication. I don't believe medication was taken. The Depakote level is extremely low. If he was taking his medication Depakote blood level would not be low. He was not on Dilantin. He was started on Dilantin at the hospital. Maybe the wrong lab work was done on him." Review of MAR's (Medication Administration Records) for 1/10 - 6/10 showed he had refused to take his Depakote. There was no documentation that the physician had been notified of these continued refusals. The Physician Notification of Change of Resident Condition dated 03/01/99 denoted to provide guidelines for facility staff to follow to ensure that there is appropriate physician notification of any change in a residents condition: (12). Unusual behavior. (A)	F9999		