STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 22 1 being Tylenol. This information was also noted on R2's facility face sheet, physician's orders, and care plan. Upon admission to the facility R2 received orders for Vicodin which is a combination narcotic medication. One of the medications in Vicodin is Tylenol. There was no documentation and no follow up from pharmacy inquiring about R2's allergy to Tylenol. Again, review of the monthly pharmacy medication regimen review only showed a box checked monthly "NI" meaning "no irregularities." The documentation of R2's Tylenol allergy remained on R2's face sheet, physician's orders, and MAR's during R2's entire stay at the facility (10/15/10 to 8/21/11).	F 428		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.686a)1)2)3)4)5) 300.686d) 300.686e)1)2) 300.690b)c) 300.1210b) 300.1210d)1)3) 300.1220b)2)3) 300.3240a) 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	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 23 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 300.686 Unnecessary, Psychotropic, and Antipsychotic Drugs a) A resident shall not be given unnecessary drugs in accordance with Section 300.Appendix F. In addition, an unnecessary drug is any drug used: 1) in an excessive dose, including in duplicative therapy; 2) for excessive duration; 3) without adequate monitoring; 4) without adequate indications for its use; or 5) in the presence of adverse consequences that indicate the drugs should be reduced or discontinued. (Section 2-106.1(a) of the Act) d) Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue these drugs in accordance with Section 300.Appendix F. e) For the purposes of this Section: 1) "Duplicative drug therapy" means any drug therapy that duplicates a particular drug effect on the resident without any demonstrative therapeutic benefit. For example, any two or more drugs, whether from the same drug category or	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 24 not, that have a sedative effect. 2) "Psychotropic medication" means medication that is used for or listed as used for antipsychotic, antidepressant, antimanic or antianxiety behavior modification or behavior management purposes in the latest edition of the AMA Drug Evaluations (Drug Evaluation Subscription, American Medical Association, Vols. I-III, Summer 1993), United States Pharmacopoeia Dispensing Information Volume I (USP DI) (United States Pharmacopoeial Convention, Inc., 15th Edition, 1995), American Hospital Formulary Service Drug Information 1995 (American Society of Health Systems Pharmacists, 1995), or the Physician's Desk Reference (Medical Economics Data Production Company, 49th Edition, 1995) or the United States Food and Drug Administration approved package insert for the psychotropic medication. (Section 2-106.1(b) of the Act) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 25 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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: d) Pursuant to subsection (a), 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. 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.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	**777 DRAPER JOLIET, IL 60432**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 26 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) 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. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. 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. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 27 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: Based on record review and interview the facility failed to: 1. Monitor 1 resident's narcotic intake to prevent opioid poisoning. (R2) 2. Monitor 1 resident's antidepressant usage/intake to prevent death. (R2) 3. Ensure documentation on the MAR (medication administration record) and Narcotic control sheet was consistent and accurate. (R2) 4. Review and monitor documentation and usage of Hydrocodone/Acetaminophen (Vicodin) on the Controlled Substance Proof of Use sheets and MAR's (medication administration records) to prevent opioid poisoning for 1 resident. (R2) 5. Review and collaborate with 1 resident's psychiatrist regarding the ordering of multiple antidepressant medications. (R2) 6. Inquire, follow up, and document results on documented Tylenol allergy for 1 resident. (R2) As a result of these failures R2 was found unresponsive in bed on 7/31/11. R2 was sent to a nearby hospital on 7/31/11, admitted into an intensive care unit, placed on a mechanical ventilator, and diagnosed with opioid poisoning. R2 was readmitted to the facility on 8/2/11. On 8/21/11, R2 was again found unresponsive in bed with no pulse and no respirations, was sent to a	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 28	F9999		

nearby hospital, and later pronounced dead.

Review of a Coroner's report dated 9/14/11 listed R2's cause of death as antidepressant (Amitriptyline and Doxepin) intoxication.

These failures have the potential to affect every resident who receives narcotic medications and every resident who receives multiple antidepressants of the same class.

The findings include:

1. Review of R2's admission face sheet and physician's orders (10/2010 -8/2011) showed R2 was a 37 year old female admitted to the facility on 10/15/10 with diagnoses including Major Depression, Hypertension, Osteoarthritis, and Morbid Obesity.

Review of facility nurses notes dated 7/31/11 at 12:33 a.m. showed the following documentation;

"Resident sent to hospital for evaluation due to unresponsiveness." Hospital lab report dated 7/31/11 showed opiates were detected in R2's blood. Facility nursing documentation dated 7/31/11 at 4:30 a.m. notes "Resident admitted to hospital for "opioid poisoning and change in level of consciousness." Review of hospital physician progress note documentation dated 7/31/11 at 8:40 a.m. notes, "Called to ICU (intensive care unit) to intubate - pt. in respiratory failure due to narcotics overdose." Hospital nursing and physician documentation showed R2 was intubated, placed on a mechanical ventilator, and treated with Narcan (narcotic antagonist) IV

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 29	F9999		

medication.

Review of R2's facility medications orders prior to her 7/31/11 hospitalization included Hydrocodone/Acetaminophen 7.5/750 mg. (Vicodin) 2 tabs every 8 hours as needed. Hydrocodone/Acetaminophen is a combination class III narcotic. R2's dosage of Hydrocodone/Acetaminophen (Vicodin) consisted of Hydrocodone 7.5 mg and Acetaminophen (Tylenol) 750 mg. R2 received 2 Vicodin tabs with each dose administered so R2 received 15 mg of Hydrocodone and 1500 mg of Tylenol with each dose of Vicodin.

According to Drug Information Online (Drugs.com) Hydrocodone is an opioid analgesic. Documentation showed at high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. Documented signs and symptoms of severe overdose of hydrocodone showed "serious overdose is characterized by respiratory depression, extreme somnolence progressing to stupor or coma... In severe overdosage, apnea, circulatory collapse, cardiac arrest, and death may occur."

R2's facility MAR (medication administration record) documentation showed R2 was taking frequent doses of Vicodin 7.5/750 mg (2 tabs with each dose) According to E3 (Director of Nurses) each time R2 received a dose of Vicodin the Vicodin should have been signed out on the Controlled Substance Proof of Use Sheets and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 30	F9999		

on the MAR. The accuracy of the Vicodin doses administered to R2 from 3/26/11 to 7/31/11 could not be checked against the Controlled Substance Proof of Use sheet because these sheets were not available. The only controlled substance proof of use sheets for R2's Hydrocodone/Acetaminophen (Vicodin) available were the sheets dated 10/16/10 to 3/25/11.

Also noted; there were many times that R2 received 3 doses of Vicodin in a 24 hour period, meaning in the 24 hour period R2 received 45 mg of Hydrocodone and 4500 mg of Tylenol. Drugs.com notes that no more than 4000 mg of Tylenol should be taken in a 24 hour period. R2 was receiving 4500 mg on many days. Drugs.com also notes that no more than 5 Vicodin 7.5/750 mg tabs should be taken in a 24 hour period. On many days R2 was taking 6 Vicodin 7.5/750 mg pills in a 24 hour period.

On 7/31/11 R2 was hospitalized, placed in ICU, intubated and put on a mechanical ventilator due to "opiate poisoning."

Review of the pharmacy monthly medication regimen review from 11/9/10 to 8/9/11 showed no documentation that the pharmacist followed up with the facility regarding the discrepancies of the Vicodin administrations documented on the Controlled Substance Proof of Use sheets and the MAR's. There was also no recommendations noted regarding R2's high level of Tylenol intake with her Vicodin dosages.

During telephone interview with Z1 (pharmacy supervisor) on 1/19/12 at 12:00 noon Z1 stated, The pharmacist should make sure the resident is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 31	F9999		

not getting over the maximum dose of 4000 mg of Tylenol per day. Telephone interview with Z2 (regional supervisor for pharmacy consultants) on 1/19/12 at 1:25 p.m. noted Z2 to say, "The pharmacy consultants and I use the Controlled Substance Proof of Use sheets to check for the frequency of medication administration. We do check the MAR's to see if they match up." As noted above, review of MAR's and Controlled Substance Proof of Use sheets from 10/16/10 to 3/25/11 did not match. There was no pharmacy documentation reflecting these issues.

During interview with E3 (Director of Nurses) on 1/20/12 at 12:30 p.m. the remaining controlled substance proof of use sheets (3/26/11 to 7/31/11) for R2's Vicodin were requested. E3 stated, "We don't have them. Those sheets were destroyed. You don't need them, you have the documentation on the MAR's." In reviewing the controlled substance proof of use sheets that were available (10/16/10 to 3/25/11) for R2's Vicodin, the documentation for the Vicodin administration did not match the documentation of administration on R2's MAR. Several doses of Vicodin was documented on the controlled substance proof of use sheets as being given and not documented on the MAR and several doses of Vicodin was documented on the MAR and not documented on the controlled substance proof of use sheets. In effect, this made it impossible to check the accuracy of the doses of Vicodin R2 received.

Review of the facility's policy and procedure on Inventory of Controlled Substances showed the procedure included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 32	F9999		

-Medication must be signed out on controlled substance proof of use sheet indicating that a medication has been administered.
-After signing proof of use sheet, nurse will administer medication and sign the MAR after medication is consumed. If medication was PRN, nurse must follow the procedure for PRN medications and sign front and back of MAR.
-It is important to remember to sign off in all places so that all records match.

In regards to discrepancies with controlled substances, the policy on Inventory Control of Controlled Substances included:

-A facility representative should regularly check the inventory records to reconcile inventory.
-The facility should reconcile current and discontinued inventory of controlled substances to the log used in the facility's controlled drug inventory system.
-The facility should reconcile the current inventory to the controlled drug declining inventory record and the resident's Medication Administration Record.

Further interview with E3 on 1/20/12 disclosed there was no system in place at the facility to monitor the accuracy of administration of PRN (as needed) controlled substance medication.
As noted above, R2 was admitted to a hospital on 7/31/11 with diagnosis of "opioid poisoning/narcotic overdose."

Review of the pharmacy monthly medication regimen review from 11/9/10 to 8/9/11 showed no irregularities and/or recommendations regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 33	F9999		

R2's Vicodin usage.

Review of a history and physical report dated 9/25/10 transferred with R2 upon admission to the facility noted R2 was allergic to 3 medications, 1 being Tylenol. This information was also noted on R2's facility face sheet, physician's orders, and care plan. Upon admission to the facility R2 received orders for Vicodin which is a combination narcotic medication. One of the medications in Vicodin is Tylenol.

There was no documentation and no follow up from pharmacy inquiring about R2's allergy to Tylenol. Again, review of the monthly pharmacy medication regimen review only showed a box checked monthly "NI" meaning "no irregularities." The documentation of R2's Tylenol allergy remained on R2's face sheet, physician's orders, and MAR's during R2's entire stay at the facility (10/15/10 to 8/21/11).

Review of R2's initial hospital history and physical transfer paperwork (9/25/10), admission face sheet, physician's orders, and care plan showed documentation that R2 has allergies which included Tylenol. R2's medications since her admission to the facility (10/15/10) included Hydrocodone/Acetaminophen (Vicodin) which is a combination drug of opiate and Tylenol. Interviews with E3 (Director of Nurses), Z1 and Z2 (pharmacists) disclosed that no one had assessed or followed up with R2 for the noted Tylenol allergy in an attempt to inquire about any reactions or problems R2 had when taking Tylenol. The documentation of Tylenol allergy remained on R2's face sheet, physician's orders and care plan throughout R2's stay at the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 34 (10/15/10 to 8/21/11).	F9999		

Interview with E3 noted E3 to say there was no investigation done in an attempt to find out why R2 was hospitalized with opiate poisoning. E1 (Administrator) and E3 also admitted that this hospitalization had not been reported to the Illinois Dept. of Public Health.

R2 remained in the hospital from 7/31/11 to 8/2/11. On 8/2/11 R2 was readmitted to the facility.

2. Review of R2's medications showed R2 had physician's orders for 4 antidepressant medications (Wellbutrin SR 150 mg every morning, Amitriptyline (Elavil) 50 mg every morning, Cymbalta 60 mg every morning, and Doxepin 150 mg every night). Nursing documentation on 8/21/11 at 4:59 p.m. showed at 4:20 p.m. E6 (CNA) went in to R2's room to see if R2 was coming out for dinner. R2 did not respond to E6 when called or when shakened. E6 called E5 and E9 (LPN's) to R2's room. E5 and E9 assessed R2 and found R2 had no pulse and remained unresponsive. E5 and E9 initiated CPR and 911 was called. R2 was sent to a nearby hospital and pronounced dead at 5:35 p.m. Telephone interviews with E6 (CNA) on 1/25/12 at 10:55 a.m. and interview with E5 (LPN) on 1/25/12 at 11:23 a.m. verified this information.

Review of Z6's Coroner's Report dated 9/14/11 listed R2's cause of death as "Doxepin and Amitriptyline Intoxication." As noted above, R2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	**777 DRAPER JOLIET, IL 60432**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 35	F9999		

was receiving Amitriptyline (Elavil) 50 mg every morning and Doxepin 150 mg every night. Review of physician's orders and nursing documentation showed R2's Doxepin had been increased from 100 mg to 150 mg on 7/14/11.

Review of monthly pharmacy medication regimen review from 11/9/10 to 8/9/11 showed no irregularities and/or recommendations regarding R4's prescribed antidepressants.

During telephone interviews with Z1 and Z2 on 1/19/12 between 12:00 noon and 1:50 p.m. both stated it is not uncommon for residents to take multiple antidepressants but, both stated that they would question the physician if the antidepressants were in the same class (such as the Elavil and Doxepin). Both stated that they would have questioned the physician as to why R2 was prescribed 4 antidepressants. Both also stated that the amount of Elavil and Doxepin should not have killed R2.

During interview with Z4 on 1/20/12 at 12:45 p.m. Z4 stated R2 was on 4 antidepressants but the combined use of these medications should not have caused toxicity, even in a person with normal weight. Z4 stated, "You have to look at volume distribution, R2 weighed almost 600 lbs. The doses of the antidepressants were not really that high to cause death."

On 1/20/11 at 11:25 a.m. Z6 was interviewed per phone. Z6 stated, "The toxicology results is what determined R2's drug levels and cause of death. Z6 explained that there were 2 medications, but 4 drug levels that were involved in R2's death. The Amitriptyline with its metabolite Nortriptyline, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	777 DRAPER JOLIET, IL 60432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 36	F9999		

Doxepin and its metabolite Desmethyldoxepin. Continued interview with Z6 and review of R2's toxicology report showed R2's Amitriptyline level was 190 ng/ml. Fatality levels ranged from 3000 -15000 ng/ml. This showed the Amitriptyline level was not at a fatal rate, but the Amitriptyline metabolite, Nortriptyline level was 430 ng/ml. Toxicology documentation for Nortriptyline showed:

"At plasma levels exceeding 200 ng/ml toxic side effects such as hyper - hypotension, tachycardia, cardiac arrhythmias, confusion, and nausea may be present. Severe overdose may result in convulsions, coma, and cardiac irregularities.

R2's Doxepin level on the toxicology report was 670 ng/ml and its metabolite, Desmethyldoxepin level was 990 ng/mg. Toxicology documentation for Doxepin and Desmethyldoxepin showed the following:

In fatalities attributed to Doxepin overdose, reported blood concentrations ranged from 700 - 29000 ng/ml for Doxepin and 100 - 6200 ng/ml for Desmethydoxepin.

As noted on the toxicology report and with continued interview with Z6, R2's Nortriptyline levels were at toxic levels, R2's Doxepin level was close to the fatal level and the Desmethyldoxepin level was in the fatal level.

Z6 went on to say, "If R2's medications ordered were not ordered at a level to cause overdose and/or intoxication, then at some point she received more medication than prescribed. If not, the toxicology wouldn't show it. The toxicology

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145311	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST NURSING & REHAB CTR	**777 DRAPER JOLIET, IL 60432**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 37 does not lie." On 1/24/12 at 3:55 p.m. Z5 was interviewed regarding R2's medications. Z5 stated, "I don't interfere with Z4. I let Z4 handle the psychotropic medications. He's the expert in that field and I defer psych management to him." When Z5 was asked if he and Z4 discuss residents' psychotropic medications Z5 stated, "I will question psych medications but I won't change them. When I ask why a resident is on more than 1 antidepressant the answer I get is--- the resident's symptoms are not controlled on 1 medication." Interview with E3 noted E3 to say there was no investigation done in an attempt to find out why R2 was hospitalized with opiate poisoning. E1 (Administrator) and E3 also admitted that this hospitalization had not been reported to the Illinois Dept. of Public Health.	F9999		