STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING _____ B. WING _____	C 01/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	**6601 WEST TOUHY AVENUE NILES, IL 60714**

(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	FINAL OBSERVATIONS Licensure Violations 300.1210d)1)2)3) 300.1620a) 300.1630b)c)e) 300.3240a)e) Section 300.1210 General Requirements for Nursing and Personal Care 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. 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. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the	F9999		

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F9999	Continued From page 4 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 b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. c) Medications prescribed for one resident shall not be administered to another resident. e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or	F9999		

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F9999	Continued From page 5 reaction shall also be described in an incident report. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. e)Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. This REQUIREMENT is not met as evidenced by: Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available , a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility. Based on interview and record review the facility failed to ensure 1(R3) out of 4 residents reviewed for abuse remained free from a significant medication error. As a result of this medication error R3 was hospitalized and treated for drug	F9999		

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F9999	Continued From page 6 overdose. Findings Include: Transferral and Referral Record dated 11-24-2011 documents that R3 was transferred on 11-24-2011 at 10:14AM to the hospital reason: "Lethargic, arousable by verbal and tactile stimuli, audible wheezing." Hospital Record History and Physical Form dated 11-24-2011 states, "R3 was transferred to the hospital due to increasing lethargy. The patient was given 2 Milligrams of Narcan(Opioid antagonists) Intravenously and immediately woke up and was found to be extremely agitated. R 3 was sent for a Computerized Axial Tomography(CAT) scan of the brain and when R3 returned from the CAT scan of the brain was again found to be very lethargic with pinpoint pupils. R3 was given another 2 Milligrams of Narcan and woke up and got agitated again. R3's urine Tox screens were negative. No clear etiology for R3's behavior could be explained. There was no history of using any narcotics or any known drug abuse. R3 was admitted to the Intensive Care Unit." Transferral and Referral Record dated 11-26-2011 and 11-27-2011 documents "R3's urine toxicology is positive for benzodiazepines and opiates" and in the Plan section the record documents "It is still unknown how the opiates got in her system, however, it is too late to do another toxicology evaluation." Patient Information and Transfer Form dated 11-29-2011(hospital discharge record) documents a diagnosis of Altered Mental Status, Possible Narcotic Disorder. Physician Orders were reviewed from October	F9999		

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F9999	Continued From page 7 2011 until January 2012, R3 did not have an order for any opiate medication. Nurses Notes dated 11-29-2011 documents that R3 was readmitted with diagnosis of Acute Mental Status Change and Narcotic Overdose. On 1-10-2012 at 3:08PM in the conference room E2(Director of Nursing, DON) stated that this incident was investigated as abuse. One of the nurses made a medication error and gave R3 Vicodin which was the roommates medication. The nurse did not realize that it was a error until R3 returned from the hospital several days later and the same nurse readmitted R3. On 1-11-2012 at 3:51PM in the conference room, E9(Nurse) stated, "I apologize, I made a mistake and gave Vicodin to R3 and I gave Xanax a few hours earlier. I did not realize it until I readmitted R3 with a narcotic overdose diagnosis, I then realized that I gave the wrong medication on 11-23-2011 and R3 went to the hospital on 11-24-2011. I reported the medication error on 11-30-2011." On 1-12-2012 at 1:08PM via telephone Z3(Pharmacist) stated, "Xanax with Vicodin can cause increased drowsiness, that's about it. Vicodin has a small amount of hydrocodone which could cause some dizziness or drowsiness. Both medications can be taken together. Vicodin and Xanax together given at one time will not likely cause an overdose even if the person was not prescribed Vicodin." (B)	F9999		