STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146093	A. BUILDING _____ B. WING _____	C 05/02/2013

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F 333	Continued From page 7 factors consist of multiple medications. Reevaluation- Appears to be having any seizure-like activity. Some of the muscle twitches is likely secondary to her psychiatric medications. R5's discharge instructions from the hospital documents: Drug reaction- dystonic. You are having a muscular reaction to a drug you have taken. The facility's policy for General Dose Preparation and Medication Administration documents: Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following- The facility should verify each time a medication is administered that it is the correct medication at the correct dose.	F 333		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.1610a)1) 300.1630b) 300.3240a) 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	F9999		

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F9999	Continued From page 8	F9999		

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 300.1630 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. 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.
Section 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 regulations were not met as evidenced by the following:

Based on record review and interview, the facility failed to ensure proper reconciliation of the Medication Administration Record (MAR) and Physicians' Order Sheet (POS) for 1 (R5) of 10 residents reviewed for psychotropic medications in a sample of 12. The facility also failed to establish an effective policy for reconciling the

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F9999	Continued From page 9 MAR and POS. This failure led to R5 receiving an excessive dose of Clozapine and being sent to the local emergency room with a diagnosis of dystonia. Findings include: R5 is a 50 year old female admitted to the facility with the following diagnoses: COPD, pneumonitis, anemia, hypoxemia, shortness of breath, urinary tract infection, diabetes, epilepsy, paranoid schizophrenia, syncope, acute respiratory failure, and orthostatic hypotension. The facility's incident report for R5 dated 3/21/13 documents that R5 was sent to the local hospital via 911 for possible seizure activity and possible drug toxicity. The final report documents that R5 had returned back to the facility with a diagnosis of dystonia and a medication error was noted. The report further documents that R5 had received the wrong dose of Clozaril (Clozapine). R5 had several Physicians' Order Sheets (POS) on the POS labeled #1, the following orders were noted: R5's POS labeled #2 documented the following orders: 2/24 Clozaril 100mg, 3 tabs (300mg) oral daily- 9:00am 2/24 Clozaril 25mg, 3 tabs (75mg) oral at HS (bedtime) - 9:00pm 2/25/13 Clozapine 100mg tablet, take 3 tablets (300mg) w/75mg (Dose=375mg) by mouth every evening- 9:00pm; 2/25/13 Clozapine 25mg tablet, take 3 tablets	F9999		

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F9999	Continued From page 10 (75mg) w/300mg (Dose=375mg) by mouth every evening- 9:00pm Both orders had been crossed out with the word " Chg (change) 2/24 " written across them. R5's Telephone Order Sheet (TOS) dated 3/8/13 documents the following order: Increase Clozapine to 400mg oral QHS (at bedtime). R5's Medication Administration Record for the week of 3/13/13 - 3/20/13 documents that R5 received 300mg of Clozaril at 9:00am and 400mg at 9:00pm indicating a total dose of 700mg on several days. R5's medical records dated 3/21/13 documents: 2:00 am (Nurse's Notes) - noted spastic movements to upper and lower extremities 6:30am (Nurse's Notes) -MD (Medical Doctor) here and alerted this writer that R5 was unresponsive. 6:45am (TOS) -Send out to local emergency room to rule out Clozaril toxicity/seizure activity. 12:00 pm (Nurse's Notes) -Received R5 via ambulance, some jerky movements still noted due to diagnosis. 2:10 pm (Nurse's Notes) - Clozapine put on hold, DX (Diagnosis): Dystonia. R5's laboratory report dated 3/21/13 documents the following lab value: Clozapine (Clozaril) -955 *Critical R5's care plan for Clozapine dated 11/1/12 documents: Administer psychotropic medication per MD order. The next care plan for Clozapine was dated 4/3/12.	F9999		

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F9999	Continued From page 11 On 5/1/13 at 2:53pm, E2 (Director of Nursing) stated that R5 was diagnoses with Dystonia related to the amount of Clozaril she received. The facility's Medication Policy did not contain documentation on reconciling the MAR and POS. However, E2 stated that both the facility and pharmacy nurses are required to reconcile the POS and MAR when the new sheets are printed. E2 stated that R5's order for Clozapine was improperly documented when the POS and MAR for Mar/2012 was reconciled. On 5/2/13 at 11:48am, Z3 (Registered Pharmacist) stated that dystonia can be caused by Clozaril. On 5/2/13 at 12:07pm, Z1 (Medical Doctor) stated that she visited R5 on 3/21/13 and noted R5 to be weak and tired. Z1 stated that according to R5's medical record, Z2 (Psychiatrist) had increased R5's dose of Clozaril, and the facility gave R5 a higher dose than what was ordered. On 5/2/13 at 12:16pm, Z2 stated that R5's Clozaril dose was supposed to be increased by 25mg. Z2 stated "I don ' t know what happened, I just told them to increase it 25mg and somehow they added those 400mgs." Z2 stated "I believe the medication most likely caused her to have a seizure." R5's Emergency Room report from the local hospital documents: History and Present Illness- character of symptoms is patient has muscle twitches. Risk factors consist of multiple medications. Reevaluation- Appears to be having any	F9999		

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F9999	Continued From page 12 seizure-like activity. Some of the muscle twitches is likely secondary to her psychiatric medications. R5's discharge instructions from the hospital documents: Drug reaction- dystonic. You are having a muscular reaction to a drug you have taken. The facility's policy for General Dose Preparation and Medication Administration documents: Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following- The facility should verify each time a medication is administered that it is the correct medication at the correct dose. B	F9999		