STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145765	A. BUILDING _____ B. WING _____	C 06/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW REHAB CENTER	5888 NORTH RIDGE CHICAGO, IL 60660

(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 000	INITIAL COMMENTS Complaint Investigation 1682707/IL85594	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

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

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F 157	Continued From page 1	F 157		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that the physician was notified of an anticonvulsant medication that was not administered. This applies to one resident out of three residents (R1) reviewed for resident rights in a sample of three.

Findings include:

According to R1's facesheet, R1 was admitted to the facility on 1/11/2016 with the following diagnosis not limited to: other seizures.

On 5/26/2016 at 10am, R1 stated he did not receive his seizure medication, Keppra (levetiracetam) on the following evenings: 4/15, 4/27, 5/18, 5/21.

On 6/1/2016 at 9:04am, E2 (Director of Nursing) stated she started working at the facility on 5/2. On 5/23, she was notified that [R1] did not get his medication on 5/18 and 5/21. E2 stated she interviewed E3 (nurse) who said that she did not give the medication because R1 was sleeping. E2 presented a form titled, "Concern/Compliment Form" dated 5/23/16 that reads in part: "Identified the nurse [E3] that worked the dates [5/18 and 5/21]. Nurse informed writer that resident was sleep that's why he did not get his medication." E2 further stated that E3 documented she gave the medication when she didn't and should have charted on the MAR (medication administration record) as "other" and document the reasons not given on a progress note.

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R1's Order Summary Report reads in part: Order and Start date - 01/11/2016: Levetiracetam tablet 500mg (milligrams) Give 2 tablet by mouth every 12 hours for seizures.

R1's MAR dated May 2016 reads in part that E3 administered levetiracetam to R1 on the following dates: 5/18/2016 at 2100 (9PM) and 5/21/2016 at 2100 (9PM). On 6/1/2016 at 11:14am, E3 stated in part that she didn't give [R1's] medication when he was sleeping and she doesn't know why it's not documented and she didn't tell the doctor. E3 could not recall the date of when and how many times this happened.

On 5/26/2016 at 4:46pm, Z1 (Attending Physician) stated R1 is compliant with medications, has history of seizures and takes Keppra twice a day. R1 had a Keppra level drawn before being admitted to the nursing home and the level was stable. Z1 stated he was not aware of any missed doses of Keppra for R1. Z1 stated that of course he would want to be aware and if he was notified, he would have told the nurses to encourage monitoring for signs and symptoms and maybe he would have ordered an extra dose to give.

R1's summary order report revealed in part a new order: 5/26/2016 - Keppra level

R1's laboratory report reads in part: final reported 5/30/2016, Results 9.8 L (low), Reference Range-10.0-40.0 ug/mL (microgram/milliliter)

The facility's policy titled, "Documentation" dated 2/14 reads in part: If a medication is not administered, then the licensed nurse will: d. Notify the physician when indicated.

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F 157	Continued From page 3 This policy was not followed.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a resident's medication was administered as ordered by the physician for one of three residents (R1) reviewed for medications in a sample of three. Findings include: According to R1's facesheet, R1 was admitted to the facility on 1/11/2016 with the following diagnosis not limited to: other seizures. On 5/26/2016 at 10am, R1 stated in part that he did not receive his seizure medication, Keppra (levetiracetam) on the following evenings: 4/15, 4/27, 5/18, 5/21. R1 stated that he had to argue with the nurse [E3/Registered Nurse] on 4/15 to give him his medication but the nurse wouldn't. On 6/1/2016 at 9:04am, E2 (Director of Nursing) stated on 5/23, she was notified that [R1] did not get his medication on 5/18 and 5/21. E2 stated she interviewed E3 (nurse) who said that she did not give the medication because R1 was sleeping. E2 presented a form titled, "Concern/Compliment Form" dated 5/23/16 that reads in part: "Identified the nurse [E3] that worked the dates	F 281		

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F 281	Continued From page 4	F 281		

[5/18 and 5/21]. Nurse informed writer that resident was sleep that's why he did not get his medication." E2 further stated that E3 documented she gave the medication when she didn't and should have charted on the MAR (medication administration record) as "other" and document the reasons not given on a progress note.

R1's MAR dated May 2016 reads: E3 administered levetiracetam to R1 on the following dates: 5/18/2016 at 2100 (9PM) and 5/21/2016 at 2100 (9PM). On 6/1/2016 at 11:14am, E3 stated in part that she didn't give R1's medication when he was sleeping and she doesn't know why it's not documented and she didn't tell the doctor. E3 could not recall the date of when and how many times this happened.

On 6/1/2016 at 4:34pm, Z3 (Ombudsman) stated R1 was not given medication a few times in April and May. Z3 stated the facility told her that they acknowledged that a nurse [E3] did not give R1's medication and E3 was educated in April when it happened the first time around and suspended in May when it happened again.

R1's Order Summary Report reads in part: Order and Start date - 01/11/2016: Levetiracetam tablet 500mg (milligrams) Give 2 tablet by mouth every 12 hours for seizures.

R1's care plan dated 03/23/2016 reads in part:
Focus- Resident is at risk for seizure activity R/T (related to) a diagnoses of seizure disorder.
Goal- Residents' seizure activity will be controlled with medication through next review.
Interventions- Administer medication as directed and follow pharmaceutical recommendations.

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F 281	Continued From page 5 On 5/26/2016 at 4:46pm, Z1 (Attending Physician) stated R1 is compliant with medications, has history of seizures and takes Keppra twice a day. [R1] had a Keppra level drawn before being admitted to the nursing home and the level was stable. Z1 stated he was not aware of any missed doses of Keppra for R1. Z1 stated that of course he would want to be aware and if he was notified, he would have told the nurses to encourage monitoring for signs and symptoms and maybe he would have ordered an extra dose to give. R1's summary order report revealed in part a new order: 5/26/2016 - Keppra level R1's laboratory report reads in part: final reported 5/30/2016, Results 9.8 L (low), Reference Range-10.0-40.0 ug/mL (microgram/milliliter) The facility's policy and procedure titled, "Medication Pass: Process and Procedure" dated 4/14 reads in part: Medication will be administered in accordance with a physician's order. 9. a. Administer medication in accordance with frequency prescribed by physician This policy was not followed.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed admistered a resident's anticonvulsant medication (levetiracetam) for treatment of seizures, as ordered by the physician. This failure affected one of three residents (R1) reviewed for physician orders in a sample of three.

Findings include:

According to R1's facesheet, R1 was admitted to the facility on 1/11/2016 with the following diagnosis not limited to: other seizures. According to R1's MDS (Minimum Data Set) dated 2/25/2016 reads: BIMS (Brief Interview for Mental Status) = 15/15, cognitively intact.

On 5/26/2016 at 10am, R1 stated in part that he did not receive his seizure medication, Keppra (levetiracetam) on the following evenings: 4/15, 4/27, 5/18, and 5/21. R1 stated that he had to argue with the nurse (E3, Registered Nurse) on 4/15 to give him his medication but the nurse wouldn't. On 6/1/2016 at 8:47am, R1 stated that when he misses his evening dose of Keppra, the next morning he feels that he is in withdrawal. R1 stated he starts to have tremors and feel dizzy, which are symptoms he feels before getting a seizure. Once he gets his morning dose, it takes about two hours to kick in his system and to relieve his symptoms.

On 6/1/2016 at 9:04am, E2 (Director of Nursing) stated on 5/23, she was notified that [R1] did not get his medication on 5/18 and 5/21. E2 stated

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she interviewed E3 (nurse) who said that she did not give the medication because R1 was sleeping.
E2 presented a form titled, "Concern/Compliment Form" dated 5/23/16 that reads in part: "Identified the nurse [E3] that worked the dates [5/18 and 5/21]. Nurse informed writer that resident was sleep that's why he did not get his medication." E2 further stated E3 documented she gave the medication when she didn't and should have charted on the MAR (medication administration record) as "other" and document the reasons not given on a progress note.

R1's MAR dated May 2016 reads in part E3 administered levetiracetam to R1 on the following dates: 5/18/2016 at 2100 (9PM) and 5/21/2016 at 2100 (9PM). On 6/1/2016 at 11:14am, E3 stated in part that she didn't give R1's medication when he was sleeping and she doesn't know why it's not documented and she didn't tell the doctor. E3 could not recall the date of when and how many times this happened.

R1's Order Summary Report reads: Order and Start date - 01/11/2016: Levetiracetam tablet 500mg (milligrams) Give 2 tablet by mouth every 12 hours for seizures.

R1's care plan dated 03/23/2016:
Focus- Resident is at risk for seizure activity R/T (related to) a diagnoses of seizure disorder.
Goal- Residents' seizure activity will be controlled with medication through next review.
Interventions- Administer medication as directed and follow pharmaceutical recommendations.

On 5/26/2016 at 4:46pm, Z1 (Attending Physician) stated in part R1 has history of

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F 309	Continued From page 8 seizures and takes Keppra twice a day. [R1] had a Keppra level drawn before being admitted to the nursing home and the level was stable. Z1 stated he was not aware of any missed doses of Keppra for [R1]. Z1 stated that of course he would want to be aware and if he was notified, he would have told the nurses to encourage monitoring for signs and symptoms and maybe he would have ordered an extra dose to give. R1's summary order report revealed in part a new order: 5/26/2016 - Keppra level R1's laboratory report reads in part: final reported 5/30/2016, Results 9.8 L (low), Reference Range-10.0-40.0 ug/mL (microgram/milliliter) The facility's policy and procedure titled, "Medication Pass: Process and Procedure" dated 4/14 reads in part: Medication will be administered in accordance with a physician's order. 9. a. Administer medication in accordance with frequency prescribed by physician This policy was not followed.	F 309		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514		

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preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to accurately document medications not given for one out of three residents (R1) reviewed for medications in a sample of three.

Findings include:

On 5/26/2016 at 10am, R1 stated in part that he did not receive his seizure medication, Keppra (levetiracetam) on the following evenings: 4/15, 4/27, 5/18, 5/21.

On 6/1/2016 at 9:04am, E2 (Director of Nursing) stated on 5/23, she was notified that [R1] did not get his medication on 5/18 and 5/21. E2 stated she interviewed E3 (nurse) who said that she did not give the medication because R1 was sleeping.
E2 presented a form titled, "Concern/Compliment Form" dated 5/23/16 that reads in part: "Identified the nurse [E3] that worked the dates [5/18 and 5/21]. Nurse informed writer that resident was sleep that's why he did not get his medication." E2 further stated E3 documented she gave the medication when she didn't and should have charted on the MAR (medication administration record) as "other" and document the reasons not given on a progress note.

R1's MAR dated May 2016 reads in part that E3 administered levetiracetam to R1 on the following dates: 5/18/2016 at 2100 (9PM) and 5/21/2016 at 2100 (9PM). On 6/1/2016 at 11:14am, E3

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stated in part that she didn't give [R1's] medication when he was sleeping and she doesn't know why it's not documented and she didn't tell the doctor. E3 could not recall the date of when and how many times this happened.

The facility's policy titled, "Documentation" dated 2/14 reads in part: 1. Each health care professional shall be responsible for making their own prompt, factual, concise, complete, appropriate, and legible entries.
If a medication is not administered, then the licensed nurse will:
a. Enter initials in medication, space allocated for the medication,
b. Circle initials indicating that the medication was not given,
c. Provide written rationale regarding why the medication was not given or refused in the designated area on the MAR
d. Notify the physician when indicated
This policy was not followed.