STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145524	A. BUILDING _____ B. WING _____	C 01/26/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW, A SR LVG COMMUNITY	**500 CENTENNIAL DRIVE EAST PEORIA, IL 61611**

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F9999	FINAL OBSERVATIONS Licensure Violations	F9999		

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F9999	Continued From page 10 300.1210(a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psycho-social 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 to each resident to meet the total nursing and personal care needs of the resident. 300.1210b)1) Medications including oral, rectal, hypodermic, intravenous, and intramuscular shall be properly administered. 300.1620a) All medications shall be given only upon the 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 calender 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. Based on observation, interview and record review, the facility failed to ensure that 1 of 4 resident's (R1) medications were accurately verified with the admitting physician, the facility's pharmacy failed to identify and verify an unusually high dose of an antipsychotic medication before dispensing the medication and five nurses failed to recognize they were giving	F9999		

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10 times the intended dose of medication on seven different occasions. R1 required admission to the hospital with altered mental state and dehydration.

Findings include:

Facility admission plan of care dated 12-23-04 states R1, a 69 year old female, was admitted from a local hospital with diagnoses including left distal femur fracture, history of bipolar disorder, and hypertension. Orders listed on this sheet include an order for Zyprexa 25 milligrams (mg) TID (three times a day). This order sheet was signed by E3, LPN (Licensed Practical Nurse.) There is no physician signature present.

Nursing notes dated 12-26-04 at 5:15 p.m. state " family up to nurses station concerned that resident is confused and sleepy. Resident is arousable, knows where she is." This note goes on to state that R1's physician was notified of her conditions and orders received to transfer R1 to the hospital for evaluation.

Review of R1's Medication Administration Record (MAR) for December 2004, shows that Zyprexa 25 mg was initialed as given seven times from 12 -24-04 to 12-26-04 by five different nurses. During interview on 1-6-05 at 12:20 p.m., E3 stated she handled R1's admission process from the hospital. E3 stated the procedure she follows for admissions is to call the admitting physician, verify the hospital transfers orders, fill out the Physician Admission Order sheet with those orders, fax them to the pharmacy and write a telephone order stating the transfer orders had been verified with the resident's physician.

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On 12-23-04, E3 stated she called R1's physician's office and verified the hospital transfer orders with the physician or nurse practitioner (E3 unable to remember who she spoke with), wrote them on the facility's Physician Admission Order sheet and then faxed the orders to the pharmacy. During review of R1's physician orders, no telephone order stating the admission orders were verified could be found. E3 confirmed that there was no telephone order dated 12-23-04 verifying the admission orders. When asked if she questioned the high dosage of Zyprexa being ordered, E3 stated "no" since the hospital physician ordered it and R1's physician verified the orders.

The Prentice Hall Nurses Drug Guide dated 2005 was reviewed. Zyprexa is listed as a "neuroleptic agent" whose use is for "management of psychotic disorders, short term treatment of acute manic episodes in bipolar disorder." Dosage states "start with 5-10mg once a day, may increase by 2.5-5 mg a week until desired response...Max: 20 mg per day." In the geriatric population, "start with 5 mg once per day." Adverse side effects of normal dosage include " somnolence, dizziness, agitation, hostility, tardive dyskinesia, elevated liver function test, neuroleptic malignant syndrome..." naming only a few.

During interview on 1-18-05 at 3:15 p.m., Z1, (R1 's physician) stated she did not verify R1's medications on 12-23-04. Z1 stated R1's medications were verified by Z2, the Nurse Practitioner in her office. Z1 stated she would never order Zyprexa 25 mg TID. Z1 stated she "

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would not order over 10 mg of Zyprexa a day for a geriatric patient."

On 1-20-05 at 3:30 p.m., Z4, Nurse Practitioner who works with Z1, was interviewed. Z4 stated on 12-23-04 she received a fax from the facility regarding R1's admission to the facility from the hospital. Z4 stated the fax contained the transfer orders from the hospital which she reviewed, signed and faxed back to the nursing facility. Z4 stated she approved the Zyprexa order as 2.5 mg TID not 25 mg TID. Z4 stated she would not have approved an order for Zyprexa 25mg TID without further verification from R1's physician. Z4 stated she did not remember, nor have record of receiving a phone call from the nursing facility to verify these orders.

Four of the five nurses who gave R1 the Zyprexa 25 mg dose were interviewed. E7, LPN was interviewed on 1-18-05 at 3:05 p.m. E7 verified she gave the first dose of the medication on 12-24-04. E7 stated she did question the dosage but when she looked at the transfer orders from the hospital, she did not see a decimal in the 25 mg. That combined with the pharmacy filling the medications order and R1 having "psychiatric problems" she felt it was OK to give the medication.

During interview on 1-18-05 at 2:40 p.m., E8, LPN verified that she gave R1 two doses of Zyprexa 25 mg on 12-24-04. E8 stated she did not question the dosage of the medication she gave R1. E8 stated at that time she did not know what the recommended dosage was.

During interview on 1-18-05 at 1:40 p.m., E6,

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LPN verified that she gave R1 two doses of Zyprexa 25 mg on 12-25-04. E6 stated she did not question the Zyprexa dosage at that time.

During interview on 1-18-05 at 3:15 p.m., E9, Registered Nurse (RN) verified that she gave R1 Zyprexa 25 mg on the morning of 12-26-04. E9 stated at the time, she did not question the Zyprexa dosage and also was unaware of the recommended dose.

During interview on 1-19-05 at 2:40 p.m., E10, LPN was interviewed regarding holding R1's second Zyprexa dose on 12-26-04. E10 stated on 12-26-04 in the afternoon, she observed R1 acting "weird", slurring her speech and not making sense which was not normal behavior for R1. E10 reviewed R1's medications, stating she had never seen 25mg of Zyprexa given, let alone 3 times in one day. R1's family also noted to E10 at that time that R1 was acting funny. E10 checked the hospital records and saw a printed sheet showing R1 had been receiving Zyprexa 2. 5 mg TID at the hospital. E10 also reviewed the hand written hospital transfer sheet which she stated could have said either Zyprexa 2.5mg or 25mg TID. E10 stated this order should have been questioned. E10 then notified the physician on call about R1's condition and how much Zyprexa was being given. The physician on call ordered R1 sent to the hospital for evaluation.

The history and physical signed by Z2 from R1's 12-26-04 hospitalization states that R1 was admitted with "mental status changes, (confusion /hallucinations), most likely secondary to medication error at the nursing facility." It also states R1 had mild dehydration.

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F9999	Continued From page 15 Z2, R1's hospital following physician, was interviewed on 1-19-05 at 1:30 p.m. Z2 stated he diagnosed R1 as having altered mental changes and mild dehydration. Z2 stated he was "informed that the nursing home had given R1 Zyprexa 25 mg TID instead of 2.5 mg TID." Z2 said R1 presented at the hospital as being "listless and disoriented" which was consistent with being given too much Zyprexa. Z2 stated R1's course of treatment included discontinuing the Zyprexa and being rehydrated. Review of hospital records shows a psychiatric consult dated 12-28-04 and signed by Z3, Psychiatrist. This consult states R1 was being admitted for "confusion and increasing hallucinations." R1 is described as being "heavily sedated and difficult to interview." The report states R1 was unable to give a recount of what happened stating only that she was "sleepy because of them pills." Report states "per chart review, there was an issue of an error in dosing Zyprexa and that perhaps patient was receiving 25 mg/TID (max dose is 20 mg every day) instead of 2.5 mg TID." Report states computerized tomography of head was negative for acute intracranial process or lesions. Report also states "feel Zyprexa (or any other atypical) should be carefully prescribed not only related to this incident but related to patients history as risk factors for further hyperlipidemia/metabolic risks." On 1-24-05 at 1:40 p.m., Z3, was interviewed regarding the above mentioned consultation. Z3 verified his consult date was 12-28-04 and stated R1's condition of sedation and confusion was consistent with someone who had been given too	F9999		

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much Zyprexa. Z3 stated the maximum dose during an acute stage for Zyprexa would be 15 - 20 mg per day.

On 1-18-05 at 9:45 a.m., Z5, manager of the nursing facility's pharmacy, was interviewed regarding R1's Zyprexa order. Z5 stated that the pharmacy did receive the order for Zyprexa 25 mg TID, filled the order and sent it to the nursing facility. Z5 stated the pharmacy did not contact R 1's physician to confirm the unusually high dosage of Zyprexa. Z5 stated a dosage this high should have raised a question and been verified. When asked what the maximum dosage of Zyprexa is, Z5 stated no more that 20 mg-30 mg per day.

On 1-18-05 at 1:20 p.m., R1 was sitting up in a wheelchair in her room at the nursing facility. R1 was alert and oriented. When asked why she was readmitted to the hospital 12-26-04, R1 stated "they gave me too much medicine and I was kind of out of it, I feel better now." R1 was able to list several of the medications she was taking now but could not state what medication made her feel "out of it."

Review of facility's policy dated 8-1-02 regarding verification of medications orders states "Center should confirm/verify all information before giving it to the pharmacy to avoid medication and billing error." This policy was provided on 1-6-05 at 2: 00 p.m. by E2, Director of Nursing.

The hospital's hand written transfer orders dated 12-23-04 for R1 were reviewed. The medication dosage of Zyprexa was not clear and could be construed as 2.5 mg or 25 mg TID. During chart

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F9999	Continued From page 17 review, a faxed copy of the written transfer orders was found to be signed by Z4 on 12-23-04. The facility's plan of care admission order sheet states the Zyprexa order as 25 mg TID and is signed only by E3, LPN. The hospital printed " copy of transfer record" under "active meds" states "Olanzapine (Zyprexa) 2.5 mg TID started on 12-20-04."	F9999		