

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145625		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2005	
NAME OF PROVIDER OR SUPPLIER CALIFORNIA GARDENS N & REHAB C				STREET ADDRESS, CITY, STATE, ZIP CODE 2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608			
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F 333	Continued From page 28 - Hydralazine 25Mg 1 tablet. Review of R11's current physician's orders dated Aug 2005 documents - Nitro-Bid ointment 2%, Apply 1 inch to chest wall every 6 hours. The scheduled times are 12 noon, 6Pm, 12Mn and 6Am. At approximately 2:30Pm, E8 was interviewed by surveyor at this time regarding the missed Nitro-Bid ointment scheduled for 12noon, E8 stated, "R 11 was not here, I could not give it, he goes out during the day, he just came back a few minutes ago but has left again! Observation of medication pass at 2:10Pm, interview of E8 at 2:30Pm and review of the MAR (medication administration record) documentation for this day indicated that R11 did not receive the Nitro-Bid as ordered at 12noon. Pharmaceutical resources list Nitro-Bid as a cardiac medication. R11 has diagnoses including Congestive Heart Failure.			F 333			
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) 300.1210b) 300.1210b)1 300.1210b)2 300.1210b)3 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care			F9999			

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F9999	Continued From page 29 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 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. b) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) Based on observation, clinical record review, staff interviews, other interviews, review of facility documents and review of hospital records, the facility failed to ensure that 1 resident (R2) was free from neglect as evidenced by the facility's failure to monitor including lab values for R2 who was newly diagnosed with Seizures and receiving a new drug to control those seizures, and failure to develop a care plan with interventions for staff to implement addressing R2's Seizures and the			F9999			

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F9999	Continued From page 30 use of a new anti- seizure drug. One of three licensed nursing staff was observed documenting medications as given when in fact the medications had not been given. These practices of not monitoring medications, not developing a care plan and not giving medications as ordered placed R2 and other residents who depend on facility staff, at risk for harm. This lack of monitoring and services resulted in R 2's Dilantin level reaching <1ug/ml (normal range is 10-20) in his blood which caused R2 having to be transferred to a local hospital due to multiple Grand- Mal seizures that could not be stabilized in the nursing home. Findings include: 1) R2 is a 45 year old resident with diagnoses including Multiple head trauma, skull fracture, left below knee amputation, and a Tracheostomy and Gastrostomy tube. R2 was admitted to the facility on 06/21/05 totally dependent on staff in all areas of care. On 07/19/05 less than 1 month after R2 was admitted to the facility, R2 had his first seizure which resulted in R2 being transferred to a local hospital to be stabilized. R2 then returned to the facility on 07/21/05 with an new order for Dilantin 100 Mg. 3 times a day via Gastrostomy tube to control these seizures. Prior to this, R2 was not on any anticonvulsant drugs. On 08/16/05 (approximately 1 month later) R2 again had to be sent to a local hospital to stabilize seizure activity .			F9999			

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F9999	Continued From page 31 On 08/22/05 and again on 08/23/05, Surveyor interviewed Z1 (local hospital emergency room head Nurse). Z1 stated, "R2 was brought to this emergency room on 08/16/05 at about 3:30 Pm due to having multiple seizures in the nursing home. When R2 arrived here we did a blood level and found no Dilantin in R2's blood and R2's blood sugar was very low. The ambulance attendants had to start an Iv (intravenous access) on R2 while enroute here and give R2 an ampule of dextrose, and upon arrival here R2 was having coffee ground emesis through the tracheostomy and R2's blood sugar was still in the 40's, we had to give additional dextrose. Z1 continued, "The ambulance was enroute to another hospital with R2 but had to be diverted here since we were closer and R2's seizures were lasting longer. " Hospital records dated 08/16/05 and timed at 3:30Pm indicates a Dilantin level for R2 as >1.0ug/ml. The normal range is 10.0 - 20.0. Further review of these hospital records included documentation by Z4 as follows: "Patient with hypoglycemia not on antihyperglycemic medications and essentially negative Dilantin levels with G-tube in at a SNF (skilled nursing facility). Will file a neglect report". On 08/29/05 at approximately 8:45Am, Surveyor attempted to interview Z4 at the receiving hospital. Z4 was not available on this day, but the documentation by Z4 was reviewed with Z1. Surveyor again attempted to reach to reach Z4 per telephone at the receiving hospital but again was not on duty. On 08/22/05 at approximately 4:05Pm, E2 (Director of nurses) and E3 (Assistant director of nurses) were interviewed on the 2nd floor regarding monitoring of high risk seizure			F9999			

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F9999	Continued From page 32 residents. Both stated, "All monitoring is documented within the nurses notes." E2 continued, "We also have a 24 hour report that communicates to staff from shift to shift who is on fall monitoring or seizure precautions, but the actual monitoring is in the nurses' notes". Later this day during interview, E2 stated, "When residents return from the hospital because of seizures, we do monitoring on them for 72 hours ." Upon further interview E2 explained, "Every shift should chart for 72 hours after a resident is readmitted to the facility." Review of R2's clinical record notes that R2 has a history of seizures and had been hospitalized for seizures on 07/19/05 and again on 08/16/05. There is also an order (started 07/21/05) for Dilantin to be given 3 times a day through R2's G-tube (Gastrostomy tube) and the scheduled times are 9:00Am, 1:00Pm and 5:00Pm. Further review of this clinical record documents staff monitoring R2 for seizures only 5 times (only on 1 shift) between 07/21/05 (the day R2 returned to the facility from 1st seizure) and 08/16/05 (the day R2 had the second seizure). The dates of monitoring were as follows: 07/22/05 @ 9:00Pm , 07/23/05@ 3:30Am. and again 10 days later on 08/02/05 @ 4Am. There was no evidence of monitoring from this day until 14 days later when on 08/16/05 at 2:15Pm, R2 was again found in bed having seizures and with coffee ground emesis coming through R2's tracheostomy and mouth. Z3 (Nurse practioner) who was present at this time documented R2 as having seizures lasting more than 10 minutes. Z3 described seizures as Grand Mal with vomiting/sputum from trach (			F9999			

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F9999	Continued From page 33 tracheostomy) coffee ground emesis. Z3 documentation continues, ' Accucheck taken- in 40s. Glucagon given 911 called. Send to hospital for evaluation. Review of this clinical record did not include that Dilantin levels had ever been drawn for R2 in an effort to assure that they were within therapeutic range after any seizure activity. Because the resident had been newly placed on this drug, closer monitoring of this drug would have been indicated. There was no care plan developed with interventions addressing these seizures. On 08/22/05 at approximately 5:30 Pm, during daily status meeting, E1 and E2 were interviewed regarding a care plan for R2 addressing seizures. Both stated that it was probably still in the computer. E1 left the meeting at this time to locate the missing care plan. After approximately 10 minutes, E1 returned and stated, "There is no care plan for R2 addressing his new seizures. " On 08/22/05 at approximately 12:45Pm Z2 (physician of R2) was interviewed regarding R2's low blood sugar and Dilantin level. Z2 stated, "R2's low blood sugar could be because of the seizure activity. The constant movement of the muscles during a seizure can cause the blood sugar to drop." Upon further interview, Z2 stated, "There are only possibly two reasons for the negative Dilantin blood level. Staff administering the Dilantin while the Gastrostomy feeding is infusing would cause the Dilantin not to be absorbed, or staff not giving the Dilantin to R2."			F9999			

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F9999	Continued From page 34 Record review indicates R2 was transferred to the local hospital on 08/16/05 at approximately 3:15Pm. R2 had orders to receive Dilantin at (9:00 Am, 1:00Pm and 5:00Pm), which should result in positive blood levels for R2 when Dilantin levels were drawn. Two doses would have been administered to R2 on this day of transfer, 9am and 1pm. The last dose (1:00Pm) should have been administered exactly 1 hour and 50 minutes before R2 was observed having seizures. On 08/22/05 at approximately 3:40 Pm surveyor toured the 2nd floor of the facility with E2. Surveyor interviewed E3 and E4 (nurse) regarding their practice of administering Dilantin through Gastrostomy tubes. E3 stated, "I turn the feeding off for 1 hour before I give the Dilantin and 1 hour after." E4 stated, "I turn the feeding off 2 hours before and 2 hours after I give the Dilantin" so there was no consistency noted in staff administration of this medication per G-tube. Approximately 4:00Pm this day, R2 was observed in bed asleep. R2 had a tracheostomy that was attached to a humidity dispenser and a gastrostomy tube feeding (Fibersource formula) that was attached to a pump that was turned off by E3 at this time. Upon interview E3 stated, "I turned the feeding off at 4:00, because R2 gets Dilantin at 5:00." Upon further interviews and record review, there was no other evidence provided from E1 (Administrator) nor E2(Director of nurses) that there was any additional monitoring of R2 including Dilantin levels being drawn to ascertain if it was within therapeutic levels to prevent a seizure from occurring or that Z2 was ever questioned regarding having Dilantin levels			F9999			

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F9999	Continued From page 35 drawn for R2. E2 was interviewed regarding a facility protocol for monitoring significant medications (e.g. Anticoagulants, Anticonvulsants etc.). E2 stated "We don't have one." On 08/30/05 at approximately 11:00Am, surveyor conferenced with Z5 (physician) regarding R2. This conference included R2's medical diagnoses, medical history and medications that R2 was receiving. Z5 was later interviewed regarding possible reasons for a resident to have Dilantin depleted from the blood. Z5 stated, "If a resident received Dilantin at 1:00Pm, the level should not be less than 1.0 upon arrival to a hospital an hour and 1/2 later. There should still be some in his blood. Seizure activity will cause the blood sugar to drop but it will not drop the Dilantin level. I really don't know any reason that would cause a Dilantin level to drop so low in such a period of time." Upon further interview Z5 stated, "I discussed this briefly with Z6 and we both feel that if such medication errors exist in the facility and residents' are suffering harm, it makes other residents in the facility at risk." On 08/31/05, surveyor did a medication pass observation at the facility. There were 21 opportunities observed and 5 errors found. These errors included a Dilantin medication. This observation and later record review of the facility's MAR (medication administration record) revealed that staff was documenting medications as given even though the medications had not been given by staff. On 08/31/05 at approximately 4:30Pm, while at			F9999			

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F9999	Continued From page 36 the facility, Surveyor was summoned to the phone by E1. Z2 was on the phone and wanted to clarify/add to the interview given to surveyor on 08/22/05. Z2 added, "On 07/21/05 while R2 was in the hospital (the first time) his Dilantin level was within therapeutic range, it was 13.2 ul/ml. When I saw R2 on 07/22/05 when he returned to the facility, R2 appeared asymptomatic, therefore I saw no reason to do anything further including ordering additional labs." Upon further interview, Z2 stated, "The last Dilantin lab was done by me was on 07/21/05 while R2 was in the hospital following that first seizure." On 09/06/05 at approximately 12:05Pm Z5 was again interviewed by surveyor. Z5 stated, "The interview I gave you on 08/30/05 still stays the same!" Z5 continued, "I have however,since consulted with another physician and we both feel that the only other possible reason for the negative Dilantin level in R2's blood could be because some facilities use generic medications for residents. Depending on the Bio availability the concentration may not be the same, however there should have still been some level in R2's blood. Upon further interview Z5 stated, "R2's Dilantin level was drawn 2 days after R2 was admitted to the hospital. R2's level was within therapeutic range (13.2) because R2 had been receiving loading doses of Dilantin once R2 got into the hospital. Usually it takes more than 2 days for the level to become within therapeutic range." Z5 continued, " R2 should have had another Dilantin level drawn at least 1-2 weeks after returning to the nursing home when R2 was on maintenance doses of Dilantin, the levels will			F9999			

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F9999	Continued From page 37 possibly be different." Z5 continued, "Even though the attending didn't order levels drawn on R2, pharmacy and the physician should have been questioned. On 09/07/05 surveyor interviewed Z4 (physician) regarding documentation on 08/16/05 that R2 was neglected at the facility because of R2's condition upon arrival to the hospital and negative Dilantin level. Z4 stated, "I stand behind my documentation on 08/16/05 because I do feel it was neglect." Z4 continued, "Obviously R2 was not getting the Dilantin. If R2 had been getting it as ordered or even 1-2 times a day there should have been some measurable amount in the blood not to mention the cumulative amounts." Upon further interview Z4 stated, "I reviewed R2's diagnoses as well as each medication R2 was on and did a drug interaction of each drug from my computer. I found nothing that would deplete the Dilantin." Pharmaceutical resources indicates that Dilantin is metabolized in the liver and has a half- life of 22 hours. Twenty-two hours or later Dilantin is excreted through the bile and urine of the resident. Interview with Z2 on 08/31/05 indicated that R2 Dilantin was within therapeutic level (13.2) when R2 was transferred back to the facility on 07/21/05, however less than 1 month later R2's level had dropped to less than 1.0. R2 was transferred to the local hospital on 08/16/05 at approximately 3:15Pm. With R2 receiving Dilantin as ordered by Z2 (9:00Am, 1:00Pm and 5:00Pm since 07/21/05), there should have been			F9999			

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F9999	Continued From page 38 some levels in R2's blood (not accounting for the cumulative amounts) when R2 was transferred to the local hospital on 08/16/05. 2) During medication pass on 08/31/05 at approximately 9:15Am, E6 was observed to prepare and administer Dilantin Suspension through R2's G-tube (Gastrostomy tube). This G-tube was observed off at this time. Surveyor observed a label on this Dilantin bottle as follows: "Hold Gastrostomy tube feeding 1 hour before and 1 hour after. Shake well." E6 was not observed to shake well this Dilantin bottle prior to preparing it in a plastic medication cup for R2. R2 has current (08/05) physician's orders as follows: Dilantin 200mg (8cc) suspension per gastrostomy tube twice daily. The scheduled times are 9Am and 5Pm. After administering these medications through R2 's Gastrostomy tube, Surveyor observed a substantial amount of residue on the inside interior of this medicine cup as E6 was discarding it. E6 was prompted by surveyor to retrieve this cup and questioned as to the amount of Dilantin that was possibly left there. E6 stated, "Approximately 1/2 cc is left in the cup." E6 was further questioned why the cup with such a substantial amount of Dilantin in it was not rinsed and given to R2 to assure the correct amount was given. E6 stated, "I guess I'm just nervous!" This observation by surveyor indicated that R2 received less than the 8cc of Dilantin ordered by			F9999			

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F9999	Continued From page 39 his physician. R2 has diagnoses including Seizure disorder and has been recently hospitalized due to having multiple seizures in the facility. 3) During medication pass on 08/31/05 at approximately 9:15Am, E6 was observed to administer the following medications to R8 through his G-tube (E6 was not observed to afford privacy to R8 during this medication administration) : -Clonidine 0.3Mg 1 tablet crushed and mixed in water. -Docusate Na+ 100 10cc liquid. -Phenytoin (Dilantin) 8cc liquid. -Norvasc 10Mg 1 tablet crushed and mixed in water. -Vitamin C- 5 cc(500mg) liquid. Five medications were given to R8 at this time. This count was confirmed with E6 prior to administration. Record review indicated that in addition to the above medications, R8 has current physician orders as follows: *Zinc sulfate 220Mg per G-tube daily. The scheduled time is 9Am. *Metoprolol 100Mg 1 tablet per G-tube daily. The scheduled time is 9Am. *Multivitamin 5cc per G-tube daily. The scheduled time is 9Am. Surveyor then reviewed the facility's MAR(medication administration record) for R8 and			F9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145625		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/08/2005	
NAME OF PROVIDER OR SUPPLIER CALIFORNIA GARDENS N & REHAB C				STREET ADDRESS, CITY, STATE, ZIP CODE 2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608			
(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 40 noted that E6 had initialed/ documented R8 as having received the Zinc sulfate, Metoprolol and Multivitamin when it was not observed by surveyor as being given to R8. E6 were interviewed at approximately 3:00Pm regarding medications not given to R8, but yet was documented as given. E6 stated, "Oh, I forgot and charted them in error, the medications are not here yet!" Later on this day at approximately 3:55Pm in the first floor conference room of the facility, E2 (Director of nurse) was interviewed regarding the practice of staff documenting medications as being given to residents when in fact they were not given to them. E2 stated, "E6 has now given the Multivitamin to R8 since it is stocked in the facility." Upon further interview E2 stated, "When a medication is not given, staff should initial and code the medication as not given and the reason ." Upon review of the MAR with surveyor, E2 observed that E6 had initialed the medication as given however there was no code indicating medication not given and the reason. E2 summoned E6 to the conference room at this time. E6 again admitted not giving the medication to R8. E6 then coded the Metoprolol and Zinc sulfate as not given on the MAR for R8. R8 has diagnoses including Hypertension, and Anemia. 4) During medication pass on 08/29/05 at approximately 2:10Pm, E8 (nurse) was observed to administer the following medications to R11:			F9999			

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F9999	Continued From page 41 -Calcium Carbonate 1250Mg 1 tablet. - Klor-con 20 MEQ 1 tablet. -Coreg 25Mg 1 tablet. - Hydralazine 25Mg 1 tablet. R11 has current physician's orders as follows: - Nitro-Bid ointment 2%, Apply 1 inch to chest wall every 6 hours. The scheduled times are 12 Mn and 6Am. -Calcium Carbonate 1250 Mg 1 tablet by mouth 3 times a day before meals. The scheduled times are 9A, 1pm and 5Pm. - Klor-Con 20MEq 1 tablet by mouth 3 times a day. The scheduled times are 9Am, 1Pm and 5 Pm. - Corg 25 Mg 1 tablet by mouth 2 times a day. The scheduled times are 9Am and 5Pm. - Hydralazine 1 tablet by mouth 2 times a day. The scheduled times are 9Am and 5Pm. Observation of medication pass by E8 at this time and the MAR (medication administration record) indicated that R11 did not receive the Nitro-Bid as ordered at 12noon. Pharmaceutical resources list Nitro-Bid as a cardiac medication. R11 has diagnoses including Congestive Heart Failure. This review also indicated that R11 received Corg and Hydralazine at this time (2:10Pm) when it should have been given at 9Am. Further review of the MAR by surveyor at approximately 2:30Pm indicated that R11 had not received the Calcium carbonate tablet or Klor-Con tablet at the scheduled times of 9:00Am.			F9999			

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F9999	Continued From page 42 E8 was interviewed by surveyor at this time regarding the missed 9Am medications (Calcium Carbonate and Klor- Con) and Nitro-Bid ointment scheduled for 12noon, as well as the medications that was given off schedule (Coreg and Hydralazine). E8 stated, "R11 was not here for his 9:00 medications this morning. He had left, I could not give them. He goes out during the day !" E8 continued, "R11 is not here now, he has left again, so I still cannot give the Nitro-bid patch to him." This observation and review of the MAR indicates that R11 had missed medications and medications were given to him at the wrong time. 5) During medication pass on 08/31/05 at approximately 9:15Am, E6 (nurse) was observed to prepare the following medications to administer through R8's Gastrostomy tube (the gastrostomy tube was observed not in use at this time): Clonidine 0.3 mg 1 tablet dissolved in 30cc of water. Docusate sodium 10cc (20mg) liquid. Phenytoin (Dilantin) 7.2 cc suspension. Norvasc 10 mg. 1 tablet dissolved in water. Vitamin c 5cc (500 mg) liquid. During the preparation of these medications, Surveyor noted the instructions on the Dilantin bottle as follows: "Shake well" as well as instructions that R8 should be receiving 8cc (200 mg) of the Dilantin suspension rather than the 7.2 cc that was prepared by E6. E6 was not observed to take this suspension			F9999			

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F9999	Continued From page 43 bottle and shake well as ordered. As E6 was preparing to administer the Dilantin through R8's G-tube, surveyor interrupted E6 and questioned her regarding the amount being given to R8. E6 stated, "R8 should be getting 8cc of Dilantin now". Surveyor prompted E6 at this time to measure the amount being given using a syringe. E6 measured the Dilantin into the medication cup using a syringe and discovered it was 7.2cc rather than the 8cc ordered by R8's Doctor. E6 stated, "This is about .8cc less, I'll add it now". This measurement indicated that R8 was almost 1cc short of the Dilantin that was ordered by the physician for him. R8 is a 79 year old resident with diagnoses including Seizure disorder, Bilateral above knee amputee and Anemia.			F9999			