STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145806	A. BUILDING _____ B. WING _____	C 08/12/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN PARK NURSING PAVILION	**6700 NORTH DAMEN AVENUE CHICAGO, IL 60645**

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F 309	Continued From page 6 side effects from narcotics. 3. On and before 8/19/05, inservices will be held with appropriate Facility staff. Outside consultants will conduct the inservices. The inservices will include: 1) A review of the requirement that the services provided or arranged by the Facility meet professional standards of quality. 2) A review of the alleged deficiency. 3) A review of the proper application of patches. 4) A review of the requirements necessary to successfully complete medication passes. Director of Nursing and /or her designees will perform spot checks to determine level of staff compliance, particularly with regard to proper application of patches and monitoring side effects from narcotics through use of Quality Assurance audit reports and observation. Director of Nursing and/or her designee will monitor for overall compliance through her general supervision and review of Quality Assurance reports.	F 309		
F9999	FINAL OBSERVATIONS STATE LICENSURE FINDINGS: Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the	F9999		

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F9999	Continued From page 7 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. 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 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. These REGULATIONS are not met as evidenced by: Based on record review and interviews, the facility failed to provide the necessary care and services to attain the highest physical well-being for one resident (R2) who is to receive one 75 mcg/hour Duragesic patch every 72 hours for	F9999		

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F9999	Continued From page 8 pain. R2 is a 78 year old resident who requires the Duragesic patch for chronic back pain. R2 was transferred to the hospital on 7/13/05 for unresponsiveness to tactile and verbal stimulation. Upon assessment in the emergency room, R2 was noted to have three 75mcg Duragesic patches on his body as well as a indwelling urinary catheter soiled with dried stool. R2 was diagnosed with mental status changes, opiate overdose, and urinary tract infection. The facility failed to assess R2's skin before applying a new 75mcg Duragesic patch as well as consistently documenting the site of where the patch was applied and did not ensure the indwelling urinary catheter was free of fecal matter. Findings include: 1. R2 is a 78 year old resident with several diagnoses including left BKA (below the knee amputee), right toes amputated, and major depression. Review of the July 2005 physician's order sheet shows R2 is to receive Duragesic 75 mcg/hour patch, apply 1 patch topically every 72 hours (6am). Precautions listed are may cause drowsiness and may cause dizziness. Review of the facility's discharge log shows R2 was discharged to the hospital on 7/13/05. Review of the nurse's notes dated 7/13/05 at 6: 15am documents E4 (nurse) attempted to wake resident up for morning meds, but R2 would just open his eyes and not wake up. E4 kept trying to wake R2 up for at least 30 - 40 minutes with no results. R2 was unresponsive to painful or tactile	F9999		

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F9999	Continued From page 9 stimuli. During interview on 7/21/05 at 3:15pm, E3 (assistant director of nursing) stated, "E4 was the one who had R2 and sent R2 out to the hospital. The Duragesic patch is every 72 hours. The old one is taken off when a new one is put on. We knew it was E4 because of the initials on the MAR (medication administration record) are his. When I asked E4, E4 said he checked and didn't see a patch. E4 said he would usually put the patch on the shoulder or on the chest." Review of the June 2005 MAR shows the following: -For 6/12: No initials to indicate if the Duragesic patch was applied. -For 6/15, 6/18, 6/21, 6/24, and 6/27: No documentation to indicate the site where the Duragesic patch was placed. -For 6/30/05; The patch was placed on R2's left shoulder. Review of the July 2005 MAR shows the following: -For 7/3: R2 wasn't given the Duragesic patch, not available - reorder from pharmacy. Review of the nurse's notes does not document if the old Duragesic patch was removed and a new one applied when it came in from the pharmacy. -For 7/6: No documentation to indicate the site where the Duragesic patch was placed. -For 7/9: The patch was placed on R2's right shoulder. -For 7/12: The patch was placed on R2's right chest. The above three patches (7/6, 7/9, 7/12) were believed to be on the residents body when	F9999		

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F9999	Continued From page 10 hospitalized. Review of the Emergency Services record nurse's notes dated 7/13/05 documents R2 was brought to the ER (emergency room) for complaint of change in mental status and increased lethargy. Review of the physician's notes dated 7/13/05 at 7:15am documents, upon presentation, nurses noted R2 minimally responsive. Would speak with questioning, not opening eyes, no movement . Nurse noted Duragesic patches on chest, right arm, and left arm; no dates. These sites are consistent with the sites documented on the facility's June and July 2005 MAR. The physician's notes further shows R2 was given 2mg of Narcan and aroused fully. Review of the Emergency Services department nurse's notes dated 7/13/05 at 7:15 documents the following: -78 year old male brought to ER (emergency room) from facility for complaint of change in mental status, increased lethargy. Three Duragesic patches removed from body. Patient placed on 3 liters of oxygen. -At 7:30am: Narcan administered IVP (intravenous push). Patient awake and talking more, asking where he was. R2 received 2mg of Narcan per IV (intravenous) push. During interview on 8/11/05 at 10:20am, Z1 stated, "yes, I remember R2. I wasn't the main nurse, but I helped out because we were so busy . R2 had 3 Duragesic patches on his body."	F9999		

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F9999	Continued From page 11 During telephone interview on 8/12/05 at 11:25 am, Z2 stated, "the physician in the ER (emergency room) informed me of the 3 patches on R2. The patches were not dated nor initialed." Z2 went on to say E1 (facility's administrator) informed him E4 was terminated because of negligence. Review of the employee report documents E4's written statement as E4 put a patch on R2 on the 12th of July on the right arm. E4 writes that he removed the patch from the right chest. E4 was terminated on 7/15/05 due to neglect and failure to follow nursing standard. Review of the facility's policy and procedure for Transdermal Patch Application shows: 3. After removing the old patch, clean site with soap and water to remove traces of old medication and pat dry. 4. Alternate sites of patch application. 5. Record location in the Medication Administration Record. 2. R2 has several diagnoses including MRSA (methicillin resistant staphylococcus aureus) in the urine and status post urethral stricture. R2 is also care-planned for being incontinent of stool. Review of the July 2005 POS shows orders for urinary catheter care every shift, change urine bag every 2 weeks, and to change the urinary catheter monthly. During telephone interview on 7/25/05 at 2:35pm	F9999		

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F9999	Continued From page 12 E3 (director of nursing) stated, "urinary catheter care is making sure of the color and amount of the urine and that it is draining. We make sure the catheter is patent and that the bags are not on the floor. The urine bags are changed as ordered. When the bag is changed, the nurse dates it. This information should be in the nurse's notes." Review of the nurse's notes dated 5/18/05 through 7/13/05 do not show if and when catheter care was done for R2. Review of Emergency Services physician's notes dated 7/13/05 documents urinary catheter changed by ED (emergency department) staff - old catheter with thick sludge, yellow/green in color in the tubing. Review of the nurse's notes R 2 had old stool around urinary catheter, on catheter, and bag. During interview on 8/11/05 at 10:20am, Z1 stated, "the urinary catheter had old, dried stool on it. They had to change the catheter as well as the urine bag."	F9999		