

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

PRINTED: 11/03/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145607		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/23/2006	
NAME OF PROVIDER OR SUPPLIER MANORCARE AT PALOS HEIGHTS				STREET ADDRESS, CITY, STATE, ZIP CODE 7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463			
(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	FINAL OBSERVATIONS STATE LICENSURE VIOLATIONS: STATE LICENSURE VIOLATIONS 300.1210b)1) 300,1210b)2) 300.1630c) 300.1630e) Section 300.1210 General Requirements for Nursing and Personal Care 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. Section 300.1630 Administration of Medication c) Medications prescribed for one resident shall not be administered to another resident. e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report.			F9999			

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F9999	Continued From page 10 These REGULATIONS are not met as evidenced by: Based on review of clinical records, hospital records, facility's policy and procedures, and staff and other interviews, the facility failed to correctly identify the appropriate individual and administered the wrong medications to R3, a known confused resident. As a result R3 developed hypotension, hypoglycemia, and renal failure. R3 was immediately taken and admitted to the hospital in acute distress, with the potential for circulatory failure, and was diagnosed with renal failure. Findings include: R3 was re-admitted to the facility on 6-11-06 after hospitalization for multiple falls and multiple periods of confusion according to the nursing notes. Review of R3's history and physical dated 6-9-06, during hospitalization, indicated that he experienced Atrial fibrillation with a bad ventricular response. R3's other diagnoses include a coronary by-pass, heart failure, 3 aortic dissection, gout, non- insulin diabetes, degenerative joint disease, COPD, and dementia. After re-admission to the facility, R3 continued to have periods of confusion on a daily basis according to nurses notes. R3 experienced confusion and forgetfulness of events which happened the day before. He at times required a sitter at night and 1:1 observation at other times. On 6-15-06 E3 (CNA) stated during interview that she got R3 up and dressed for the morning			F9999			

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F9999	Continued From page 11 breakfast and took him to the dining area. E4 (LPN) stated that around 8:30 AM she approached R3 in the dining room while he was sitting with other residents. "I approached him and said I have your insulin, and R3 responded 'Are you going to give it in my arm or stomach?'" E4 further stated that "I asked him was he R2." R3 who has a documented history of confusion stated "yes." No other method of identification was done. E4 proceed to give R3 22 units of NPH subcutaneously although his morning accu-check level was recorded as 98, within normal limits according to the medication administration record (MAR). E4 proceeded to continue administering pills to R3 which were prescribed for R4. E4 failed to verify that the right medications were given to the right resident. E4 failed to identify the right person and the right medications at the right time for R3. As a result the wrong, significant medications were given to R3. The medications R3 received in error were: (1) Insulin 22 unit of NPH- Long acting (2) Alphagan eye drops (whose actions lower blood pressure). Based on literature review individuals who have cardiovascular disease, as R3, are at high risk for developing irregular pulses and heart rate. It is contraindicated in people who have cardiovascular disease and should be used with caution. R3's history on 6-9-06, prior to this incident, reported a irregular heart rhythm known			F9999			

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F9999	Continued From page 12 as heart atrial fibrillation with a bad ventricular response. (3) Hytrin 5mg (a alpha blocker which lowers the blood pressure). Literature review warns that the medication should not be taken if you are already taking blood pressure lowering medications. R3 regularly takes Atenolol (lowers blood pressure), Vasotec 5mgm (lowers blood pressure & is an ace inhibitor), Lasix 40mgs (diuretic which lowers blood pressure). (4) Magnesium Oxide, 400mg. (5) Oscal 1.256 (6) Proscar 5 mg. E3 stated "After breakfast I put him to bed; he said he did not feel well. He did not look good. He said he was not OK. This was about 9:15 am. I did not take his blood pressure. I did tell the nurse. When I saw him again, he was being wheeled out by the ambulance. He was pale looking and lethargic; he looked weak. I was not told to take his blood pressure. I left his room and continue to pass the trays. He was in the room alone." E4 stated that she arrived in R3's room at round 9:30 am after being told by the CNA that R3 complained of dizziness. E4 further admitted "I immediately realized that he was given the wrong medications this morning. I gave him (R3) another resident's medications". As a result of this significant medication error, R3 's blood pressure dropped to 61/42; his heart rate			F9999			

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F9999	Continued From page 13 was 62. His normal blood pressure is recorded at a range of 97/53 to 104/55. Although his accu-check at this time was 160, R 3's who is not on insulin (lower the blood sugar) received NPH. Based on literature review, NPH is a long acting insulin which begins to work in an hour. Its effects can last at least 24 hours. Staff called 911, and R3 was taken to a local hospital. R3's blood pressure (R3 has a history of hypertension) was recorded at 80 systolic according to the hospital records. R3 was admitted to the hospital with a diagnoses of accidental medication administration, Hypotension, and renal failure. According to the lab reports performed in the emergency room, BUN was 47 (10-23), Creatinine was 3.2 (0.6 - 1.4), Sodium was 131 mg, Potassium was 4.5, and Chloride was 100. R3 remained hospitalized at the time of this survey. (A)			F9999			