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ROSEWOOD CARE CENTER OF EDWARDSVILLE	6277 CENTER GROVE ROAD EDWARDSVILLE, IL 62025

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F 426	Continued From page 17 Under the "Procedure for Medication Pass" it states that the nurse should always check the " Right Time" for administration of medications. It further states "If a PRN is administered, nursing shall document on the back of the MAR. Include the date, time, medication, reason for administration and initials. In addition, nursing shall document the results of the administration of the PRN medication."	F 426		
F9999	FINAL OBSERVATIONS Licensure Violations: 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 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. Restorative measures shall include at a minimum the following procedures: 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	F9999		

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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 300.1610 medication Policies and Procedures
a) Development of Medication Policies
1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.

Section 300.1620 Compliance with Licensed Prescriber's Orders
a) 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 calendar 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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
These Requirements are not met as evidenced by:

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Based on record review and interview it was determined that the facility failed to provide adequate monitoring and correct administration of controlled substance pain medication to one of six residents, (R2). R2 returned to the facility from the emergency room with orders for OxyContin 20 mg every 12 hours. R2 had received the OxyContin just 4 hours prior to administration of the OxyContin again at the facility. R2 "died from acute toxicity with oxycodone and opiates" as determined by the Coroners toxicology report.

The findings include:

1. R2 was originally admitted to the Facility on 7/16/05. R2 was readmitted to the Facility on 8/4/05 after a hospital admission on 8/1/05 for congestive heart failure. R2 was admitted to the Facility for "therapies" as identified by the Social History dated 8/4/05. The history also stated that R2's stay was projected to be of short duration with discharge within 90 days. R2 was 86 years old. R2 had diagnoses, in part, of congestive heart failure, coronary heart disease, hypertension, osteoporosis with L1 compression fracture, degenerative arthritis and dementia. R2 had orders for skilled physical and occupational therapy according to the August physician order sheet.

R2 was admitted with physician orders for pain medication of "Lortab 5/500, 1-2 po q 6 hours prn pain", and "Tylenol 1000 mg (1) po q 6 hours prn pain." On 8/17/05 "Darvocet N-100 1 q 4 hours prn" was ordered. The "Medication Notes" for August 4 through 26, 2005 identified R

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2 was given 5 doses of Lortab, one dose of the Tylenol, and 4 doses of Darvocet for back pain during this time. The "Controlled Substances Record" for August identifies 8 doses of Darvocet and 15 doses of Lortab was given during this time. Other medication R2 was receiving was Buspar 15 mg twice a day, Phenergan 25 mg IM/po four times a day PRN, Lomotil four times a day PRN, Lasix 40 mg twice a day, Plavix 75 mg daily, amiodarone 200 mg daily, Lisinopril 20 mg daily and Ambien 5 mg at HS PRN. The "Pain Assessment" dated 8/4/05 states the pain is related to "L1 comp. fx." The pain was rated as a 5 which is moderate pain.

On 8/25/05 the nurses notes state Z1, Physician, called the Facility and gave the name and number for a physician to perform a vertebroplasty procedure. He asked that this information was to be given to Z5, daughter of R 2. On 8/26/05 at 2:30 AM R2 was given 25 mg of Phenergan for nausea and vomiting. At 10:00 AM R2 was given 1 tablet of Darvocet after therapy. At 11:00 AM R2 requested staff to call Z 5. According to the nurses notes, Z5 was at the Facility at 11:30 AM and reported to E7, Licensed Practical Nurse, (LPN), that R2 was continuing to complain of severe back pain. E7 wrote that she was at "lunch et gave 600 hall nurse keys to give pt. Lortab 5/500 2 tabs per MD orders." E7 signed the "Controlled Substances Record" that two tablets of Lortab were given.

At 11:45 AM Z5 spoke to E7 about sending R 2 to the hospital to see Z6, Physician. E7 paged Z1 for orders to send R2 to the hospital. Z1 was not in the office so Z7, Physician, returned the call. E7 documented in the nurses notes that Z7

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"was upset with pts dtr et stated vertebroplasty is a scheduled procedure et would not give order to send pt. to ER." At 12:15 PM, E7 was called to the "office" and was told by E1, Administrator, and E2, Director of Nursing, that R2 would be going to the hospital. Z7 was paged and returned the call at 12:35 PM and was informed that R2 was going to be sent to the hospital. Z7 responded "OK." R2 was sent by ambulance to the hospital emergency room at 1:15 PM. The hospital emergency room was contacted at 12:55 PM to give report and was told Z6 was not in the emergency room and the vertebroplasty procedure has to be scheduled. Z5 was informed and still wanted R2 sent to the emergency room. At 1:10 PM, Z1 called the facility and wanted to know why R2 was being sent to the emergency room. Z1 was informed Z5 was informed that Z6 was not available. The nurses notes state "MD upset et stated, "Maybe she can find another doctor when she comes back."

Z1 treated R2 at the emergency room. The emergency room record identifies Z1 as the attending physician. The emergency room report dated 8/26/05 states R2 had back pain and a L1 fracture was noted in a recent Xray. The transfer sheet from the facility to the emergency room did not list any medications R2 had been given that day. Interview with E7 on 11/16/05 at 2:50 PM noted that she had called the emergency room to give report and gave the medications R2 was on then. There is no documentation about medications taken that day on the emergency room record. At 2:25 PM in the emergency room R2 was given 4 mg of Morphine and 12.5 mg of Phenergan by Intravenous therapy. At 4:05 PM R2 was given 4 mg of Morphine by IV and 20 mg

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of OxyContin orally. At 5:50 PM Z1 wrote orders for R2 to be sent back to the facility with medications of "OxyContin 20 mg po q 12 hours", "Percocet 5/325 2 po q 6 hours prn pain," and " Morphine 8 mg + Phenergan 25 mg with m q 4 hours prn severe pain."

In an interview with Z1 on 11/16/05 at 5:30 PM at the facility, Z1 stated he wasn't aware of the medications prescribed at the emergency room. Z1 did not mention he was the emergency room physician that treated R2 or that he would not sign the death certificate. Review of the Coroner Report on 11/30/05 noted that Z1 refused to sign the death certificate because R2 had changed physicians without his knowledge. Z1 stated the OxyContin should have been given every 12 hours and not at 8:00 PM as given. Z1 stated he would have to check respirations of R2 to see if the medications had caused any respiration problems such as a depression in the respirations. There was no monitoring of the respirations of R2 after she returned to the facility . Z1 stated he knew R2 had expired but was not aware why.

The nurses notes dated 8/26/05 at 6 PM note R2 returned to the facility. There are no vital signs such as respiration taken. At 6:30 PM the nurses notes by E10, LPN, states "Guest seen by this nurse upon her arrival back to this facility via ambulance service with 2 attendants. Alert, oriented, but did c/o pain to her mid back still even with all the medication she received at the hospital. Medication ordered from pharm and they called to confirm medication was on the way ." The next nurses note at 9:00 PM states "Guest c/o nausea with some emesis. sm. amt.

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F9999	Continued From page 23 medication given, had received oral pain medication earlier and did not eat anything at supper." There are no vital signs documented in the medical record. Review of the "Vital Sign Flow Sheet" for 8/26/05 had the most current vital signs documented at 11:00 AM. The blood pressure was 128/56, temperature was 96.9, pulse 84 and respirations 16. The "Daily Skilled Nursing Assessment Tool" dated 8/26/05 for the evening shift was signed at 10 PM by E10. E10 wrote across the page "@ Hosp ER". R2 returned to the facility from the hospital emergency room at 6:00 PM. In an interview with E10, LPN, by phone on 11/17/05 at 11:13 AM E10 stated she did not recall any of the events documented. E10 stated she did not work there that long. E10 was terminated from employment on 10/27/05 after E10 quit. R2 had received 20 mg of OxyContin at 4:05 PM at the hospital emergency room. The order sent to the facility was for OxyContin 20 mg every 12 hours. E10 gave the OxyContin only 4 hours after the last dose. The Medication Administration Record dated 8/26/05 documented that R2 was given 20 mg of OxyContin at the 8:00 PM medication pass. The "Controlled Substances Record" had documented that 20 mg of OxyContin was given to R2 on 8/26/05 at 8 PM. Interview with Z2, Pharmacist, on 11/17/05 by phone indicated the doses of the medication were "excessive". Z2 stated R2 received a lot of respiratory depressing medications. Z2 stated that it was "certainly possible" for the medications to cause respiratory or cardiac arrest. Z2 stated	F9999		

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the dose of OxyContin should have been given as ordered for every 12 hours. Z2 stated all the medications given after 2:00 PM on 8/26/05 were excessive.

The next entry is on 8/27/05 at 1:00 AM by E8 , LPN. The nurses notes state "Guest found in room by this writer, unresponsive, not breathing and no pulse. This writer called for assistance from other nurses and got the crash cart. Moved guest from bed to floor and began CPR, this nurse doing compressions and the other nurse bagging. Called the CNA and told her to call 911. The bag valve mask was hooked to high flow O2. Performed CPR for 5 min and switched position with other nurse and checked for pulse. Guest remained unresponsive without pulse. Continued CPR. One of the CNA's continued bagging-this nurse went to prepare paper work to transfer. Ambulance arrives 10-15 min after called. Guest was transferred from facility via stretcher-accompanied by 3 attendants and 1 police officer . This writer noted the guest was intubated and the the continued CPR as the wheeled her out. MD, family & ADON notified." The transfer sheet to the emergency room did not list any medications that R2 had received that day. The next nurses note at 1:40 AM noted that R2 had expired.

E8 was interviewed by phone on 11/17/05 and 11/30/05. E8 stated when he entered R2's room she was breathing shallowly and didn't look good. E8 stated R2 was in her bed. E8 stated he left to go get the pulse oximetry machine and the machine to check her blood sugar. When he reentered the room R2 was not breathing. E8 stated he yelled for the other nurse and went to

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F9999	Continued From page 25 get the crash cart. E8 stated they first tried to put a back board under R2 then he and the other nurse lifted R2 out of the bed by a sheet and placed her on the floor to start CPR. E8 stated a CNA took over the CPR and he went to fill out the paperwork for transfer. E8 stated he had not been told of any problems or pain with R2 by E10 in the verbal shift report. E8 stated he had not seen R2 until the time he found her unresponsive . Interview with E9, CNA confirmed R2 was found in bed. E9 stated she could not remember if she had seen her prior to when she was found unresponsive. E9 stated she could not remember if any vitals had been taken during her shift. The "Emergency Physician Record" dated 8/ 27/05 documents R2 was brought to the emergency room at 12:30 AM due to cardiac arrest or "Code Blue." R2 was pronounced dead at 12:37 AM. R2's rectal temperature was noted to be 94.5 degrees Fahrenheit at 12:35 AM as documented on the emergency room medical record. In an interview with Z3, Coroner, on 12/1/05 he stated the standard accepted is that the body temperature drops 1 degree per hour after death. Z3 stated there were factors that affect that such as age, diseases, and environment. Z3 stated in an interview on 11/16/05 that this was a coroner case due to the Physician refusing to sign the death certificate, the fact that R2 was at the hospital less that 24 hours and the fracture of the vertebrae. The toxicology report from the Coroners office identified the following	F9999		

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F9999	Continued From page 26 medication in R2's blood: Propoxyphene, Promethazine, Acetaminophen, Morphine, Hydrocodone, Oxycodone, and Hydrocodol. The Coroners report dated 11/22/05 for R2 states " Final Summary: This 83-year-old female died from acute toxicity with oxycodone and opiates. The manner of death is classified as undetermined."	F9999		