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	145669	A. BUILDING _____ B. WING _____	C 01/17/2006

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F 309	Continued From page 10 for possible change in dosing." (This was clarified with E2 to mean that staff will be proactive in obtaining results that are not reported to them after the resident receives his 3rd dose but prior to administering the next dose). 2) On 12/28/05 the facility developed monitoring sheets for IV medications that require peak and trough levels. 3) On 12//28/05 the facility implemented Quality Assurance Worksheets for Laboratory Orders and Results. 4) On 1/12/06 the facility completed in-services on "IV medications that require peak and trough level monitoring" to all nursing staff who administer these medications. The facility also identified all residents in-house who were receiving IV Antibiotics and required peak and trough level monitoring. Also, all new orders for antibiotic therapy are to be relayed to the Assistant Director of Nursing (E2).	F 309		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) 300.1210b)1) 300.1210b)2) 300.1610a)1) 300.3220f) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 11 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. 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 300.1610 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 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have	F9999		

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F9999	Continued From page 12 been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on record review and interviews the facility neglected to obtain the results of an initial Vancomycin trough blood draw, in a timely manner, for 1 resident (R2) who was new to the facility The facility also neglected to check further trough levels prior to administering every 3rd dose. This resulted in 1 resident (R2) receiving 6 additional doses of Intravenous Vancomycin, after an "alert" high level should have been known, causing the toxicity level to rise even higher. R2 was admitted to the hospital and required dialysis. The findings include: 1. R2 is a 60 year old resident who was admitted to the facility on 12/4/05 with multiple diagnoses including Cellulitis of the Leg, Trimalleolar Fracture and Diabetes Mellitus per admission summary sheet dated 12/8/05. R2 had a physician's order dated 12/4/05 for Vancomycin 2 grams Intravenous Piggy-back given over 2 hours every 12 hours, and an order dated 12/5/05 for a Vancomycin trough level prior to the 3rd dose, per the December 2005 physician order sheets. R3 received his first and second dose of IVPB Vancomycin at 8:00 AM and 8:00 PM,	F9999		

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F9999	Continued From page 13 respectively, on 12/5/05 per the December 2005 medication administration record (MAR). The MAR documents that a Vancomycin trough blood draw was obtained at 7:00 AM on 12/6/05 and that R2 received his 8:00 AM Vancomycin dose. Per the MAR and nursing notes dated 12/9/05, R 2 continued to receive Vancomycin until 12/9/05 (6 more doses/12 grams) before the facility was aware that the 12/6/05 trough results had not been received. During this time frame the facility did not track the result of the 12/6/05 blood draw and never obtained additional trough levels prior to every 3rd dose, per review of the medical record and 24 hour report. R2's 12/6/05 Vancomycin trough results were at an "alert level " at 27.5 (5.0 - 10.0 mg/L) per laboratory report. 2. E5 (nurse) was interviewed on 12/22/05 at 12: 50 PM. E5 reported that R2's Vancomycin dose was much higher than the usual dose of 1 gram once a day. E5 reported that R2 had an initial Vancomycin trough drawn on 12/6/05 but that it wasn't followed up on for several days. E5 reported that on 12/9/05 she received a phone call from the facility's pharmacy wanting to know if the facility had done a trough on R2. E5 said that she called the lab on 12/9/05 to see if the 12/ 6/05 trough was done and was told that the result was a panic alert value and that it was called in to the facility on 12/6/05. E5 stated that she called the pharmacy back and they recommended to hold the Vancomycin and to obtain a random Vancomycin level on Monday 12/12/05. E5 stated that on 12/13/05 R2 had multiple idiosyncratic complaints. E5 reported that R2 was sent to the emergency room in the afternoon of 12/13/05 after his family reported facial drooping and slurred speech. Per nursing notes	F9999		

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F9999	Continued From page 14 of 12/13/05, R2's sister and mother reported to the nurse that he was having trouble speaking and that his face was drooping on one side. The notes state that R2 was assessed to have weak, garbled speech and was sent to a local emergency room via 911. 3. Z3 (PharmD) was interviewed on 1/4/06 via the telephone and also provided the following information in a written statement derived from the monitoring documentation in their computer: On 12/7/05 the pharmacy called the facility to obtain the Vancomycin trough results and they were told by E8 (nurse) that the lab was drawn on 12/6/05. The facility was supposed to call the lab and then call the pharmacy back to relay the result. The facility failed to call the pharmacy back. The pharmacy called the facility repeatedly on 12/7, 12/8 and 12/9 to finally get the results. At that point the Vancomycin was placed on hold because of the high trough result of 12/6/05. 4. Z7 (R2's Nephrologist) was interviewed by telephone on 1/12/06. Z7 stated that R2's renal function was "relatively normal at stage 1" when he was at the local hospital just prior to being admitted to the facility on 12/4/05. When Z7 saw R2 at the hospital on his 12/13/05 admission R2 was at a stage 5 renal failure and required dialysis. Z7 stated that R2 was diagnosed with acute over chronic renal failure most probably caused by the high Vancomycin levels. Z7 stated that R2 remains on dialysis to this day. 5. E5, E6 and E7 (nurses) were interviewed on 12/22/05 between 12:00 PM and 3:00 PM. All stated that Vancomycin trough levels should be done prior to every 3rd dose until the resident is	F9999		

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stable. All stated that they would contact the physician for a trough order if they did not have one. R2 was cared for by seven different nurses (E5, E8, E9, E10, E11, E12, E13) at the facility between 12/6 and 12/9/05 per documentation provided by E2 (Director of Nurses). It was not until 12/9/05 that 1 of these nurses (E5) was alerted to follow-up on the 12/6/05 Vancomycin blood draw per interview with E5 on 12/22/05. Prior to 12/9/05 none of these 7 nurses obtained physician's orders to conduct trough levels prior to every 3rd dose. Had the facility followed the nurses stated guideline of obtaining a trough every 3rd dose, R2 would have had a trough level drawn prior to his evening Vancomycin dose on 12/7/05 and his morning dose on 12/9/05. These labs were not done.

6. Z1 (R2's physician at the facility) was interviewed by telephone on 1/3 and 1/11/06. Z1 stated that a Vancomycin trough level should be drawn every 3rd dose. Z1 stated that the facility should inform the doctor of the result, especially if it is abnormal. Z1 said that if the lab result is not received within 1 or 2 days she would expect the nursing staff to follow-up with the lab.

7. Z8 (R2's current physician) was interviewed by telephone on 1/12/06. Z8 saw R2 in the emergency room at the hospital on 12/13/05. Z8 stated that R2 was lethargic and came to the hospital with dehydration and renal failure due to high Vancomycin levels and required dialysis. Z8 stated that she sees R2 every month and he remains on dialysis.

8. E2 (Director of Nursing) was interviewed on 12/22/05 and 1/3/06 (via phone). Vancomycin

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F9999	Continued From page 16 laboratory results were not in R2's medical record per review of the record with E2. On 12/22/05 E2 found the laboratory report result of 12/6/05 in a " to be filed" file at the nurses station. E2 stated that even if the lab calls the facility with an "alert" and sends a FAX, a hard copy is still sent to the facility within a couple days. E2 stated that the results go to the nursing office and are divided up before being brought to each floor. The results are then put on the nurses clip board to review and to call or FAX the doctor. E2 stated that the nurses are supposed to initial the lab results to indicate that they Faxed or called the doctor. The Vancomycin trough laboratory result dated 12/6/05 was not initialed and no indication was made on it that the result had been reviewed . The facility's "Vancomycin" policy documents that Alert Values are considered potentially life threatening. The policy also states that the facility will be notified of these results via FAX or telephone "in a timely manner by laboratory personnel." The policy does not describe how the facility will follow-up on Vancomycin trough results that were drawn but not reported to them by the laboratory. R2 had a physician's orders dated 12/4/05 for Vancomycin 2 grams intravenous piggy-back (IVPB) given over 2 hours every 12 hours, and an order dated 12/5/05 for a Vancomycin trough	F9999		

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F9999	Continued From page 17 level to be drawn prior to the 3rd dose. R3 received his first and second dose of IVPB Vancomycin at 8:00 AM and 8:00 PM, respectively, on 12/5/05 per the December 2005 medication administration record (MAR). The MAR documents that a Vancomycin trough blood draw was obtained at 7:00 AM on 12/6/05 and that R2 received his 8:00 AM Vancomycin dose. Per the MAR and nursing notes dated 12/9/05, R 2 continued to receive Vancomycin until 12/9/05 (6 more doses/12 grams) before the facility was aware that the 12/6/05 trough results had not been received. R2's 12/6/05 Vancomycin trough results were at an "alert level" at 27.5 (5.0 - 10.0 mg/L) per laboratory report. On 12/9/05 the pharmacy recommended to hold the Vancomycin and obtain a random Vancomycin level on Monday 12/12/05 per nursing notes. No other Vancomycin trough levels were drawn between 12/6 and 12/12/05. The Vancomycin random level was also an "alert" value of 65.7 (5.0 - 40.0) on 12/12/05 per the laboratory report dated the same. The facility's "Vancomycin" policy documents that Alert Values are considered potentially life threatening. The policy also states that the facility will be notified of these results via FAX or telephone "in a timely manner by laboratory personnel." The policy does not describe how the facility will follow-up on Vancomycin lab results that were drawn but not reported to them by the laboratory. Per nursing notes of 12/13/05, R2's sister and mother reported to the nurse that he was having trouble speaking and that his face was drooping on one side. The notes state that R2 was assessed to have weak, garbled speech and was sent to a local emergency room via 911.	F9999		

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