STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145893	A. BUILDING _____ B. WING _____	C 05/29/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE AT PALOS HTS WEST	**11860 SOUTHWEST HIGHWAY 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
F 501	Continued From page 19 The Hospital medical record for R1 included a medical certificate of death, dated 2/4/07. The immediate cause was listed as: (a)Anoxic Encephalopathy due to (Conditions. . . which give rise to immediate cause)-- (b) Cardiopulmonary Arrest. (c) Multiple Cerebrovascular Accident.	F 501		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.1620 c) Section 300.1620 Compliance with Licensed Prescriber's Orders c) Review of medication orders: The staff pharmacist or consultant pharmacist shall review the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical experience and judgment, and Section 300.Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be done at the facility and shall be documented in the clinical record. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon. This REGULATION is not met as evidenced by: Based on medical record review, review of a drug reference handbook, and staff interview, it was determined that, for one sampled resident (R1), the Facility failed to ensure the pharmacist	F9999		

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F9999	Continued From page 20 reviewed all medications prior to dispensing, and to ensure the dose was appropriate for the resident's age and condition. The pharmacist failed to report irregularities to the attending physician and director of nursing related to the excessive dosage of Risperdal that was ordered. After receiving the incorrect dosage for 10 days, the resident suffered a cardiopulmonary arrest and died. Findings include: R1 was a 68-year-old, 102 pound female, admitted 1/15/07 with multiple diagnoses including Anemia, Acute Cerebrovascular, Generalized Anxiety Disorder, Chronic Airway Obstruction, and Hypertension. The medical record included documentation of a physician's order, dated 1/15/07, for Risperdal 5 mg twice daily. This dose is 10 times the recommended geriatric dose. The Medication Administration Record (MAR) included documentation that R1 received 19 doses of Risperdal 5 mg from 1/16/07 through 1/25/07. The record lacked documentation to indicate that the pharmacy reviewed the medication for appropriate dose based on the resident's age and condition. At the time of resident's admission from the hospital, 1/15/07, the discharge/transfer medication reconciliation form did indicate the dosage to be Risperdal 5 mg twice daily, but the record also had conflicting information about R1's actual Risperdal dose in the hospital prior to transfer as 0.5 mg which required a nurse to check and confirm which dose should actually have been administered and which dose the	F9999		

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F9999	Continued From page 21 resident was currently taking. According to the Lexi-Comp Geriatric Dosage Handbook, 12th Edition, copyright 2007, "Dosage-Geriatrics: A starting dose of 0.5 mg twice daily, and titration should progress slowly in increments of no more than 0.5 mg twice daily; increases to dosages greater 1.5 mg twice daily should occur at intervals of greater than or equal to 1 week . . . Adults: . . . daily dosages greater than 6 mg do not appear to confer any additional benefit, and the incidence of extrapyramidal symptoms is higher than with lower doses." The Handbook lists agitation as an adverse reaction, and symptoms of overdosage/toxicology include drowsiness, sedation, and cardiopulmonary arrest. R1 was given the 5 mg dose which is listed as excessive due to R1's age, body weight, and current medical condition, and further the dose had not been increased gradually in increments as recommended. R1 was also having observed side effects that were not being assessed and linked back to her psychotropic med. A telephone interview was conducted with Z2 (Pharmacy Operations Manager) on 5/24/07 at 12:10 P.M. Z2 stated that the pharmacy consultant visited the Facility on 1/17/07 and 1/22/07, and the only recommendation for R1's drug regimen was a diagnosis for Zoloft. No recommendation was written for Risperdal. Z2 stated that the pharmacy consultant did not remember that R1 was on Risperdal at the time of the consultant's visits to the Facility on 1/17 and 1/22/07. Z2 further stated that it is their policy to check the appropriateness of a dose prior to	F9999		

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F9999	Continued From page 22 dispensing, "but we fill for 4000 residents. I don't know what was done at that time." The medical record of R1 included documentation, dated 1/26/07 at 2:30 P.M., that at 8:45 A.M., the "dietitian states patient is non-responsive and further states she had a spasm, not like a seizure. Patient brought to patient room with assessment of no lung sounds, no pulses or heart sounds. . . CPR started. . . 911 called. . . ." Patient "out to Palos Emergency Room." At 3:15 P.M. on 1/26/07 the note included, "Per ER nurse, patient will be admitted with admission diagnosis of status post cardiac arrest and anemia." The Hospital medical record for R1 included a medical certificate of death dated 2/4/07. The immediate cause of death was listed as: (a) Anoxic Encephalopathy due to (Conditions. . . which give rise to immediate cause)-- (b) Cardiopulmonary Arrest. (c) Multiple Cerebrovascular Accident. (A)	F9999		