STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145714	A. BUILDING ____ B. WING ____	09/21/2007

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OAK PARK HEALTHCARE CENTER	625 NORTH HARLEM OAK PARK, IL 60302

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F 520	Continued From page 37 revealed a level of 3.2 . Z2 (Medical Director) stated in phone interview on 9/18/07 that the facility, through Quality Assurance Meetings, had recognized a delay in laboratory results being relayed to the physician in a timely manner. Z2 stated though reporting had slightly improved, the reason why the labs were not being reported timely was not identified and no new plans were implemented to correct the practice. 2. R16 was admitted to facility on 9/14/07 with diagnosis that include vomiting/diarrhea and Liver Cancer. Upon admission, R16 was placed on Hospice with orders for the following medication for pain management: Roxanol 20mg/ml (5mg-10mg) sublingual every two hours. R16 never received the ordered Roxanol for three days while in the facility. E1 stated the facility failed to inform staff that a new fax number for ordering medications was instituted by the pharmacy on 9/14/07. This failure in communication resulted in R16 requiring hospitalization for stat pain management	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)1) 300.1220b)2) 300.3240a) 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	F9999		

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F9999	Continued From page 38	F9999		

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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These REGULATUIONS were not met as evidenced by:

Based on observation, interviews and record

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F9999	Continued From page 39	F9999		

review, the facility failed to ensure that appropriate care and services were provided for 8 of 24 sampled residents identified with needing laboratory check up and with pain control management. (R7, 16, 2, 17, 18, 19, 20 & 28). The facility failed to follow physician's order for laboratory tests, diagnostic tests and pain management medications and update the physician with abnormal/critical laboratory results in a timely manner.

R7 has a diagnoses of seizure disorder. R7 had a seizure episode on 7/28/07. R7's Dilantin level on 7/28/07 was 2.2-low (normal range is 10.0-20.0), and 2.5 (still low) on 8/6/07. R7's physician was not informed of R7's persistent low Dilantin level. This resulted in R7 having a grand mal seizure episode on 9/17/07 at 12:10 PM and being sent to immediate care hospital via paramedics due to the seizure episode.

R16 has a diagnosis of end stage cancer. R16 has an order on 9/14/07 for Roxanol pain medication every two hours around the clock for pain management. R16 was not given his pain medication for three days. This resulted in R16 being sent to the immediate care hospital on 9/17/07 at 10:00 AM for immediate pain relief.

R2, R17, R18, R19, R20 and R28 had abnormal laboratory results that were not followed up on with their attending physician for appropriate treatment. R2's and R8's diagnostic results were not followed through with attending physician as ordered.

Findings include:

1) R7 has diagnoses that include seizure,

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F9999	Continued From page 40	F9999		

chronic respiratory failure, hypertension, and left cerebral infarct. Records showed that R7 was sent to the hospital on 7/2/07 due to a seizure episode. R7 was readmitted to the facility on 7/5/07 following hospitalization related to seizure disorder. Records showed that R7 receives Dilantin 300 mg daily. Further record review showed that R7 had another seizure episode on 7/28/07 lasting for one minute. Z1(Attending Physician) was notified on 7/28/07 and gave an order for Dilantin to be drawn stat. R7's Dilantin level was drawn after the seizure episode on 7/28/07 and the result was 2.2. Z1 was made aware of the low Dilantin level on 7/28/07 and gave an order for "Dilantin 600 mg. now, Dilantin level in one week and every two weeks." R7's Dilantin level on 8/6/07 was 2.5. Further review of this Dilantin level indicated that this result was reported to the facility on 8/6/07, the same day it was drawn. This Dilantin level dated 8/6/07 was faxed to Z1 on 8/15/07. This was a week after the result was made available to the facility. There were no follow up to Z1 after this was faxed on 8/15/07.

Record review also showed that there were no additional labs drawn for the Dilantin level that was done 8/6/07. The physician order dated 7/28/07, to monitor Dilantin levels every two weeks was not done.

When interviewed on 9/16/07 at 12:30 PM, E18 stated that facility's practice is for E23 (former Director of Nursing) to receive all laboratory results that are done. E18 also added that nurses on the floor has no idea of any laboratory results after the blood draw, since E23 kept all the results in her office and followed up on the results with the physician in her own time. E18 confirmed that

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F9999	Continued From page 41 R7's persistent low Dilantin level on 8/6/07 was faxed a week after the result was made available to the facility on 8/15/07. E18 also confirmed that there was no follow up with Z1 regarding any treatment or Dilantin dosage adjustment to address the low levels. E18 also added that there were no further blood draws after the 8/6/07. E2 (Director of Nursing) was present during the interview with E18 on 9/16/07, and E2 stated that this practice is a problem and they will have to implement a policy/protocol to ensure that laboratory orders were done as ordered and that results are promptly relayed to physician. R7 was observed on 9/17/07 at 12:10 PM at the main dining room. R7 was up sitting in her wheelchair. At the time of this observation, R7 was noted having a grand mal seizure. R7 was having involuntary twitching and jerking movements of her entire body. R7's eyes were rolled back into her head. R7's mouth was noted with some greenish secretion that was coming from her mouth in a forceful manner. This seizure lasted four minutes. R7 was sent to the immediate care hospital via paramedics following the seizure episode. R7's Dilantin results upon arrival to the hospital was 3.2. When interviewed on 9/18/07 at 12:50 PM, Z1 (Attending Physician) confirmed that he was not made aware of R7's persistent low Dilantin level that was drawn on 8/6/07. Z1 also stated that if he would have known about the low Dilantin level, he could have given an order to address the persistent low level such as giving an additional dosage of the medication, adjusting the dosages and close monitoring to prevent any further seizure episode.	F9999		

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F9999	Continued From page 42	F9999		

2) R16 was admitted to facility on 9/14/07 with diagnoses that include vomiting/diarrhea and Liver Cancer. Upon admission, R16 was placed on hospice with orders for the following medication for pain management: Roxanol 20mg/ml (5mg-10mg) sublingual every two hours.

Review of Hospice notes dated 9/14/07 at 6:35 PM denotes R16 was complaining of generalized pain with no signs of acute distress. On 9/15/07 at 5:55 PM, hospice notes state that upon visit with patient complaint of pain, spoke with nurse (E3) and will follow-up and make sure medications here by 10:30 PM, patient rates pain level as a nine. (1-10 highest).

Hospice notes of 9/16/07 state that R16 had been admitted to facility two days ago and has not received pain medication yet. Documentation indicates that E1 was informed, then contacted facility contracted pharmacy for medications and a stat medication fax was sent. R16's alternate physician was notified and an order was given for R16 to receive Tylenol #3 two tablets by mouth times one dose.

Z3 (Hospice Nurse) documented on 9/17/07 at 12:00 PM that R16 complained of "hurting all over and no pain medication since last evening. No Roxanol available. R16's physician was notified and R16 was transferred to the hospital for pain management. Z3 was visibly upset that R16 had not received the ordered Roxanol. Z3 was asked to rate R16's pain and stated its "10 of 10." Z3 was asked if R16 was able to verbalize pain and Z3 stated "just touch him he grimaces and pulls away."

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F9999	Continued From page 43	F9999		

R16's record lacks documentation that a pain assessment was done upon admission. There was no ongoing pain assessment for R16 after admission or reassessment of R16's pain after receiving only one dose of the Tylenol #3 on 9/16/07.

Review of R16's record and computer documentation, the pharmacy had faxed a memo to the facility on 9/14/07 informing the facility the old fax number for placing orders will be disconnected soon. The memo provided the facility with the new fax number and instructed facility staff to look around the nursing stations to assure the old number is not posted. E1 stated this information had not been relayed to nursing staff therefore causing a delay in R16 receiving his medication as ordered for pain. The failure of the facility to assess, monitor and provide pain management for R16 resulted in R16 requiring immediate hospitalization for pain management on 9/17/07, three days after admission. R16's medications arrived at the facility as he was transferred to the hospital.

3) R19's diagnosis includes Schizoaffective Disorder and Major Depression. Review of R19's POS indicates R19 is receiving valproic acid 500 mg every 12 hours. A valproic acid level is done every three months for therapeutic monitoring. Review of R19's labs indicate that a valproic acid was drawn on 5/10/07 and was reported to facility on 5/10/07 with a level of 6.0 L. Normal reference range is from 50.0-100.0 mcg/ml. R19's physician was notified of the level by fax one day later on 5/11/07. There was no follow up or documentation after the results were faxed to the physician. A valproic acid level was drawn on 8/23/07 and reported on 8/29/07. R19's physician

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F9999	Continued From page 44	F9999		

was not faxed the results until six days after the facility received the results.

R19 was post-operative after a left breast mastectomy in June 2006. Review of R19's POS reveals an order dated 7/11/07 by R19's physician to "please get biopsy results from hospital." Review of the facility's facsimile sheet revealed the biopsy report was faxed to R19's physician five days later. The facility failed to notify the physician in a timely manner or document follow-up on results for further labs ordered by R19's physician. Basic metabolic profile, complete blood count and lipid profile was collected on 7/2/07 and reported to the facility on 7/3/07. Physician was not faxed results until 7/6/07.

4) R17's diagnosis includes Chronic Renal Failure, Dementia and Electrolyte Imbalance. On 8/9/07, a complete blood count and comprehensive metabolic profile was done and results faxed to the facility the same day. On 8/15/07, R17's physician was faxed the results with no documentation of further follow-up by the facility.

5) Record review for R18 indicate that a lab drawn, per order, on 8/23/07 indicated a very low Dilantin level of 1.3 mcg/ml. The lab result was faxed on 8/29/07 with no confirmation that the physician was aware of this abnormality. On 9/5/07, the physician ordered a BMP and serum digoxin level now and every six months. These labs were not drawn and the facility did not follow up. The physician was not aware that the labs were not being drawn.

6) Review of R2's record show an order in August

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F9999	Continued From page 45 for CBC, CMP and TSH (Thyroid Stimulating Hormone). These labs were not drawn and facility records show there is no follow up to assure these were done. Physician was not notified that the orders were not followed. In addition, hematology labs were done 9/6/07 with hemoglobin of 11.0 (14 to 18 reference) RBC 3.98 (4.7-6.10) Hematocrit 33 (42-52) and Chemistry Labs showing very high BUN 39 (5-20), SGPT of 67 (0-35), and SGOT of 37 (9-35). The physician was not notified of these abnormal labs. 7) Review of R20's record shows lab orders for CBC with differential were ordered and done on 8/10/07 and 8/30/07. R20's record shows that the facility did not follow up with the physician, faxing the result with no acknowledgement that the physician was actually aware of the abnormal results. Red blood cells was 3.53, Hemoglobin was 10.1, Hematocrit was 31.5 on 8/10/07. On 8/30/07, RBC 3.44, Hemoglobin 9.7 and Hematocrit 30.5. 8) R28 had CBC and BMP labs drawn as ordered on 9/11/07. The lab results were not available in the facility as of 9-19-07. R28 also had CBC drawn 8/17/07, 7/23/07, 7/1707 and 7/5/07 all with abnormal results for RBC, Hemoglobin, Hematocrit, MCV, MCH and MCHC RDW, lymphocyte and digoxin levels were below therapeutic levels. These labs were faxed 8-20-07 to the doctor with no indication that the doctor was aware of these result. 9) R8 has a physician's order dated 9/11/07 for "please follow up EKG (electrocardiogram) report." Review of record shows that there were no indication that a follow up was done to obtain	F9999		

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F9999	Continued From page 46 the EKG result. E18 confirmed on 9/16/07 at 11:45 AM, that the EKG was not done. (A)	F9999		