STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G204	A. BUILDING _____ B. WING _____	C 08/05/2009

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CLEARBROOK EAST	3802 SOUTH OLD WILKE ROAD ROLLING MEADOWS, IL 60008

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W 368	Continued From page 11 reads, "Paramedics picked her up at 2:50pm and she(R2) was still seizing." The Medication Administration Record(MAR) dated 6/15/09 to 7/14/09 for R2 was reviewed. R2's Keppra dosage reads, "750mg(milligrams). Take one tablet by mouth twice daily at 8am and 8pm. The boxes on the MAR for 6/18/09 and 6/19/09 were initialed, but circled. During an interview with E3 on 7/24/09 at 1:00pm, E3 stated that the entries are circled, indicating the medications were not given. The boxes remained circled through 6/22/09 until the pm shift. E3 explained that after R2 had her seizure at DT on 6/19/09, she was admitted to the hospital, and did not return until the pm shift of 6/22/09. E3 confirmed that R2 missed three consecutive doses of her Keppra, and had a seizure at DT in the afternoon of 6/19/09. The facility failed to administer Keppra as ordered for R2 for three consecutive doses, and R2 had a seizure in the afternoon on 6/19/09 while at her DT program, lasting longer than 18 minutes. R2 was transferred by paramedics, and admitted to the hospital for three days.	W 368		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1210 350.1410a) 350.3240a) Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health.	W9999		

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W9999	Continued From page 12 Section 350.1410 Medication Policies and Procedures a) 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. Medication policies and procedures shall be developed with the advice of a pharmaceutical advisory committee that includes at least one licensed pharmacist, one physician, the administrator and the director of nursing. This committee shall meet at least quarterly. Section 350.1420 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 350.1610. 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 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	W9999		

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W9999	Continued From page 13 resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on record review and interview, the facility failed to meet the nursing needs of 1 of 1 client in the sample (R2) when the facility failed to: 1. Administer seizure medication as ordered by the physician for R2. 2. Notify Nursing Personal that R2 was out of her seizure medication. 3. Notify R2's physician that R2 had not received her seizure medication. 4. Follow through on a STAT order from Pharmacy to ensure R2 received her seizure medication as ordered. 5. Follow Policies and Procedures to ensure R2 received her seizure medication as ordered by her physician. Findings include: R2, per review of Physician Order Sheet dated 7/5/09, is a 26 year old female whose diagnoses include Moderate Mental Retardation, Seizure Disorder, Cerebral Palsy, and Autism. The fax dated 6/19/09 to the Illinois Department of Public Health regarding R2 was reviewed. Under Description, it reads, "R2 had a seizure while at the Day Program. She was taken to the hospital. Investigation to follow."	W9999		

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W9999	Continued From page 14 The investigation completed by E8 (Quality Assurance Facilitator) dated 6/22/09, regarding the incident of 6/19/09 involving R2, was reviewed. Under Description of Incident, it reads, "On 6/19/09, R2 began to have a seizure at her DT (Day Training) program. When her seizure did not stop, they called 911 and had her taken to the hospital. It was discovered that staff at the Wilke home did not give R2 her 6/18/09 dosages of Keppra (seizure medication). She missed her 6/18/09 AM, PM and 6/19/09 AM dosages. R2 was admitted to the hospital. She expected to return to the Wilke home on 6/22/09." Under written interview with E13 (Registered Nurse), it reads, "I (E8) asked her had anyone called her last week at any point about R2 running out of her Keppra. She stated no one called her all week.(6/15/09 - 6/19/09)." Under Written Statement from E3 (Qualified Mental Retardation Professional) dated 6/19/09, it reads, "E9 (Direct Care Staff) passed the 8:00pm medications on 6/17/09. Used last of Keppra pills. No notification." Under date of 6/18/09 on this same written statement, it reads, "E10 (Direct Care Staff) passed the 8:00am medications. No notification during her medication passing that medications were missing. E10 told me (E3) around 10:00am that R2 was out of Keppra. I asked if R2 had her Keppra this morning...No (1st missed Keppra). I called Pharmacy around 12:00pm.....I told them that R2 was out of her Keppra and I needed the medication STAT (Immediately). I was told it would there in the afternoon. E11(Shift Supervisor) passed the 8:00pm medications. No notification of missing medications.(2nd missed	W9999		

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W9999	Continued From page 15	W9999		

Keppra). 11:00 pm. Keppra arrives from pharmacy. E12 (Direct Care Staff) signed for the medications. No notification of medications received. Other staff in attendance that knew the medications had arrived....E11 and E9." The written statement continues and under the date of 6/19/09 it reads, "E10 passed the 8:00am medications. No notification of missing medications. (3rd missed Keppra). I (E3) came in at 8:30am, and asked if R2 had gotten her Keppra medications. I was told no, but there was a bag from pharmacy. I looked through that bag and R2's Keppra was in it."

The Apparent Seizure Form involving R2 dated 6/19/09 was reviewed. Under date of incident, it reads, "06/19/09." Under when did it occur, it reads, "2:32pm." Under how long did it last, it reads, "Paramedics picked her up at 2:50pm and she (R2) was still seizing."

The Medication Administration Record (MAR) dated 6/15/09 to 7/14/09 for R2 was reviewed. R2's Keppra dosage reads, "750mg(milligrams). Take one tablet by mouth twice daily at 8am and 8pm. The boxes on the MAR for 6/18/09 and 6/19/09 were initialed, but circled. During an interview with E3 on 7/24/09 at 1:00pm, E3 stated that the entries are circled, indicating the medications were not given. The boxes remained circled through 6/22/09 until the pm shift. E3 explained that after R2 had her seizure at DT on 6/19/09, she was admitted to the hospital, and did not return until the pm shift of 6/22/09. E3 confirmed that R2 missed three consecutive doses of her Keppra, and had a seizure at DT in the afternoon of 6/19/09.

The Physician Progress note for R2 dated

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W9999	Continued From page 16 6/30/09 was reviewed. It reads, "Break through Sz(seizure), was admitted to hospital 3 da(days). .....Sz(seizure) dx(diagnosis), breakthrough 2* (secondary) to missing 3 doses Keppra (seizure medication). Observe, back on Keppra." The nursing notes were reviewed for R2. The entry for 6/22/09 at 10:05am reads, "Pt(Patient) missed 3 doses of anti-seizure medication (2 doses on 6/18 and 1 dose on 6/19); pt. had a seizure at day program on Friday, 6/19 and was taken to the hospital." This note was signed by E5 (Registered Nurse) There was no entry from 6/18/09 or 6/19/09, indicating that R2 had missed any of her Keppra dosages for seizure prevention, nor was there an entry that R2's physician had been notified, or that R2 had a seizure on 6/19/09, while at her DT program. No documentation could be located that the Pharmacy had been followed up with, regarding the STAT order for Keppra taking so long to arrive. During an interview with E1(Administrator) on 7/24/09 at 9:45am, E1 confirmed that no staff notified E13 (Registered Nurse) that R2 was out of her Keppra, nor did they notify the nurse regarding any of the doses that R2 did not receive. E1 stated that the facility has policies in place that instruct staff to contact the nurse when medication is missing, and that all staff had just been in-serviced on these policies. E1 continued, and stated E3 (Qualified Mental Retardation Professional) was aware that R2 was out of her Keppra, and that she was the staff who contacted the Pharmacy regarding the STAT order. E1 confirmed that E3 knew about the missing medication at 10:00am on 6/18/09, but did not put the order into Pharmacy until	W9999		

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W9999	Continued From page 17 12:00pm. E1 stated he was not sure why E3 waited to contact the pharmacy. E1 also stated that E3 should have let the nurse know about the missing medication as well. E1 also stated that a STAT order should arrive from the Pharmacy in 2-4 hours. E1 confirmed that they are having problems with the Pharmacy, and have been meeting to ensure a more timely process. E1 confirmed that the order originally placed at 12:00pm on 6/18/09 did not arrive until 11:00pm on this same evening., well after the 2-4 hours window for a STAT order. E1 stated that E3 should have passed this information onto the nurse, and that way the nurse could have followed up with pharmacy, and contacted the physician for further direction. E1 also confirmed that when the medication finally did arrive on 6/18/09 at 11:00pm, the nurse should have been contacted. E1 confirmed that no staff notified the nurse that evening, or the following morning when E3 discovered the medication had arrived the night before, but R2 still did not receive her am dose. The Policies and Procedures that E1 was referring to in the above interview were handed to this surveyor from E3. The Policies read as follows: Policy and Procedure for Medication Errors with a revision date of 4/2/09. Under Purpose, it reads, "To ensure that medication errors are properly reported and that the appropriate follow-up occurs." Under Procedure, it reads, "....The administration of medication other than prescribed resulting in the wrong medication being taken, or medication being taken at the wrong time or in the wrong dosage or via the wrong route, or by the wrong person, or omitted	W9999		

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W9999	Continued From page 18 entirely. It is meant to include a lack of documentation of medication administration or any error in that documentation. When a staff member discovers a medication error, the following procedure shall be followed: 1. The staff person discovering the error shall complete the Medication Error Sheet. 2. Before the end of each shift, the supervisor/person in charge is responsible for checking the MAR book, and controlled substance sheets for medication errors and then filling out a medication error sheet as needed. 3. The error shall be immediately reported to the registered nurse. 4. The RN (Registered Nurse) shall contact the physician or pharmacist if the error involves the administration of medication other than as prescribed by the physician..... 5. The RN shall ensure that the QMRP(Qualified Mental Retardation Professional) is aware of the medication errors. .....Ongoing Review of Medication Errors. 3. Medication omissions, missed doses, wrong doses and wrong medications given will be followed up in the same fashion." The Policy and Procedure for New Medication Orders dated 4/2/09 was reviewed. Under Procedure it reads, ".....Any new prescription can be sent stat, at the nurse's discretion. This will reduce the turnaround time by as much as 75%. It is the responsibility of the nurse faxing the prescription to ensure that it is received by the facility 'in a timely fashion' and administered to the resident as prescribed upon receipt. He/she must make arrangements to be notified of the	W9999		

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W9999	Continued From page 19 receipt or lack of receipt of the prescription by the facility. 'In a timely fashion" is defined as: 6-8 hrs.(hours) for medications ordered STAT and within 24 hrs. for all other medications. If the medication is not received by the requesting facility within the time frames above: *Contact the pharmacy and complete an incident report *Check the convenience box for the first dose of a first dose of medication *Call the prescribing physician for an alternative that might be in the convenience box for a first dose or alternative prescription. *Contact the local 24Hr. pharmacy and fax the prescription to them and have it picked up by staff *Contact your administrator or director *Document all attempts to obtain the medication" The Policy and Procedure for Nurse Notification dated 4/2/09 was reviewed. Under Procedure, it reads, "When calling, clearly inform the nurse, your name and the name of the resident. The Direct Service Personal (DSP) will use the following as a guideline of when to notify the facility Nurse: *....When a resident status report indicates that the nurse should be notified. *IF A NEW MEDICATION IS NOT DELIVERED AS EXPECTED OR IF THE NEW MEDICATION ARRIVES, CALL THE NURSE." During an interview with E3 (Qualified Mental Retardation Professional) on 7/24/09 at 11:15am, E3 clarified that the policy from pharmacy reads 6-8 hours for a STAT order, but since this incident, E1 and Pharmacy have been meeting,	W9999		

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W9999	Continued From page 20 and now the new expectation is for STAT medications to be received in 2-4 hours. E3 also clarified that R2's Keppra was a new medication that Pharmacy was filling for the first time. E3 stated that R2 was just recently admitted and had come with her own bottle of Keppra from home. When they used the last pill from her own bottle, Pharmacy was filling the Keppra for the first time. E3 also confirmed that Pharmacy was still out of the 6-8 hour time frame as indicated in the Policy, as the medication did not arrive until 11:00pm, 11 hours after it was called into the Pharmacy. As the interview continued, this surveyor asked E3 why she had a two hour delay in contacting Pharmacy, after she was informed at 10:00am that the medication was gone. E3 did not place the order until 12:00pm. E3 stated that it was just an over-site, and that it was her fault. E3 continued stating that she should have called the nurse, and let her place the order, and follow up with Pharmacy. E3 stated that she does realize how important Keppra is for a client who has a history of seizures, and stated that she should have called the nurse right away, so the nurse could have called the physician. E3 stated that E9, E10, E11 and E12 did not follow the Policies that their facility has in place. E3 stated, "I will never make a mistake like this again. Next time I will let the nurse know. My mistake affected someone else, and this is very hard for me." E3 stated that R2 had to be admitted because she had a 25 minute seizure at DT. (A)	W9999		