STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145946	A. BUILDING _____ B. WING _____	C 02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA POST ACUTE CARE	**4600 NORTH FRONTAGE ROAD HILLSIDE, IL 60162**

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F 514	Continued From page 6 Based on interview and record review the facility failed to consistently document medication administration involving 1 (R1) of three residents reviewed for clinical documentation. Findings include: R1's medication administration record (MAR) from 11/22/12 thru 1/30/13 indicate the following concerns regarding omitted nurses' initials after medication administration: R1's medication administration record indicates omissions for 5:00PM dose of Megace on 11/23/12, 11/27/12, 11/29/12, 11/31,12, 12/2/12, 12/20/12, 12/27/12, 12/30/12, 1/2/13, and 1/4/13. Physician order sheet for R1 dated 11/21/12 indicated an order for Megace 200 mg by mouth daily. R1's medication administration record indicates omissions for 5:00 PM dose of calcium on 11/29/12, 11/31/12, 12/5/12, 12/6/12, 12/11/12, 12/13/12 through 12/30/12, 1/1/13, 1/2/13, 1/3/13, 1/4/13, 1/8/13, and 1/9/13. R1's physician order sheet dated 11/21/12 indicated an order for calcium 500 mg by mouth daily During interview with E3 (Director of Nursing) on 2/7/13 at 2:45 PM, E3 stated the nurses gave the medications to R1. "I have no explanation as to why the initials are not on the MAR". The facility policy indicates that after medication administration the nurses are to initial their names on the MAR. Review of this policy on medication administration confirms E3's statements.	F 514		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 7 LICENSURE VIOLATION: 300.610a) 300.1010h) 300.1210d)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	F9999		

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F9999	Continued From page 8 Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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 regulations were not met as evidenced by the following: Based on interview and record review, the facility failed to accurately reinsert a gastric tube and failed to obtain a physician order prior to gastric tube reinsertion involving 1 (R4) of 3 residents, reviewed for Gastric Tube care and physician orders. These failures resulted in stomach swelling, extensive gas and contrast material in the subcutaneous tissues associated with migrated Gastric tube, abnormal labs, and hospitalization . Findings Include:	F9999		

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F9999	Continued From page 9	F9999		

R4 was admitted to the facility on 10/4/12 with medical diagnosis including: Diabetes, Sepsis, CHF (Congestive Heart Failure) and Peg Tube Insertion (10/1/12). POS (Physician Orders Sheet) dated October 2012 indicates that R4 receives Glucerna at 50 cc ' s per hour x 22 hours. The Gastric tube is described as being a 18 french with 15 cc size balloon.
Nurses notes dated 10/16/12 at 6:00 AM indicates that the gastric tube (g-tube) replaced by E16 (Nurse Supervisor/Licensed Practical Nurse) g - tube size 18 french. Placement was verified by gastric contents and per auscultation. Gastric tube feeding resumed. Review of the October 2012 POS (Physician Orders Sheet) does not show an order for the reinsertion of the g-tube.
On 10/16/12 at 5:45 PM, nurse's notes describe R4 as being diaphoretic, lethargic but responsive. The gastric tube feeding is infusing at 50 cc's per hour. Resident is also of short of breath. The nurse's note further describes R4's LUQ (Left Upper Quadrant), LLQ (Left lower Quadrant) of the abdomen to be swollen; also swelling of the LUE (Left Upper Extremity). Z4 (Physician) was notified. Orders included to send out to the hospital for an exam.
R4 was admitted to the hospital with diagnoses of hypoglycemia, hypotension, hypernatremia , elevated cardiac enzymes , altered mental status and migrated Gastric tube.
Review of hospital records show a discharge Summary dated 10/26/12 which indicates that R1 was found to have a migrated g-Tube. Physician progress Note dated 10/17/12 indicates g-tube dysfunction noted on CT (Computerized Axial Tomography) abdomen; g-tube migration.
Physician progress note dated 10/18/12 indicates:

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F9999	Continued From page 10 CT abdomen/pelvis misplaced g-tube. Extensive gas and contrast material in subcutaneous tissue consistent with misplaced g-tube and subsequent feedings. Interview with Z4 (Physician) on 1/31/12 at 1:00 PM, " I was not notified of the gastric tube being out and replaced with one in the facility. In my opinion, once it was discovered that the gastric tube was out; the resident should be evaluated by a gastroenterologist for accurate assessment and tube replacement. If notified, I would have ordered that the resident be sent out to the hospital; not to reinsert the gastric tube in the facility. Perhaps the placement was not accurate; KUB (Kidneys Ureters Bladder) X-Ray is the most accurate test to determine placement. " Interview with E16 on 1/31/13 at 1:30 PM, " I examined R4 and noted that the tip of the gastric tube was not in the stoma; the bulb was deflated. I clipped the sutures that anchored the bumper to the stomach followed by inserting a G-tube size 18 french. I checked the placement by air/auscultation followed by aspiration of stomach contents. I did not resume the feeding; R4 was without distress. " Nurse's notes dated 10/16/12, from 6:00 AM thru 5:45 PM documents that the gastric tube feeding was infusing. There is no documentation that the physician was notified of the problem with the g-tube or its reinsertion. Review of facility policy regarding gastrostomy tube replacement states that "a gastrostomy tube can only be replaced with a physician or nurse practitioner order". It further states that "after placement of the gastric tube, staff should communicate with the physician". The policy does not require gastric tube placement confirmation by KUB .	F9999		

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F9999	Continued From page 11	F9999		

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