Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016695	A. BUILDING: ______ B. WING ______	12/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF SHOREWOOD	**710 W BLACK ROAD SHOREWOOD, IL 60404**

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S9999	Final Observations	S9999		

Statement of Licensure Violations

300.610a)
300.696c)3)
300.1210b)
300.1210d)1)
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. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.696 Infection Control

c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340):

3) Guidelines for Prevention of Intravascular Catheter-Related Infections

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall 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 resident care plan. 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.

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:

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 300.3240 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 requirements were not met as evidenced by:

Based on observation, interview and record review the facility's Administrator, Director of Nursing (registered nurse-RN), Assistant Director of Nursing (RN) and Minimum Data Set Coordinator (RN) failed to ensure that all

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registered nurses (RN) administering IV's have the knowledge and skill to perform these procedures effectively and efficiently, to ensure the standards of practice in the administration of intravenous fluids (IV) and IV medications were followed for the proper mixing of IV antibiotics and correctly priming IV tubing without air pockets or air bubbles to prevent infusing air into the resident causing an air embolus.

This applies to 2 of 2 residents (R4, R5) reviewed for Intravenous Therapy in the sample of 15 and one resident in the supplemental sample (R16).

The Findings include;

On 12/9/13 during medication pass observation two residents R4 & R5 had intravenous piggy back (IVPB) medication ordered to be administered at 12:00 PM. E4, the registered nurse, stated that she already mixed the IVPB medications for these residents and the medication was hanging ready for administration. R5's record contains a physician's order for Oxacillin Sodium reconstituted 2 gram (gm) in 100 milliliter (ml) of normal saline IVPB over 30 minutes every 6 hours for osteomyelitis. R5 had his central venous access port sticking out from his shirt. R5's central venous access site was not visible. E4 did not check R5's central venous access site for signs of infection or infiltration. E4 flushed the port with 5 ml of sterile normal saline. E4 started to administer the IVPB when air pockets and air bubbles were seen in the IV tubing. E4 was made aware of the air in the tubing. She tried to clear the IV tubing wasting more than half of the IVPB solution. R5's IVPB bag was observed on 12/9/13 at 1:30 PM. The IV pump was off. R5 stated that the pump began

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S9999	Continued From page 3 alarming and he pushed his call light and turned the pump off because the infusion was completed and he does not like listening to the alarm. The IVPB was empty, the IV drip chamber was empty and the IV tubing was empty until it meets the IV Infusion pump. An operative report for R5 dated 9/25/13 states he had placement of a tunneled central venous catheter. R4 has a physician order dated 11/23/13 for Nafcillin Sodium reconstituted 2 gm intravenously over 30 minutes every 4 hours for an infected knee until 12/31/13 via IVPB. On 12/10/13 at 12:15 PM E4 stated that the IVPB for R4 was mixed and ready to administer. E4 checked the IV line for bubbles and started draining IV antibiotic into the garbage receptacle until she had drained about half of the IVPB solution into the garbage. E4 was ready to connect the IV to the resident when her attention was directed to the air pockets and air bubbles and the fact that half of the antibiotic solution was drained. E4 then stated that she would get a new IVPB antibiotic for R4. E4 mixed the IVPB leaving clumps of undissolved medication and a large clump of undissolved medication on top of the plastic cup medication chamber. E4 proceeded to prime the IV tubing with the solution and connected the tubing to the resident and turned the infusion pump on. At that time E4 was informed that the IV tubing contained large pockets of air (three to four- 1.5 inch areas of air) and that there were clumps of medication in the IVPB bag. E4 stopped the infusion. E5, a registered nurse, took over to administer the medication. R5 obtained a new IVPB for R4 and began to mix. E5 brought a new IV tubing and after the IVPB was completely mixed (no clumps of medicine) she primed the tubing. E5 required cues to ensure that the tubing would be primed	S9999		

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without air. E5 then administered the medication.

During the group discussion on 12/10/13 one resident, R16, stated that she had problems with getting her IV antibiotics properly.

R16 is a very alert resident with a BIMS (Brief Interview for Mental Status) score of 15 on the Minimum Data Set dated 11/7/13. On 12/10/13 at 2:40PM R16 said that the first three days she was at the facility the IV infusion pump would alarm constantly. When asked why, R16 stated that she would have air bubbles in the tubing and the machine would alarm. R16 stated that it took 1.5 hours to get her antibiotics when it should have taken an hour. R16 stated that when the pump alarmed it took 20 minutes for her call light to be answered and another 20 to 30 minutes to have the nurse come and fix the problem R16 stated that it took three infusion pumps before she did not have these problems. R16 stated that she told a person in administration about the problem and the air in her IV tubing.

The form Resident Census and Condition (672) completed by the facility shows that there are 4 residents receiving IV antibiotics.

On 12/10/13 at 12:50 PM, Z2 (R4's physician) stated that the amount of air in IV tubing that was described can lead to air embolus. Z2 stated that an air embolus can have very serious consequences and even death. Z2 stated that he wants a more experienced nurse to administer IV antibiotic to his residents and that the facility needs to be made aware of these concerns and consequences.

On 12/10/13 at 12:30 PM, E2 (director of nursing) Z3 (nurse consultant from the pharmacy) and Z4

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(pharmacist) were interviewed. Z4 stated that the consequence of receiving only half of the bag of antibiotic was that the resident did not get the full dose of medication. Z4 stated that it is not OK to infuse IV antibiotics with clumps in the IVPB bag. Z4 stated that these clumps can cause a clog in the IV tubing or in the peripherally inserted central catheter (PICC) or in the Central Venous Catheter. Z4 stated that these are potentially serious consequences of infusing IV solutions with clumps of medicine in the solution. Z4 also said infusing IV medication that has clumps in the solution also has the potential of the resident not receiving the full does of medication.

The Infusion Nursing Standards of Practice developed by Infusion Nurses Society and revised in 2011 states, "All air shall be purged from syringes, administration sets, needless connectors, and all other pieces added to the catheter...The nurse shall document in the patient's permanent record the signs and symptoms of air embolism, interventions implemented, and patient response to treatment."

R5 had a central venous catheter for IV antibiotic therapy and R4 and R16 had peripherally inserted central catheters (PICC).

On 12/10/13 at 3:00 PM E3 stated that nurses do not have return demonstrations/competencies regarding IV medication administration, IV setup or priming IV tubing without air pockets or air bubbles.

The facility's job description of the Administrator states, "The Administrator is delegated with full responsibility and authority for the internal operation of the facility in accordance with current Federal, State and Local standards, guidelines,

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S9999	Continued From page 6 regulations, facility policies and as may be directed..." The facility's job responsibilities of the Administrator include, "Directly supervise employees and instruct staff providing inservice training to promote job knowledge, assure that quality care is being rendered, oversee the recruitment, hiring and training of a qualified staff capable of carrying out authorized programs and make daily rounds to assure that personnel are performing required duties and to assure that appropriate procedures are being followed." The facility's job description of the Director of Nursing states, "Plan, develop, organize, implement,evaluate and direct the Nursing Department, directly supervise employees and instruct staff providing inservice training to promote job knowledge, identify problems, develop and implement solution with the assistance of the Administration, make daily rounds to assure that nursing personnel are performing duties and to assure that appropriate procedures are being followed. Make physical rounds on all residents daily, monitor medication passes and treatment schedules to assure medications are being administered as ordered and that treatments are provided as scheduled participate in the development, maintenance and implementation of quality assurance programs for the nursing department." These job descriptions require these administrative staff to be accountable for nursing practices including the assurance that standards of nursing practice are maintained. The standards of nursing practice with regards to IVs was not maintained and the administrative staff are accountable according to the job description.	S9999		

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