

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145728</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/09/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYVILLE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2133 VADALABENE DRIVE</b> <b>MARYVILLE, IL 62062</b>		
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F 000	INITIAL COMMENTS  Complaint Investigation #0840037/IL 32770- (F157, F280, F314, F323, F333, and F514) Incident Investigation of 12/29/07/ IL 32785-no findings/deficiencies	F 000			
F 157 SS=D	An extended survey was not conducted. 483.10(b)(11) NOTIFICATION OF CHANGES  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's	F 157			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to immediately notify the family, and failed to notify the physician of a significant medication error requiring physician intervention, for one, (R4), resident involved in a medication error.</p> <p>Findings include:</p> <p>1. Per Admission Records and Medication Administration Records, for 12/07, R4 does not have a diagnosis of Diabetes Mellitus. The Minimum Data Set, dated 1/17/08, shows R4 has no cognitive or memory impairment, and is identified by the facility as an interviewable resident.</p> <p>In an interview with R4 on 1/07/08, at 9:20 AM, R4 reported she had been given another resident's oral diabetic medication, (two pills), and the nurse had attempted to give her an injection of insulin, "about 2-3 weeks to a month ago". R4 reported a drop in her blood sugar levels requiring the facility staff to monitor blood sugar levels every hour, and to give her glasses of orange juice and peanut butter and jelly sandwiches. R4 reported her family was not notified until the evening of 12/09/07, when they visited.</p> <p>E4, Licensed Practical Nurse, (LPN), E5, LPN, and E6, LPN, all confirmed on 1/08/08, that they had not notified the physician of the medication error for R4. E4 reported R4's family was notified the evening of 12/09/07, when they visited. E2, Director of Nursing, confirmed on 1/08/08, no documentation of the physician notification could</p>	F 157			

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F 157	Continued From page 2 be found at the facility. On 1/08/08, at 10:35 AM, Z1, R4's physician, confirmed he was unaware of the incident, and error, of 12/08/07. Z1 reported he should have been immediately notified of the error for medical intervention for R4. The Nurses Notes for 12/08 and 12/09/07 were reviewed on 1/07/08. No documentation was noted related to the medication error, physician notification, or medical intervention for the adverse effects of the error for R4. On 1/09/07, E1, Administrator, confirmed she had been notified by staff of the error, after the incident.	F 157			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced	F 280			

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F 280	<p>Continued From page 3</p> <p>by: Based on observation, interview, and record review, the facility failed to adequately address and update the comprehensive careplan to address the needs of four, (R1, R2, R4, and R6,) residents with pressure ulcers, and one, (R11) resident on psychotropic medication, of eleven sampled residents.</p> <p>Findings include:</p> <p>1. On 1/07/07, R1 was observed to have two large pressure ulcers to both heels. A small pressure area was noted to the knuckle of the right second toe, with eschar. Throughout the days of 1/07 and 1/08/08, R1 was observed to have heel protectors on and off of her feet, with her feet floated off the mattress, or dangling off the bed. The pressure area to the right second toe was observed to directly rub the top sheet. A review of the Care Plan, updated 12/20/07, does not include approaches of the use of heel protectors, floating R1's heels off the mattress, the treatment ordered by the physician, or the time interval for turning and repositioning. No documentation was noted in R1's Care Plan to address the area to the right second toe. During an interview on 1/08/08, at E2, Director of Nursing, (DON), confirmed R1's Care Plan needed updating. On 1/08/08, at 11:00 AM, E9, Licensed Practical Nurse, (LPN), Treatment Nurse reported she was unaware of the skin breakdown to R1's right second toe.</p> <p>2. On 1/07/08, at 9:36 AM, 10:20 AM, 11:20 AM, R2 was observed to have heel protectors on the bedside stand. At 3:45 PM, R2 was observed to have the heel protectors on both feet.</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>The Care Plan, updated 12/26/07, documents R2 as having a "mushy heel", but does not address the use of heel protectors as an approach.</p> <p>3. On 1/07/08, at 11:45 AM, R4 was observed to have a Duoderm dressing to the left ischium. R2's left heel was observed laying directly on the mattress on 1/07, and 1/08/08.</p> <p>Review of the Treatment Notes for R4, dated 12/01/07 through 12/27/07, read, "float heel off bed every shift". The Care Plan, does not show a time interval for turning and positioning, or the use of a heel protector for the left foot.</p> <p>4. Throughout the day, on 1/07/08, R6 was observed to have heel protectors on the bedside stand, not on her feet. R6's feet were not floated off the mattress.</p> <p>R6's Care Plan, updated 12/28/07, shows a problem as a Stage II to the coccyx. No approaches are documented in the Care Plan for the use of heel protectors, or floating the heels off the mattress.</p> <p>On 1/08/08, at 10:30 AM, E9, Treatment Nurse, reported R6's area to the coccyx had healed. R6's Care Plan did not reflect this change.</p> <p>5. A review of R11's the Psychotropic Monitoring Assessment, dated 1/08/08, Risperdal was ordered on 12/13/07, for the diagnosis of Dementia, and to decrease agitation.</p> <p>R11's Care Plan, updated 12/31/07, does not address the use of the psychotropic medication Risperdal, or the approaches to monitor the</p>	F 280			

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F 280	Continued From page 5	F 280			
F 314 SS=G	<p>effectiveness, or potential side effects of the medication</p> <p>483.25(c) PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: . Based on observation, record review, and interview, the facility to failed to prevent skin breakdown, and failed to provide adequate treatment to ensure healing, and prevent further pressure ulcer development for four, (R1, R2, R4, and R6) of 11 sampled residents. This failure resulted in the development of facility acquired Stage II pressure ulcers to R1's left and right heels; a facility acquired Stage II to the left ischium of R2 on 12/19/07; a facility acquired Stage II to R4's left ischium on 12/31/07. This failure resulted in the prevention of a potential to develop pressure ulcers to the heels of R6, who is a high risk for skin breakdown, with a recent history of a healed Stage II to the coccyx.</p> <p>Findings include:</p> <p>1. Per the Care Plan, updated 12/20/07, R1 has diagnoses, in part, of Skin Disorders, History of Chronic Skin Ulcer, Septicemia, Urinary Incontinence, Fecal Incontinence, Diabetes</p>	F 314			

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F 314	<p>Continued From page 6</p> <p>Mellitus, and Osteoporosis. The Minimum Data Set, (MDS), dated 10/26/07, shows R1 is moderately cognitively impaired, requires extensive assistance with bed mobility and personal hygiene, and is incontinent of bowel and bladder. The MDS shows R1 has a history of resolved ulcers.</p> <p>The Braden Scale assessment report, dated 11/13/07, scores R1 as a high risk for the development of pressure ulcer. R1's Care Plan, updated 12/29/07, lists a Problem as, "Resident is at risk for pressure ulcer related to diagnoses of history of fractured femur, hypertension, decreased mobility, depression, incontinence, decreased nutrition, decreased sensory perception, and a history of skin breakdown. 12/20/07-fluid filled blister to left heel, bruise noted to right heel."</p> <p>The Treatment Administration Record, (TAR), for 1/08, reads, "Heel protectors on while in bed with heels elevated. A Physician's Order, dated 1/02/08, reads, "Discontinue treatment to bilateral heels-Cleanse with normal saline. Apply Betadine daily. Apply Podus boots to bilateral lower extremities at all times." On 1/08/08, at 11:00 AM, E9, Licensed Practical Nurse, (LPN), Treatment Nurse, reported the boots had been ordered on 12/31/07.</p> <p>On 1/07/07, at 9:22 AM, R1 was observed sleeping on the right side. Both feet were floated off the mattress by a pillow. Heel protectors were observed to R1's lower extremities. Dry dressings were noted to both heels. A small scabbed area was observed on the knuckle of the second toe on the right foot. At 10:00 AM, 11:05 AM, and 11:50 AM, R1 remained asleep and on her right side. At 12:15 PM, R1 was observed to be in the same position, until staff turned her for incontinent care, and removed the</p>	F 314			

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F 314	<p>Continued From page 7</p> <p>heel protectors. This was an interval of 2 hours and 57 minutes, that R1 remained on her right side. At 12:15 PM R1 was observed to be incontinent of bowel and bladder.</p> <p>At 2:03 PM, R1 was observed to be laying on her back, with the head of the bed elevated 30 degrees. The heel protectors were observed on the wheelchair. R1's heels were resting on the pillow. At 3:20 PM, R1 was observed with the head of the bed elevated, and her lower extremities dangling off of the bed. R1 was awake, and attempting to get out of bed. The heel protectors remained on the wheelchair. E13, Certified Nurse Aide, (CNA), Shift Coordinator was notified, and assisted R1 back to bed, placing her on her back. The heel protectors were not placed on R1's feet at that time.</p> <p>At 3:45 PM, R1 was observed laying on her back, asleep. The heel protectors remained on the wheelchair. The top sheet was observed to be directly rubbing on the scabbed area, on the knuckle of the second toe of the right foot.</p> <p>On 1/08/08, at 11:00 AM, R1 was again in bed without heel protectors. E9, LPN, reported she was unaware of the scabbed area to the second toe of the right foot. Treatment was observed to R1's heels. A very large, dark brown area was noted to the left outer heel, with dried eschar. The right heel also had a very large area with eschar and pink tissue. E9 reported the right heel had recently been open, but was now closed. E9 confirmed R1 should be wearing the heel protectors, until the pressure relieving boots were delivered. E9 applied the heel protectors after completing the treatment. E9 reported the areas to R1's heels were facility acquired, and she had been seen by a special wound nurse last week.</p>	F 314			

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F 314	<p>Continued From page 8</p> <p>The facility's Weekly Infection Control Report, dated 12/28/07-1/04/08, shows R1 has facility acquired pressure ulcers to the right heel on 12/20/07, measuring 7.3 centimeters,(cm), X 5.5 cm., and to the left heel, measuring 5.5 cm X 5.0 cm. The Wound Report, dated 1/02/08, shows the same measurements. The Nurses Note, dated 12/20/07, at 6:52 AM, reads, "Purple discolored area remains to right heel..." The Nurses Note, dated 12/21/07, at 9:47 AM, reads, "Blister remains on left heel....turned and repositioned every hour...."</p> <p>2. Per the Care plan, updated 12/31/07, R4 has diagnoses, in part, of Below the Right Knee Amputee, Depression, Peripheral Vascular Disease, History of Cerebral Vascular Accident, Hypertension, Dementia, and Osteoarthritis. The MDS, dated 1/07/08, shows R4 has no cognitive impairment, requires extensive assistance with bed mobility, transfers, and personal hygiene, and is occasionally incontinent of urine. The MDS shows R4 has a Stage II ulcer, with a history of a resolved ulcer.</p> <p>The Braden Assessment Scale, dated 1/07/08, scores R4 as a moderate risk for the development of pressure ulcers. The facility's Weekly Infection Control Report, dated 12/28/07-1/04/08, shows R4 developed a Stage II decubitus on 12/31/07, to the left ischium, measuring 0.9 cm X 0.2 cm. No documentation is noted in the Treatment Notes, or Nurses Notes for 12/07, related to the Stage II to the left ischium.</p> <p>A Physician's Order for 1/08, reads, "FLOAT LEFT HEEL OFF BED every shift", with an original order date of 1/30/07. The Treatment Notes for 12/07 also reads, "FLOAT LEFT HEEL</p>	F 314			

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F 314	<p>Continued From page 9 OFF BED every shift".</p> <p>On 1/07/08, at 9:20 AM, R4 was observed laying on her back, with the head of the bed elevated 30 degrees. R4 reported she needs help with repositioning herself. R4's heels were not floated off the mattress, nor was R4 wearing a heel protector to the left foot. An elastic circulatory stocking was observed to the left lower extremity.</p> <p>At 10:00 AM, E12, Certified Nurses Aide, (CNA), was observed to ask R4 if she was wet, and R4 stated she was dry. R4 was not repositioned at that time. At 11:05 AM, 11:45 AM, and 11:50 AM R4 remained with the head of the bed elevated, asleep. on her back. At 11:55 AM, R4 was assisted to the left side by E12 and E13, CNA's. R4's left heel continued to lay directly on the mattress, with no heel protector. R4 had been incontinent of urine. The incontinent pad beneath her was urine soaked. R4 had been laying on her back, with the head of the bed elevated for 2 hours, and 35 minutes, with continuous pressure on the existing pressure ulcer, to the left ischium. The facility failed to provide pressure redistribution to the area, at a minimum of every two hours.</p> <p>At 11:55 AM, R4 was observed to have redness noted to the left lower buttock, with a Duoderm dressing to the left ischium. Heavy creases from indentation of the incontinent pad, on the left buttock were noted.</p> <p>3. Per the Care Plan, updated 12/26/07, R2 has diagnoses, in part of Skin Disorders, Muscle Weakness, Hypertension, and Atherosclerosis of the Extremities. The Care Plan lists a Problem as, " Decreased Mobility...,History of skin breakdown, peri-area reddened and red mushy</p>	F 314			

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F 314	<p>Continued From page 10</p> <p>heel. 12/19/07, Stage II to the left ischium. 12/26/07, Mushy heel improved; heel is now firm."</p> <p>The MDS, dated 9/27/07, shows R2 requires extensive assist with transfers, limited assist of one staff for personal hygiene, and is incontinent of bowel and bladder. The Braden Scale skin assessment tool, dated 12/17/07 shows R2 is scored as a high risk for development of pressure ulcers.</p> <p>The Physician's Orders for 1/08, read, "skin prep to left heel bid, (twice daily), until healed." The facility's Weekly Infection Control Report, dated 12/28/07-1/04/08, shows R2 developed a facility acquired Stage II to the left ischium, on 12/19/07, measuring 2.0 cm X 1.4 cm X 0.2 cm.</p> <p>On 1/07/08, 9:36AM, R2 was observed laying on her back in bed. Heel protectors were observed on the bedside stand. No heel protectors were noted to R2's feet. At 10:20 AM, CNA staff had completed incontinent care, and left the room. The heel protectors were not applied at this time.</p> <p>At 11:10 AM, R2 was noted to be incontinent of urine, and incontinent care was provided. The dressing to the left ischium had fallen off, exposing two small Stage II areas. The nurse was informed to replace the dressing. E3, Licensed Practical Nurse, (LPN), confirmed at 11:30 AM, R2 should be wearing heel protectors, and applied them to both feet.</p> <p>4. Per the Care Plan, updated 12/28/07, R6 has diagnoses, in part, of Hypertension, Senile Dementia, Dermatomycosis, and Fracture of Hip. The MDS, dated 10/15/07, shows R6 is cognitively impaired, requires extensive assistance from staff for bed mobility, transfers,</p>	F 314			

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F 314	Continued From page 11 and personal hygiene. The MDS shows R6 is incontinent of bowel and bladder. The Braden Scale skin assessment tool, dated, 12/27/07, shows R6 is scored as a high risk for pressure ulcer development. The Care Plan lists a problem as; "history of skin breakdown. 7/25/07 reddened area noted to bottom. 12/28/07, Stage II to coccyx." R6 is not listed on the Weekly Infection Control Report, dated 12/28/07-1/04/08, as having any pressure ulcers or excoriation of the skin. On 1/07 and 1/08/08, R6 was observed not wearing heel protectors, nor were R6's heel floated off the mattress. The heel protectors were observed on the bedside stand both days. On 1/08/08, at 10:30 AM, R6 was observed to be incontinent of bowel and bladder. Severe excoriation was observed to the perineal area, with R6 complaining of extreme pain to the area, when cleaned. The area to the coccyx was newly healed. E9, LPN, confirmed the coccyx pressure ulcer was recently healed, and had been acquired while hospitalized.	F 314			
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to identify and address risks factor, provide adequate	F 323			

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F 323	<p>Continued From page 12</p> <p>supervision and assistive devices to prevent accidents for 3 of 4, (R11, R2, R3), sampled residents that sustained accidents with injuries. This failure resulted in R2 sustaining bruises to her right leg, R3 sustaining a fracture of her shoulder and R11 sustaining a fracture to her hip and shoulder.</p> <p>The findings include:</p> <p>1. On 10/17/07 at 4:00 PM, the nurses notes for R3 states " Called (Z3). New order rec'd for Right shoulder and humerus x-ray. (X-ray company) notified". Earlier at 2:15 PM the nurses notes stated that R3 complained of pain to the right shoulder and upper arm. Vicodin was given for the pain. An X-ray was done of the right shoulder and humerus and identified a "suspicious fracture of the neck and greater tuberosity." The physician ordered a sling for R3 until a shoulder immobilizer was obtained and Ultram 250 mg every 8 hours for 20 days.</p> <p>The nurses notes dated 10/9/07 at 12:32 noted that early in the shift R3 had complained of right axilla pain. Vicodin was given and there were no further complaints. On 10/10/07 at 8:05 PM R3 complained of right arm pain and again Vicodin was given for the pain. The next nurse note was the 10/17/07 note. Review of the nurses notes from 10/1/07 to 10/17/07 did not identify any accidents or incidents.</p> <p>In an interview with E2, Director of Nursing, on 1/7/08 at 1:00 PM she stated that R3 had been lowered to the floor by E2, Certified Nurse Aide. E2 stated that they were unsure of the date of the incident. E2 stated that E11, Licensed Practical Nurse, had checked R3 after she was told she had been lowered to the floor and had not observed any injuries. E2 stated that E11 did not</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>fill out an incident report as she did not consider it a fall nor did she call the physician. Review of E2's written statements regarding the investigation confirms her statements. Review of the "Employee Disciplinary Action" form dated 10/19/07 for E11 notes that she given a written warning for not opening an incident investigation and notifying the appropriate people.</p> <p>In an interview with E8 on 1/7/08 at 2:30 PM in the 300 Hall lounge area, she stated that she had taken R3 to the restroom with no other staff assistance. E8 stated R3 was holding onto the rail with her good arm. E8 stated R3 had a stroke and can only hold on with her good arm. E8 stated R3 got weak and sat down on the floor. E8 stated she tried to get the wheelchair under her before she sat down. E8 stated she may have hit her arm with the wheelchair but she was not sure. E8 stated R3 did not have any pain and there were no problems the rest of the shift. E8 stated she did report the incident to E11. E8 stated she did not use a gait belt to transfer R3. E8 was not sure of the date of the incident but thought it was about a week before her arm was found to be broken. E8 received a written warning on the "Employee Disciplinary Action" form dated 10/19/07 that stated the reason for the discipline was due to "Transferring resident with gait belt and 2 person assist as indicated in care plan".</p> <p>R3 has diagnoses, in part, of right sided hemiplegia due to Cerebral Vascular Accident, weakness, breast cancer with double mastectomy on 9/10/07, aphasia, and diabetes mellitus. R3 was assessed on the 12/10/07 Minimum Data Set as modified independence with cognitive skills and extensive assistance needed for transfer with 2 person physical assist. In an interview with R3 on 11/8/08 at 11:30 AM</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>R3 was unable to state what had happened due to aphasia.</p> <p>The care plan dated 10/25/07 identified increased risk for falls due to right sided hemiplegia as a problem for R3. The approach states to "assist resident with all transfers" and "provide assistive devices as needed."</p> <p>2. R11 has diagnoses, in part, of dementia, osteoporosis, vertigo, hypertension, abnormality gait, and anemia. R11's care plan with a date of 12/13/07 notes a problem for R11 is increased risk for falls due to diagnoses of hypertension, vertigo, and an unsteady gait. The Minimum Data Set dated 12/03/07 assessed R11 as severely impaired with cognition, supervision needed with walking and transfer, unsteady balance with standing, and no falls in the last 31-180 days.</p> <p>The nurses notes dated 12/13/07 states "resident refused all AM meds...call placed to MD waiting for return call." The physician called back and the nurses notes states "MD called back regarding resident refusing meds. new order for Risperdal...". On 12/13/07 R11 was started on 1 mg of Risperdal per day due to "Res refusing current medication. MD ordered Risperdal" according to the "Psychopharmacological Assessment" dated 12/13/07. The diagnosis for the medication had documented "None given by MD". The summary states that the facility "must address alternatives/less restrictive methods used; non-pharmacologic interventions; if reduction is unsuccessful-why; any pertinent observations. Include evaluation of residents's target symptoms and any change in severity, frequency and/or change in characteristic symptoms, any change in ADL functioning, and if the resident has experienced any</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>medication-related adverse reactions". On 12/17/07 in the nurses notes it states "Spoke with (Z3-physician) re res sleeping a lot this am. New order noted to decrease Risperdal to 0.5 mg from 1 mg." The "Medication Consent" dated 12/13/07 identifies potential side effects as blurred vision, dizziness, shuffling walk, and fainting.</p> <p>Review of the care plan did not include the addition of the Risperdal to R11's medications nor the side effects. The care plan did identify that R11 had verbal and physical aggression during care.</p> <p>Interview with E2, Director of Nursing, on 1/9/08 at 12:30 PM confirmed that there was no other assessment done prior to the use of the anti-psychotic for R11 nor had the use of the medication been included on the care plan.</p> <p>On 12/24/07 at 2:31 AM staff heard R11 screaming and found her laying on the floor. R11 was screaming with pain and stated her arm hurt. The physician was called and R11 was sent to the emergency room. R11 was found to have a fracture to her right shoulder and transferred back to the facility with an immobilizer in place. At 12:24 PM on 12/24/07 R11 complained of hip pain and was sent back to the hospital where a fractured hip was found. R11 underwent surgical repair of the hip. On 12/31/07 R11 was readmitted to the facility. A bed alarm was placed for personal safety. An order for 2.5 mg oxycodone for pain was given on admission and increased on 1/3/08 after R11 continued to have pain after the medication was given. On 1/5/08 R11 continued to "cry out and scream, resident is unable to rest even when given PRN pain med." The physician was called and ordered Ativan 1 mg to help R11 rest. On 1/6/08 R11 was screaming out in pain according to the nurses notes. The physician was called and ordered a</p>	F 323			

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F 323	Continued From page 16 stat X-ray due to increased pain. R11 was sent to the hospital for evaluation of the pain due to post status fracture of the right humerus and shoulder. According to the nurses notes R11 was admitted to the hospital for a Urinary Tract Infection.  3. According to the "Skin Integrity Event-Bruise" for R2, dated 12/28/07 at 2:06 PM, staff were transferring R2 with a mechanical lift, and bumped her leg on the chair. R2 sustained a 6 x 2.3 centimeter bruise to the right lower leg. Observation of the area on 1/7/08 at 9:36 AM noted there were two large dark purple bruises to the right shin. The top right shin was rectangular in shape and 2 cm x 3 cm. The bruise under that bruise was irregular in shape and 3 cm x 7 cm. The care plan, dated 9/17/07, states R2 has the potential for injury due to decreased skin elasticity and the medication regimen. R2 receives aspirin daily. For transfers, R2's approach was for two assist with a gait belt to transfer. The nurses notes do not reflect the incident.	F 323			
F 333 SS=G	483.25(m)(2) MEDICATION ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that 1(R4) of 11 sampled residents was free of significant medication errors. This failure resulted in R4 feeling "really sick" from the low blood sugars, upset from fear of going into a diabetic coma ; and, had to undergo hourly	F 333			

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F 333	<p>Continued From page 17</p> <p>needlesticks for monitoring of her blood sugar throughout the night.</p> <p>The findings include:</p> <p>1. According to the medication error investigation, dated 12/10/07, on 12/8/07 R4 told staff that a nurse, E7, had tried to give her an injection of insulin. According to the report, R4 stated she had told the E7 that she was not diabetic and the nurse did not give her the injection. R4 also stated that the E7 had given her a long white pill and a pink pill and not the two Tylenol she had stated she had given R4. R4 is assessed as independent for cognitive skills on the Minimum Data Set dated 12/30/07.</p> <p>In an interview with E4, Licensed Practical Nurse, on 1/8 /08 by phone she stated that the Certified Nurse Aide, E10, reported to her on 12/8/07, at approximately 7:30 PM, that R4 stated a nurse, E7, had tried to give her some insulin in the dining room and had given her a couple of pills-a long white pill and a small pink one. E4 stated she confronted E7 who stated she had given R4 two Tylenol and had not tried to give her any insulin. E4 stated she took two Tylenol to R4's room to show her and R4 stated "No, those are two Tylenol".</p> <p>E4 stated that E7 said she thought R4 and R10 looked alike and that gave her the idea to check R4's blood sugar. E4 stated she checked R4's blood sugar between 9 and 10:30 PM and it was low. E4 stated she could not remember what the reading was but thought it was in the "mid to high 50's-low 60's". E4 stated that she thought that E7 had given R4 the two diabetic medications that was prescribed for R10. E4 stated another nurse, E5, stayed in the room with R4 and after giving her a glass of apple juice and</p>	F 333			

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F 333	<p>Continued From page 18</p> <p>two glasses of orange juice and peanut and jelly sandwiches her blood sugar went up. E4 stated that when the blood sugar began going down again they gave her milk and it began to go up again and stabilize. E4 stated she thought she had written down the blood sugar readings but was not sure. E4 stated R4 did not exhibit any signs or symptoms of low blood sugar. E4 stated she did not call the physician and she would have sent her to the hospital if she thought it was needed. E4 stated she called the on call nurse who told her to fill out an incident report and call the administrator. Review of the written statement dated 12/8/07 by E4 confirmed the statements made in the interview were true.</p> <p>In an interview with E5, Licensed Practical Nurse, on 1/8/08 at 1:55 PM by phone, she stated that R4 also told her that E7 had given her two pills and she took them. E5 stated R4 then said E7 tried to give her insulin injection and she told her she was not not diabetic. E7 did not give R4 the insulin. E5 stated R4 became upset due to the fact that her daughter had died from a diabetic coma previously. E5 stated she monitored R4 throughout the night and the paper with the vital signs and blood sugar levels was on the desk. E5 stated that at 10:30-11:00 PM the nurse aides did the vital signs and there were no problems. The blood sugar was 51 or 52 and R4 was given orange juice and peanut butter sandwich. E5 stated the blood sugar was checked every 30 minutes and went up to 71. E5 stated the blood sugar went up to 200 then back into the 100's and R4 seemed fine the whole time. E5 stated she felt E7 had given E4 the diabetic medications of R10 as E7 had stated she thought R4 and R10 both looked alike. E5 stated she did not call the physician and had told E4 to call the physician. Numerous attempts to contact</p>	F 333			

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F 333	<p>Continued From page 19</p> <p>E7, Certified Nurse Aide, (CNA), were not successful.</p> <p>On 1/10/08, at 3:50 PM, E10, CNA, was interviewed. E10 reported she was informed of the incident by R4, then informed the nurse, E5. E10 reported E7 had tried to give R4 insulin in the dining room, and had given her two pills that were not hers. E10 reported she was standing next to E5 when she telephoned E1, Administrator, E2, DON, and the registered nurse on call. E10 reported E5 did not notify R4's physician, or her family of the medication error. E10 stated E5 was told by E2 to write the information on a piece of paper, and place it under her office door. E10 reported she was not aware of what happened to the documentation of the incident.</p> <p>E10 reported sitting with R4 all evening and night to monitor her. E10 reported R4 became flushed, sweaty, and confused, and her blood sugar level fluctuated up and down three times. The lowest blood sugar level registered at 41.</p> <p>In a written statement with no date, E7 stated she had drawn up the sliding scale insulin for R10 and had gone over to the table with the insulin and with what she thought was 2 regular Tylenol for R10 and two extra strength Tylenol for R12. R12 was seated with R4 at the table. The statement goes on to say that for a "bit I thought (R4) was (R10) (In the face only I have always felt their features were similar)". The statement notes that R4 held out her hand for the medication. The note goes on to say that after she had given R12 and R10, (instead of R4), the regular medications that R12 had made it clear that she wanted something stronger and so she went back to R12 and R10 and was going to give them Tylenol when she gave them their insulin. The written statement is very difficult to follow as</p>	F 333			

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F 333	<p>Continued From page 20</p> <p>E7 goes back and forth with R4 and R10. E2 stated in an interview on 1/8/08 that E7 was terminated but not for the medication error. The exit interview does not list the cause for termination.</p> <p>Interview with E6, Licensed Practical Nurse, on 1/8/08 at 2:45 PM stated she had not worked on 12/8/07 but had worked the next day. E6 stated she was told in report that R4 had been given the wrong medication. E6 also stated she was told that R4's blood sugar level was in the "low 20's" and that she was sweaty and lethargic. E6 stated she was not aware if the physician had been called. E6 stated she had made a note on 12/9/07 with the results of the blood sugar finer stick monitoring for R4 and she was fine.</p> <p>R4 was interviewed on 1/7/08 at 9:20 AM, in her room, and stated that a nurse had given her diabetic medications that were not hers. R4 stated she got 2 pills and when the nurse started to give her an insulin injection she stated to E7 that she was not diabetic. R4 stated one of the pills was a long white pill and one was smaller and pink. R4 stated that later that night her blood sugar went down and they kept giving her orange juice and peanut butter and jelly sandwiches. R4 stated that staff checked her blood sugar every hour and stayed with her. R4 stated "I was really sick".</p> <p>Interview with E2, Director of Nursing, on 1/8/08 and 1/9/08 confirmed that there were no nurses notes on 12/8/07 and from 12/9/07 to 12/30/07 nor was there any documentation for the blood sugar levels for R4. E2 stated E7 told her she had given two Tylenol to R4 so it was not clear if a medication error had occurred. E2 stated she had not interviewed R4 regarding the medication.</p> <p>Review of the Medication Administration</p>	F 333			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145728</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/09/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYVILLE MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2133 VADALABENE DRIVE</b> <b>MARYVILLE, IL 62062</b>		
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F 333	Continued From page 21 Record for December of 2007 for R4 did not have any Tylenol documented as given on 12/8/07. However, there are two Tylenol documented as given by E7 on the Medication Administration record for R10 on 12/8/07 at 6:30 PM. R10 also had documented that two diabetic medications were given by E7 on 12/8/07. The two medications were Glucophage 1000 mg twice a day and DiaBeta 5 mg twice a day. The scheduled time for administration was 4:00 PM. Review of the nurses notes for R4 had no nurses notes documented in the medical record or on the computerized nurses notes for 12/8/07. R4 was assessed as independent for cognitive skills on the Minimum Data Set dated 12/30/07. There was no diagnosis of Diabetes for R4 in the medical record. Review of the Physician Progress Note done by Z2, Nurse Practitioner, dated 12/11/07 states the chief complaint for the visit was "seeing pt to Hf/u pt received wrong meds over the weekend Pt states she feels fine (no) residual noted". For the assessment/plan the note states " medication error-no apparent injury Pt states she feels fine". In an interview with Z1, Medical doctor for R4, on 12/8/08 by phone, he stated he had not been notified of the medication error for R4. Z1 stated staff should have called him when the error was discovered and the blood sugars were low. The "Geriatric Dosage Handbook", 12th edition, states the "Reference Range" for glucose for older adults is 100-180 mg/dl for Metformin and 100-150 for Glyburide. Adverse reactions include, in part: hypoglycemia, drowsiness, and sedation	F 333			
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS  The facility must maintain clinical records on each resident in accordance with accepted	F 514			

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F 514	<p>Continued From page 22</p> <p>professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to maintain 1 of 11, (R4), sampled residents clinical record with accurate documentation and progress notes when R4 was given medication in error.</p> <p>The findings include:</p> <p>According to the medication error investigation dated 12/10/07 on 12/8/07 R4 told staff that a nurse had tried to give her an injection of insulin. R4 stated she had told the nurse that she was not diabetic ad the nurse did not give her the injection. R4 also stated that the nurse had given her a long white pill and a pink pill and not the two Tylenol she had stated she had given R4. R4 is assessed as independent for cognitive skills on the Minimum Data Set dated 12/30/07.</p> <p>R4 was interviewed on 1/7/08 at 9:20 AM in her room and stated that a nurse had given her diabetic medication that wasn't hers. R4 stated she got 2 pills and when the nurse started to give her some insulin she stated she was not diabetic. R4 stated one of the pills was a long white pill and one was smaller and pink. R4 stated that</p>	F 514			

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F 514	<p>Continued From page 23</p> <p>that night her blood sugar went down and they kept giving her orange juice and peanut butter and jelly sandwiches. R4 stated that staff checked her blood sugar every hour and stayed with her. R4 stated "I was really sick".</p> <p>In separate interviews with E4 and E5, Licensed Practical Nurses, on 1/8/08 by phone both stated they had monitored R4's blood sugar levels every hour. E5 stated there was a piece of paper on the desk and everyone was writing the blood sugars on that piece of paper. Neither knew what had happened with the paper. Both confirmed that they had not called the physician.</p> <p>Review of the nurses notes for R4 identified that there were no nurses notes or progress notes for R4 for 12/8/07 and from 12/9/07 until 12/30/07. There were no blood sugar levels for R4 documented for 12/8/07 and only one level on 12/9/07 after the medication error. There is no documentation that the physician was notified until 12/11/07 when the nurse practitioner saw R4 for the medication error.</p> <p>Interview with E2, Director of Nursing, on 1/8/08 and 1/9/08 confirmed that there were no nurses notes on 12/8/07 and from 12/9/07 to 12/30/07. E2 confirmed there no documentation found for the blood sugar levels for R4.</p>	F 514			