Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	IL6000236		C 09/11/2015

NAME OF PROVIDER OR SUPPLIER: MANORCARE OF OAK LAWN EAST

STREET ADDRESS, CITY, STATE, ZIP CODE: 9401 SOUTH KOSTNER AVENUE OAK LAWN, IL 60453

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 1594735/ IL79751	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1630 d) e) Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report. This requirement is not met as evidenced by: Based on interview and record review the facility failed to administrate a medication as ordered, inform a physician when a medication was not available in a dose ordered and make an incident report of a resident's medication error. This failure applies to one of three residents (R1) reviewed for psychoactive drugs in a sample of eight. Findings include:	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 1. A physician's order sheet (POS) dated 8/1/15 to 8/31/15 indicates that on 8/28/15 R1's Remeron 15 mg was discontinued and changed to Remeron 7.5 mg (milligram) to be given at bedtime for Depression. R1's medication administration record (MAR) indicates that Remeron 7.5mg was given on 8/28/15 and 8/29/15 at 8:00pm "pass time." Nursing Progress Note dated 8/30/15 at 11:55pm indicates that at 6:00pm on that date R1's family requested that "if possible" Remeron tablet be tapered down to 5mg, due to R1 being drowsy in the daytime. Note indicates that R1's physician was made aware of the daughter's request and an order was received to give Remeron 5mg on evening dose then he will come to facility "tomorrow" and review R1's medications. MAR indicates that Remeron 5mg was administered to R1 at 10:46pm on 8/30/15. On 9/10/15 at 12:35pm E8, Registered Nurse stated that she called R1's physician because R1's family was requesting to taper down R1's Remeron. E8 stated that R1's Physician ordered Remeron 5g dose for one night only. E8 stated that she did not tell the physician that Remeron was a 15 mg tablet and that she would have to break half of the tablet (7.5mg) to get a 5mg dose. E8 stated that she "Cut the 7.5mg in 3/4ths to try to get 5mg and gave it to R1. E8 stated that now she knows that was not accurate and that she should have notified the physician of the incorrect dosage. On 9/10/15 at 2:00pm E9, Registered Nurse stated that on (8/31/15) R1's family told her that R1's physician wanted R1 to be on 5g of Remeron. E9 stated that she paged the physician	S9999		

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S9999	Continued From page 2 and looked for 5mg Remeron dose in the medication supply. E9 stated that she could not find Remeron 5mg, so she called the pharmacist who told her that the lowest dose for Remeron is 7.5mg and that nothing lower is available in any form of that medication. E9 stated at that time she reordered the previous dose of 7.5mg. E9 stated that she canceled the call to the physician after talking with the pharmacist. On 9/10/15 at 12:03pm Z1, Consultant Pharmacist stated that Remeron does not come in a 5mg dosage and that it's impossible to break 7.5mg (1/2 tab) to get 5mg. Z1 stated that it's not accurate and not dosed that way. Z1 stated that "Nurses are not supposed to break any medications and that the medication should come packaged in the dosage ordered." On 9/10/15 at 4:05pm Z2, Physician stated that R1's family wanted R1's Remeron tapered and wanted R1's Remeron to go to 5mg. Z2 stated that he wasn't sure if Remeron came in a 5mg dose so he told the nurse (E8) to check with pharmacy and give 5mg if they have that dose. On 9/10/15 at 12:45pm E3, Director of Nursing (DON) stated that the expectation for nurses is that if they have questions about a medication or physicians orders to call pharmacy, call the physician back to clarify order or call a nurse manager. E3 stated that the nurse must call the physician back. 2. Facility Policy/Medication and Treatment Administration Guidelines dated 2014 indicates: Medications are administered in accordance with standards of practice and state specific and federal guidelines.	S9999		

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S9999	Continued From page 3 The licensed nurse noting an order is responsible for accurate transcription and initiation of orders. Medication errors are documented in the Incident Management System. On 9/10/15 at 4:50pm E3, DON was asked if an incident report was completed, E3 responded that a report was not done. On 9/11/15 at 10:10am E3, DON stated that the facility was not aware of the incident until the progress notes were reviewed on 9/9/15 (after surveyor requested notes). E3 also stated that the decision was made last night to complete an incident report after discussion of the incident. Incident Report dated 9/10/15 indicates "Type of Incident : Medication error without harm. Report indicates that R1's Physician (Z2) was notified on 9/10/15 at 3:30pm and R1's family was notified at 6:00pm on that date. (B)	S9999		