STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HEALTH & REHABILITATION	2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154

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F 000	INITIAL COMMENTS Complaint investigation 1695820/IL89104 - F157 & F333 1695942/IL89242 - no deficiency 1696025/IL89323 - F332	F 000		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure two residents(R15, R16) out of three reviewed received ordered medication as prescribed over multiple days and failed to provide medications as ordered during medication pass observation on 10/26/16 resulting in an medication error rate of 6.0% with 2 total errors out of 33 opportunities. Findings include: R15 did not receive all of her medications by E8(Registered Nurse) as ordered on 10/26/16. Following the administration of R15's scheduled 8:00 am medications, physician order sheet identified an order on 9/21/16 to "decrease lasix to 20 mg daily." Lasix was not given during that 8:00 am medication pass. Review of medication administration record for October, 2016 did not include any documentation of the Lasix 20 mg order. There's a Lasix 40 mg order documented on the medication administration record which	F 332		

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

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has entries for October 1st and October 2nd. That entry has a changed sign with the 40 mg crossed off and 20 mg written in its place. The body of that entry is crossed off. There is no order to discontinue administration of lasix. In reviewing the documentation, E1(Director of Nursing) reported on 10/26/19 at 2:00 pm, the nurse did not follow standard documentation procedures and as a result R15 did not receive the lasix as ordered for multiple days. No discernible harm could be determined for the medication error.

R16 during the October 26 th morning, 9:00 am medication pass observations, did not receive "Florastor 250 mg capsule" by E9(Licensed Practical Nurse) which is scheduled according to the physician order sheet for October of 2016 at 8:00 am and 4:00 pm. On the October 2016 medication administration record Florastor 250 mg orally twice a day has been crossed out with comment of "double entry" written in the area where nurses chart administration of the medication. There are entries for administration of this medication through October 3rd, after this point no further documentation of this medication is noted. There is no other entry for Florastor listed on the October medication administration record. E1(Director of Nursing) acknowledged on October 26th during daily status this medication was not administered on multiple dates as ordered.

Facility policy titled, "Medication Administration," states, "Medications are administered in accordance with written orders of the attending physician. Facility failed to follow its policy and procedure for medication administration on 10/26/16 .

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F 332	Continued From page 2 Facility was advised of these errors on 10/26/16 in the afternoon and on 10/27/16 facility administration declined to present any documentation refuting the medication errors.	F 332		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility failed to ensure administration of Dilantin as ordered for one resident (R1) out of three reviewed in a total sample of three. The failure to administer Dilantin as ordered resulted in R1 having a seizure which required treatment at a hospital. Findings include: R1's computerized face sheet lists a date of birth of 6/22/31 and diagnoses which are not limited to: Dementia, Epilepsy, unspecified, not intractable without epilepticus, Dysphagia and Cerebral infarction. Physician order sheet of July 2016 includes listing of "Filter" as additional diagnosis. For treatment of seizures, R1 is listed on current October, 2016 medication administration record as being on Phenytoin and Keppra. It is unclear how long R1 has been on Phenytoin but Physician order sheets have stamp date of 1/27/16 for the Phenytoin suggesting R1 has been on Phenytoin consistently for a long time period. In addition to antiseizure medications,	F 333		

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R1's medication administration record for October lists, "Coumadin 7 mg one tab per G-tube(gastrostomy) Monday, Wednesday and Friday and dosage of 7.5 mg on Tuesday, Thursday, Saturday and Sunday. Coumadin is a blood thinner.

R1's October medication administration record lists "Phenytoin(Dilantin) 150 mg BID(Twice a Day) via G-Tube(gastrostomy feeding tube) scheduled for 8:00 am and 4:00 pm. HOLD FEEDING 1 hour prior and After." R1 receives "Jevity 1.2 60 ml(milliliter) via G-tube(gastrostomy), off 2:00 pm, on 4:00 pm." October MAR for dates of 1, 2 and 3 lacks documentation for administration of Phenytoin 150 mg at 8:00 am and 4:00 pm. Nursing note of 10/3/16 5:30 pm states, "Res(R1) observed having "Tonic Clonic seizure activity. " 5:44 pm nursing note reports, "Active seizure still ongoing. Increased intensity of seizure. Still ongoing." At 5:55 pm paramedics have arrived and R1 is transferred to the hospital.

Emergency room encounter dated 10/3/16 for R1 lists an arrival time of 6:02 pm. R1 is discharged back to the facility after receiving a bolus of Dilantin from the emergency room. Documented under the emergency room physical exam portion, R1 is found to "acutely have Seizure disorder(primary encounter diagnosis), Breakthrough seizure, Dilantin level too low, and these can carry with them a high risk of complication or comorbidity...." Initial Phenytoin(Dilantin) level on admission to the emergency room is listed as critically low "at less than 2.5". Facility's last Dilantin level prior to R1's seizure was within normal limits at 18.3 on 8/8/16 with a referance range of 10.0 - 20.0.

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On 10/18/16 at 3:20 pm, Z5(Pharmacist Consultant) via telephone was asked to determine the cause of the low Dilantin level and seizure. Z5 responded, "...1st suspicion whatever caused Dilantin to be low caused seizure. Possibility not receiving for 3 days could make it(level) low. I would expect level greater then 2.5 if giving with feeding..." Z5 added, "...continuous enteral(by gastrostomy) feeding interferes with Phenytoin absorption and low serum concentration affecting up to 80% (absorption) in some patients." On 10/18/16 at 2:30 pm via telephone Z1(Attending Physician) for R1 stated, "Could affect absorption, giving Dilantin with tube feeding... Level goes down placing resident (R1) at risk for seizure. Seizure could be life-threatening. Could aspirate. Long seizure also detrimental. I've never seen anyone die. Low level could have breakthrough seizure. Low level caused by? I don't know. Could be feeding or could be didn't get medicine. Don't know of anything else. Don't know if didn't get medication."

E1(Director of Nursing) maintains the nurse(E5) on duty for time period of October 1st reports administering the Dilantin and presented copy of a write up for failure to document administration of Dilantin. On 10/21/16 at 1:20 pm E5(Licensed Practical Nurse) stated, "...I didn't know you supposed to turn feeding off 1 hour before and after(administration of Dilantin). I was putting her feeding back on immediately after giving Dilantin. They gave inservice."

On 10/13/16 from 8:50 am until 11:35 am continuous observations consisting of walking back and forth the entire length of wing 2 were

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completed. Continous Observations without interruption were resumed on the 2nd wing specifically for R1 at 2:55 pm and completed at 4:30 pm.

On 10/13/16 at 11:25 am, E7(Licensed Practical Nurse) stated, "Started with dining room for medication pass. Started at 7:15 am. First person I gave medications to after 1 person in dining room was (R1). Gave (R1) meds between 7:30 am and 8:00 am. 8:00 am medication pass, gave Dilantin, Keppra, Lipitor, Vitamin C. Gets pleasure feed. Gastrotomy feeding was on at 7:30 am and 8:00 am. Turned off feeding to put on hold for medications. Feeding on hold. Gave medications. Turn feeding back on. Feeding on hold for 5 to 6 minutes before gave medications which included Dilantin and everything due for, then (enteral) feeding resumed." E6(L.P.N) worked with R1 during the evening shift of 10/13/16. E6 at 4:20 pm drew up R1's Dilantin and medications taking them into R1's room. Medications were administered and at 4:25 pm, E6 turned the enteral feeding of R1 back on. On 10/13/16 at 4:26 pm E6(L.P.N) stated, "(R1) check for placement(of feeding tube), took blood pressure. Flush Gastrostomy tube. Gave medications of metropolol, coumadin, magnesium oxide, Vitamin C, Dilantin 150 mg, Ascorbic Acid. Gave medications, flush, then feeding started of Jevity 1.2 @ 60 cc/hr. Hung at 4:25 pm. Medications given right before feeding.

E1, E6, and E7 failed to turn enteral feeding off for an hour prior to and after administration of Dilantin for R1 as per the written instructions on the medication administration record.

This failure contributed to subtherapuetic Dilantin level on 10/3/16 which led to R1 having a

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F 333	Continued From page 6 seizure. Z5(pharmacist) in her statement of 10/18/16 notes the dilantin level was so low at 2.5 it was more probable R1 had not received her Dilantin doses at all for time period prior to 10/3/16 seizure. The nurses administration of the Dilantin with the enteral tube feeding had been occuring longer then early October timeframe as 2 out of 3 nurse observations/interviews for administration of Dilantin confirmed improper administration of the Dilantin. Nursing notes from August through October 2 do not document any seizures.	F 333		