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 |
|---|---|---|---|
| | IL6006126 | A. BUILDING: ______ B. WING ______ | C 03/20/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| KENSINGTON PLACE NRSG & REHAB | 3405 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616 |

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| S9999 | Final Observations | S9999 | | |

Statement of Licensure Violations

300.610a)
300.1010h)
300.1210d)3)
300.1210d)6)
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 300.1010 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.

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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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:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

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These Regulations were not met as evidenced by:

Based on interviews and record review, the facility failed to notify the physician of abnormal X-ray result and failed to notify the physician of critical high/low phenytoin level upon receipt from the laboratory for one of three resident (R1) reviewed for change in condition. This failure resulted in a R1 having a seizure, and being sent the hospital for evaluation and assessed to have a fractured hip.

Findings include:

Phenytoin level reference range is 10 - 20.

1/12/15 at 3:55am, R1's phenytoin level was 38.2 CH (critical high); this lab result was phoned and faxed to E12 RN (registered nurse) at 5:14pm on 1/12.

1/13/15 at 9:25pm, R1's phenytoin level was 39.2 CH; this result was phoned and faxed to E12 RN at 11:04pm on 1/13. There is no notation on this report to indicate R1's physician was notified.

2/9/15 at 4:00am, R1's phenytoin level 25.0 CH; this result was phoned and faxed to E11 LPN at 2:20pm on 2/9.

3/16/15 at 3:50am, R1's phenytoin level 4.9 CL (critical low); this result was phoned and faxed to E12 RN (registered nurse) at 6:20pm on 3/16.

Review of R1's progress notes dated 1/12, 2/9, and 3/16 do not indicate R1's physician was notified of the abnormal lab results until the following day. The progress notes do not indicate

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R1's physician was notified at all regarding the abnormal lab result on 1/13.

Review of R1's POS (physician order sheet) for January 2015 notes an order for phenytoin 300mg (milligram) capsules oral daily at bedtime and an order for phenytoin capsules 100mg oral daily in morning. There is no order indicating to hold R1's phenytoin dose on 1/10, 1/13, 1/14, or 1/18.

Review of R1's MAR (medication administration record) for January 2015 notes the following:

Phenytoin capsules 300mg (milligram) oral at bedtime was not administered on 1/13/15 or 1/14/15.

Phenytoin capsules 100mg oral in the morning was not administered on 1/10/15 or 1/18/15.

Review of R1's POS (physician order sheet) for February 2015 notes an order for phenytoin capsules 300mg oral daily at bedtime and an order for phenytoin capsules 100mg oral daily in morning. There is no order indicating to hold R1's phenytoin dose on 2/10, 2/11, 2/12, or 2/13.

Review of R1's MAR for February 2015 notes the following:

Phenytoin capsules 300mg oral at bedtime was not administered on 2/10, 2/11, 2/12, or 2/13.

Review of the safety event dated 2/15/15 notes R1 was found on the floor and difficult to arouse. R1's neurological assessment notes R1 was lethargic/drowsy, did not perceive the environment fully, responded to stimuli appropriately but slowly and with delay.

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Review of R1's POS (physician order sheet) dated 2/15/15 notes an order for x-ray of R1's right hip and right femur.

Review of R1's right hip and femur x-rays report dated 2/15/15 notes degenerative arthritic changes with suspicious deformity of the subcapital region of the neck of the right femur.

Review of R1's progress notes dated 2/15 and 2/16 do not indicate that R1's physician was notified of R1's x-ray results.

Review of R1's hospital record dated 3/4/15 notes that R1 was transferred to an acute care facility after having a seizure. R1's phenytoin level on admission was 7.0. An x-ray of R1's pelvis noted an impacted fracture of the right hip. R1 required surgery on right hip on 3/5.

During interview on 3/17/15 at 4;30pm, R1 stated that R1 had a seizure in February and fell out of bed. R1 stated that R1's right hip and right knee were injured at that time. R1 stated that R1 received medication as needed for complaints of right hip pain. R1 denied falling out of bed during recent seizure on 3/4.

During interview on 3/18/15 at 10:45am, E4 CNA (certified nursing assistant) stated that she found R1 lying in bed having seizure; at no time did R1 fall out of bed. E4 stated that R1 frequently used a wheelchair after fall on 2/15.

During interview on 3/18/15 at 10:51am, E5 LPN (licensed practical nurse) stated that she found R1 lying in bed having a seizure; at no time did R1 fall out of bed. E5 stated that R1 was observed using a wheelchair more frequently

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| S9999 | Continued From page 5<br>after fall on 2/15. E5 stated that R1 was receiving phenytoin to prevent seizures.<br><br>During interview on 3/18/15 at 2:30pm, Z1 (attending physician) denied being notified of x-ray results dated 2/15/15 and stated this is the first time hearing that it was suspicious for right femur fracture. Z1 stated that R1 should have had further workup for this at that time. Z1 stated that R1 is receiving phenytoin to prevent seizures from occurring. Z1 stated that R1's falls on 1/25, 1/27, and 2/15 could have been due to R1 not receiving phenytoin as ordered resulting in seizure.<br><br>During interviews on 3/19/15 at 12:00pm, E18 (restorative aide) and E19 (restorative aide) stated that R1 ambulated with a rolling walker since admission. After R1's fall on 2/15/15, R1 had difficulty walking, unsteady gait, used a wheelchair, and complained of rigth hip pain..<br><br>During interview on 3/19/15 at 3:50pm, E13 ADON (assistant director of nursing) stated that after R1's fall on 2/15, she often observed R1 in a wheelchair but occasionally R1 ambulated with rolling walker. E13 stated that she was not aware of R1's x-ray results dated 2/15.<br><br>Review of falls care plan initiated 1/16/15 notes R1 is at increased risk for injury related to diagnosis of seizure disorder.<br><br>(B) | S9999 | | |