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
	IL6006134	A. BUILDING: _____ B. WING _____	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MID AMERICA CARE CENTER	4920 NORTH KENMORE CHICAGO, IL 60640

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S9999	Final Observations Annual Licensure and Certification Survey STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b) 3001220b)3) 300.1620a) 300.1630d) 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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the	S9999		

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S9999	Continued From page 2 written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by: Based on interview and record review, the facility failed to ensure medication administration as ordered by a physician and failed to notify the physician regarding missed doses of medication for one resident (R10) of 18 residents reviewed for quality of care in a sample of 30. This deficient practice resulted in critically low Dilantin blood levels and a seizure. Findings include: R10's Face Sheet documents a primary diagnosis of Seizure Disorder.	S9999		

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On 12/8/15, E22 (Nurse Supervisor) indicated that R10 was readmitted to the facility on 11/21/15 from a local hospital.

R10's Physician Order Sheet (POS) dated 11/21/15 documents an order for Phenytoin Sodium (Dilantin) Extended Release 100 mg (milligram) two capsules by mouth twice a day. On 12/8/15, E22 indicated that Dilantin was ordered for R10 because of a history of seizures.

R10's Medication Administration Record (MAR) dated 11/21/15 through 12/9/15 documents that the Dilantin medication was not given on 11/22/15 at 9:00pm and 11/24/15 at 9:00am.

There is no documentation in R10's Nurses Notes which indicate that R10 refused the Dilantin on 11/22/15 and 11/24/15. The facility did not notify R10's physician regarding the missed doses of Dilantin.

On 11/25/15, R10's blood was drawn for a Phenytoin (Dilantin) level. The result: 6.2 Critically low.

On 11/26/15, R10's POS documents that the Dilantin dose was increased to 300 mg in the morning and 200 mg in the evening.

R10's MAR denotes that a Dilantin dose was not administered on 11/26/15 at 9:00am. There is no documentation in R10's Nurses Notes which indicate that R10 refused the Dilantin on 11/26/15. The facility did not notify R10's physician regarding the missed dose of Dilantin.

R10's MAR denotes that a Dilantin dose of 300 mg was not administered on 11/30/15 at 9:00am.

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There is no documentation in R10's Nurses Notes which indicate that R10 refused the Dilantin on 11/30/15. The facility did not notify R10's physician regarding the missed dose of Dilantin.

On 11/30/15, R10's blood was drawn for a Phenytoin (Dilantin) level. The result: 8.0 Critically low.

On 11/30/15 at 9:45am, R10's Nurses Notes document that R10 had a seizure.

R10's MAR's were reviewed with E22 on 12/8/15 at 11:35am. E22 confirmed that the Dilantin had not been given on the dates when the medication was not initialed. E22 stated, "With each dose that is missed or not given, then the physician should be notified.

On 12/9/15 at 2:15pm, Z2 (Physician) stated, "If patient is taking medication as prescribed, chances are much less for seizures. Antiseizure medications are taken, seizure chances are less. If leaves on pass, then the medications should be given so they can take them. I'm aware of the times he didn't take Dilantin when not in the facility. That's all I know about."

A review of R10's complete Care Plan, as submitted by E3 (DON-Director of Nursing), indicates that R10 does not have a Care Plan to address his Seizures.

A facility policy dated April 2010 and titled, "Administering Medications" documents, in part: "POLICY: Medications shall be administered in a safe and timely manner, as prescribed. 3. Medications will be administered in accordance with the orders, including any required time frame."

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S9999	Continued From page 5 (B) _____ _____ 300.625j) 300.625k) 300.625l) Section 300.625 Identified Offenders j) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care. k) The facility shall incorporate the Identified Offender Report and Recommendation into the identified offender's care plan. (Section 2-201.6(f) of the Act) l) If the identified offender is a convicted (see 730 ILCS 150/2) or registered (see 730 ILCS 150/3) sex offender or if the Identified Offender Report and Recommendation prepared pursuant to Section 2-201.6(a) of the Act reveals that the identified offender poses a significant risk of harm to others within the facility, the offender shall be required to have his or her own room within the facility subject to the rights of married residents under Section 2-108(e) of the Act. (Section 2-201.6(d) of the Act) This requirement is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to assure that a registered sex offender was maintained in a private room and failed to incorporate the requirements for a private room in the resident's care plan. This has the potential to affect two residents (R3, R19) in the sample of 30 and two residents (R34, R35) in the supplemental sample	S9999		

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and specifically involved one of one resident (R19) in the sample listed as a convicted sex offender out 24 identified offenders housed in the facility.

Findings include:

On 12/7/15 during initial tour, R19 was observed in bed four of a four-bed room in the corner of the unit/floor with the nurses' station positioned in the center of the floor. Three other residents (R3, R34, R35) were also present in the room.

On 12/7/15, the facility provided a census and room roster listing R19 in a fully-occupied four-bed room.

Record review on 12/9/15 noted that R19's Physician Order Sheets listed R19 with a four-bed room number with orders dated 11/6/15 to 11/9/15, 11/7/15 to 11/8/1511/11/16 to 11/18/15 and 11/30/15 to 12/1/15.

On 12/8/15, R19 was noted relocated into a private room.

On 12/9/15, census documents provided by E46 (Admissions) did not list R19 in a four bed room, but on 12/10/15, E46 provided the Midnight Census for 11/6/15 that indicates R19 was readmitted to the facility into bed four of a four-bed room. E46 stated census documents provided 12/9/15 were in error.

R19's care plans in the medical record with dates "10/13/15 -Present" and Goal date of 1/13/2016, as well as care plans printed 12/9/15, note that R19 is an identified offender but make no mention of R19's designation as a sexual offender and do not include any mention of the

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S9999	Continued From page 7 requirement for a private room. On 12/10/15 at 9:15 AM, E24 (Social Worker) recalls R19 being in rooms with roommates but indicated no knowledge of behavior issues. R19 stated room changes are initiated by nursing and was not aware of why R19 was in a four bed room or why R19 changed to a private room. On 12/10/15 at 9:30 AM, E4 (Social Service Director) stated he was aware R19 had a history of sexual exposure, but was not aware R19's care plan did not include any mention of sex offender status or need for a private room. E4 stated he has been with the facility for over ten years. Facility records indicate the Criminal History Analysis Security Recommendations Report dated 9/3/2013 lists R19 as Moderate Risk. An addendum "Sex Offender Evaluation/Risk Assessment dated 9/4/2013 reads in relevant part: "The SVR-20 a guided clinical risk assessment schema was utilized in analyzing [R19]'s history and presentation. His scores placed him in the High Range of risk, however given his severe physical limitations and debilitation, a clinical adjustment downward to Moderate was indicated. Recommendations: Moderate Risk - concurrent with placement in a single room, the resident requires closer supervision and more frequent observation than standard or routine for most residents in an open facility." (B)	S9999		