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	IL6004642	A. BUILDING: _____ B. WING _____	04/25/2018

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ACCOLADE HEALTHCARE OF PONTIAC	300 WEST LOWELL PONTIAC, IL 61764

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S 000	Initial Comments Annual Licensure and Certification Survey Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210d)1)2) 300.3220f) 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3220 Medical Care f) All medical treatment and procedures shall	S9999		

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be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders.

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 were not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure physician's orders related to diuretic use were implemented for one of four residents (R67) reviewed for hospitalizations in the sample of 19. R67 returned to the facility from being hospitalized for Acute Kidney Injury due to Dehydration with orders to discontinue Lasix, a diuretic medication, which was not transcribed or carried out at the facility. The facility also failed to ensure fluids were within reach and encouraged for hydration of the resident. This failure resulted in R67 receiving 45 doses of Lasix in error and R67 to develop an ongoing, worsening Acute Kidney Injury (AKI) due to Dehydration from continued Lasix use and a Urinary Tract Infection.

Findings include:

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R67's Medication Review Report dated April 2018 documents R67's diagnoses including Essential Hypertension, Disorder of Prostate, Diabetes Mellitus and Major Depressive Disorder. This report also documents an order for Lasix (Diuretic) 40mg (milligrams) by mouth twice daily for Edema.
There is no documentation in R67's medical record of history of Chronic Kidney Disease or Chronic Renal Failure.

R67's Basic Metabolic Panel (BMP) laboratory results (labs) sheet dated 3/14/18 documents R67's labs that are within reference range as follows:
Blood Urea Nitrogen (BUN) 21 mg (milligrams)/dL (deciliter); Creatinine (Cr) 0.93 mg/dL; and Glomerular Filtration Rate (GFR) > =(greater than or equal to) 60 mL (milliliters)/min (minute)/1.73 sq (square) m (meters).

This laboratory sheet also documents the reference ranges for the labs as follows:
BUN 8 - 26 mg/dL; Cr 0.70 - 1.30 mg/dL; and GFR > = 60 mL/min/1.73 sq m.

R67's Hospital Discharge Summaries dated 3/27/18 document R67 was sent to the emergency room on 3/26/18 and was found to be "clinically dehydrated." This summary documents R67's Computed Tomography (CT) of the head showed "questionable" subacute ischemic changes in the right caudate and internal capsule besides multiple old infarcts but no bleed. The summary also documents, "Following overnight hydration, patient (R67) is more awake and oriented this morning." This summary also documents R67 had an acute kidney injury, Lasix and Hydrochlorothiazide (HCTZ), (Diuretic) were held and intravenous fluids were administered to

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R67. This summary documents R67's creatinine level had improved. This Summary also documents "medications at discharge" including "Stopped Lasix 40mg tabs (tablets)."

R67's BMP laboratory sheet documents lab results as follows:
3/26/18 (upon arrival to the emergency room)
BUN 34 mg/dl; Cr 1.42mg/dl; and GFR 49

3/27/18 (morning of R67's discharge back to the facility after stopping Lasix and administering intravenous fluids for hydration)
BUN 23 mg/dL; Cr 1.08; and GFR > (greater than) 60

R67's Progress Notes dated 3/27/18 at 8:36pm document R67 returned from the hospital at 7:00pm. "Medication list updated."

R67's After Visit Summary dated 3/27/18 document orders including, "Your medications have changed, STOP taking: Lasix 40mg tabs." The orders to discontinue the Lasix medications were not transcribed or carried out by the facility.

On 4/19/18 at 12:30pm, V2, Director of Nursing stated he spoke to V17, Licensed Practical Nurse (LPN) who stated V17 overlooked the order to stop the Lasix. V2 stated that the orders to discontinue the Lasix were overlooked and not transcribed or carried out by the facility and that they should have been.

On 4/24/18 2:30pm V17, LPN, stated a nurse puts the orders in from the hospital and a second nurse from another shift double checks the orders. V17 stated when a resident comes back from the hospital, the nurses are to compare the orders from the hospital with what the resident

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S9999	Continued From page 5 was on at the facility prior to the hospital and update the orders at the facility with any new orders. V17 stated she would call the physician for clarification of an order if she saw a red flag or needed clarification, but this was just "human error" and she "overlooked" the order to discontinue the Lasix that was on the hospital discharge paperwork. V17 stated she didn't know if there is documentation of the double check of orders anywhere. V17 stated R67's orders from previous stay prior to hospitalization were still active, since R67 was not "totally discharged" from the electronic medical record system, so R67's medications from prior to hospitalization were still active. V17 stated she was unaware of the order to discontinue the Lasix upon readmission for R67 until V2, Director of Nursing called her in to the office and showed her the order and told her of the error. R67's Progress Notes dated 3/28/18 at 1:29pm by V5, Nurse Practitioner (NP) document "Lasix therapy was discontinued at discharge (3-27-18)." R67's March 2018 Medication Administration Record (MAR) documents R67 received Lasix 40mg by mouth twice daily from 3/28/18 through 3/31/18. R67's April 2018 MAR documents R67 received Lasix 40mg by mouth twice daily from 4/1/18 through 4/18/18 and one dose on 4/19/18. R67 continued to receive the Lasix 40mg BID in error for a total of 45 doses. R67's Progress Notes dated 3/28/18 at 1:50pm document V20, Registered Dietician (RD) nutritional evaluation for readmission. This note does not document R67's hydration needs due to the use of diuretics and R67's hospitalization for Acute Kidney Injury with Dehydration on 3/26/18.	S9999		

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R67's Progress Notes dated 4/2/18 by V5, Nurse Practitioner (NP) document staff reported concerns of lethargy and R67 had been compliant with cares which is "atypical" for R67. This note documents V5 would order laboratory blood tests, including BMP and staff are to ensure R67 is drinking fluids.

R67's BMP laboratory result sheet dated 4/4/18 documents decline in kidney function with laboratory results as follows:
BUN 28; Cr 1.45; and GFR 47

R67's Medication Review Report dated April 2018 document orders dated 4/10/18 for a BMP to be drawn on 4/11/18. Laboratory BMP blood draw tests V5, NP had requested on 4/10/18 to be completed on 4/11/18 were not completed until 4/16/18 with results documenting ongoing decline in kidney function as follows:
BUN 27; Cr 1.70; and GFR 39

R67's Urinalysis with Urine Culture laboratory sheets dated 4/17/18 documents results with reference ranges in parentheses as follows:
White Blood Cell - WBC Esterase: 3+ (Negative)
Urine Blood: 2+ (Negative)
Urinalysis Clarity: Cloudy (Clear)
WBC: Packed (Negative, 0-5/hpf (high power field))
Urine Red Blood Cells - RBC: 6-10 (Negative, 0-5/hpf)
Bacteria: Moderate (Negative/hpf)

R67's Care Plans dated 2/5/18 documents R67 receives a diuretic medication daily, but does not document potential dehydration focus or goals and/or interventions related to R67's hydration needs.

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S9999	Continued From page 7 The following observations were made throughout the survey: 4/16/18 11:35 AM R67 was in R67's room. R67's lips and skin were very dry and flaky. There were no fluids within reach of R67. 4/16/18 12:48 PM R67 was in the dining room. R67's clear cup for water was upside down on the table. R67's clear cup remained upside down, unused at this meal. R67 received one cup of hot cocoa of which R67 drank 100% with no additional fluids being offered. 4/16/18 01:30 PM R67 was sitting up in wheelchair in room. R67 did not have fluids within reach. There were three bottles of water located on the bedside table which was positioned two feet behind the R67. 04/18/18 11:38 AM R67 was in bed. R67's bedside table with three unopened and one 2/3 full water bottles were on the bedside table. V16, Registered Nurse (RN) was in R67's room and left room without ensuring R67's fluids were within reach. 4/19/18 4:18 PM R67 was up in the wheelchair in R67's room. R67 stated R67 was not feeling well. R67's lips and skin were dry and flaky. There were three full unopened water bottles and one water bottle 1/3 full on R67's bedside table in addition to a cup with lid that was positioned three feet away from R67. Res with left foot rest on and right leg dependent to floor with foot on floor. 4/24/18 8:40 AM R67 was in bed. R67's head of bed was elevated. There were two full bottles of water on the bedside table located at the end of R67's bed and not in reach for R67. R67's Care Plans dated 4/3/18 do not document/address R67's at risk for dehydration. R67's AKI, dehydration were not identified on R67's Minimum Data Set (MDS) dated 4/3/18.	S9999		

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S9999	Continued From page 8 On 4/19/18 at 2:20pm, V21, R67's hospital physician who provided care of R67 during the hospitalization from 3/26/18-3/27/18 for Acute Kidney Injury and Dehydration stated the orders upon discharge were for the facility to discontinue Lasix because of the AKI due to R67's Dehydration. V21 stated the facility should have followed the orders to discontinue the Lasix upon R67's return to the facility on 3/27/18. V21 stated continuing the Lasix after discharge could jeopardize R67's renal function of which was back to baseline upon discharge from the hospital on 3/27/18. On 4/19/18 at 11:10am, V5, Nurse Practitioner (NP) stated R67 has been declining since the last admission on 3/27/18. V5 stated R67 does not have a history of Chronic Kidney Disease or Chronic Renal Failure/Impairment. V5 stated she has been telling staff to make sure R67 has water within reach due to risk for dehydration and to help R67 with hydration by encouraging and assisting as needed to drink fluids. V5 stated she told R67 she had concerns R67's kidneys were shutting down and that staff had stated R67's urine was "pretty strong" smelling. V5 stated she did not restart R67's Lasix and it should not have been restarted. V5 stated she was unaware R67 was receiving the Lasix medication as the facility was to be following the orders from the hospital to discontinue the Lasix. V5 stated the Lasix was never discontinued as ordered and that it should have been. V5 stated "I just went in and discontinued the Lasix order for R67." V5 stated Lasix can cause an increase in Creatinine levels and impaired renal function. V5 stated R67 had been resistive to hospice but after V5's discussion related to R67's declining kidney function agreed to a hospice consult. V5 stated she placed a hospice consult due to R67's	S9999		

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S9999	Continued From page 9 decline and kidney function concerns. On 4/23/18 at 11:35am, V22, R67's Primary Care Physician (PCP) stated R67 does not have a history of Chronic Kidney Disease or Chronic Renal Failure/Impairment. V22 stated he was not notified of the incidents of R67's declining kidney function or that there were 45 doses of Lasix given in error. V22 stated the facility continuing to administer the Lasix to R67 would definitely cause the acute kidney injury for R67, especially at such a high dose (Lasix 40mg by mouth twice daily). V22 stated R67 receiving 45 doses of Lasix 40mg after it was discontinued for Acute Kidney Injury (AKI) is "definitely a problem" and that the orders upon readmission to the facility on 3/27/18 "clearly document" to hold the Lasix. V22 stated the facility continuing to administer the Lasix to R67 caused R67's ongoing decline in renal function and put R67 at a high risk for permanent kidney damage. V22 stated R67's kidney function would "absolutely" decline if the facility continued to administer the Lasix and that the continued administration of the Lasix is the probable cause of R67's AKI. V22 also stated the resident now has a Urinary Tract Infection which is also a problem from the dehydration from the continued administration of Lasix. V22 stated R67's ongoing decline in renal function was avoidable if the Lasix would have been stopped/discontinued as ordered. (A)	S9999		