

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010912	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/25/2018
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NAME OF PROVIDER OR SUPPLIER MANORCARE OF PALOS HEIGHTS EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463
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S 000	Initial Comments Complaint: 1893343/IL102835	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)3) 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

09/01/18

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S9999	Continued From page 1 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 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 300.3220 Medical Care f) All medical treatment and procedures shall 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	S9999			

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S9999	Continued From page 2 issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review the facility failed to ensure that an initial physician ordered PT/INR lab was drawn (prothrombin time/international normalized ratio) to determine the effectiveness of the anticoagulant therapy and failed to follow the verbal order of the attending physician to have the PT/INR redrawn after an initial refusal, and failed to obtain a lab result prior to continued administration of Coumadin for (7) consecutive doses for 1 resident (R2) reviewed for anticoagulant therapy. The facility also failed to conduct a comprehensive assessment for a change in baseline condition with signs of frequent urination, weakness, and failed to notify the physician of change the baseline changes and a change in hemodynamics to include increased temperature, heart rate and decreased oxygen saturation for R2 and failed to obtain a physician order prior to the administration of oxygen. Theses failure resulted in a R1 having complaints of weakness and experiencing a fall, having abnormal vital signs and decreased oxygen saturation for 1.5 hours and then became unresponsive without breath or pulse and CPR (Cardiopulmonary resuscitation) was initiated. R2 was taken to the local hospital and was treated for cardiac arrest and extreme coagulopathy and elevated PT/INR levels	S9999			

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S9999	Continued From page 3 Findings Include: Review of the incident report dated 5/17/18 at 7:50 pm described, R2 was trying to put self into the bed from W/C when R2 slipped from the W/C onto the floor. The incident report documents that the nurse conducted a full body assessment with no noted injury. C/O back pain, able to move all extremities with gait belt assistant of other staff members. R2 was placed in bed this report was completed by V12 (nurse). A review of the R2's nursing notes dated 5/17/18 at 18:00 V12 was called to room to find R2 on the floor near bed, that R2 was trying to get out of W/C when R2 slipped on to the floor. Full body assessment done with no injury noted, able to move all extremities, vital signs recorded as temp 99.2, heart rate 110bpm, Respiration 20 per minute. The report documents that R2's family and physician was notified. On 5/17/18 at 18:05, a nursing note by V12 documented R2 Neuro checks initiated with vital signs recorded as temp 99.2 heart rate, 110bpm, respirations 20 pm, oxygen saturation 92% on oxygen per nasal cannula at 2 liter, Denies pain at this time. Nursing note 5/17/18 at 19:00 V12 documented, R2 very restless oxygen saturation at 88% oxygen administered at 4 liters nasal cannula, R2 noted to refuse to take pain meds. V12 documents will continue to monitor. Nursing notes dated 5/17/18 at 20:30, V12 documents V12 was called to the room to find R2 lying on the floor, with no respirations and no B/P, 911 called and CPR was initiated. R2's family members was noted to be at the bedside. The note documents that V25 (physician) was notified	S9999			

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S9999	Continued From page 4 about R2 status and change in condition. R2 was transferred to local hospital via 911 paramedics. V12 said earlier that day R2 slipped out of her wheelchair onto the floor while trying to get into bed. V12 said that R2 usually uses a walker to ambulate and that R2 being in the wheelchair was not R2's normal baseline. V12 said that no one informed her that R2 was weak, and that she didn't conduct any assessments based on the knowledge. V12 said that I don't usually do an assessment unless there is a problem. V12 said because R2 fell earlier in the shift she placed R2 in the wheelchair next to nurses station so she could watch her, and because R2 usually can ambulate with a walker. V12 said it was after the 6pm fall. V12 said that she didn't recall R2 having an order for oxygen. Nursing note 5/17/2018 at 18:05 was reviewed with V12. V12 said that she didn't have an order to apply oxygen, V12 said that she didn't notify the physician of R2's vital signs and requiring oxygen. V12 said that she felt R2 needed the oxygen so she applied it. Nursing note dated 5/17/2018 at 19:00 was reviewed with V12. V12 said that R2 was becoming restless and her oxygenation level was worsening so she adjusted the oxygen to 4 liters per nasal cannula with a saturation of 88%. V12 said that she may have notified the physician, but didn't document. V12 said the physician didn't give any new orders after relaying R2's status. V12 said that the times in the electronic medical record may not be true but these are all things that I did. V12 said that she charted when time allowed. V12 said she called the physician but it wasn't in the charting because there was a lot going on. R2 was admitted to the facility on 5-10-2018, a review of the admitting hospital records dated 5/10/18 documents a lab anticoagulant report	S9999			

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S9999	Continued From page 5 with at PT-25.8 / INR2.6 (prothrombin 8.0 13.0 time/International Normalized Ratio 2.5-3.5) A review of the admitting Physician orders dated on 5/10/18 documents Coumadin (anticoagulant) 5mg by mouth at 21:00 and Coumadin 6mg by mouth at 21:00 ordered to given on alternating days. A review of admitting Physician orders on 5/10/18 a CBC, CMP, TSH AND PT/INR was ordered to be drawn on 5/11/18. A review of Physicians note signed and documented by V25 (Attending Physician) dated 5/11/18 at 21:56 Documents Coumadin dose will be adjusted according to INR. A review of the requisition on 5/11/18 of PT\INR refusal note and at bottom of lab documented V25 made aware. A review of Outpatient Lab services on 5/11/18 CBC, CMP, TSH, was drawn and documents PT/INR refused. A review of nursing note dated 5/11/18 through 5/17/18 there was no physician notification or R2's refusal of the lab draw of the PT/INR documented in the notes. A review of R11/R12 also reviewed for Coumadin Therapy there was a document titled PT/INR Coumadin (Warfarin) flow sheet located in both residents clinical record; however a review of R2's clinical record there was no flow sheet available. On 6/28/18 V4 (nurse) said that the nursing staff use these forms on all residents receiving Coumadin to review current dosing and record and review INR levels prior to administration of Coumadin and to know when the next PT/INR lab draw is due.	S9999			

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S9999	Continued From page 6 On 6/28/18, V26 (nurse) said that staff track PT/INR results on the PT/INR tracking sheet and that's how we know what to do when there have been a dosage change or the next lab draw due. On 6/29/18 at 10:00 am V5 (Director of Nursing) said the PT/INR Coumadin (Warfarin) Flow Sheet is an internal document, and that the facility destroyed R2's flow sheet after discharge. A review of the (EMAR) electronic medication administration record dated 5/10/18 through 5/17/18 Coumadin was administered as followed: On 5/10/18 Coumadin 6mg was administered by V26 according to the (EMAR). On 5/11/18 Coumadin 5mg was administered by V12 (nurse) according to the (EMAR). On 5/12/18 Coumadin 6mg was administered by V12 according to the (EMAR). On 5/13/18 Coumadin 5 mg was administered by V12 according to the (EMAR). On 5/14/18 Coumadin 6 mg was administered by V4 (nurse) according to the (EMAR). On 5/15/18 Coumadin 5 mg was administered by V12 according to the (EMAR). On 5/16/18 Coumadin 6 mg was administered by V12 according to the (EMAR). On 5/17/18 Coumadin 5mg was administered by V12 according to the (EMAR). On 7/5/18 at 4:15 pm via phone V25 (physician) said that R2 came to the nursing home needing therapy and R2 also had a urinary tract infection. V25 said that he was made aware that R2 refused a lab draw. V25 was unable to recall when he was made aware of the refusal. V25 said that he spoke to R2 about refusing the lab draw. V25 said that he didn't document the conversation. V25 said that the INR is best method to determine the efficacy of the anticoagulant therapy. V25 said " I could have	S9999			

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S9999	Continued From page 7 put R2 on heparin but I didn't because I didn't know R2 levels. V25 was asked did staff make V25 aware of R2 refusal ? V25 said that the PT/INR is the only way for him to evaluate and make dosage adjustments based on the results, V25 said that it may have been harmful to just stop the medication. The hospital lab result was reviewed with V25 noting a INR>20.0 flagged as (H) high, PTT>100.0 was flagged as (HH) double high, after reviewing the lab results with V25, V25 indicated that the results are dangerous, he also said that it was dangerous to stop the Coumadin. V25 said that he attempted to send R2 the hospital to get the lab drawn but R2 refused. V25 said that he didn't document the conversation with R2 in the notes or clinical record. When asked if it was safe to continue R2's current dosage of Coumadin without a PT/INR V25 said he didn't say it was safe, but said it could be more harm if he stopped the medication completely. V25 didn't respond when asked about decreasing the dose rather than stopping the medication completely. On 7/24/18 at 10:46am, via phone, V25 said that a verbal order to draw PT/INR was given and that V25 was not made aware of R2 condition declining, and after reviewing records R2 was not hemodynamically stable and that R2 should have been sent hours before the incident occurred. On 7/25/2018 at 2:00pm via telephone, V25 said that he would provide records of the times he was paged by the facility on 5-17-2018 on the status of R2. However V25 never supplied the survey team the accounts of the documented times that the facility paged him. On 7/5/18 at 4:15 pm via phone the survey team reviewed R2's clinical notes with V25 via phone and V25 said that R2 was not hemodynamically stable and that R2 should have been sent out	S9999			

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S9999	Continued From page 8 hours before the incident occurred if he had been notified. On 7/25/2018 at 2:00pm, via the telephone V25 said that he now recalls he was notified of R2's fall at 7:43pm on 5/17/2018, V25 was unable to state acknowledgement of R2's change in condition as V12 documented on 5/17/2018 starting at 6:00pm to include change in vital signs and decrease in oxygen saturation. V25 said that he didn't give an order for oxygen to be applied to R2 as documented in the nurse notes by V12. V25 said that he would provide records of the times he was paged by the facility on 5/17/2018 on the status of R2. However V25 never supplied the survey team the documented accounts of the times that the facility paged him on 5/17/2018 for R2. Review of R2's hospital record dated 5-17-18 at 9:17 pm, documents Chief compliant -cardiac arrest R2 arrived initially unconscious. Shortly after cardiac meds are given with high quality CPR R2 has a carotid /femoral pulse. Hospital records 10:05 pm documents INR>20 and PTT >100. R2 has extreme coagulopathy and cannot place a central line given this finding. According to the facility change in condition policy the attending physician should be notified when the resident's baseline changes to include heart rate above 110 beats per minute, temperature above 99 degrees fahrenheit. A review of V25 physician progress note 5/17/18 at 13:11 entered into the electronic record at 1:15am 5/18/2018 documents discuss with R2 about her refusing blood work. R2 is on Coumadin and is not feeling well R2 doesn't want blood work, spoke to R2 about that R2 is on Coumadin and R2 would be at high risk for CVA intracranial bleed, plan is to continue Coumadin	S9999			

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S9999	Continued From page 9 and will adjust dose according to INR. On 6/28/18 at 10:10 am V1 (Administrator) said the facility does not have an anticoagulant policy or protocol, V1 said we follow physician orders. V1 was asked did they have a corporate policy on anticoagulant therapy. V1 said we do not have a corporate policy on anticoagulant therapy, and that R2 always refused labs. On 6/28/18 at 10:35 am, V5 said that the facilities practice is to follow the doctor's order for anticoagulant therapies. V5 said that R2 was alert and oriented and refused lab draws, V5 said the physician was made aware of the refusal, and that R2 was informed of the risk of not allowing the lab draw. V5 said that the facility nursing staff did continue to follow physician orders and administer the Coumadin after R2 refused the lab draw. V5 said that when residents refuse lab work we notify the physician. On 6/28/18 at 2:45 pm V4 (nurse) was asked do you remember R2? V4 said "yes". What do you remember about R2? V4 said I remember R2 needing therapy and refusing labs. The staffing schedule for 5/11/2018 was reviewed with V4, and V4 noted that he worked on 5/11/2018. V4 said that nursing is responsible for notifying the physician when a resident refused a lab draw. V4 said that he notified the physician but V25 didn't give any new orders because V25 said that he would be coming into the facility later on 5/11/2018, however V4 said that he notified the on-coming nurse of R2's refusal. V4 said that he couldn't recall if he documented R2 refusal and documented notifying the physician of the refusal. V4 said that it not be safe to administer Coumadin without a current PT/INR level. V4 said	S9999			

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S9999	Continued From page 10 he didn't administer Coumadin to R2 between 5-11-2018 through 5-17-2018. The electronic medication administration record was reviewed with V4 which noted V4's initials administering 6.0mg of Coumadin to R2. V4 said that something was wrong because he don't recall working that day. V4 said that the facility has a protocol that includes a Coumadin Level flow sheet which to be reviewed for current lab levels, Coumadin dosage, and when the next lab draw is due. V4 said that he can't recall a flow sheet on R2. But there is usually one for all residents receiving Coumadin. On 6/28/18 at 4:30pm, V26 (Nurse) was asked how did they monitor anticoagulant levels? V26 said , 'The lab book and the PT/INR tracking sheet. How do the nurses know what to do when the dosage change? V26 we check the PT/INR Coumadin flow sheet, we check the computer. If you do not have a PT/INR level what do you do? V26 said 'I haven't seen that happen but I would call the medical doctor and get a level before administering the medication. V26 said she doesn't feel it is safe to administer the medication without a current PT/INR. On 7/5/2018 at 8:43 am, V48 (lab tech) via phone interview at the local outpatient laboratory, was asked what is the policy when a resident refuses labs? V48 said we notify the nurse and get them to sign the requisition. V12 said that she was aware of Coumadin and that it is a blood thinner. V12 said that in her opinion that it is not safe to administer Coumadin without a recent PT/INR level result on file. The electronic medication administration record was reviewed with V12. V12 is noted as administering	S9999			

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S9999	Continued From page 11 6 doses of Coumadin to R2 between 5/10/18 through 5/17/2018. V12 said that she was not aware that R2 had refused the lab draw PT/INR. V12 said that she doesn't deal with lab draws, V12 said I wouldn't know if a resident refused a lab draw. V12 said she was aware of the PT/INR flow sheet and that the facility uses the form to track current Coumadin dosages, PT/INR results and to track when the next lab should be drawn. V12 didn't respond when asked if she reviewed the PT/INR flow sheet prior to administering the Coumadin. On 7/24/18 at 10:46am, V25 notified Surveyor and said that a verbal order to draw PT/INR was given and that V25 was not made aware of R2 condition declining, and after reviewing records R2 was not hemodynamically stable and that R2 should have been sent hours before the incident occurred. 7-25-18 (B)	S9999			