

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009625	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/03/2018
NAME OF PROVIDER OR SUPPLIER GROVE OF SKOKIE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 9000 LA VERGNE AVENUE SKOKIE, IL 60077		
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S 000	Initial Comments Annual Certification Complaint Investigation 1890971 / IL100274 - F684G, F710G, F757G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b)3) 300.1220b)2)3) 300.1620a) 300.1620b) 300.1620c) 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	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

05/21/18

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S9999	Continued From page 1 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 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: 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 300.1220 Supervision of Nursing Services	S9999			

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S9999	Continued From page 2 b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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 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	S9999			

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S9999	Continued From page 3 are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. b) Telephone orders may be taken by a registered nurse, licensed practical nurse or licensed pharmacist. All such orders shall be immediately written on the resident's clinical record or a telephone order form and signed by the nurse or pharmacist taking the order. These orders shall be countersigned by the licensed prescriber within 10 calendar days. c) Review of medication orders: The staff pharmacist or consultant pharmacist shall review the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical experience and judgment, and Section 300.Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be done at the facility and shall be documented in the clinical record. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon. 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:	S9999		

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S9999	Continued From page 4 Based on interview and record review, the facility failed to 1) identify and intervene for a change in the resident's condition related to adverse side effects from medication. 2) the facility failed to ensure the physician supervised the resident's medical care by the physician failing to consult with physician specialist regarding new medications for the resident and the possible adverse side effects of new medication when used in combination with residents existing medication regimen; the physician also failed to include instructions for monitoring of adverse side effects when adding new medication to regimen in conjunction with medications ordered by physician specialist and failed to ensure that the physician reviewed all orders for an assessment of contraindications. 3) the facility failed to clarify new orders for medication prior to administration, including instructions for monitoring of potential side effects; failed to have communication between the primary care provider and other provider specialists related to changes to the medication regimen and appearance of signs and symptoms; failed to use an interdisciplinary evaluation in considering that new medications were the underlying cause of signs and symptoms. This failure resulted in (R185) experiencing symptoms including headache, loss of appetite, sensitivity to light, muscle weakness, and chest pain for a period of approximately two weeks and then being sent to local hospital and R185 was admitted to the local hospital due to cardiac arrest and died six days after admission. Findings include: R185 was a 60 year old female initially admitted	S9999		

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S9999	Continued From page 5 to the facility on 04/13/2012. R185 had diagnoses including but not limited to schizoaffective disorder, schizophrenia, low back pain, major depressive disorder, anxiety disorder, fibromyalgia, and essential (primary) hypertension. R185 was referred to V11 (Physician - Pain Specialist) by V9 (Primary Care Physician) for treatment of back pain and fibromyalgia. Review of medical record documents that R185 visited V11 on 12/29/17 for an initial consultation. Visit summary includes orders for three new medications to treat the back pain and fibromyalgia; Mexiletine HCL 150mg oral capsule, 1 by mouth twice a day; Nortriptyline HCL 10mg oral capsule, 1 by mouth at bedtime; and Memantine HCL 5mg oral tablet, 1 by mouth twice a day. Nursing Progress Note entered by V17 (LPN) on 12/30/17 1:21pm, reads: Physician (V9) was called X2 with no response for medication clarification. Endorse to next shift to follow up. Interview with V17 on 05/01/18 at approximately 10:35am, stated that he didn't remember the specifics of the issue but that he did not enter the order to start the new medications (ordered from V11) because the patient was telling him that the instructions from the doctor were different than what was written on the order. He did not want to start new medications for the resident without first getting clarification; so he called V9 since he is the primary care physician, to get clarification on the medication orders. Physician Order Sheet (POS) dated 01/01/18 - 01/31/18 includes new medication phone orders entered on 01/02/18 by V14 (Registered Nurse)	S9999			

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S9999	Continued From page 6 for the following medications: Mexiletine HCL 150mg oral capsule, 1 by mouth twice a day; Nortriptyline HCL 10mg oral capsule, 1 by mouth at bedtime; and Memantine HCL 5mg oral tablet, 1 by mouth twice a day; start date for all three new medications is 01/02/2018. There are no instructions for monitoring of the resident or indication of how to identify signs and symptoms of possible adverse reactions to medication. As documented on pharmacy recommendations: Mexiletine HCL may interact with (not limited to) medicines for depression, anxiety, or psychotic disturbances. Side effects that should be reported to doctor or health care professional as soon as possible, when taking Mexiletine HCL include (but not limited to): chest pain, continued irregular heartbeats, and unusually weak or tired. Side effects that should be reported to doctor or health care professional as soon as possible, when taking Memantine can include (not limited to): dizziness. Nortriptyline HCL should not be taken with other medicines for mental depression; may interact with (not limited to) thyroid medicine, and side effects that should be reported to doctor or health care professional as soon as possible include (not limited to): feeling faint or lightheaded, stiff muscles, trouble sleeping, and unusually weak or tired. Interview with V14 on 05/01/18 at approximately 4:00pm, stated that she called the primary care doctor to get clarification before entering the orders for the three new pain medications and spoke to the primary care doctors nurse practitioner, (V12 / Nurse Practitioner). V14 stated that she always calls the primary care physician for clarification on orders since the primary care is the one responsible for the resident's care.	S9999			

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S9999	Continued From page 7 Interview with V11 on 05/01/18 at approximately 3:40pm, stated that he returned a call to the facility on 01/02/18 and that he left a message with the receptionist for the nurse (V14) to call him back regarding medications that he had prescribed for the patient. V11 stated that he likes to speak to the nurse directly so that they understand how the medications should be taken (one week apart to watch for side effects and to know if the medications are effective or not; these medications take time to build up in your system). "I made it a point to speak to the nurse to explain that the medications should be started a week apart and that they (nurses) must look for signs that the patient is having a reaction to the medication for safety of the patient." Interview with V14 on 05/01/18 at approximately 4:00pm stated that she did not call V11 for clarification or ever speak to V11 regarding how to enter in the order for medications or instructions for administration. She just entered the order for all three medications to start on 01/02/18 after getting approval from V12. Progress note dated 01/03/2018 3:26pm, "Per patient, she states that (V11) told her to start each medication, Nortriptyline, Memantine, and Mexiletine HCL and see what are her side effects. (V11's) order (written order) doesn't state that way, instead, to take them all at once, no tapering dose. Per (V12), confirm with (V11) first. Called (V11's) office but no answer. Left a voice message. On 1/3/18 at 4:48pm, (V11's) phone record documents that (V11) called facility back in regards to voice mail message at 2:48pm, spoke to receptionist (V18), he stated that he will leave a	S9999			

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S9999	Continued From page 8 message for someone to return the call, stated ok. Nursing Progress Note dated 01/04/18 at 10:02pm, documents, "Writer called (V11) to clarify new orders he gave to resident in that a start date was needed. V11 informed writer, "As long as medication start dates are one week apart from each other it does not matter which medication in started which week." There is no information in the progress note stating that the patient should be monitored for adverse reactions to the new medications. Per the facility medication administration record (MAR) of January, 2018, R185 was administered Mexiletine HCL 150mg oral capsule once on 01/02/18, twice on 01/03/18, and once on 01/04/18; the order for this medication was then discontinued on 01/05/18 and then started again on 01/16/18; Nortriptyline HCL 10mg was given every day in January, once a day, except for a dose not given on 01/14/18; Memantine HCL 5mg was given once on 01/02/18, twice on 01/03/18, and once on 01/04/18; the order for this medication was then discontinued on 01/05/18 and then started again on 01/09/18. Interview with V9 on 05/01/18 at approximately 1:55pm, when asked if he was ever contacted for clarification on orders or notified of resident not receiving medication as ordered he stated that he didn't recall since his nurse practitioner was the one who mostly saw the resident. V9 stated that he relies on the specialist to check the medications that the resident is taking and sometimes his medication list is not correct because he uses his own system, which doesn't interface with the facility's electronic record. When asked if he was aware of the new	S9999			

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S9999	Continued From page 9 medications the resident was receiving, V9 stated that he tries to review the record when he's onsite at the facility and has to personally go in and catch any changes to medications, etc. V9 stated that he is working on getting better at signing the physician orders. There was no documentation in the record to show that V9 reviewed the new medications ordered by V11. Interview with V1 (Administrator) on 05/03/18 at approximately 11:56am, stated that they have talked to V9 about signing the physician orders timely and that they now have an EMR (Electronic Medical Record) person who follows up with the physicians to make sure they are reviewing and signing the orders. V9 is one of the physicians who does not always sign the orders. Physician Visit Note dated 01/30/18 for V9; Current Medications listed do not include Mexiletine HCL 150mg, Nortriptyline HCL 10mg, or Memantine HCL 5mg. Review of R185's Physician Order Report for January 2018, approval of orders is signed by V9 with a date of 04/30/2018. Interview with V12 (Nurse Practitioner) on 05/01/18 at approximately 2:25pm, stated that she collaborates with V9 when new medications are ordered but could not specifically remember discussing the new medications ordered by V11 with V9. Order Note dated 1/2/18 at 1:34pm, Nortriptyline order has triggered the following drug protocol alerts/warning: Drug to Drug interaction with Ipratropium-Albuterol Solution (moderate severity,	S9999			

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S9999	Continued From page 10 cardiovascular adverse effects), Invega Sustenna (severity level: severe, prolongation of the QT interval with possible development of cardiac arrhythmia, including torsades de pointes), Ondansetron (severity level: severe, additive QT interval prolongation), Synthroid (moderate severity, tachycardia and other cardiac arrhythmias), and Trazodone (severity level: severe, additive QT interval prolongation). Interview with V2 (Director of Nursing) on 05/01/18 at approximately 10:00am, was asked who should respond to order notes that come up in the EMR (electronic medical record) related to possible drug to drug interactions. V2 stated that the RN's (nurses) are responsible for reviewing the order notes and communicating the information to the physician and document their communication; the psychotropic nurse should also be making the physician aware of any order notes related to psychotropic medications and documenting the communication. Interview with V16 (RN - Psychotropic Nurse) on 05/01/18 at approximately 10:40am, was asked if she had reviewed and communicated the order note related to the possible drug interactions with Nortryptiline (since it's an anti-depressant) that R185 was taking and she stated that she was sure she had but probably didn't document it. She stated that V10 (Psychiatrist) is very well aware of this patient since he's been seeing her for 20 years. There was no documentation provided during the course of the survey to indicate that the drug to drug interactions with the Nortryptiline had been reviewed or discussed as part of the interdisciplinary management of care.	S9999		

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S9999	Continued From page 11 Review of facility Job Description: Psychotropic Nurse dated 06/17 includes under Essential Functions: 4. Monitor patients on psychotropic medications quarterly/or as needed for possible drug reductions and identify/document in patient medical record the clinical reasons why reduction attempts clinically contraindicated or recommended. On 1/22/18 per (V9) telephone encounter document, the caller from the facility, (V14), stated that patient was complaining of weakness, headaches, and dizziness. No fever. On 1/25/18 per (V9) telephone encounter document, the nurse from the facility states that the patient is complaining of sore throat, sensitive to light, nausea, light headed. Nurse thinks that it may be because of one of the meds she started on within last 3 weeks or because of Morphine decrease. Asking to speak to you (MD)? Action taken per (V9) is: This is likely due to Morphine decrease. Which medication has been started? Also, ask nurse to send throat swab for strep and flu, as well as put patient in contact isolation (in case if this is a flu). Facility Response is: Patient was started on Mexiletine HCL 150mg, Nortryptiline 10mg, Namenda 5mg. Response by (V9) is: Please advise nurse to call psychiatrist to see if any of those medications may have caused symptoms. On 1/26/18, Facility Response: called to check if order received, was asked to call in 30 minutes. Called again, spoke with nurse. Patient scheduled to see Pain specialist on 2/2/18. She is on Morphine ER 60mg BID also Morphine 15mg every 8 hours PRN (for additional pain). But at present time have no order for those present meds, was rejected by pain specialist unless seen in his office. They're asking if possible you	S9999		

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S9999	Continued From page 12 can give order for it until 2/2/18. Or asking if can speak with your for further actions. On 1/26/18, (V9) response is: Advise to call (V11) for all pain medication orders. Nursing Progress Note dated 1/25/18 at 7:36pm, "Resident presented at beginning of writers shift with signs and symptoms of opioid withdrawal as evidenced by c/o nausea, sensitivity to light, and muscle pain. Resident also has c/o headache and dry cough. Vital signs presented as follows: HR 69, BP 130/70/rr (respiratory rate) 17/o2 saturation 97 room air, temp 97.6. Resident recently has had 60 mg morphine d/c on 01/21/2018, and 3 new medications started within the last month. Resident's PCP has been informed. New order for throat culture and flu swab. Please f/u on results." Nursing Progress Note dated 01/26/18 at 2:38pm, "Received a call from (V9)'s office as per secretary (V9) will call back the facility to follow up with residents s/sx, and current orders. Informed secretary awaiting for strep throat results. Ask secretary if they can suggest another lab for flu test. Secretary informed writer, MD will call back the facility. Nursing Progress Note dated 1/26/18 at 6:23pm documented that resident is complaining of nausea, sensitivity to light, muscle pain, headache and dry cough. Follow up with lab in regards to throat culture and flu swab. Throat culture is pending and machine to test for flu is broken, and will not be fixed until Monday. Please follow up with MD and inquire about sending resident to immediate care facility. On 1/26/18 per facility lab results report, throat culture was done and was resulted negative on	S9999			

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S9999	Continued From page 13 1/28/18. Health Status Note dated 1/28/18 at 12:00pm documents that resident was complaining of "weakness, muscle pains, headache, stiff neck, bilateral axillary lymphadenitis and pain, sore throat, loss of appetite and occasional or on and off chest pain for more than a week. She wants to go to hospital if above signs and symptoms cannot be controlled." Pulse rate documented at 51 bpm. Nursing Progress Note dated 1/28/18 at 11:22pm documents that resident was complaining of weakness and generalized pain. Left a voicemail to the MD regarding overall condition of the resident. Endorsed resident's condition to next nurse on duty. Nursing Progress Note dated 1/29/18 at 5:28pm documents that resident complains of muscle weakness, sore throat, muscle aches, nausea, sensitivity to light, headache, and little appetite. POS dated January 2018 includes order to start on 01/30/2018 Azithromycin 500mg by mouth one time only for cough. Start order on 1/31/18 for Azithromycin 250mg by mouth one time a day for cough for 4 days. MAR documents that the medication was given as ordered, with last dose administered on 2/3/18. Order Note dated 01/30/18 documents that Azithromycin Tablet 250mg has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction with Invega Sustenna Suspension 156mg/ml, Ondansetron HCL Tablet 4mg, Trazodone HCL Tablet 50mg, Trazodone HCL 150mg, Nortriptyline HCL Capsule 10mg; All interactions are listed as "severe" and list prolongation of the QT interval with possible	S9999			

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NAME OF PROVIDER OR SUPPLIER GROVE OF SKOKIE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 9000 LA VERGNE AVENUE SKOKIE, IL 60077			
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S9999	Continued From page 14 development of cardiac arrhythmias, including torsades de pointes, when co-administered with Azithromycin. Interview with V11 on 05/02/18 at approximately 9:40am stated that there are certain antibiotics, like Azithromycin, that can interfere with the metabolism of other medications. There is a sudden spike in all of the meds that are broken down in their pathway. When Azithromycin is given with other medications it can cause a dramatic change in the plasma levels of all other medications; so some caution should be exercised when ordering the antibiotic. The patient should be flagged for closer monitoring when Azithromycin is ordered. There is no documentation that was provided in the medical record to show that these risks were evaluated in determining the benefit to the resident prior to administration of Azithromycin for cough. Nursing Progress Note dated 02/01/18 at 3:23pm documents that the resident continues to have complaints of muscle weakness, sore throat, muscle aches, nausea, sensitivity to light, headache and little appetite. Tylenol offered, but refused. Flu results are final and negative for flu. NP informed of final result. Nursing Progress Note dated 2/5/18 at 11:23pm documents, "Resident received awake in bed disheveled and tired looking. Writer inquired as to if resident has been sleeping in which she informed she has not been for "several days." Resident is AOx2 (alert and oriented X 2) in which an incorrect last name was given. Resident's VS are as follows: BP 145/80, HR 64, o2 97 room air RR 16 c/o 7/10 "all over in	S9999			

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S9999	Continued From page 15 muscles." Resident cont. to have c/o headache, sensitivity to light, no appetite, dizziness, muscle aches and pain. Resident ate 30% of dinner, and took only Trazodone and Ambien. Psychiatric doctor informed as well as PCP NP and resident's father. New order for UA and C/S. If test results are negative for infection NP wants an order for psychiatric evaluation. Please follow up on results of UA and C/S and keep multidisciplinary team updated on resident's status. Nursing Progress Note dated 2/6/18 at 9:55am documents, "At 9:55am, Writer went to resident's room to administer medicine to her roommate when writer overheard resident gasping for air; Writer immediately assessed patient. Observed resident lying completely flat on the bed. HOB was elevated for optimal breathing. Resident was non-responsive at this time. Writer immediately called for assistance, code blue initiated. Oxygen administered via face mask. IV 0.9% normal saline via peripheral line started on left arm. 911 called. CPR initiated until paramedics took over at 9:59am. MD informed. POA notified. DON and all departments aware. On 2/6/18, R185 was taken to local hospital and admitted with a diagnoses including but not limited to cardiac arrest, ventricular tachycardia, long Q-T syndrome, and ventricular fibrillation. R185 expired at the hospital on 02/12/18. Cause of death as listed on death certificate was anoxic brain injury (due to or as a consequence of) ventricular fibrillation (due to or as a consequence of) cardiac arrest. Interview with V9 on 05/01/18 at approximately 1:55pm, asked if he ever considered that the resident was having an adverse reaction to the additional medications that were started from the	S9999		

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S9999	Continued From page 16 pain doctor and he stated that she (R185) was a very complicated case and he would assume that the specialist looked at her history and medications. V9 stated that he would refer psych medication interactions to the psychiatrist. Interview with V2 on 05/01/18 at approximately 10:00am, stated that all physicians have access to the facility's EMR and that V9 and V10 can review all of the current medications that the resident is taking. The primary care physician still needs to be aware of everything the patient is getting; even if they go to an outside specialist, they (specialist) are not contracted by us so it's still the primary care doctors' responsibility. Interview with V19 (Nurse Consultant) on 05/03/18 at approximately 11:56am, stated that the primary care physician should take the lead when it comes to the coordination of patient care. The nurse, nurse practitioners, and physicians need to all coordinate. If there are consultation orders, they need to be coordinated through the primary care physician. Interview with V10 on 05/01/18 at approximately 12:58pm, was asked if he was ever notified of the recurrent symptoms that R185 was having during the month of January 2018, specifically after she started the three new medications for pain. V10 stated that he doesn't remember the specifics of her symptoms or of being notified about any signs and symptoms. Asked V10 if he specifically remembered getting a call on 01/25/18 (Based on telephone encounter with V9, who requested to "Please advise nurse to call psychiatrist to see if any of those medications may have caused symptoms.") V10 stated, "No, I don't specifically remember". V10 also stated that if he knew about the three new medications he would have	S9999			

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S9999	Continued From page 17 made some special recommendations and excluded the new medications if they were exacerbating the symptoms; if there was an underlying medical issue, then the medications could be the issue ...if the symptoms were acute and different then you must investigate it and not assume it's psychiatric. Interview with V11 on 05/01/18 at approximately 3:40pm, was asked if he was ever notified of resident symptomatic complaints (such as headache, sensitivity to light, and chest pain, among others as documented in nursing progress notes) that she was having during the month of January 2018. V11 stated that he was never notified or updated on anything related to this patient. He only saw her when she came in for consultation on 12/29/17 and that he was not updated again on her status. He did not know that she had passed away until his office called to follow up. V11 stated that his office received a call from the facility on 02/02/18 and were told that she would not be going to her appointment because she had the flu; at this time the facility did not tell V11 that the resident was complaining of any signs and symptoms. V11 stated that if he had been made aware of any of the complaints from the resident since starting the new medications for pain, that he would have stopped all medications immediately. V11 stated that these signs and symptoms are significant and that there needs to be improved communication both ways and a better way to monitor patients. Facility policy for Physician Orders and Services dated 11/10/14 reads: 5. Provision of care, treatment and services administered by the facility to the patient must be approved by the attending physician unless these treatment and services are governed by the facility's clinical	S9999		

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S9999	Continued From page 18 policy and procedures as approved by the medical director. Care Plan with initiation date of 03/25/2013 includes (but not limited to) intervention: Monitor/record/report to MD prn side effects and adverse reactions of psychoactive medications; refusal to eat, dry mouth, depression, fatigue, insomnia, loss of appetite, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. (B)	S9999			