

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000806	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/17/2018
NAME OF PROVIDER OR SUPPLIER BEECHER MANOR NRSG & REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 DIXIE HIGHWAY BEECHER, IL 60401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation 1873033/IL102517	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3) 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 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	S9999		

Attachment A
Statement of Licensure Violations

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

TITLE

(X6) DATE

06/04/18

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S9999	Continued From page 1 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. 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 300.3240 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 Requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to monitor a resident who was taking Warfarin (blood thinner). The facility failed to ensure that a resident does not receive an unnecessary and discontinued medication. This resulted in R307 having critical INR (International Normalized Ratio) of greater than 11 (therapeutic level 2 to 3), R307 was hospitalized and admitted to ICU (Intensive Care Unit), R307 was intubated, had severe anemia and the CT (Computed Tomography) scan showed a hematoma measuring 7.4 X 7.7 X 10 centimeter to R307's right thigh.	S9999			

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S9999	Continued From page 2 This applies to 1 of 4 residents (R307) reviewed for inadequate monitoring and 1 resident (R62) in the supplemental sample observed during medication pass. Findings include: 1). The electronic health record showed R307 was admitted to the facility on 12/06/17 at 6:15 PM with diagnoses that included displaced intertrochanteric fracture of the left femur, encounter for other orthopedic aftercare, aftercare presence of pacemaker, chronic ischemic heart disease and congestive heart failure. R307's Physician Order Report (POR) showed Warfarin 3mg (milligram) tablet to be administered once a day at 5:00 PM; this order had a start date of 12/06/17 and the end date of 12/21/17. R307's Medication Flow sheet showed Warfarin 3 mg was administered from 12/7/17 through 12/21/17 as ordered. R307's Lab Order record showed V17 (nurse) obtained an order on 12/19/17 for a PT (prothrombin time) and INR lab to be drawn on 12/21/17. Review of R307's POR showed this is the first and only time the order for PT and INR was obtained but it was not drawn as R307 was hospitalized. R307's progress note dated 12/20/17 at 2:26 PM showed R307 remained in bed due to not feeling well. R307's progress note dated 12/21/17 at 8:38 AM	S9999		

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S9999	Continued From page 3 showed R307 as slow to respond. R307's progress note dated 12/21/17 at 9:30 AM showed R307's family member requested R307 be sent to the hospital R307's progress note written by V27 (nurse practitioner) dated 12/21/17 at 10:00 AM showed R307 was minimally responding to verbal questions, following some commands and was ordered 325 mg of aspirin to be administered at that time. R307's progress note dated 12/21/17 at 10:43 AM showed R307 was transported to community hospital. R307's care plan showed a start date of 12/18/17 and with a problem identified as "resident is prescribed anticoagulant therapy" with approaches that included to adjust medication dosage per facility protocol and to monitor lab work. R307's hospital history and physical recorded by V30 (Physician) showed the following about R307: UTI (Urinary Tract Infection); Hemoglobin of 6 and INR of more than 11 in the Emergency Room. In ICU (Intensive Care Unit) R307 was intubated; CT (Computed Tomography) scan showed a right anterior thigh hematoma measuring 7.4 X 7.7 X 10 centimeter and R307 received 2 units of packed RBCs (Red Blood Cells) and FFP (Fresh Frozen Plasma). R307's discharge summary printed 1/24/17 showed R307 was found to have severe anemia, right thigh hematoma and supratherapeutic INR due to the use of Coumadin (Warfarin). R307	S9999			

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S9999	Continued From page 4 was on anticoagulation because of an aortic valve replacement. On 5/16/18 at 12:58 PM, V2 (Director of Nursing) stated monitoring of R307's INR levels began after R307 returned from the hospital and added V2 could not find any records of INR being drawn prior to hospitalization on 12/21/17. On 5/17/17 at 11:27 AM, V30 (Physician) stated the following: "A baseline INR should have been ordered as well as monitored; lack of monitoring contributed to R307 being hospitalized due to continued administration of the medication without monitoring of the INR. R307's critical INR level was greater than 11 upon arrival to the emergency room. The therapeutic level is between 2-3 and R307 was critical upon arrival to the hospital." On 5/17/18 at 11:39 AM, V29 (Nurse Practitioner) stated there should have been ongoing INR monitoring for R307 between 12/6/17 to 12/21/17. Upon viewing R307's hospital INR results, V29 responded that the lack of monitoring contributed to R307's hospitalization. The facility policy titled "Orders for Anticoagulants Policy" dated February 2014 showed "... anticoagulants are only prescribed when proper clinical and laboratory monitoring is in place. ... Prior to initiating a Warfarin regimen, a baseline INR will be obtained and results report to the Attending Physician ..." 2.) R62 has multiple diagnoses which included paroxysmal atrial fibrillation, anemia and dementia without behavioral disturbances. R62's quarterly MDS dated 4/12/18 showed a	S9999		

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STREET ADDRESS, CITY, STATE, ZIP CODE

BEECHER MANOR NRSG & REHAB CTR

**1201 DIXIE HIGHWAY
BEECHER, IL 60401**

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S9999	Continued From page 5 BIMS score of "05" which meant that the resident is severely impaired with cognition. During medication pass observation on 5/15/18 at 8:50 AM, V18 (nurse) prepared and administered multiple medications to R62 which included Aspirin 81 mg, 1 tablet. R62's physician order report generated on 5/15/18 showed no order to administer the Aspirin medication. R62's consultant pharmacist note to attending physician/prescriber faxed to the facility on 4/24/18 showed in-part, "This resident is receiving the following antiplatelet/anticoagulant therapy with history of GI (gastro-intestinal) bleed." "Combining anticoagulant and antiplatelet medications increases the risk of bleeding. Please take a moment to assess risk vs.(versus) benefit of this combination in therapies and consider discontinuing Aspirin therapy while on Eliquis, if appropriate." R62's progress notes dated 4/27/18 (4:52 PM) created by V2 showed, "New pharmacy recommendations to d/c (discontinue) ASA (Aspirin). Floor nurse notified." R62's prescription order dated 4/27/18 showed an order to discontinue the daily Aspirin 81 mg. Review of R62's medication administration flow sheet on 5/16/18 showed that the resident had been receiving Aspirin 81 mg, 1 tablet by mouth, every 8:00 AM from May 1 through May 16, 2018. On 5/16/18 at 4:15 PM, V2 (Director of Nursing) stated that she received and transcribed the physician order to discontinue R62's Aspirin 81	S9999		

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S9999	Continued From page 6 mg on 4/27/18, due to the pharmacy consultant recommendation because the resident is already on Eliquis medication. On 5/16/18 at 4:30 PM, V26 (consultant pharmacist) stated that he recommended to discontinue R62's Aspirin therapy because R62 was receiving Eliquis which is an anticoagulant and Aspirin which is an antiplatelet; together these medications increase the risk for bleeding. Per V26, "Aspirin is not necessary for the resident, because it increases her risk for GI irritation." (B)		S9999		