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	IL6001630	A. BUILDING: _____ B. WING _____	C 10/04/2018

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S 000	Initial Comments Annual Licensure and Certification Survey Complaint # 186643 / IL106204	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d)1)2)3) 300.1620a) 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. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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

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 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. (Section 3-202.2a of the Act)

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

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S9999	Continued From page 2 care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 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 300.1620 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 are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the	S9999		

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S9999	Continued From page 3 designated time. 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 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. These regulations were not met as evidence by: A. Based on observation, interview and record review, the facility failed to follow physician orders for laboratory testing and provide prompt treatment for prolonged bleeding for one of one resident reviewed for anticoagulation medications (R27) in the sample of 28. This failure resulted in R27 having a critical laboratory value (Prothrombin Time) and bleeding for 3 days from a wound before being sent to the hospital. R27 required the wound being cauterized to stop the bleeding. B. Based on interview and record review, the facility failed to assess and treat chest pain for one of three residents (R50) reviewed for medication administration in the sample of three. This failure resulted in R50 enduring chest pain through the night and being unable to attend R50's scheduled hemodialysis treatment due to unrelieved chest pain.	S9999		

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S9999	Continued From page 4 Findings Include: a. On 10/01/18 at 12:42 PM, R27 had petechiae (pinpoint red round spots) on both arms. R27 stated, "I {R27} have it all over my tummy, legs and arms but it is much better than it was last week." R27 stated R27 is on coumadin and the facility had not checked R27's Prothrombin Time (PT) levels for over a month and R27's blood was too thin. R27 stated, R27 had "a small wound" in the groin that broke open and was bleeding uncontrollably last week, which required cauterization to stop the bleeding and that since R27's coumadin has been being held, the petechiae has gotten much better. R27's Care Plan dated 8/16/18 documents a potential for bleeding or blood clot related to use of anticoagulant for AFib (Atrial Fibrillation) with interventions of: administer anticoagulant exactly as ordered, adjust medication dosage and document on medication administration, monitor for INR (International Normalized Ration)/PT, labs as ordered with results communicated to Physician. R27's POR (Physician Order Report) dated 10/3/18 documents frequent Coumadin {Blood Thinner} dosage changes and PT/INR labs ordered during August 2018. R27's Progress Notes dated 8/28/2018 documents, "new orders as follows: hold coumadin 8-28 and 8-29, 1 mg Thursday the 30th, recheck PT/INR Friday the 31." R27's Coagulation Laboratory Test dated 8/31/18 documents a PT of 30.9 seconds and INR of 3.0 ratio. It is documented on the Test that V29 NP	S9999		

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S9999	Continued From page 5 (Nurse Practitioner) was "notified" but no orders for a repeat Laboratory Test was documented. R27's Progress Notes document: 9/26/2018 by V33 LPN (Licensed Practical Nurse) - "Writer was notified around 1845 by dayshift CNA'S {Certified Nursing Assistant} that Resident {R27} was bleeding from right side, upon assessment bleeding was coming from right abdominal fold at area where treatment was in place, treatment is NYSTATIN powder, writer cleaned area and applied mepilex dressing to protect the area that was shearing. NYSTATIN is not working to protect the skin, on call for {V5, Physician} has been paged awaiting call." 9/29/2018 at 4:15 am by V34 RN (Registered Nurse) - Blood drawn and sent to lab for INR. Laboratory called and stated R27's INR is 6.07. Will pass on to morning nurse to notify NP/Physician in the morning. 9/29/2018 at 6:22 am, "bleeding continues, will send to ER (Emergency Room). 9/29/2018 at 17:55, R27 "returned from ED (Emergency Department) early this morning via ambulance. Daughter states that the ED "put some cream to stop the bleeding from R27's groin." Upon inspection per LPN site continues to ooze. Approximately 1 hour later called to unit 4 to eval {R27's} condition, the bleeding to R27's groin has increased. ED and ambulance called and Mary transported back for further treatment per doctor's instructions." R27 then arrived back at facility "at 5:45 pm via ambulance daughter and grand daughter at bedside. New order to hold Coumadin until Monday October 1st." V29 NP called and received order to draw PT/INR	S9999		

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S9999	Continued From page 6	S9999		

Monday early AM and call with results.

R27's PT/INR results dated 9/29/18 from the hospital documents a PT of 54.8 seconds with a normal reference range of 12.1 - 14.9 seconds and an INR of 6.1 ratio with a normal reference range of 0.9 - 1.1 ratio.

R27's Emergency Medicine Note dated 9/29/18 by V35 ER Physician documents, R27 "presents to the emergency department today for (R27's) second visit within a few hours for a small oozing bleed on the right side of (R27's) pannus." "INR elevated of 6. Still active bleeding from groin area." The Emergency Department Course of Treatment documents, "Let was applied to the area and then I used a nitrogren Cartery stick to seal this wound." Clinical Impression: "Coumadin Toxicity."

On 10/02/18 at 9:57 AM, V36 RN lifted R27's gown to complete the ordered treatment to R27's groin wound. The wound was not bleeding but was surrounded by petechiae. R27 stated, "I told you it was all over and right there in the middle is where I was bleeding from. You can see all the blood underneath the skin there, but it is much better than it was."
On 10/03/18 at 11:20 AM, V36 RN stated, we realized R27 hadn't had an INR level checked in a long time after R27's daughter was asking about it due to R27 bleeding out. V36 stated, V36 doesn't really know how that happened because V29 NP is at the facility almost daily.

On 10/04/18 at 10:33 AM, V29 NP stated, "it was a very unfortunate situation." V29 stated V29 gave a verbal order to recheck R27's PT/INR levels in a week back on 8/31/18 when they called to notify V29 of the laboratory results. "The

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S9999	Continued From page 7	S9999		

order for a PT/INR was not placed in computer and {R27} ended up with an INR of 6.1, bleeding from an abdominal wound and ended up in the hospital requiring cauterization after being treated with vitamin k at the facility. Something really bad could have happened. V29 stated, V29 always orders PT/INR's at least weekly unless someone is stabilized with INR of 2-3 for at least 2 months. "I'm not sure what happened but the nurses have got to put the verbal orders into the computer. The facility is lucky that {R27} didn't bump (R27's) head or something like that." V29 stated, V29 had been following R27 closely because R27's PT/INR levels were not stable. V29 stated the facility should have absolutely caught that there was a problem when R27 started bleeding, if not sooner with the petechiae. The first thing you should think about if someone is on coumadin and bleeding, is that you need to check their level and make sure they are not supra therapeutic. They should have requested a level be drawn when they called the on call physician back on 9/26/18. "They need to get a system in place to ensure something like this does not happened again."

The facility Anticoagulant - Clinical Protocl dated October 2010 documents to "assess for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to that particular drug (for example, a residentn with an above therapeutic level of an anticoagulant medication should be assessed for bleeding.", "The physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications", "If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled

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S9999	Continued From page 8 dose of anticoagulant." The facility undated Physician's Orders Policy documents when a licensed nurse recieves a physician's order verbally, the order will be recorded on a three part Physician's Telephone Order Form and the nurse will immediately take steps to institute the order. b. The facility's Abuse Prevention Program dated 2/7/17 documents, "Neglect means the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain or mental anguish (42 CFR 483.5). Neglect means a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident (201 ILCS 45/1-117)." The facility's Change in Condition or Status-Notification policy dated 3/2016 documents, "Our facility shall promptly notify the resident, his or her Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g. {example} changes in level of care, billing/payments, resident rights, etc. {etcetera})." R50's Care Plan with a revised date of 8/29/18 documents the diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Hypertension and End Stage Renal Disease. This Care Plan also documents R50 requires Dialysis. R50's Physician Order Report (POS) dated 10/3/18 documents an order for Nitrostat	S9999		

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S9999	Continued From page 9	S9999		

(Nitroglycerin) tablet, sublingual; 0.4mg (milligram) give every 5 minutes times 3 doses, if no relief call MD (Medical Doctor) with a start date of 10/18/17. This POS also documents an order for Dialysis visits on Tuesdays, Thursdays and Saturdays at 6:30 AM.

On 10/3/18 at 9:30 AM, R50 stated a couple of weeks ago R50 was having chest pain during the evening and requested nitro (Nitrostat). R50 stated the nurse (V27) Licensed Practical Nurse (LPN), told R50 there was no Nitro in the building. R50 stated V27 brought R50 Tylenol. R50 stated the chest pain was severe. R50 stated R50 was unable to go to R50's hemodialysis appointment the following morning because R50 felt so bad.

On 10/3/18 at 9:54 AM, V1 Administrator confirmed V27 did not give R50 Nitrostat when requested on 9/19/18 for chest pain. V1 stated we (the facility) terminated V27 for that incident.

R50's Nurses Progress Notes have no documentation on 9/19/18 or 9/20/18 by V27. There is no documentation of complaints of pain and no documentation of any assessment of R50 by V27.

R50's Nurses Progress Notes dated 9/20/18 at 9:33 AM, by V28 RN (Registered Nurse) documents, "(R50) complains of chest pain. Rated pain a 7 on a scale from 1-10. Writer (V28) gave 0.4 mg of Nitro as per order. (R50) had two doses (of Nitro). (R50) states (R50) feels better. Color is not as pale as earlier. (R50) missed hemodialysis today. Writer (V28) contacted (R50's) POA (Power of Attorney) and informed her of the above. Writer (V28) informed (V29) Nurse Practitioner."

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S9999	Continued From page 10	S9999		

On 10/3/18 at 10:05 AM, V28 confirmed that V28's written statement was accurate. V28 confirmed when V27 gave report to V28 on the morning of 9/20/18, V27 told V28 that everyone was fine. V27 did not mention R50's chest pain or the fact that R50 did not go to hemodialysis due to the chest pain.

On 10/3/18 at 1:18 PM, V30 Registered Nurse (RN) Unit 3 Manager stated V30 was notified about the Nitro not being given. V30 stated V30 spoke with V27 and V27 confirmed V27 did not give R50 any Nitro, V27 did not perform an assessment on R50 and did not notify R50's Power of Attorney or Physician of R50's distress. On 10/4/18 at 9:50 AM, V1 confirmed V27 worked on 9/19/18 from 6:33 PM to 6:53 AM on 9/20/18.

On 10/4/18 at 10:15 AM, V29 Nurse Practitioner stated, "it was a big thing that (R50) complained of chest pain and was told there was no Nitro." V29 stated V29 would have expected V27 to administer Nitro because R50 has a history of Coronary Artery Disease and R50 has a PRN (as needed) order for Nitro. V29 stated V29 is on call during the day from 7:00 AM to 5:00 PM. V29 stated the facility has V29's cell phone number and the facility can also have V29 paged. V29 stated from 5:00 PM to 7:00 AM the facility calls go to an on call Physician. V29 stated V27 should have called the on call Physician but V29 stated there was no record of V27 calling the on call Physician.

On 10/4/18 at 11:00 AM, V27's employee file contained a termination letter to V27 signed by V37 Human Resources Director. This letter documents the specific reason for termination as "endangering the welfare of a resident by failing to follow standard protocol and for false

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S9999	Continued From page 11 documentation when questioned about the incident." This letter documents the terminated effective date as 9/25/18. B	S9999		