Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003420	A. BUILDING: _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHAB & HC	5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614

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S 000	Initial Comments Complaint Investigation 2420595/IL169023	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)1)2)3) 300.1630e) 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. 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	S9999		

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S9999	Continued From page 1 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. 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 300.1630 Administration of Medication e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a	S9999		

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physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report.

These requirements were not met as evidenced by:

These failures resulted in three deficient practice statements.

A. Based on interview and record review the facility failed to monitor laboratory tests results for a high-risk medication, Warfarin (anticoagulant) for one of two residents (R11) reviewed for anticoagulants in a sample of 42. This failure resulted in R11 being admitted to the hospital with a critical PT (Prothrombin level/normal 9.8-12.2 seconds) and INR (International Normalized Ratio/normal range 0.9-1.2 milligrams per deciliter).

B. Based on interview and record review the facility failed to provide medications and discontinue a medication as ordered for 4 of 4 residents (R4, R8, R12 and R13) reviewed for medication administration. This failure resulted in R4 experiencing ongoing, unrelieved pain from 01/13/24 through 01/23/24.

C. Based on observation, interview and record review, the facility failed to recognize a potential ongoing life-threatening double dosage of medication from 6/24/23 when a second, similar medication was added to a resident's daily medication regime, for one of seven residents (R5), reviewed for medications, in a sample of 42.

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Findings include:

The facility's Medication Administration policy, dated 11/18/17, documents, "Drug administration shall be defined as an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container, verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given."

The facility's Adverse Drug Reactions and Medication Discrepancy policy, dated 11/6/18, documents, "It is the policy of the facility adverse drug reactions and drug errors are to be reported to the resident's physician, documented in the nursing notes and documented in the Adverse Drug Reaction or Medication Discrepancy Report. These reports are to be completed in coordination with the Director of Nursing and filed with the Administrator and reviewed by the Medical Director and Consult Pharmacist." This policy also documents "A medication discrepancy/error has been made when one of the following occurs: Wrong medication administered. Wrong dose administered. Medication administered by wrong route. Medication administered to wrong resident. Medication administered at wrong time. Medication not administered. A medication discrepancy report shall be completed for any of the above occurrences."

A. R11 was admitted to the facility on 7/08/23 with

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S9999	Continued From page 4 a diagnosis of Atrial Fibrillation and with an order for Warfarin 5mg (milligrams) every evening, with no physician ordered PT/INR labs to be drawn. R11's MMR (medication monthly review) dated 7/31/23, 8/29/23 and 9/27/23, documents (R11) receives warfarin and the most recent INR documented in the medical record is 2.4mg/dl from 7/8/23, the date he was admitted to this facility. (R11) does not have orders stating when to draw the next PT/INR. This form documents the "Rationale for Recommendation: Warfarin has a BOXED WARNING describing the potential for major, sometimes fatal, bleeding. To avoid adverse consequences (e.g., bleeding, thrombosis), individuals should be closely and continually assessed both clinically and through appropriate INR monitoring." R11's first PT/INR, dated 10/4/23, documents an elevated PT of 25.6 seconds (normal range: 9.8-12.2 seconds) and elevated INR of 2.5 (normal range: 0.9-1.2mg/dl). R11's PT/INR dated 1/8/24, documents a high PT of 21.9 seconds and INR of 2.1mg/dl. R11's medical record has no documentation indicating R11's high PT/INR results were called to V17, (R11's Primary Care Physician). R11's Progress Notes, dated 1/18/24 at 6:45pm, documents R11 has had three episodes of a bleeding nose. R11's Progress Notes at 9:30pm, document, "R11's epistaxis episodes around 8:40pm, R11 was observed with chest covered with blood and a bloody towel in his hand. Blood was running out from R11's left nostril like a faucet. R11 reported he felt lightheaded. R11's blood pressure was 88/44 (diastolic/systolic), pulse was 72, respirations 18 and pulse oximetry was 99 percent. (V17) was notified and orders	S9999		

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S9999	Continued From page 5 were received to send R11 to the emergency room for labs and start intravenous fluids". R11's emergency room diagnosis, dated 1/18/24, include Hypotension Epistaxis, Acute Renal Failure, Supratherapeutic INR. R11's Hospital Problems list includes Hypovolemic Shock. On 1/18/24 R11's PT was 42.3 seconds (11.6-14.8 seconds) and INR was 4.5 mg/dl (Milligrams per deciliter). R11's hemoglobin was low at 8.8g/dl (grams per deciliter) R11's hospital notes document R11 received two units of red packed blood cells due to a diagnosis of hypovolemic shock. R11's Readmission Physician Orders, dated 1/25/24, documents Warfarin dose reduced to 5mg every evening due to elevated INR on date of admission as well as new drug interactions with antibiotics. Repeat INR in 3 days. On 2/20/24 at 11:00am, R11 stated his labs are not drawn on a regular basis. R11 stated on 12/18/23 he had a bloody nose for most of the day. He was told to hold pressure on it. R11 stated by evening, he was seeing double and lightheaded. R11 stated his blood pressure was very low. R11 stated he was sent to the emergency room and admitted to the intensive care unit. R11 also stated he received two units of blood while in the hospital. R11 verified he has not had any labs drawn since being readmitted to the facility. On 2/23/24 at 11:30am, R11 stated he still has not had any labs drawn. On 2/26/24 at 11:30am, R11 stated he had to go the emergency room on 2/25/24. R11 verified labs were drawn at that time. On 2/20/24 at 12:00pm, V17, R11's Primary Care Physician, verified anyone on Warfarin is to have	S9999		

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S9999	Continued From page 6 a PT/INR drawn monthly and every 3 days if on an antibiotic. V17 stated he was not notified of R11's PT/INR results on 1/8/24, when an elevated PT/INR results were obtained. V17 also stated he was not notified of R11's bloody nose until the evening he gave the orders for R11 to be sent to the emergency room. At 2/20/24 at 3:00pm V2, Director of Nursing, was unable to provide R11's INR results were to be drawn within the three days after readmission. V2 verified R11's INR was not drawn. On 2/21/24 at 11:00am, V2 stated the facility does not have any policy's concerning high risk medications. ---- B. 2. R4's Physician Order Sheet, dated February 2024, documents R4 has diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction, Pain and Neuropathy. This same order sheet documents R4 has an order to receive Pregabalin (Analgesic) 300 MG (Milligrams)two times daily for nerve pain. R4's Medication Administration Record (MAR), dated February 2024, documents R4 did not receive the ordered medication on 2/13/24 through 2/23/24. R4's Progress notes for February 2024 document that R4 was not given the twice daily doses of his scheduled medication due to "not available." 3. R8's Physician Order Sheet, dated December 2023 and January 2024, documents R8 has diagnoses of Traumatic Hemorrhage of Right Cerebellum, Traumatic Brain Injury and Pain. These same order sheets document R8 has an	S9999		

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S9999	Continued From page 7 order to receive Pregabalin (Analgesic) 300 MG (Milligrams)two times daily for nerve pain. R8's Medication Administration Records (MAR), dated December 2023 and January 2024, document R8 did not receive the ordered medication from 12/14/2023 through 01/03/2024. R8's Progress notes for December 2023 and January 2024 document R8 was not given the twice daily doses of his scheduled medication due to "not available." 4. R12's Physician Order Sheet, dated February 2024, documents R12 has diagnoses of Peripheral Vascular Disease, Diabetes Mellitus, Cerebral Infarction, Polyneuropathy. These same order sheets document R12 has an order to receive Pilocarpine (Cholinergic Agonist) 5 MG three times daily. R12's Medication Administration Records (MAR), dated February 2024, documents R12 did not receive the ordered medication on 2/13/2024, 2/14/2024 and 2/15/2024. R12's Progress notes for February 2024 document that R12 was not given the thrice daily doses of scheduled medication due to "not available." On 2/17/24 at 11:30 A.M., V2/Director of Nurses confirmed that facility staff should notify Pharmacy immediately if a medication was unavailable. 5. R13's Monthly Medication Review, dated 1/23/24, documents R13's medical record documents the following irregularities were noted on the medication administration record	S9999		

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S9999	Continued From page 8 (MAR)/prescriber order sheets (POS): 1/16/24 (R13) had Eliquis 2.5mg BID (twice daily) ordered but the pre-existing 5mg BID dose was not stopped. R13's MAR (Medication Administration Record), dated 1/16/24, documents to take Eliquis 5mg tablet twice daily and Eliquis 2.5mg twice daily. R13's MAR has each medication signed out as being given on 1/19/24 through 1/23/24. R13's MAR documents that R13's Eliquis 5mg was discontinued at 1:08pm. On 2/20/24 at 3:00pm, V2, Director of Nursing, stated that R13's Eliquis order was decreased due to a pharmacy recommendation, but the previous 5mg dose was not discontinued. V2 verified that R13 did receive the wrong dose of Eliquis for three and half days. --- C. R5's Physician Order Sheet, dated June 2023 includes the following medications: Calcium 600 MG (Milligrams) with Vitamin D 800 MG. Give 2 tablets orally one time a day for Supplement - Start Date 06/01/2023 and Oyster Shell Calcium 500 MG. Give 3 tablets orally one time a day for supplement -Start Date 06/24/2023. On 2/15/2024 at 9:18 A.M., V11/Licensed Practical Nurse prepared to administer medications for R5. After adding Calcium 600 MG with Vitamin D 800 MG two tablets and Oyster Shell Calcium 500 MG three tablets to the plastic medication cup, V11/LPN stated," I don't know why (R5) gets so much calcium. That's like a double or triple dose. V11/LPN then administrated R5's pills, with the Calcium and Oyster Shell	S9999		

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S9999	Continued From page 9 Calcium, to R5. On 2/20/24 at 12:30 P.M., V17/R5's Physician stated, "(The dosage of calcium) that (R5) receives can be toxic. (R5) should have never been given that much calcium." (A)	S9999		