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Z 000	COMMENTS Complaint Investigation: 2443679/IL172999	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) Section 300.610 Resident Care PoliciesSection 300.1210 General Requirements for Nursing and Personal Care 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. 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	Z9999		

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Z9999	Continued From page 1 following procedures: 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. This requirement was not MET: Findings include: A. Based on interview and record review the Facility failed to ensure blood thinner medication was not stopped abruptly for an extended period of time without being restarted for 1 of 3 residents (R2) reviewed for blood thinners in the sample of 6. This failure has the potential to cause a blood clot which could form in the veins and arteries and increase the risk of serious bleeding, stroke or even death. The Facility also failed to ensure urinary analysis were completed in a timely manner and treatment was given for 1 of 3 residents (R2) reviewed for treatment in the sample of six. Findings include: R2's Physician Order Sheet (POS) for May 2024 documents diagnoses of peripheral vascular disease, type 2 diabetes (6/19/2023), parkinson's disease, chronic atrial fibrillation, personal acute embolism, and thrombosis of unspecified deep veins of lower extremity, and presence of cardiac pacemaker, benign prostatic hyperplasia with lower urinary tract symptoms, and neuromuscular dysfunction of bladder.	Z9999		

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R2's Care Plan under Vulnerable Adults, Approach, "Administer medications as ordered. Resident needs assist with dressing, personal hygiene, and bathing due to cognitive impairment. He is noted with incontinent episodes as well and requires staff assistance with all ADL (activities of daily living).

On 5/16/2024 at 5:04 PM, V14, Family of R2 stated, "Back in December the facility was going through a change of physician and (V16) was the medical director. Now my husband (R2) has been on blood thinners for over 20 years. He was taking apixaban (blood thinner) and has been on it for over twenty years. Back in March I had to take (R2) to an appointment, and I had his orders in a packet and while I was waiting, I was going through everything, and I saw (R2) did not have any order for any blood thinner. I thought that was strange. Now remember we are in the beginning of April now and I do not see any order. I asked (V2) who was the new Director of Nursing at that time, and she said she looked into (R2's) blood thinner order, the order was discontinued on 1/10/2024 and the facility had a new Medical Director now. When I asked why the order was stopped, she said she was not here at that time so she could not tell me. I asked her if nobody cared that (R2) was supposed to be on blood thinners, and he was not on blood thinners, but again she said that was before she started working there. I immediately called (R2's) cardiologist and he was in shock, and he said he would call in an order immediately because my husband also has a pacemaker, and he didn't want him to throw a clot or have an embolism and it could be dangerous for him without taking a blood thinner."

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Z9999	Continued From page 3 On 5/17/2024 at 9:49 AM, V2, Director of Nursing stated, "I believe (R2) is on Eliquis (apixaban). I remember (V14) coming to me about her concern because (R2) was not on any blood thinners at that time and I went to the charge nurse and physician and told them my concern. I am not sure what happened as I was not here working at the time when the order was discontinued. I do not have any answers and I followed up with (V18) the cardiologist and (R2) is on Eliquis now and he put in an order for it in April." On 5/17/2024 at 10:03 AM, V1, Administrator stated, "(V14) came to us with concerns about his medications. (R2) had been in the hospital. (V14) was concerned because she wanted to know why he was not on all of his medications. I am not sure what the outcome was." On 5/17/2024 at 8:07 AM, V16, Former Medical Director stated, "If I remember correctly and it is hard because I do not have his records in front of me and I have not been at the facility for several months now. Normally, I only take someone off blood thinners if they are having bleeding issues. I vaguely remember something about him being hospitalized and something going on with him from his urologist, but I would have to see the records to know more. As far as when to stop and when to start back up the blood thinners it's hard to say. Normally, we would work together to ensure what is best for the patient. Again, I cannot say what would have happened or when he was supposed to go back on the medication without records. I am not even sure if I d/c (discontinued) (R2's) Eliquis medication." R2's Physician Order Sheet (POS) for January 2024 documents an order for Eliquis (apixaban) 5 mg (milligrams) by mouth open ended start date	Z9999		

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4/3/2024: special instructions give 1 tablet by mouth twice a day. Start date 6/19/2023-1/12/2024 (dc date).

R2's POS for January 2024 documents Eliquis (apixaban) 5 mg (milligrams) by mouth open ended with a start date 4/3/2024.

R2's Progress Notes 1/11/2024 to 1/31/2024 does not document anything related to why R2's blood thinner was discontinued or when it was to be restarted.

R2's Hospital Discharge Records dated 1/10/2024 documents an order for apixaban 5 milligrams, take 1 tablet (5mg total) by mouth 2 (two) times a day.

R2'S Medication Administration Records from 01/14/2024 to 4/3/2024 does not document R2 was taking any blood thinners.

On 5/17/2024 at 12:07 PM, V19, Pharmacist stated, "The original order I have for (R2) was for Eliquis with a start date on 6/19/2023. We have a d/c order dated 1/12/2024 but there are no notes or cut off dates. Usually when a resident is having a procedure, they will cut off the blood thinners one week before the procedure and then they will resume the blood thinners 24 hours after the procedure. If a resident is supposed to be on blood thinners and they do not take the blood thinners this puts them at risk for blood clots and stroke. I am not the medical doctor, so I am not sure if (R2) was or was not supposed to be on them from 1/12/2024 to 4/3/2024. The ordering doctor for 1/12/2024 and 4/3/2024 was (V16)."

On 5/17/2024 at 12:56 PM, V20, Licensed Practical Nurse (LPN) stated, "I remember (R2's)

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wife (V14) had asked me about the blood thinner medication, Eliquis and why (R2) was no longer on it. (V14) said she noticed on the pharmacy paper that (R2) was no longer on Eliquis and was asking me about it. I looked into (R2's) chart and it was true he was not on Eliquis. But, when I reviewed his POS, I saw the order had been discontinued. I talked with (V2) and (V21) our Nurse Practitioner. (R2) was off of the blood thinner for a few months. I believe (V16) left in January or February and we switched over to (V17). After talking with (V21) (R2) was put back on the blood thinner, and this was in April."

R2's Progress Notes dated 4/16/2024 at 12:52 PM, "Out with wife for cardio appointment."

R2's Progress Notes dated 4/16/2024 at 7:46 PM, Resident returned from cardiology appointment with (V18, cardiologist). New order to discontinue ASA 81 milligrams. Noted on after visit summary to continue Eliquis 2.5 mg BID (two times a day). Resident is currently on 5 mg PO BID. Fax sent to (V18's) Office clarify which dosage he wanted resident to take."

R2's Progress Notes dated 4/17/2024 at 3:00 PM, "Clarification received from (V18's) office regarding Eliquis: continue Eliquis 5 mg PO (by mouth) BID (two times a day)."

On 5/21/2024 at 1:42 PM, V29, Nurse Practitioner for V18, Cardiologist stated, "(R2) was on a blood thinner for A-fib, and he had history of embolism so there is always a potential that he could stroke out, or that he could form a blood clot that would go to the brain or cause a stroke and possible death. There is always a risk for stroke and that is why we are prescribing the blood thinner. Even with blood thinner (R2) is still at risk, that is why

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Z9999	Continued From page 6 we have prescribed the blood thinner." The Administration Medication policy dated 2020 documents, "To ensure safe administration of resident medication as indicated and ordered by the provider. To administer resident medications in a safe and accurate manner that will ensure the 6 rights of patient identification for administration. Medications are administered by licensed nurses or as otherwise delegated, trained associates. Medications are administered in accordance with the orders. Medications are administered within their prescribed time. The person preparing or administering the medication will contact the provider if there are questions or concerns regarding medication. With any irregularities, appropriate notifications will be completed for clarification. Check for allergies. Obtain vitals as ordered with medication administration prior to administering the medications. Check expiration dates prior to administering medications. Ensure multi-dose containers have the date opened identified on the container. Administer medications following the 6 Rights of medication administration." On 5/16/2024 at 5:04 PM, V14, Family of R2 stated, "My husband was having issues with urinary tract infections when he was admitted, and he was constantly battling them while he was in the facility. I was constantly trying to stay on top of them to make sure he was getting his needs met and they were getting the results back." R2's Progress note date 2/1/24 at 1:52 PM documents "Wife in building and inquired about a follow up to UA (urinary analysis) to ensure that infection has been cleared after recent hospitalization with IV (intravenous) antibiotics. New orders were received from (V16) for a repeat	Z9999		

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urinalysis."

R2's Progress note dated 2/06/24 at 4:27 AM, documents that Catheter specimen was obtained for urinalysis, culture, and sensitivity, (UA C&S) as ordered for follow-up urinalysis.

R2's Progress note dated 2/11/24 at 6:38 am documents that writer was cleaning out lab box and noted that lab did not pick up urinalysis on 2/6/24. Is now rescheduled for 2/13/24.

R2's Progress note date 2/13/24 at 2:42 am documents that urinalysis was obtained via straight catheter.

R2's Progress notes dated 2/17/24 at 2:25 PM, documents, "UA culture received positive for ESBL, e-coli. This nurse contacted PCP (primary care physician) and received orders to send resident to (Hospital) for IV ATB TX (intravenous antibiotic treatment.)

R2's Progress Notes dated 2/18/2024 at 1:58 AM, "Received a call from nurse at ER stating they are sending resident back on PO (by mouth) doxycycline. Discussed results of urine test we had, and she stated they did not receive this/ states resident is already discharged out of their systems but allowed me to fax the UA and C/S results to her to show the MD (medical doctor). Awaiting response."

R2's Progress Notes dated 2/18/2024 at 2:25 PM, "Started doxycycline today for ESBL in urine."

R2's Progress notes dated 3/20/24 at 11:22 PM documents that urinalysis was collected via straight cath.

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R2's Progress notes dated 3/21 at 2:08 PM that wife brought results of CT (computed tomography) abdomen and pelvis to the facility.

R2's Progress notes dated 3/25 at 3:09 PM reports that recent labs and urine culture were faxed to doctor's office.

R2's Lab collected dated 2/13/2024 documents, UA culture was positive for ESBL, and e-coli.

On 5/21/2024 at 9:13 AM, V26, Registered Nurse (RN), stated, "Normally when I know we are waiting for a culture, I will check the computer and if I do not see my results after one day then I would double check and make sure the lab picked everything up. We normally get results back within 24-48 hours."

On 5/21/2024 at 4:25 PM, V1, Administrator stated, "(R2's) specimen was collected and the order was followed. The lab is here every Tuesday to pick up routine labs. (R2's) specimen was collected and placed in the fridge for the lab to pick up. We have confirmed with the lab and their GPS tracking that they were on our campus picking up labs after the specimen was collected. We are not sure why (R2's) lab was not picked up that day. We are thinking maybe it was picked up but then lost. I am not sure."

On 5/21/2024 at 4:30 PM, V2, Director of Nursing stated, "If the nurse is waiting for a lab and they see no results I would expect staff to confirm that the lab was received and if the urine was left behind, I would expect them to notify the physician immediately. I am not sure what happened with (R2)."

The Specimen Collection Policy dated 2018

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Z9999	Continued From page 9 documents, "To provide guidelines for the collection of various specimens ordered by the provider. Correct collection and handling of culture specimens helps ensure more accurate and timely results and subsequent treatment. Results of specimen collection will be reported to prescribing provider as soon as they are made available to nursing associates. (B)	Z9999		