STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146015	A. BUILDING _____ B. WING _____	C 10/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE MANOR	**920 N SEMINARY AVE P O BOX 520 WOODSTOCK, IL 60098**

(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) COMPLETION DATE
F 309	Continued From page 7 staff on the revisions of the QA Audit tool "Daily Verification of physician Orders" by 10/05/10. (6) 10/06/10 posted a notice on Nurses board about when to notify physicians of significant changes in condition (7) 10/06/10 evaluated all nursing stations 24 hour nurses reports to evaluate if any residents had a significant change and if the physicians were notified as needed. (8) 10/06/10 posted direction for when to notify a residents physician with a significant change of condition on Nurses board and had nursing staff sign that they received this information. (9) 10/07/10 Administration met with facility Medical Director and discussed IJ and reviewed and revised facility policy and procedures for notifying physicians of significant changes in conditions. Facility also developed new 24 hour report and a QA tool to evaluate if physicians are being notified timely of changes in conditions. (10) 10/07/10 Nursing staff Inservices initiated regarding facilities revised policy and procedures for physician notification of significant changes in conditions. This inservicing is to be completed by 10/08/10. (11) Additional formal Nursing Inservices have been set up for the weeks of 10/11/10, 10/18/10 and 10/25/10 regarding medication errors, administration of medications and transcription of physician orders. The facility remains out of compliance at a level 2 due to the need for the facility to assure all the immediacy removal plan is implemented.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 8 300.1010h) 300.1210a) 300.1620a) 300.1630b) 300.3240a) 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 of notification Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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. 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	F9999		

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F9999	Continued From page 9 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 designated time. Section 300.1630 Administration of Medication b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility. 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 the following: Based on record review and Interviews the facility failed to: (1) verify/reconcile admission medication orders	F9999		

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F9999	Continued From page 10 with the attending physician prior to administering an anti-coagulant medication to R1 for four consecutive days. (2) notify the attending physician of a significant change in R1's condition (lethargy, decline in mental status and decreased ability to swallow), in a timely manner. (3) follow the facility protocol in performing a thorough "Nursing Quality Assurance Daily Order Verification Audit " on R1's 8/12/10 admission orders. These failures contributed to R1 being admitted to a local hospital for: - a sub-arachnoid brain hemorrhage and new bleed in the Ventricles of his brain. - an acute, newly diagnosed GI bleed that required hospitalization and medical intervention. R1's sustained a delay in timely medical evaluation and treatment. This applies to 1 of 6 residents with medication errors (R1). Findings include: R1 is an 86 year old resident that was admitted on 8/12/10 with diagnoses including CVA and Sub-dural bleed after a fall. R1 was hospitalized between 8/06 - 8/12/10 for a Sub-dural Hematoma after a fall at home. R1 required brain surgery by Z5 (Neuro-surgeon) during that hospitalization. On 8/06/10 R1 was evaluated by Z6 (Neurologist) at the hospital. Z6 documented on consult report to hold Coumadin. R1's 8/12/10 hospital transfer forms included an	F9999		

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F9999	Continued From page 11 order from Z1 (R1's medical doctor) to not administer Coumadin unless Z5 feels it is safe to re-start. R1's 8/06 - 8/12/10 hospital Medication Administration Record (MAR) does not include Coumadin as having been administered. These MAR's were provided to facility on 8/12/10 upon admission. R1's 8/12/10 admission Physician Order Sheet (POS) includes Coumadin 3mg daily to be administered. E3 (nurse) wrote this medication along with multiple other medications on R1's August 2010 POS and MAR. R1's 8/12/10 Medication Incident Report and the 9/29/10 interviews of E1 (Administrator) and E2 (DON) verify that E3 never called Z1 to verify R1's admission orders prior to transcribing them onto R1's MAR. R1's POS does not include a physician's signature or a telephone order from Z1 to administer the Coumadin or any medications. R1 was administered Coumadin 3mg daily at 9PM on 8/12, 8/13, 8/14 and 8/15/10. On 8/16/10 while notifying Z1 about R1's Urinary retention, the nurses asked if Z1 wanted any Coag profiles while R1 was on Coumadin. Z1 immediately gave an order to discontinue the Coumadin and documented that it was never to have been started. R1's medical records included: 8/12/10 Nursing note Patient alert but confused. No complaint of discomfort. 8/13/10 Occupational Therapy (OT) evaluation	F9999		

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F9999	Continued From page 12 includes that R1 is able to feed self, follows directions with assist, is pleasant and cooperative. 8/16/10 9AM nurses note: Pt more lethargic, remains confused ,awakened and up in wheelchair, very vague. Awoke with difficulty for dinner. 8/16/10 11AM nursing progress note of the first time Z1 was contacted about R1. This progress note includes the family wanted Valium stopped so R1 would be more awake. No documentation that Z1 was notified of any mental status changes or increased lethargy. 8/16/10 Speech therapy note that the nurse reported another change in mental status, unable to state his name, unable to follow one step directions or eat his meals independently. R1 coughing and choking on general diet. Diet downgraded to mechanical soft. 8/17/10 Speech therapy note that R1 is tired today, swallow evaluation done related to recent difficulty chewing. 8/17/10 Physical Therapy progress notes includes that R1 is very sleepy and required tactile clues at times. 8/17/10 Occupational progress note includes that R1 is tired today. R1's 8/12 - 8/18/10 Daily Medicare Nursing Documents do not include any neuro assessments or documentation of any mental status changes. 8/17/10 nurses notes do not include any assessment of any neuro status changes. 8/17/10 11:30PM nurse note includes "Small emesis light brown clear liquid." 8/18/10 12:15AM nurses note "Emesis moderate amount light brown clear liquid." 8/18/10 12:45AM nurses note "Emesis of small amount dark brown clear liquid."	F9999		

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F9999	Continued From page 13 8/18/10 2:00AM nurses note "Emesis large amount dark brown clear liquid Z1 called." 8/18/10 2:15AM nurses note Z8 (MD) notified of Emesis and orders received. 8/18/10 2:35AM nurses note R1 sent to hospital per ambulance. 8/18/10 7:30AM nurses note R1 admitted to ICU at hospital. R1's care plan included a problem "Potential for bleeding and bruising secondary to use of Coumadin," and one of the interventions listed was to administer the Coumadin as ordered by the physician. R1's 8/06/10 Consultation report by Z7 (Cardiologist) includes that R1 has no history of GI or GU bleeding. The Facility's only policy and procedure for notifying the physician of a significant change in condition or verifying and transcribing physician orders was in their "Resident Care Policies," stating under Charge Nurse responsibilities: "Communicate changes in physical or mental condition of resident to appropriate staff (Doctor, DON). Be responsible for transcribing, maintaining and following doctors orders." On 10/07/10 E1 documented on a fax to surveyor that he feels these issues need to be addressed under their own individual policies and that this is being addressed. During a 9/29/10 interview with E2 (DON), surveyor was told that facility was unaware of R1's Coumadin error until after he was sent to the hospital 8/18/10. E2 said that Z1 told the facility about it.	F9999		

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F9999	Continued From page 14 R1's medical record documents that facility was aware of R1's Coumadin error on 8/16/10 when Z1 ordered the Coumadin be discontinued and documented that it never should have been started. The Facility had no documentation that R1's family was notified of this medication error. E2 also told surveyor that since her May 2010 start date as the facility's DON, E2 initiated a new form "11-7 shift Nursing quality assurance daily order verification audit. Including POS and telephone orders." E2 said the the night shift nurse is supposed to check the orders from that day to make sure they were verified and transcribed appropriately. R1's record included one of these forms dated 8/13/10 with nurses initials that everything was Okay. During a 9/30/10 1:20PM telephone interview, Z1 stated that R1 was hospitalized on 8/18/10 with diagnosis to include a new small sub-arachnoid bleed, a small GI bleed, UTI and Pneumonia. Z1 also said that R1 was not supposed to receive Coumadin while at the facility. So R1's receipt of the Coumadin 8/12 - 8/15/10 was a medication error. The nurse failed to verify R1's admission orders with Z1. Z1 stated that he feels that R1's 8/18/10 diagnosed new Sub-arachnoid bleed and GI bleed could have possibly been due to the Coumadin administered 8/12 - 8/15/10. During a 10/06/10 3:00PM telephone interview with Z5, surveyor was told that R1 should not have been administered the Coumadin at the nursing home, this was definitely a medication error. R1's medical records clearly stated not to administer Coumadin to R1 at the Nursing Home. Coumadin is a blood thinner, it causes a high risk	F9999		

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F9999	Continued From page 15 of hemorrhage. R1 had recent brain surgery for a Sub-dural hemorrhage during his 8/6 - 8/12/10 hospitalization and it's standard not to administer anti-coagulants for at least a month after this type of surgery. I had spoke to the family prior to his admission to nursing home and explained that R1 would not be restarted on Coumadin for at least a month post-op. On 8/18/10 I did a CT scan on R1's brain and found a new sub-arachnoid bleed and blood in the Ventricles - definitely a new bleed from his prior hospitalization (8/6 - 8/12/10). This type of bleed can cause mental status changes and compromise the patient neurologically. Z5 also said that the delay in obtaining medical evaluation when R1 started having neurological changes (8/16 through 8/18/10 hospitalization) could have affected the progression of his physical decline. Z1 also said that on 8/18/10 R1's "INR," a bleeding time lab test was still slightly elevated, even after being off the Coumadin since the last dose on 8/15/10. Z1 concluded his interview by saying that "It is very clear to me that R1's new brain bleed, diagnosed 8/18/10, was directly correlated to the high does of Coumadin he was administered 8/12 - 8/15/10." (A)	F9999		