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
	IL6015648	A. BUILDING: ______ B. WING ______	C 10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF HAZEL CREST	**3701 WEST 183RD STREET HAZEL CREST, IL 60429**

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S 000	Initial Comments Complaint Investigation 1494550/IL72539 - 330.1110a), d),f), 330.1155 a), 330.1710 d),e), 330.4220 f), 330.4240a) Incident Investigation IRI of 9/28/2014/IL72457 - 330.1110 a),d),f), 330.1155 a), 330.1710 d),e), 330.4220 f), 330.4240a)	S 000		
S9999	Final Observations Statement of Licensure Violations 330.1110 a), d),f) 330.1155 a) 330.1710 d),e) 330.4220 f) 330.4240 a) Section 330.1110 Medical Care Policies a) The facility shall have a written program of medical services approved in writing by the advisory physician that reflects the philosophy of care provided, the policies relating to this and the procedures for implementation of the services. The program shall include the entire complex of services provided by the facility and the arrangements to effect transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility. d) All residents shall be seen by their physician as often as necessary to assure adequate health care. f) The facility shall notify the physician of any accident, injury, or unusual change in a resident's condition.	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1	S9999		

Section 330.1155 Unnecessary, Psychotropic, and Antipsychotic Drugs

a) A resident shall not be given unnecessary drugs in accordance with Section 330.Appendix E. In addition, an unnecessary drug is any drug used:

1) in an excessive dose, including in duplicative therapy;

2) for excessive duration;

3) without adequate monitoring;

4) without adequate indications for its use; or

5) in the presence of adverse consequences that indicate the drugs should be reduced or discontinued. (Section 2-106.1(a) of the Act)

Section 330.1710 Resident Record Requirements

d) All physician's orders and plans of treatment shall have the authentication of the physician. The use of a physician's rubber stamp signature, with or without initials, is not acceptable.

e) The record shall include medically defined conditions and prior medical history, medical status, physical and mental functional status, sensory and physical impairments, nutritional status and requirements, special treatments and procedures, mental and psychosocial status, discharge potential, rehabilitation potential, cognitive status and drug therapy.

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S9999	Continued From page 2 Section 330.4220 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 330.4240 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 are not met as evidenced by: Based on interviews and record review, the facility failed to follow their physician order policy by administering Lovenox without physician order and they failed to administer Coumadin as ordered. The facility failed to have a policy in place to direct the care of residents receiving anticoagulation medication, including assessment, monitoring, and physician notification. This failure resulted in R1 being hospitalized for renal insufficiency and critical level of PTT (prothrombin time) and high PT/INR (International Normzlized Ratio). Findings include: R1 ' s move-in record report indicated that R1 was admitted to the facility on 9/18/14 with diagnosis that includes but not limited to Hypertension, dementia, Psychosis and hypo-potassium. On 10/14/14, review of R1 ' s POS (Physician Order Sheet) and MAR (Medication Administration Record) documents medications order that includes but not limited to Coumadin	S9999		

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S9999	Continued From page 3 (Warfarin Sodium)5mg (milligram) by mouth every evening and Lovenox solution 80mg (milligram)/ 0.8ml (milliliter) with order to give 75mg every morning and subcutaneous. R1 ' s admission Medication Review Report dated 9/17/14 documented Coumadin 4mg. R1 ' s MAR documented that R1 was actually administered Coumadin 5mg from 9/21/14 to 9/27/14. There were no current physician order for lovenox solution 80mg/o.8ml with order to give 75mg daily and subcutaneously but according to R1 ' s MAR lovenox was administered from 9/21/14 to 9/27/14. This error resulted in R1 receiving unnecessary medication and overdose of Coumadin and being hospitalized on 9/28/14 for renal insufficiency and critical level of PTT (prothrombin time) and high PT/INR (International Normzlized Ratio). On 10/14/14 at 3:04pm, Z1 (Physician) stated in part that as a rule the facility nurses calls to verify residents medication orders at admission and " I normally just follow the order the resident comes with pending the time I come in to see the resident. " Z1 further stated " I assumed the nurse will call to me the right order and with (R1) the right order should be the one dated 9/17/14. (R1) was hospitalized because she was bleeding from the Coumadin and it caused Renal Failure. The PT and the INR level were too high. " Z1 further stated in part that although he came to assess (R1) ' s he did not go through (R1) ' s medication. On 10/14/14 at 4:25pm Z1 stated he was not aware of (R1) bruising and bleeding because this will indicate that R1 needs to be monitored and treated for possible overdose of Coumadin. E2 RSC (Resident Service Coordinator) who was present at the time also stated " I was not notified also of (R1) ' s bruising. " The facility could not provide any laboratory	S9999		

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S9999	Continued From page 4 coagulation report for the period of 9/18/14 to 9/28/14. On 10/14/14 at 12:12pm E2 (Resident Service Coordinator) stated " (Z1) wants Lab drawn (referring to Coagulation Laboratory Value) that includes PT and PTT (Partial Prothrombin Time) not including INR. E2 could not present any facility policy for anticoagulation therapy policy stating " I don ' t have any in my book (referring to the facility policy book). " On 10/14/14 at 1:50pm E2 presented a Clinical Services FYI (For Your Information) stating this is what was faxed from the cooperate office. This information paper indicated in part that " the standardized INR has become the accepted method of evaluating oral anticoagulation effectiveness. Excessive bruising or other signs and symptoms of bleeding are reported to the physician. If warfarin (Coumadin) dose has not yet been given, the dose is held until the physician can be notified of the resident ' s clinical condition and instructs that the dose is given. Monitor for and report to physician signs and symptoms of bleeding i.e. (that is) excessive bruising, red or tarry black stool. Protective measures are instituted to reduce the risk of excessive bruising according to the resident ' s condition. " This information was not followed. R1 ' s individual service notes dated 9/18/14 11am documented in part that R1 was admitted with no open area and no discoloration to the skin areas. On 9/27/14 9:00am and 7:45pm Both E3 and E4 (Care Givers) documented in part that (R1) was noted with red sores on both thighs with slightly bleeding and bruising, both E5 LPN (Licensed Practical Nurse) and E6 LPN were notified. On 10/14/14 at 3:04pm, Z1 (Physician) stated in part that as a rule the facility nurses calls to verify residents medication orders at admission and " I normally just follow the order the resident comes	S9999		

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S9999	Continued From page 5 with pending the time I come in to see the resident. " Z1 further stated " I assumed the nurse will call to me the right order and with (R1) the right order should be the one dated 9/17/14. (R1) was hospitalized because she was bleeding from the Coumadin and it caused Renal Failure. The PT and the INR level were too high. " Z1 acknowledged that although he came to assess (R1) ' s he did not go through (R1) ' s medication. On 10/14/14 at 4:25pm Z1 stated he was not aware of (R1) bruising and bleeding because this will indicate that R1 needs to be monitored and treated for possible overdose of Coumadin. E2 RSC (Resident Service Coordinator) who was present at the time also stated " I was not notified also of (R1) ' s bruising. " On 10/15/14 at 3:00pm, E5 acknowledged that he was made aware of (R1) condition stating " I assumed that the red sore and the bruises have been addressed with the physician. Yes I did not call the doctor because there is already a bandage on the sore. " R1 ' s individual service note dated 9/27/14 timed 7:47pm , E5 documented in part that R1 ' s sore was cleansed with normal saline and dressing change applied, no detailed assessment documented and no documentation that the physician was notified. The facility incident report titled State Report of Patient Incident (Illinois Only) indicated that " Coumadin and Lovenox dosage transcribed incorrectly on residents medication record, as a result (R1) received incorrect dosage for 7days which resulted in (R1) current hospitalization as of 9/28/14 with high level of PT and INR. " R1 ' s POS (Physician Order Sheet) does not have physician signature and there was no telephone order documentation presented. E2 and E7 (Director of Wellness Management) acknowledged that the POS should have been	S9999		

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S9999	Continued From page 6 signed and a telephone order made at the time the R1 of moved in. R1 ' s hospital record dated 9/28/14 documented in part that R1 was arrived at the hospital with the facility and the EMS (Emergency Medical Services) not able to obtained blood pressure. And R1 ' s Emergency Department Documentation documented coagulation laboratory report of PT level above 200.0 seconds, PTT (Prothrombin Time) Level of 158 seconds at critical level with normal level ranging from 12.0 to 14.3 seconds and INR level that is above 20.0 normal level ranges from 0.9 to 1.3. R1 ' s transfer order from a Long Term care documented that R1 ' s INR was 2.9 and the INR should be done 9/23/14. This order was not carried out. On 10/22/14 at12:20am, E2 stated in part that when (Z1) was asked if the Coumadin or the Lovenox should be continued (Z1) said no. E2 further stated (Z1) did not order for PT or INR to be drawn. On 10/22/14 at 12:12:48pm, Z1 stated "I did not remember whether I reviewed the medication order of this patient (R1)." When asked whether he ordered for INR for R1 since R1 is on Coumadin, Z1 stated " It was not ordered but it ' s unusual for me not to order INR, I can ' t remember specifically but it is my practice to order a INR on all patients who are admitted that are taking Coumadin. " The facility policy and procedure on Physician Order documented in part that "the licensed nurse is responsible for providing specific instructions and verifying the accuracy of the transcribed order. Changes or interim orders given verbally to either the registered nurse or licensed practical nurse by the physician via telephone and recorded on the Telephone Interim Order form. This procedure was not followed.	S9999		

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S9999	Continued From page 7	S9999		

The facility policy on Instruction for Completing Physician Order Forms under the title Physician's Move-in Orders with revised date 8/09 documented in part that Lab (Laboratory) Test should specify test to be done and it ' s frequency. The policy further documents that the licensed nurse receiving the order should follow the facility procedure after sending the orders by fax the pharmacy to "send the top white copy to the physician for review and signature. Order sent to the physician for review and signature must be returned within 7 (seven) days or per state regulation." This procedure was not followed. The facility Documentation policy and procedure with last revised date 8/09 documented that "when an instance is documented on 24 hour report sheet, follow up detailed documentation should in the resident's Individual in the resident information Book. The RSC (Resident Services Coordinator)/ RN (Registered Nurse)/ LPN (licensed Practical Nurse) will then follow up in the RIB (Resident Information Book) to ensure proper documentation was done and add any additional notes needed. Medication and treatment related situations/changes are documented following standard documentation procedure." This procedure was not followed.

(A)

Imposed Plan of Correction

PLAN OF CORRECTION

ARDEN COURTS OF HAZEL CREST

IL6015648

Survey completion date: 10-23-2014

Section 330.1110 Medical care policies

a- The facility shall have a written program of medical services approved in writing by the advisory physician that reflects the philosophy of care provided, the policies relating to this and the procedures for implementation of the services. The program shall include the entire complex of services provided by the facility and the arrangements to effect transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility.

Arden Courts Resident services manual includes policies and procedures related to medical care services.

d- All residents shall be seen by their physician as often as necessary to assure adequate health care

Physician will see residents as needed to assure adequate health care. Resident Service Coordinator or designee will notify resident's physician of all accidents, injuries and unusual changes and document such notification.

f-The facility shall notify the physician of any accident, injury or unusual change in a resident's condition

In-service conducted by Director of wellness Management **10-23-2014** related to physician order, move in process, documentation and incident reports. (See attachment-Program attendance record).

Executive Director or designee will in-service the nursing staff on Physician notification for unusual changes.

Completion Date: 11-23-2014