STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145609	A. BUILDING _____ B. WING _____	C 01/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE REHAB & CARE CENTER	**1308 GAME FARM ROAD YORKVILLE, IL 60560**

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F 000	INITIAL COMMENTS Complaint Investigation: 2170075/IL129954-F770G	F 000		
F 770 SS=G	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to perform physician ordered laboratory blood tests for monitoring of residents receiving a blood thinner. This affected 4 residents of 5 (R1, R3, R4, and R5) reviewed for management of prescribed blood thinners and resulted in R1 being admitted to the hospital for an acute epidual hematoma bleeding in the head requiring emergency treatment. According to the facility EMR (electronic medical record), R1 has lupus erythematosus, paralysis from the waist down, peripheral vascular disease, enlarged heart, migraine headache, and recent history of DVT (deep vein thrombosis). Deep vein thrombosis is also known as a blood clot. R1 is receiving warfarin (blood thinner) for the DVT. According to the facility EMR, a blood draw was ordered for R1 for 12/26/20 to check the PT/INR	F 770	IDPH-Survey Date: 1/13/21 F770 483.50(a)(1)(i) Laboratory Services This plan of correction also represents the facility□s allegations of compliance. The following plan of correction does not constitute an admission of any liability or wrongdoing by the facility. 483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i)If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. 1. R1, R3, R4, R5 record lab review completed for any discrepancies 2. The facility will identify other residents at risk to be affected of this deficient	1/28/21

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

Electronically Signed | 01/28/2021

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F 770	Continued From page 1 (Prothrombin time/international normative units - the effective level of warfarin, a blood thinner). The record revealed no lab results for 12/26/20. The laboratory technician was sent to the facility on 12/29/20. The lab technician was not able to draw the blood on R1 because R1 was admitted to the hospital on 12/27/20 and had not returned to the facility as of 12/29/20. The record shows at the hospital R1 was found to have an INR of 7.5. The laboratory reference range for warfarin INR is 0.8 to 3.5, depending on the therapeutic goal. The record from the hospital shows R1 was admitted with an acute epidual hematoma - bleeding in the head outside the brain and was given "Prothrombin complex concentrate" to stop the bleeding. A radiological scan done the following day showed there was no increase in the bleeding and no displacement of the brain. The same record shows that one reason for the hematoma would be the blood thinner. The hospital record continues to document on December 28, 2020, "hematoma, likely secondary to supratherapeutic INR." On 1/11/21 at 2:33pm, V5 (Registered Nurse - RN) stated the nurse receives the order for blood draw from the doctor and routinely uses 3 different methods to send that order to the lab (laboratory): through the EMR email system, telephone call, and by faxing a copy of the order. The laboratory service then sends a technician to draw the blood on the appointed day. V5 stated this didn't happen on 12/26/20. No technician arrived and no blood was drawn. V5 stated she keeps the log of INR blood draws. V5 stated the laboratory has been "getting worse" for 2 to 3	F 770	practice as all residents of the facility at the time of survey. A. All other residents had the potential to be affected by the alleged deficient practice. 3. Measures to assure identified issue is corrected and will not recur: A. On 1/18/21 alternative lab service secured B. On 1/26/21 all physician progress notes from 1/13/21 to current reviewed for lab orders and follow up. C. On 1/27/21 Nursing Admin in-service completed on running daily order report. D. On 1/27/21 & 1/28/21 licensed nursing staff in-serviced on Laboratory Reports and Physician Orders. 4. The measures and systems the facility will take to ensure the alleged deficient practice has been corrected and will not recur: A. DON/Designee with audit/monitor all lab orders/follow up 5x/week times 90 days. B. During morning QA meeting, daily findings will be discussed with nursing administration. C. DON/designee will continue to monitor through the internal Quality Assurance process. 5. Date of Completion: 1/28/21	

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F 770	Continued From page 2	F 770		

months and has been especially bad in the past month. V5 stated the nurses could draw the blood but the sample would still need to be picked up by the lab in a timely manner and the facility has no other options available.

On 1/11/21 at 3:10pm, V4 (Medical Doctor) stated R1 had a very high INR and there was a missing blood test. V4 stated if he had had the test result information on 12/26/20, he would have known and been able to stop the warfarin and administer medication to reverse the warfarin. V4 stated it is critical to have these tests in a timely way because warfarin needs to be monitored to protect the patient.

R3 has diagnoses of DVT of right lower leg and long-term use of anticoagulants as well as other diagnoses.

According to the lab report R3 had blood draw for INR on 12/23/20 and V4 ordered another draw in one week (12/30/20). The facility could produce no evidence that the ordered blood draw was done. No lab result report or reference to such report could be found for 12/30/20.

R4 has diagnoses including but not limited to difficulty walking, history of pulmonary embolism, and long-term use of anticoagulants.

The facility POS (Physician's Order Sheets) in the EMR for R4s shows an order for blood draw for INR to be done on 12/26/20. The facility provided the laboratory report showing the blood was drawn on 12/29/20, 3 days later than ordered.

R5 has diagnoses including right femur fracture, congestive heart failure, atrial fibrillation, and

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F 770	Continued From page 3	F 770		

long-term use of anticoagulants as well as other diagnoses.

The EMR for R5 shows a physician order for INR blood draw on 12/23/20 and the results provided show that was done. The physician ordered an INR to be drawn in one week (12/30/20) however, there is no record of that blood draw or test being done. The facility could provide no information. The next INR test shown in the record was for 1/6/21.

On 1/12/21 at 11:00am, V1 (Administrator) stated no blood test was done for R5.

On 1/7/21 at 2:00pm, V2 (Director of Nurses) stated the facility has obtained permission from the corporate office to contract with a new laboratory and we have set up a meeting with them to discuss it next week. We have not made other arrangements to get the blood tests done when the technician failed to arrive.

On 1/11/21 at 1:17pm, V7 (Registered Nurse) stated the lab has missed many blood draws. I talked with the DON and Administrator. V7 stated she has spent a lot of time talking to the lab on the phone trying to ensure the labs get done or to get results. V7 stated she talked with the DON about this just last week again.

On 1/11/21 at 5:22pm, V6 (Licensed Professional Nurse - LPN) stated the laboratory has been a problem. We "fax, call, and email and get verification" and they wouldn't show up. V6 stated when she was able to get through to their office, they would say they did the blood draw when they didn't. V6 stated this has been going on for more than a month. "All the Nurses are

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F 770	Continued From page 4 mad!" V6 related, one day the laboratory technician refused to do the blood draw because we had just cleaned up the resident (R4) and the room still smelled a little even after air freshener. And V6 stated, I have told the DON and the Administrator about this. They are trying to find a new Laboratory.	F 770		

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S 000	Initial Comments Complaint Investigation: 2170075/IL129954	S 000		
S9999	Final Observations Statement of licensure violation: 300.1210 b) 300.1210 d)2) 300.1620 c) 300.3220 f) 300.3240 a) 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. Restorative measures shall include, at a minimum, the 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: 2) All treatments and procedures shall be administered as ordered by the physician. 300.1620 Compliance with Licensed Prescriber's Orders c) Review of medication orders: The staff pharmacist or consultant pharmacist shall review the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical	S9999		

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S9999	Continued From page 1	S9999		

experience and judgment, and Section 300.Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be done at the facility and shall be documented in the clinical record. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon.

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. (A, B) (Section 2-107 of the Act)

This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to perform physician ordered laboratory blood tests for monitoring of residents receiving a blood thinner. This affected 4 residents of 5 (R1, R3, R4, and R5) reviewed for management of prescribed blood thinners and resulted in R1 being admitted to the hospital for an acute epidual hematoma bleeding in the head requiring emergency treatment.
According to the facility EMR (electronic medical record), R1 has lupus erythematosus, paralysis from the waist down, peripheral vascular disease, enlarged heart, migraine headache, and recent history of DVT (deep vein thrombosis). Deep vein thrombosis is also known as a blood clot.

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R1 is receiving warfarin (blood thinner) for the DVT.
According to the facility EMR, a blood draw was ordered for R1 for 12/26/20 to check the PT/INR (Prothrombin time/international normative units - the effective level of warfarin, a blood thinner). The record revealed no lab results for 12/26/20. The laboratory technician was sent to the facility on 12/29/20. The lab technician was not able to draw the blood on R1 because R1 was admitted to the hospital on 12/27/20 and had not returned to the facility as of 12/29/20.

The record shows at the hospital R1 was found to have an INR of 7.5. The laboratory reference range for warfarin INR is 0.8 to 3.5, depending on the therapeutic goal.
The record from the hospital shows R1 was admitted with an acute epidual hematoma - bleeding in the head outside the brain and was given "Prothrombin complex concentrate" to stop the bleeding. A radiological scan done the following day showed there was no increase in the bleeding and no displacement of the brain. The same record shows that one reason for the hematoma would be the blood thinner. The hospital record continues to document on December 28, 2020, "hematoma, likely secondary to supratherapeutic INR."
On 1/11/21 at 2:33pm, V5 (Registered Nurse - RN) stated the nurse receives the order for blood draw from the doctor and routinely uses 3 different methods to send that order to the lab (laboratory): through the EMR email system, telephone call, and by faxing a copy of the order. The laboratory service then sends a technician to draw the blood on the appointed day. V5 stated this didn't happen on 12/26/20. No technician arrived and no blood was drawn. V5 stated she keeps the log of INR blood draws. V5 stated the

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laboratory has been "getting worse" for 2 to 3 months and has been especially bad in the past month. V5 stated the nurses could draw the blood but the sample would still need to be picked up by the lab in a timely manner and the facility has no other options available.
On 1/11/21 at 3:10pm, V4 (Medical Doctor) stated R1 had a very high INR and there was a missing blood test. V4 stated if he had had the test result information on 12/26/20, he would have known and been able to stop the warfarin and administer medication to reverse the warfarin. V4 stated it is critical to have these tests in a timely way because warfarin needs to be monitored to protect the patient.
R3 has diagnoses of DVT of right lower leg and long-term use of anticoagulants as well as other diagnoses.
According to the lab report R3 had blood draw for INR on 12/23/20 and V4 ordered another draw in one week (12/30/20). The facility could produce no evidence that the ordered blood draw was done. No lab result report or reference to such report could be found for 12/30/20.
R4 has diagnoses including but not limited to difficulty walking, history of pulmonary embolism, and long-term use of anticoagulants.
The facility POS (Physician's Order Sheets) in the EMR for R4s shows an order for blood draw for INR to be done on 12/26/20. The facility provided the laboratory report showing the blood was drawn on 12/29/20, 3 days later than ordered.
R5 has diagnoses including right femur fracture, congestive heart failure, atrial fibrillation, and long-term use of anticoagulants as well as other diagnoses.
The EMR for R5 shows a physician order for INR blood draw on 12/23/20 and the results provided show that was done. The physician ordered an INR to be drawn in one week (12/30/20) however,

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there is no record of that blood draw or test being done. The facility could provide no information. The next INR test shown in the record was for 1/6/21.

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On 1/7/21 at 2:00pm, V2 (Director of Nurses) stated the facility has obtained permission from the corporate office to contract with a new laboratory and we have set up a meeting with them to discuss it next week. We have not made other arrangements to get the blood tests done when the technician failed to arrive.
On 1/11/21 at 1:17pm, V7 (Registered Nurse) stated the lab has missed many blood draws. I talked with the DON and Administrator. V7 stated she has spent a lot of time talking to the lab on the phone trying to ensure the labs get done or to get results. V7 stated she talked with the DON about this just last week again.
On 1/11/21 at 5:22pm, V6 (Licensed Professional Nurse - LPN) stated the laboratory has been a problem. We "fax, call, and email and get verification" and they wouldn't show up. V6 stated when she was able to get through to their office, they would say they did the blood draw when they didn't. V6 stated this has been going on for more than a month. "All the Nurses are mad!" V6 related, one day the laboratory technician refused to do the blood draw because we had just cleaned up the resident (R4) and the room still smelled a little even after air freshener. And V6 stated, I have told the DON and the Administrator about this. They are trying to find a new Laboratory.

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