STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145703	A. BUILDING _____ B. WING _____	C 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI RESTORATIVE CARE	**1455 HOSPITAL ROAD SILVIS, IL 61282**

(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 000	INITIAL COMMENTS Incident Report Investigation for Incident of 3-21-16/IL84690	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

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

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the physician of a significant change in condition for one of seven residents (R1) reviewed for a change in condition in a sample of seven. This failure resulted in R1 having continued bloody bowels movements and expiring four days later from a Gastro-intestinal bleed due to Warfarin toxicity. Findings include: R1's "Progress Notes", dated 3/22/2016, at 3:10 a.m., documents: Patient had at least two large bloody stools on second shift; [R1] then had three bloody stools on third shift; [R1] was pale, cool to the touch, altered level of consciousness, delayed responses; [R1] began throwing up bright red blood; and [R1] was sent to the local hospital-emergency room. R1's "Event Debriefing Tool", dated 3/22/2016, documents, "Delay of care. [R1] started having coffee ground stools, pale, and weakness during first shift on 3/21/2016. On second shift, [R1] had one large coffee ground stool. E3 (Licensed Practical Nurse) went right to the E2 (night nursing supervisor) and gave E2 this information. E2 stated, the labs from earlier were ok, Z2 (Medical Doctor) will see R1 tomorrow. E3 stated that R1 had another coffee ground stool at the end of E3's shift, and E3 relayed all of the information to the third shift nurse. The nurses did not contact the doctor about any issues." R1's "Physician's Progress Note", from the local hospital, dated 3/23/2016, documents: R1's INR to critically high at 7.7 (INR was drawn in the	F 157		

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F 157	Continued From page 2 emergency room 3/22/2016) and [R1] "was admitted for GI [Gastro-intestinal] bleed. After discussing with the family, it was decided to make [R1] comfort care." R1's "Admission Record", dated 3/25/2016, documents, R1 was readmitted to the long-term care facility on 3/24/2016. R1's "New Admit Report", not dated, documents R1's admitting diagnosis [on 3/24/2016] includes: Comfort care only, lower GI bleed, and Warfarin toxicity. R1's "Death Record", dated 3/26/2016, documents R1 expired 3/26/2016, at 8:15 a.m. On 4/12/2016, at 12:10 p.m., E1 (Director of Nursing) confirmed: on 3/21/2016, R1 started having bloody bowel movements on day shift and at that time Z2 was notified and ordered some lab work; Z2 was not notified of any bloody stools that occurred on evening or night shifts and in the early morning hours of 3/22/2016, R1 was sent to the local hospital where R1 was admitted with a GI bleed and Warfarin toxicity. ON 4-13-16 at 3:35 PM, Z2/Medical Director stated that the facility did not contact him regarding R1 ' s continued bloody stools and that he would have expected the facility to do that. He also said they made a mistake and someone was fired.	F 157		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		

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F 329	Continued From page 3 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to monitor Prothrombin/International Normalized Ratio (PT/INR) laboratory blood work for one resident (R1) of seven residents who were taking the medicationWarfarin in a sample of seven residents. This failure resulted in R1 expiring from a Gastro-intestinal bleed secondary to Coumadin (Warfarin) toxicity. Findings include: R1's online medical record documents R1 was admitted, to the long-term care facility, on 3/12/2016, with the diagnosis of sepsis, type 2 diabetes, atrial fibrillation, and entercolitis due to	F 329		

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F 329	Continued From page 4	F 329		

Clostridium Difficile. R1's Physician's Orders, dated 3/11/2016, document R1 was to have: 1) "Stat INR every day"; and 2) "Warfarin 3 milligrams (mg) daily-check INR before giving Warfarin".

On 3/15/2016, a "Consultation Report", from Z1 (Registered Pharmacist), documents "upcoming labs have not been scheduled". Z1 left a note, on the "Consultation Report", for Z2 (Medical Doctor) stating, "[Z2], No INR's scheduled? When do you want this checked?"

R1's "Medication Administration Record" documents, R1 received daily Warfarin medication from 3/12/2016 up to and including 3/21/2016.

R1's "Progress Notes", dated 3/22/2016, at 3:10 a.m., documents: Patient had at least two large bloody stools on second shift; [R1] then had three bloody stools on third shift; [R1] was pale, cool to the touch, altered level of consciousness, delayed responses; [R1] began throwing up bright red blood; and [R1] was sent to the local hospital-emergency room.

Local hospital's "Final Report-History and Physical," dated 3/22/16 and dictated by Z3/Physician, states, "Gastro-intestinal bleed secondary to coumadin toxicity" that required close monitoring in the intensive care.

R1's "Physician's Progress Note", from the local hospital, dated 3/23/2016, documents: R1's INR to critically high at 7.7 (INR was drawn in the emergency room 3/22/2016) and [R1] "was admitted for GI [Gastro-intestinal] bleed. After discussing with the family, it was decided to make

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F 329	Continued From page 5 [R1] comfort care." R1's "Admission Record", dated 3/25/2016, documents, R1 was readmitted to the long-term care facility on 3/24/2016. R1's "New Admit Report", not dated, documents R1's admitting diagnosis [on 3/24/2016] includes: Comfort care only, lower GI bleed, and Warfarin toxicity. R1's "Death Record", dated 3/26/2016, documents R1 expired 3/26/2016, at 8:15 a.m. On 4/12/2016, at 12:10 p.m., E1 (Director of Nursing) confirmed: R1 was admitted 3/12/2016 with daily INR orders; R1's INR orders were not processed, thus R1 did not have daily INR blood work done; R1's pharmacy consultation report [dated 3/15/2016] was misplaced; R1 continued to receive Warfarin; on 3/21/2016, R1 started having bloody bowel movements; and in the early morning hours of 3/22/2016, R1 was sent to the local hospital where R1 was admitted with a GI bleed and Warfarin toxicity.	F 329		