STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000129	A. BUILDING: _____ B. WING _____	C 10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE FIRESIDE HEALTH CENTER	3650 NORTH ALPINE ROAD ROCKFORD, IL 61114

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S 000	Initial Comments Complaint Investigation 1816688/IL106483	S 000		
S9999	Final Observations Statement of Licensure Violations 330.1110a) 330.4220f) 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. 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 issues to assure facility compliance with such orders. (Section 2-104(b) of the Act) These requirements were not met as evidenced by:	S9999	**Attachment A** **Statement of Licensure Violations**	

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Based on interview and record review the facility failed to follow physician's orders by not ensuring laboratory testing for determining blood clotting time was performed. This failure resulted in R1 going to the hospital with a critically high blood clotting time which resulted in a subdural hematoma (bleeding on the brain).

This applies to 1 of 3 residents (R1) reviewed for medications in the sample of 5.

The findings include:

R1's electronic medical record lists diagnoses to include: cerebral infarction, atrial fibrillation, chronic kidney disease, and dementia.

The facility's coumadin (blood thinner) log for R1 lists:
1. Date: July 5, 2018; PT/INR (Prothrombin/International Ratio - blood clotting time): 39.1/3.9; Current dose (blood thinners): 2.5 milligrams (mg); New dose: hold for 7/5 & 7/6 start 2 mg on 7/7; Next PT/INR lab draw: 7/12/2018

2. Date: July 12, 2018; PT/INR: 24.4/2.2; Current dose: 2 mg; New Dose: same; Next PT/INR lab draw: 7/19/2018

3. Date: July 19, 2018; PT/INR: 14.8/1.1; Current Dose: 2 mg; New Dose: 4 mg on 7/19 & 7/20 then 3 mg daily; Next PT/INR lab draw: 7/23/2018.

There was not another PT/INR lab draw listed on the log for R1.

On October 16, 2018, V2 (Director of Nursing) stated the July 23, 2018 PT/INR lab draw for R1 was missed. R1 never had another PT/INR done.

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S9999	Continued From page 2	S9999		

"The nurse processed the order but failed to do a laboratory requisition. There is a new protocol in place (because R1's PT/INR was missed)." R1 was discharged from the facility to a local hospital on September 5, 2018 without a PT/INR being done again since July 19, 2018.

The medication administration records (MAR) for R1 dated July 2018 shows R1 was given coumadin 2 mg on July 19 & 20th, 2018 (the physician order was to give 4 mg on 7/19 & 7/20, not 2 mg). On July 21, 2018, R1 was given 4 mg of coumadin. The rest of the month of July 2018, R1 was given 3 mg of coumadin per day. The MARs for August and September 2018 shows R1 received 3 mg of coumadin every day, once a day.

The nursing notes for R1 dated September 4, 2018 shows "Resident had yellow emesis in dining room this AM. Denies nausea at this time. Has been c/o neck pain since yesterday..."

The nursing notes for R1 dated September 5, 2018 shows "This nurse notified by NP (nurse practitioner) V6 that she lowered resident to floor at 0900. Upon nurse's and NP's assessment, resident lying on back on floor in room next to bed. No injuries noted. ROM WNL (Range of motion within normal limits). She c/o (complained of) bilateral knee pain upon ROM which is her baseline. Resident assisted to wheelchair. Neuro checks initiated due to unsure if resident bumped head prior to self transfer to bed. Resident was in the middle of self transferring to bed from wheelchair when her feet got stuck in wheelchair. NP heard resident yelling and lowered resident to the floor. BP (blood pressure) high upon first vitals 160/62, but decreased to 100/52 upon second set. Final BP 112/76. Daughter, notified

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of fall at approximately 1100 when in facility. Will continue to monitor."

The next nursing note for R1 with the same date of September 5, 2018 shows "Upon notifying resident's daughter, of fall, she stated, 'I'm going home to shower because I just got done with a 36 hour shift. Then I am coming back and taking my mom to the hospital. Something is wrong with her. She does not even recognize who I am or her grandson." This nurse explained to resident's daughter that the primary physician will be in the facility early afternoon and can assess her. Resident's daughter refused. NP notified. This nurse called residents daughter after she left and explained to her once more that primary physician can assess resident and that if she takes resident herself, she will be waiting in the ER (emergency room) for awhile until she is seen. Resident's daughter stated, 'Don't worry about that. I am taking her to the hospital when I get back.'"

The next nursing note for R1 with the same date of September 5, 2018 shows "This nurse notified at 1115 that CNA (Certified Nursing Assistant) lowered resident to floor onto back. (This is the second fall on the same day) Resident was attempting to self transfer and got feet stuck in wheelchair. CNA witnessed resident and lowered her to the floor for safety. ROM WNL. She c/o bilateral knee pain which is her baseline. NP in room assessing resident when this nurse was notified. Vital signs taken: T (temperature) 97.9 F (Fahrenheit), P (pulse): 54, R (respirations): 16, BP: 115/48; O2: 93% (oxygen saturation) saturation on room air. NP notified daughter and spoke with her about taking resident to the hospital. Daughter stated she, 'Is taking care of it.' Daughter called ambulance and resident was

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S9999	Continued From page 4 transported to local hospital at 1230." On September 6, 2018 the nursing notes for R1 show "call placed to local hospital regarding resident's status. report was that resident was admitted to ICU (intensive care unit) with high INR 7.4 (critical number/level) and with subdural hematoma." On September 17, 2018 at 1:50 PM, V5 (R1's daughter) stated, "She was in the wheelchair in the middle of the room. She had food all over her and her food was in her room. She was just sitting there. I asked her what's going on? She couldn't answer me. I knew something was wrong. She was so out of it. She was not herself." The local hospital's cat scan of the head for R1 dated September 5, 2018 shows, "Findings: The skull is intact. Subdural blood surrounds the cerebellum bilaterally and is seen along bilateral tentorium cerebelli. The subdural collection is widest to the left of midline posteriorly up to 18 mm (millimeter) diameter. There are rounded areas of diminished attenuation within this subdural collection with blood fluid levels, etiology uncertain." The local hospital's laboratory results for R1 dated September 5, 2018 shows, "Protime: 72.3 and INR: 7.4." Per local hospital therapeutic range for INR: usual 2.0-3.0; intense: 2.5-3.5. The local hospital's emergency room assessment/plan for R1 dated September 5, 2018 shows "bleed/posterior brain subdural hematomas/with signs of impending brain herniation? spontaneous hemorrhage or from falls/anticoagulation? any tumor- INR high..."	S9999		

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S9999	Continued From page 5 The local hospital's physician discharge summary for R1 dated September 5, 2018 shows, "Hospital Course: Posterior Fossa SDH (subdural hematoma) due to supra therapeutic INR (high INR)." On October 18, 2018, at 2:25 PM V6 (Nurse Practitioner) stated the goal of the INR depends on the reason a person is on the medication. "Therapeutic range is 2-3 and people with valves (heart valves) is 3.5. Some people go to 4." V6 stated, "You check the INR depending on the goal that you are trying to reach. Sometimes every week, sometimes every 2 weeks, and sometimes people are stable for several weeks. Normally if INR is off and make a change then you recheck in 1 week. The contraindication to coumadin is bleeding." The facility's routine medication therapy: warfarin (coumadin) policy (no date) shows, "c. The recommendation includes: Obtain monthly serum prothrombin time and INR, unless physician orders differently. Dosage adjustments may indicate the need for more frequent testing until stabilized. Contact physician with results, whether normal or abnormal. Document and process order received in the electronic medical record." (A)	S9999		