STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009989	A. BUILDING: _____ B. WING _____	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON LIVING AND REHABILITATION CENT	811 SOUTH 10TH STREET OREGON, IL 61061

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S 000	Initial Comments Annual Licensure and Certification Survey Complaint #1916643/ IL115592	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 licensure findings: 300.610a) 300.1210a) 300.1210b)4)5) 300.1210d)3)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 1	S9999		

resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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	IL6009989	A. BUILDING _____ B. WING _____	09/12/2019

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S9999	Continued From page 2	S9999		

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These Regulations were not met as evidence by:

Based on observation, interview, and record review the facility failed to ensure the safety of a resident during personal care for 2 residents (R34, R27) dependent on staff for care. The facility failed to supervise residents with a history

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S9999	Continued From page 3	S9999		

of falls for 2 residents (R39, R16) in the sample of 20.

This failure resulted in R34 sustaining a traumatic fracture of her left arm, significant bruising to her neck, and significant bruising and swelling to her left arm. This failure also resulted in R39 sustaining a fracture of her left hip.

The findings include:

1. On September 10, 2019 at 9:04 AM, R34 was in her room with the lights low and was laying in her bed with her eyes closed. On September 10, 2019 at 3:39 PM, R34 had deep purple bruising around her upper left arm which wrapped completely around her arm. R34's arm was swollen from the shoulder down to her elbow. The back of R34's neck had vibrant red and purple bruising. As nursing staff was gently attempting to move the hospital gown down from R34's shoulder she winced and yelled out.

On September 10, 2019 at 3:09 PM, V17 (R34's daughter) said a nurse from the facility contacted her on Sunday (9/8/19) at about 8:30 PM and told her R34's left arm had excessive bruising and swelling. V17 said she was told that the nurse practitioner was notified and they had an order for a mobile xray company to come and do xrays in the facility. V17 said she could not go to bed that night until she went to the facility and saw her mother because she was so worried. V17 said when she saw her mother's arm it was totally bruised and somewhat misshapen. V17 said the nurse told her that she thought [R34's] arm was broken. V17 said she told the nurse that she wanted her mother sent to the emergency room for evaluation. V17 said R34 does not have mobility in her arms or her legs and is a total lift

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S9999	Continued From page 4	S9999		

for transfers. V17 said her mother cannot move herself about in bed because she had failed hip replacements which had to be removed which left her immobile.

R34's nursing progress note entered on September 8, 2019 at 8:05 PM by V20 RN (Registered Nurse) showed, "With HS (bedtime) care CNAs (Certified Nursing Assistants) brought to my attention a bruise encircling resident's left upper arm. Swollen. Area marked. Painful with movement... X-rays ordered... POA (Power of Attorney) notified..." Another nursing progress note was entered by V20 at 8:56 PM which showed, "Resident's daughter here, wants resident sent to [hospital] for evaluation..."

R34's progress note titled, Hospice Aide Visit Note, dated September 10, 2019 showed, "Left shoulder from elbow to the front up to chest to behind patient's neck is deep dark purple."

R34's acute care hospital Emergency Department Provider note dated September 8, 2019 at 10:33 PM showed "Shoulder Trauma.... Primary Complaint Shoulder Trauma L (left) shoulder....patient is a (mechanical) lift and is otherwise bedbound, staff are unaware of any recent falls... is transferred using a (mechanical) lift, does not walk, in fact has no hip joints..." R34's imaging results from the acute care hospital dated September 9, 2019 showed R34 had a comminuted proximal humeral fracture (a break in the upper arm bone in two places).

R34's MDS (Minimum Data Set) dated July 29, 2019 showed R34 is dependent upon the assistance of two staff members for bed mobility and dressing and requires the use of a mechanical lift and the assistance of two staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009989	A. BUILDING: _____ B. WING _____	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 5	S9999		

members for transfers. R34's care plan initiated on March 21, 2016 showed R34 is dependent upon two staff for bed mobility and dressing. R34's nursing progress note dated July 29, 2019 showed, "...Total dependence with 2 assist in transfers with the use of (mechanical) lift and a purple sling. Does not assist in dressing any longer, required extensive 2 assist. Bed mobility is an extensive 2 assist..."

On September 12, 2019 at 3:05PM, V19 CNA (Certified Nursing Assistant) said she did morning cares for R34 on the morning of September 8, 2019 by herself including washing her up and dressing her. V19 said when they were trying to get R34 ready for bed on Sunday night (September 8, 2019) they had a terrible time getting her shirt off. V19 said they had to take it off "the good arm" and then try to get it off of "the bad arm" because she was in pain.

On September 12, 2019 at 2:55PM, V22 Corporate Administrator said she did the investigation of R34's fracture. V22 said V19 washed up and dressed R34 by herself on the morning of Sunday, August 8, 2019.

The facility's investigation into the September 8, 2019 incident involving R34 and completed on September 11, 2019 showed it was determined that V19 had provided cares by herself on Sunday, August 8, 2019. The facility's investigation conclusion showed, "The fracture most likely occurred during the process of am (morning) care on 9/8/19 in the simple act of putting on her t-shirt and moving the contracted shoulders to do so.... The CNA who provided care during that time was interviewed and investigated..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009989	A. BUILDING: _____ B. WING _____	09/12/2019

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S9999	Continued From page 6	S9999		

On September 11, 2019 at 10:35 AM, V16 RN (Hospice Registered Nurse) said she sees R34 on a weekly basis and had last seen her on the previous Tuesday after Labor Day, September 3, 2019. V16 said R34 does not typically complain of pain but when she came in on Monday, September 9, 2019, she was clearly in pain. V16 said they are making adjustments to her pain medication schedule to try and give her some relief. V16 said they were discussing discharging R34 from hospice because she had not shown any decline in her condition for the previous two months. V16 said we will likely see a decline now due to the fracture.

On September 11, 2019 at 2:11 PM, V23 CNA said she took care of R34 on September 8, 2019 and September 9, 2019. V23 said R34 was her usual self on September 8 but on September 9, 2019 she was complaining of pain. V23 said when she went into R34's room on the morning of Sunday, September 9, R34 was already cleaned up and dressed. V23 said she and V15 CNA started to use the mechanical lift to get R34 out of bed she started yelling "Ouch". V23 said throughout the day on September 9, R34 continued to say "ouch" and yell loudly when they were providing cares. V23 said it was unusual for her to yell out. V23 said R34 kept her left arm stiff and by her side on September 8 and at one point she had to pick it up and move it for her. V23 said R34 probably yelled out when she did that but she does not remember.

On September 12, 2019 at 9:41 AM, V20 RN said the CNAs called her to R34's room on Sunday (September 8) to look at R34's arm. V20 said when she saw R34's arm she was dumbfounded. V20 said her left arm was swollen and bruised and had an indention on the outside of her arm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009989	A. BUILDING: _____ B. WING _____	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 7	S9999		

V20 said, "I am furious because somebody knows what happened."

On September 12, 2019 at 10:20 AM, V18 Orthopedic Surgeon said he reviewed R34's xrays at the request of R34's family. V18 said in regards to R34's xrays the fracture was caused by some sort of trauma. V18 said the bruising around the back of R34's neck would not typically be caused by a fractured humerus (shoulder).

R34's physician order sheet was reviewed for September 2019 and showed a new order on September 11, 2019 for R34 to have pain medication every hour as needed for pain in addition to her other scheduled pain medications.

2. On September 10, 2019 at 9:41 AM, R39 was in her room laying in bed with her eyes closed. On September 10, 2019 at 12:45 PM, R39 was in a reclining wheelchair and being pushed out of the dining room by a staff member. R39 had her head tilted back and her eyes closed.

On September 10, 2019 at 12:45 PM, R39's daughter said this is not a good time to talk because her mother is not doing well and they are going to admit her to hospice services today.

R39's face sheet showed R39 was readmitted to the facility on September 1, 2019 with diagnoses to include bipolar disorder, major depressive disorder, osteoarthritis, anxiety disorder, and a new dianognosis of left femur fracture.

R39's nursing progress note dated August 29, 2019 at 2:50 PM showed R39 had an unwitnessed fall in her room and was experiencing left hip pain. The same note showed the physician was notified and ordered a mobile

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON LIVING AND REHABILITATION CENT	811 SOUTH 10TH STREET OREGON, IL 61061

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S9999	Continued From page 8	S9999		

xray of the left hip. A nursing progress note entered by V24 at 9:42 PM showed R39 was being sent to an acute care hospital for a minimally displaced fracture through the femoral neck (broken hip).

The facility provided incident reports for R39's documented falls since February 2019 which showed R39 to have 12 unwitnessed falls between February and August 2019 and 1 witnessed fall. The February 8, 2019 incident showed R39 was found on the floor in her room. The April 11, 2019 incident showed R39 was found on the floor between the heating unit and bed. The April 16, 2019 incident showed a CNA (Certified Nursing Assistant) witnessed R39 kneeling on the floor of her room. The April 19, 2019 incident showed R39 was found laying on the floor between the bed and the heater. The April 20, 2019 incidents showed R39 was found on the floor outside of her bathroom in her room at 12:15 PM and was found on the floor in front of the doorway to her room at 9:03 PM. The April 26, 2019 incident showed R39 was found again between her bed and the heating unit. The May 11, 2019 incident showed R39 was found laying on her bathroom floor. The May 12, 2019 incident showed R39 was found on her bathroom floor. The May 16, 2019 incident showed R39 was found laying on the dining room floor. The June 11, 2019 incident showed R39 was found on the floor at the foot of her bed. The June 26, 2019 incident showed R39 was found on the floor by her bathroom in her room. The August 28, 2019 incident showed R39 was found on the floor of her room.

R39's nursing progress note dated April 18, 2019 at 10:25 PM showed R39 was found in her room laying on the floor. There was no incident report

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	IL6009989	A. BUILDING: _____ B. WING _____	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 9	S9999		

for this fall.

R39's nursing progress note dated August 2, 2019 at 11:11AM showed, "[R39] is up ad lib (as she chooses) with wheeled walker and requires supervision to limited assistance for activities of daily living."

R39's care plan for falls which was initiated on February 29, 2016 showed R39 was at risk for falls due to diagnosis of dementia, osteoarthritis, and tremors. The care plan showed no intervention added to include increased supervision at any time.

R39's physical therapy discharge summary dated March 27, 2019 showed R39 required multiple verbal cues for safety when moving from sitting to standing and R39 forgot her walker at times. R39's physical therapy discharge summary dated June 14 2019 showed discharge recommendations to include standby assistance in her room. The same June 14, 2019 discharge summary showed R39 forgets to use call light, forgets to use her walker, and loses balance backward upon standing during transfers.

R39's MDS (Minimum Data Set) dated September 8, 2019 showed R39 requires extensive assistance of 2 staff members for bed mobility, transfers, and dressing. The same MDS showed R39 requires extensive assistance of 1 staff member for ambulation.

R39's nursing progress note dated September 8, 2019 at 11:01 AM showed, "decline in condition, poor appetite, not attempting to help transfer or propel own wheelchair. Slow to respond... needs to be reminded to open eyes when being spoken to."

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	IL6009989	A. BUILDING: _____ B. WING _____	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
S9999	Continued From page 10	S9999		

On September 11, 2019 at 1:59 PM, V23 CNA said prior to R39's fall on August 28, 2019 she was a stand by assist with ambulation. V23 said R39 was known to get up and walk without stand by assist. V23 said she would see her in her room walking around and would have to stop her and sometimes she would just be walking down the hall. She used a walker. V23 said R39 does not fall frequently.

On September 12, 2019 at 12:03 PM, V12 CNA said R39 was being walked with a gait belt and supervision just as a precaution before her fall. V12 said she would not consider R39 to be a resident who falls frequently. V12 said when she arrives for her shift each day she reads the "update book" which includes information about residents who have had falls or changes to their care.

On September 12, 2019 at 2:15 PM, V2 DON (Director of Nursing) said R39 is on hospice services now and declining quickly. V2 said before R39's fall she was getting up without assistance. V2 said R39 fell frequently. V2 said she would expect fall interventions to include increased supervision. V2 said when a fall occurs the nurse on call will be called by the nurse at the facility and there will be interventions discussed and implemented immediately. V2 said the next morning when the interdisciplinary team meets they discuss the interventions and make changes if needed.

The facility's policy titled Fall Prevention and Management with review date of July 1, 2019 showed, "To provide for resident safety and to minimize injuries related to falls; decrease falls.... Fall management/safety supervision is an

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON LIVING AND REHABILITATION CENT	811 SOUTH 10TH STREET OREGON, IL 61061

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S9999	Continued From page 11	S9999		

interdisciplinary process designed to develop systems to provide individualized person-centered care.... Post Investigation: Immediate interventions may be instituted by the nurse to prevent further falls until IDT (interdisiplinary team) reviews....based on the findins and the review of risk factors, environmental factors and other clinical conditions the residents comprehensive care plan is to include individualized person-centered interventions."

3. On September 10, 2019 at 9:16 AM, R16 was using her feet to propel her wheelchair out of the dining room. A CNA assisted her to a common area and gave her some cards. R16 immediately left the table and began propelling herself about the unit independently.

R16's fall incidents were provided by the facility for September 28, 2018 through August 17, 2019 which showed R16 to have 13 unwitnessed falls and 1 witnessed fall.

R16's face sheet showed R16 to be 72 years old and was admitted to the facility originally on November 16, 2016 with diagnoses to include Alzheimer's Disease with early onset, restlessness, agitation, repeated falls, polyosteoarthritis, anxiety disorder, major depressive disorder and dementia with behavioral disturbance. R16's face sheet showed R16 was readmitted to the facility on February 21, 2019 with a new diagnosis to include a fracture of part of the neck of left femur (hip fracture).

R16's care plan for risk for falls showed no interventions to include increased supervision were added until August 15, 2019 when an intervention was added to encourage R16 to stay

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009989	A. BUILDING _____ B. WING _____	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON LIVING AND REHABILITATION CENT	811 SOUTH 10TH STREET OREGON, IL 61061

(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) COMPLETE DATE
S9999	Continued From page 12	S9999		

in high areas of visibility after meals and or common areas after meals and while not in bed.

On September 12, 2019 at 12:03 PM, V12 CNA said R16 would not be someone she would consider that falls frequently. V12 went on to say R16 has a seat belt with an alarm on it because she would stand up incessantly and is a fall risk.

4. On September 10, 2019 at 9:14 AM R27 was sitting in her wheelchair in the dining room and had a large bruise to the right side of her forehead.

R27's face sheet printed September 12, 2019 at 10:22 AM showed R27 to be 95 years old and admitted to the facility on July 26, 2017 with diagnoses to include Alzheimer's Disease, muscle weakness, and myelophthisis.

R27's MDS (Minimum Data Set) dated July 22, 2019 showed R27 requires the physical assistance of 1 staff member to propel her wheelchair and the physical assistance of 1-2 staff members for all cares.

R27's incident report provided by the facility showed on August 29, 2019 night shift staff reported that R27 had a raised and bruised area to her right forehead that is painful to touch. The report showed R27 was unable to state what happened due to her confusion but a CNA (Certified Nursing Assistant) said the bed remote had ricocheted while she was performing cares and hit R27 on the right side of her head. The same incident report does not include the name of the staff member providing cares. The incident report does not indicate there were any witnesses to the incident.

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	IL6009989	A. BUILDING: _____ B. WING _____	09/12/2019

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(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) COMPLETE DATE
S9999	Continued From page 13	S9999		

R27's incident report provided by the facility showed on August 1, 2019 a CNA reported a bruise on R27's left shoulder which measured 5.0cm x 3.0 cm and was dark blue to deep purple in color. The incident showed R27 was unable to explain what happened. The incident did not report any witness to the incident.

R27's care plan with an initiation date of February 1, 2017 showed R27 required extensive assistance by 1 staff for locomotion using a wheelchair.

R27's nursing progress note dated August 2, 2019 showed, "IDT (Interdisciplinary team) reviewed resident room positioning and environmental... resident leans forward in wheelchair, will adjust positioning and move dresser in room."

On September 11, 2019 at 11:23 AM, V2 DON (Director of Nursing) said she knew the cause of R27's bruise to her head because "the CNA came right out and told us that [R27] got hit in the head with the bed remote during cares."

(A)

2 of 2 Licensure Findings:

300.610a)
300.1210d)1)2)
300.1620a)
300.3220f)
300.3240a)

Section 300.610 Resident Care Policies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009989	A. BUILDING _____ B. WING _____	09/12/2019

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S9999	Continued From page 14 a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 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 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.	S9999		

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S9999	Continued From page 15	S9999		

(Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

Section 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.

These Regulations were not met as evidence by:

Based on interview and record review, the facility failed to hold anticoagulant medications for one of one residents (R21) reviewed for anticoagulant use in the sample of 20. This failure resulted in the resident having a critical high lab value and needing to be sent to the hospital.

The findings include:

The Admission Record printed on 9/12/19 by the facility shows R21 has diagnoses including atherosclerotic heart disease (a narrowing of arteries due to build up of plaque) and atrial fibrillation (an abnormal, rapid and irregular heart beat). The facility assessment dated 7/8/19 shows R21 has moderate cognitive impairment. The orders summary report from 3/1/19-3/31/19

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S9999	Continued From page 16	S9999		

shows R21 was receiving Coumadin (blood thinner).

The nurse progress note dated 4/8/2019 shows "Resident sent to (local hospital emergency room) per ambulance for FFP (fresh frozen plasma) due to elevated INR (international normalized ratio-a test to see how well the blood clots)."

The orders summary report from 3/1/19-3/31/19 shows on 3/19/19 R21's Coumadin order was 3.5 mg every evening.

Coagulation (clotting) lab results dated 3/21/19 show R21's INR level was 6.6, which is a critical high level. New orders on the lab results, written by V9 (Nurse Practitioner-NP) show "Hold coumadin today and tomorrow, recheck labs on Saturday" (3/23/19).

On 9/12/19 at 8:12 AM, V2 Director of Nursing (DON) was asked for the 3/23/19 coagulation lab results for R21 because the lab results were not in R21's electronic medical record. At 9:02 AM, V2 Director of Nursing (DON) said she was not able to produce the PT/INR lab for 3/23/19 because it was not done. All labs from 3/18/19 through 4/10/19 were requested. The next PT/INR that was done for R21 was on 4/8/19 in which the results show R21 had an INR level of 22, which is a critical high level.

R21's Medication Administration Record (MAR) from March 2019 - April 2019 show R21 received the coumadin on 3/21/19 and 3/22/19 and continued receiving the same coumadin dose throughout her being sent to the hospital on 4/8/19.

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S9999	Continued From page 17	S9999		

On 9/12/19 at 9:42 AM, V8 LPN (Licensed Practical Nurse) said when PT/INR results come in we call the NP and get new orders and then document the orders. V8 said it is important to follow the doctor's orders.

On 9/12/19 at 10:14 AM, V10 RN (Registered Nurse) said when a resident's PT/INR results come in if the results are not a panic or critical high the nurses put them in the binder for the NP to review when she comes in on Mondays and Thursdays, the same day as labs are done. If the lab results show a panic high or a critical high result, the nurses would call the NP (Nurse Practitioner) or the doctor to get new orders.

On 9/12/19 at 11:02 AM, V10 verified on the March and April 2019 MAR that R21 received Coumadin from 3/19/19 through the day she went to the hospital on 4/8/19.

On 9/12/19 at 12:47 PM, V9 NP said it is important to ensure orders are followed when you have a resident with a critical high INR level. V9 said The previous Director of Nursing (DON) managed the resident's INRs. V9 said she wrote new orders on 3/21/19 to hold the coumadin for 2 days and recheck her INR levels on Saturday. V9 said on 4/8/19 the DON realized the orders had not been processed and she notified her (NP). V9 said she told previous DON to get a stat PT/INR lab. V9 said the facility called her back and told her that R21's INR level was 22. "I told them to send her to the hospital immediately because she needs blood products." V9 said it was a pretty critical situation because R21 could have spontaneously bled from pretty much anywhere in her body with an INR of 22.

On 9/12/19 at 1:45 PM, V2 (Current DON) said

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S9999	Continued From page 18	S9999		

she would have expected the nurses to hold the coumadin per the NP's orders, until new orders were received.

The facility's undated policy and procedure titled Lab and Diagnostic Test Results-Clinical Protocol shows "Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results...4. High or toxic drug levels. If a atest was obtained to monitor the blood level of a medication and the level is reported as high (above the therapeutic range) or toxic, the nurse will notify the physician promptly and will not give the next dose until the situation has been reviewed with the physician."

The facility's undated policy and procedure titled Medication Orders shows the purpose of the procedure is to establish uniform guidelines in the receiving anad recording of medication orders. The procedure shows "2. A current list of orders must be maintained in the clinical record of each resident. 3. Orders must be written and maintained in chronological order.

(A)