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
	IL6002729	A. BUILDING: ______ B. WING ______	C 10/29/2020

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EDWARDSVILLE NSG & REHAB CTR	401 ST MARY DRIVE EDWARDSVILLE, IL 62025

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S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation 2043088/IL122233 2044582/IL123810 2044771/IL124011 2047240/IL126754	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 3) 300.610a) 300.1210b) 300.1210d)2) 300.1210d)5) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.
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.
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 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 Requirements are not met as evidenced by:

A.) Based on observation, interview and record review, the facility failed to ensure that resident's received proper wound care treatments and discontinued treatments without a Physicians order for 4 of 6 residents (R26, R28, R105 and

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R108) reviewed for non-pressure related wound care in the sample of 42. This failure resulted in not treating wounds and R108 returned to ER for wound care and treatment and R108 did not receive 2 dialysis treatments because of lack of facility arranging transportation.

B.) Based on observation, interview, and record review, the facility failed to identify, assess and monitor pressure ulcers and provide timely turning and repositioning in 4 of 6 residents (R26, R39, R51, R205) reviewed for pressure ulcers in the sample of 42.This failure resulted in R51 getting multiple pressure ulcers to his left upper and lower heel and to his sacrum area.

Findings include:

A.) 1. On 9/30/20, V40 (R108's spouse) stated the hospital discharged R108 to the facility (unsure of date) with a dressing in place to his abdomen. V40 stated she went to the facility to get him for dialysis on a Tuesday and could "smell the wound." V40 stated the facility (unable to state who) told her R108's dressing hadn't been changed, because they didn't have wound care orders, but the Physician was coming on Wednesday to do a wound assessment. V40 stated she looked at the dressing and it was dated for 07/10/20, the day he was admitted to the facility.

R108's Face Sheet documents R108 was admitted on 7/10/20 with a diagnosis of Cellulitis of the Left and Right Lower Limbs and Chronic Osteomyelitis of the Right Ankle and Foot. R108 was discharged on 7/14/20.

R108's Minimum Data Set/MDS, dated 7/14/20, documents R108 requires assistance with bed

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mobility, toileting and hygiene.

R108's Admission Body Observation Report, dated 7/10/20, documents R108 was admitted to the facility with vascular wounds to both lower extremities, fungal infection to multiple skin folds, rashes to the neck and abdomen and open wounds to the left upper abdomen and left foot.

R108's Care Plan, dated 7/10/20, fails to document R108's wounds or interventions related to the wounds.

R108's Hospital Discharge Records, dated 7/10/20, document R108 underwent a "sharp excisional debridement of necrotic skin and subcutaneous tissue of the abdomen" on 7/3/20.

R108's Hospital Discharge Orders, dated 7/10/20, document orders for dressing changes daily and as needed and to "see wound care sheet for orders." In review of R108's hospital discharge records and orders there was no "wound care sheet" identified to address treatment orders for the wound to the abdomen. The Discharge Orders included orders for Ketoconazole 2% cream, apply to affected skin folds twice daily and Miconazole 2% cream, apply to affected skin folds twice daily. Both orders fail to clarify which skin folds the creams are to be applied to.

R108's Hospital Discharge Records, dated 7/14/20, document R108 was admitted to the hospital with a diagnosis of End Stage Renal Disease; Candidiasis of the Perineum; Open Wound of Anterior Abdominal Wall and Chronic Venous Stasis Ulcer of Bilateral Lower Extremities. The records go on to document that R108 comes from the nursing home "in which he was not receiving proper wound care. Underwent

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an I&D on abdomen last week but has not had appropriate dressing changes. Patient also notes his chronic lower extremity wounds have not been redressed in 4 days." There was no documentation identified in the hospital discharge records identifying if dressings were in place to R108's wounds upon arrival to the hospital.

R108's Hospital Skin Exam, dated 7/14/20 at 6:59pm documents R108 has "beefy red painful skin in the inguinal bilateral folds consistent with yeast infection, moist satellite lesions."

R108's Progress Notes were reviewed and document the following: 7/13/20 at 3:28pm - "Called hospital wound care clinic, resident stated he routinely goes there for wounds. Message left to call facility with wound orders for lower extremities;" 7/13/20 at 4:34pm - "Dressing to abdomen dry/intact;" 7/13/20 at 9:37pm - "Dressing to abdomen dry/intact;" 7/14/20 at 4:32pm - "Hospital wound center called and stated resident has never been seen by their facility. The nurse practitioner to see resident in the morning;" 7/14/20, no date, Cardiology note - "Facility is reporting non-compliance with dialysis. Patient missed last 2 appointments this week as wife has been unable to transport. According to facility, dialysis is requesting patient be sent to ER;" 7/14/20 at 7:35pm - "Wife at facility took all belongings and meds." The progress notes fail to document that R108's Physician was notified of the need for treatment orders and to clarify the current treatment orders for R108's wounds.

R108's Treatment Administration Records for July 2020 were reviewed and fail to document the sites the Ketoconazole and Miconazole creams were applied to or any treatments completed to the leg wounds or abdominal wounds.

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On 10/20/20 at 10:14am, V2 she would expect staff to notify the Physician of a new wound/pressure ulcer, need for treatment orders or a change in condition.

The facility policy and procedure titled "Pressure Ulcers/Skin Breakdown," dated April 2018, document staff will examine newly admitted residents for evidence of existing pressure ulcers or other skin conditions and the physician will order pertinent wound treatments.

The facility policy and procedure titled "Resident Change in Condition Physician Notification" dated 10/10/12, documents staff will notify the attending physician or physician on call of all condition or health status changes.

2. On 10/06/20 at 3:39 PM R26 was lying on her back in her bed and stated she has a lot of pain in her legs, especially her left hip and knee. She stated she had been in the hospital with a bad urinary tract infection (UTI) and was just readmitted to the facility a day ago. She had pressure relieving boots on both lower legs, and left lower leg and foot were turned outward and knee was contracted. R26 was not wearing a splint or brace on her left leg.

On 10/7/20 at 9:55 AM V17 (Wound Nurse) stated R26 needs to be medicated before they turn her and do her dressing changes because she has a lot of pain in her legs.

On 10/7/2020 at 10:25 AM V17 stated R26 did not want to be turned for a skin check until it was her scheduled time to be turned because it was too painful for her to turn and reposition. V14 (CNA) stated she had last changed and turned

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R26 before she assisted her with breakfast at about 7:45 AM or 8:00 AM, 2 and 1/2 hours ago. V14 did not turn and reposition R26 at this time.

On 10/07/20, per constant observation from 10:25 AM until 1:20 PM (3 hours) R26 was lying in the same position on her back in bed with indwelling urinary catheter tubing laying across her right leg. At 1:20 PM V14 and V17 turned R26 onto her right side, and she had a bordered foam dressing on her sacrum which was dated 10/02/20, indicating it had been applied 6 days ago. The dressing was not a DuoDerm dressing that was ordered by R26's physician. When V17 removed the dressing, it had dark material on it, that appeared to be feces. There were two small open areas on her inner right buttock. V17 stated she would be doing her weekly wound measurements on the next day, but both open areas appeared to be about 0.5 centimeters (cm) by 0.5 cm in size, with top layer of skin off. R26 had deep wrinkles on her buttocks and upper posterior thighs, and her skin on buttocks was red. Her pad was damp, and R26 stated she had spilled some water earlier. Her indwelling catheter was draining dark tea colored urine, so the moisture on her pad did not appear to be urine.

On 10/08/20 at 1:00 V17 stated she would expect anyone with a wound on their coccyx, or at risk for skin breakdown, to be turned and repositioned at least every two hours.

R26's Face Sheet documents her diagnoses to include Parkinson's Disease, Muscle Weakness, Chronic Pain, and Unspecified Fracture of Lower End of Left Femur.

R26's Physician Order Report dated 01/01/20 -10/15/20 documents an order with start date of

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10/2/20: Apply DuoDerm dressing to open area on coccyx - change every 72 hours and prn (as needed) until healed.

R26's Admission Body Assessment dated 10/02/20 at 7:34 PM documents R26 has a pressure ulcer on her coccyx but did not include any documentation of description of wound or measurements.

R26's Minimum Data Set (MDS) dated 8/13/20 documents she is alert and oriented and requires extensive assist for bed mobility.

R26's Care Plan, dated 5/11/20 documents: Category: ADL (Activities of Daily Living) Functional/Rehabilitation - has recent fractured left knee; documents: Approach Start Date: 5/11/20 - DC (discontinue) on: 9/19/20 - Discontinued left knee immobilizer hip to ankle

R26's Progress Notes dated 5/2/20 at 5:15 PM document R26 was found lying on the floor on her back in her room. The progress note documented she complained of pain to her left hip and left foot at the time of the fall, and the Medical Doctor ordered x-rays of both her left hip and left foot.

The radiology reports dated 5/2/20 document there were no acute fractures or dislocations of R26's left hip or left foot.

R26's Progress Notes dated 5/6/20 at 10:56 AM document R26 complained of pain in her left knee that was not relieved with the pain medication administered. The progress note documented R26 had a fall a few days ago, and she had knee surgery in the past. R26's physician was notified, and she ordered an x-ray of R26's left knee.

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The radiology report of R26's left knee, dated 5/6/20, documented R26 had a complete comminuted distal femoral fracture involving the femoral component of the total knee replacement. A handwritten note at the bottom of the report documented that the Medical Doctor was notified of the report and orders received to send R26 to the local emergency room.

R26's Progress Note dated 5/9/20 at 4:45 PM document she returned from the hospital with an immobilizer to her left lower extremity from her hip to her ankle. The progress note documented that instructions from the hospital indicated the brace is only to be removed for skin checks and for adjustments.

R26's Progress Note dated 6/12/20 at 11:10 AM documents the nurse from V23 (Orthopedic doctor) called and canceled her follow up appointment and left an order for a follow up x-ray of R26's left knee, femur and ankle to be done and film to be sent to V23's office.

R26's Progress Note dated 6/25/20 at 9:01 AM documents V22 (Assistant Manager of the orthopedic office) called the facility with new orders for R26 to continue to wear the knee immobilizer, making sure it is centered, perform daily skin checks to monitor for skin breakdown, and continue to be non-weight-bearing to left side for 6-8 weeks, and get x-rays in 6-8 weeks.

Review of R26's Progress Notes from 6/26/20 through 10/12/20 do not document any communication between the facility and R26's orthopedic doctor. There is no documentation of any changes in the orders regarding R26 wearing the left knee immobilizer. R26's Electronic Medical Record does not document any follow up

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x-ray results after those done on 6/12/20.

R26's Progress Note dated 10/02/20 at 2:45 PM documented the facility had received report from the hospital that she would be returning to facility on that day and that R26 had maceration on her coccyx, and there was a bordered foam dressing in place.

R26's Physician Order Report dated 01/01/20 -10/15/20 documents an order with start date of 10/2/20: Apply DuoDerm dressing to open area on coccyx - change every 72 hours and prn (as needed) until healed.

R26's Admission Body Assessment dated 10/02/20 at 7:34 PM documents R26 has a pressure ulcer on her coccyx but did not include any documentation of description of wound or measurements.

R26's Care Plan dated documents: 10/08/2020 03:14 PM Category: Skin: PROBLEM: stage 2 pressure ulcer sacrum has re-opened. Interventions for this problem include: Start Date: 10/08/2020: APPROACH: Educate caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning.

R26's Braden Scale for predicting Pressure Ulcer Risk, dated 10/12/20, documents a score of 11, indicating she is at high risk for pressure ulcers. According to this assessment, R26's sensory perception (ability to respond meaningfully to pressure related discomfort) is very limited, R26 is chair bound, her skin is very moist, R26's ability to change and control body position is very limited, her nutrition is probably inadequate, and

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S9999	Continued From page 10 she requires moderate to maximum assist in moving. R26's Progress Notes dated 10/13/20 at 8:55 AM document the facility's Nurse Practitioner was notified of need for a follow-up x-ray of R26's left knee and new order received. There was no documentation of the facility notifying V23 that the x-rays ordered to be done 6-8 weeks after 6/25/20 were not done, or that the facility had discontinued the splint. On 10/13/20 at 10:31 AM V4 (MDS/Care Plan Nurse) stated the facility did not get the x-rays as ordered for R26 by her orthopedist in 6-8 weeks from 6/25/20 but would be getting them today because they had notified the facility's Registered Nurse Practitioner of need for the x-rays and she gave the order for them to be done. V4 stated the facility's contracted radiology company will be coming today to do them. V4 stated the appointment with the orthopedist was rescheduled for 10/27/20. V4 stated V8 (Licensed Practical Nurse/LPN) informed V4 that she had gotten the order to discontinue R26's left leg splint in September. On 10/13/20 at 10:31 AM V4 provided the following documentation: R26's Physician Order Report dated 1/1/20 -10/15/20 which included an order dated 10/13/20 documenting: Per (V23) ortho order clarification ok to dc (discontinue) left leg immobilizer in September." V4 also provided R26's Care Plan dated 5/11/20 with Problem: ADL (Activities of Daily Living) Functional/Rehabilitation Potential: has recent fracture of left knee, with an intervention: Approach start date: 5/11/20 - DC on 9/19/20-discontinue left knee immobilizer hip to ankle: Discontinued (DC'd) 9/19/20; DC reason:	S9999		

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doctor discontinued. V4 also provided an order, dated 10/13/20 for: x-ray left knee f/u (follow up) fracture May 2020 and ordered by the facility's nurse practitioner.

On 10/13/20 at 4:00 PM per phone interview, V22 stated regarding R26's splint and x-ray orders from that office, the orthopedic office documentation on communication with the facility regarding R26 includes: On 6/12/20 V23's office called and requested X-rays be done...continued to recommend treatment to be non-operative tx (treatment). V22 stated the physician's office received the images (x-ray), and on 6/25/20 V23 (Orthopedist) continued to recommend non-operative treatment, continue the immobilizer, remain non-weight bearing for 6-8 weeks, and V23 gave a detailed instruction on how splint was to be worn and cared for and this was relayed to V39 (Registered Nurse/RN) at the facility, and new x-rays were to be done in 6 weeks, which should have been the beginning of August, according to V22. She stated the last communication from the facility regarding R26, with the physician's office, was on 6/25/20 until today, 10/13/20, when someone from the facility called and made an appointment for R26 on 10/27/20 for follow-up visit. V22 stated that will be the first time R26 will be seen in the physician office. She stated there was no documentation of the immobilizer splint ever being discontinued, and if the x-rays would have been done in 6 weeks after they were ordered on 6/25/20, the physician would have given appropriate orders at that time.

On 10/14/20 at 6:36 AM V8 (LPN) stated she is the nurse who discontinued R26's splint on September 19,2020. V8 stated she came in to work that morning on day shift and R26 had

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S9999	Continued From page 12 pressure relieving boots on her feet but V8 could not find her knee splint, so she discontinued it. She stated she felt the boots on her lower legs offered just as much support as the splint had so she did not feel like R26 needed it. V8 stated she did not know if R26 was even being followed by an ortho doctor or if she had been seen by one after she got out of the hospital. V8 stated she discontinued the splint and meant to tell the facility's Nurse Practitioner that she did it and get the order, but she forgot. V8 stated she had her personal notes from the date that she discontinued the splint and was able to tell V4 (Care Plan Coordinator) that she discontinued it on 9/19/20. V8 stated, "That was my mistake...I forgot to tell anyone that I had discontinued the splint." As of 10/15/20 at 4:00 PM R26 still did not have an order to resume wearing the knee brace/immobilizer that was ordered by the orthopedist. R26's Progress Note dated 10/20/20 at 4:00 PM documents: "(V23's) office called the facility. Reports the resident (R26) needs to be seen on 10/27/20 to re-eval of femur fracture. Dr. office reports if previously used knee brace available - reapply. Use Ace wraps (elastic bandages) under brace. If unable to find knee brace, ace wraps to be applied." R26's Progress Note dated 10/20/20 at 8:11 PM documents, "Unable to find knee brace. Ace wrap times 2 applied to left upper leg. Air boots on left used as temporary splint for knee." R26's Progress Note dated 10/21/20 documented that ortho office was ordering the proper brace for R26's left knee.	S9999		

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R26's Progress Note dated 10/21/20 at 2:11 PM documents, "New order received for leg brace on at all times per (facility's Nurse Practitioner) and applied."

On 10/27/20 at 12:17 PM V2 stated V23 (Orthopedist) should have been notified and asked if the splint he ordered for R26 could be discontinued. V2 stated a nurse should never discontinue an order for a splint or brace without a physician's order. V2 stated V8 should have contacted R26's orthopedist regarding her left leg splint.

On 10/28/20 V22 sent a copy of V23's Progress Note from visit on 10/27/20. V22 stated V23 will be doing surgeries for the rest of the week and probably will not be available to talk about the report. V23's Progress Note documents that he had reviewed R26's radiographs of her knee which demonstrates a further impacted apex anterior periprosthetic femur fracture without any evidence of healing. Under "Plan," V23's Progress Note documents that he thinks the only treatment for the patient's pain through her fracture site would be an above the knee amputation. The knee immobilizer has potential to give her soft tissue compromise due to her contractures.

3. On 10/8/20 at 9:15 AM V17 (Wound Nurse) removed a soiled dressing from R28's left lower leg, while V33 (Certified Nursing Assistant/CNA) lifted his leg to allow V17 access to R28's entire lower leg, including his posterior calf. The old dressing was moist due to R28's left lower extremity weeping serous fluid, and his exposed skin was red, with areas of flaking skin particles coming off. V17 used a wet washcloth and wound

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cleanser to wipe the skin on R28's left lower extremity, and applied Ammonium Lactate Lotion 12% to top of R28's left lower leg but did not lift his left leg off the mattress and failed to apply the ordered lotion to the macerated skin on his posterior lower left leg.

R28's Face Sheet documents his diagnoses which include Cellulitis of left lower limb and Chronic Peripheral Venous Insufficiency.

R28's Minimum Date Set (MDS) dated 8/7/20 documents a Brief Interview for Mental Status score of 15, indicating he is alert and oriented to person, place, time and situation. The same MDS documents R28 requires extensive assist of 2 staff for bed mobility and bathing, and he is dependent on staff for transfers. It documents that he is always continent of bowel and bladder, and he has 3 arterial/venous ulcers and Moisture Associated Skin Damage (MASD). Per the MDS, his treatment for skin problems includes a pressure reducing device for his bed (has air mattress), application of nonsurgical dressings, and applications of ointments/ medications other than to his feet.

R28's Care Plan dated 05/28/2020, last reviewed 10/6/20 documents, "Category: Skin;
PROBLEM: 9-16-20 right lower lateral leg mixed vascular 9-17-20 right inner calf mixed vascular 9-28-20 left lower extremity posterior venous; diagnosis: peripheral artery disease and chronic cellulitis
APPR0ACH: treatment to left lower extremity
APPR0ACH: treat to right inner calf as ordered

R28's Physician Order dated 8/14/20 documents the order: ammonium lactate
lotion; 12 %; amount: thin layer; topical

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Special Instructions: Cleanse bilateral lower extremities with soap and water, apply thin layer, wrap with Kling (gauze dressing) and then Ace wrap (elastic bandage) daily.

R28's lab reports include a Wound Culture Final Report, dated 9/18/20 with results "right and left lower legs: Heavy growth of Proteus Mirabilis. A handwritten documentation at the bottom of the report stated, "Sent to NP (Nurse Practitioner) NO (New Order): Levofloxacin (antibiotic) 750 mg QD x 5 days."

4. On 10/14/20 at 12:32 PM per review of R105's electronic medical record, she was admitted to the facility with wounds on her right foot and toes that were infected with ESBL. Her wounds to her right foot were healed on 5/19/20 and then she developed a blister on her right foot which opened on 6/18/20.

R105's Discharge Summary dated 7/28/20 documents she was discharged to another long-term care facility on that date.

R105's Face Sheet documents her diagnoses to include: Non-pressure chronic ulcer of other part of right foot with unspecified severity, Non-pressure chronic ulcer of other part of left foot with unspecified severity, and Peripheral Vascular Disease.

R105's Progress Notes dated 06/15/2020 at 5:51 PM documents: Resident noted with 1.5 cm x 1.5 cm fluid filled blister to RLE. Resident states unsure how she obtained it. New order: cleanse with NS or wound cleanser and apply dry dressing daily. Resident aware. Will monitor area.

R105's Progress Notes dated 06/18/2020 at

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11:03 AM documents: Blister to RLE ruptured with moderate amount of serous drainage noted. New orders: D/C dry dressing. Start: cleanse with Dakin's solution and apply calcium alginate and bordered gauze dressing daily and PRN until healed. Resident aware of new orders. Will monitor area.

R105's Progress Notes dated 06/24/2020 at 09:48 AM documents: Weekly wound assessment performed. Ruptured blister to RLE measures 1.5 x 1.5 cm. Light amount of sanguineous drainage noted. No s/s infection noted. Cont. with Dakin's cleanse and applying calcium alginate with dressing. Right second toe noted with scabbed area. Cont. cleansing area and covering with dry dressing. No c/o pain to either area. Will re-assess areas next week.

R105's Progress Notes dated 07/01/2020 at 09:00 AM documents: Weekly wound assessment performed. Area to RLE measures 0.5cm x 0.3 cm with scant amount of serosanguinous drainage. No s/s infection noted. Denies pain to area. Area noted with 100% granulation. Cont. with calcium alginate + dry dressing. Scabbed areas cont. to right 2nd and 3rd toes. No drainage noted. Denies pain to area. Cont. with cleansing with Dakin's solution and applying dry dressing as preventative. Will re-assess next week.

R105's Physician Order Sheet dated 1/1/20 - 10/15/20 documents the following order dated 6/18/20: Cleanse area to RLE (right lower extremity) with Dakin's solution. Apply calcium alginate and apply bordered gauze dressing daily and PRN (as needed) until healed.

R105's Care Plan with the start date: 10/17/19

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documents history of skin impairment to lower extremities: 10/16/19 admitted with arterial ulcers right foot/toes;
11/19/19 arterial ulcer right anterior ankle - healed 5/20/20; 4/13/20 right lower leg arterial ulcer healed 5/19/20; 5/20/20 right lower extremity and left lower extremity continue with dry scabbed areas; 6/03/20 right lower extremity healed; 6/15/20 right lower extremity blister. Interventions to this care plan document: treatment as ordered

R105's TAR dated 7/1/20 -7/31/20 documents an order to Cleanse right lower extremity with Dakin's solution, apply calcium alginate and apply bordered gauze dressing daily and prn until healed with no diagnosis documented for this order, but progress notes indicated R105 had a blister on her right foot as of 6/15/20. Documentation of administration of this order indicates it was not administered as ordered on 7/4/20, 7/5/20, 7/7/20, 7/12/20, 7/17/20, 7/20/20, 7/21/20, or 7/27/20. The TAR documents R105 refused treatments on 7/6/20 and 7/8/20.

R105's Discharge Summary dated 7/28/20, when she was transferred to a sister facility, documents discharge instructions documents R105 has treatments but does not specify what type of treatment or the where the treatment is applied.
5. On 10/07/20 at 9:30 AM, R45 was observed sitting up in her wheelchair in her room. R45 was confused and only alert to herself. There was a dressing observed on left lower leg that was dated 10/03/20. When R45 was asked about the dressing, she did not recall which leg the dressing was on. When R45 was asked how often the staff change the dressing, she stated "every day."

On 10/08/20 at 10:00 AM, V17 (Wound Nurse) stated she already changed the dressing on

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R45's lower leg. She stated it was scabbed and almost healed and she would probably heal out next week. V17 confirmed that R45 was a daily dressing change and could not explain why the dressing had not been changed since 10/03/20.

The Event Summary List report, dated 10/03/20 at 6:09 PM, documented skin tear to left lower leg. No other information given regarding type of dressing or treatment applied.

The Physician Order Sheet, dated 10/04/20, documented "Cleanse skin tear on left anterior leg with wound cleanser. Cover with bordered dressing. Until healed."

The Treatment Administration Record (TAR), dated 10/04/20, 10/05/20, 10/06/20 and 10/07/20 were blank for any treatments completed for R45.

On 10/20/20 at 1:30 PM, V2 (DON) stated she was not aware that R45's dressing had not been changed from 10/03/20 to 10/08/20.

B.) 1. R51's Face Sheet documents R51 was admitted on 10/01/18 with a diagnosis of Age-Related Physical Debility; Type 2 Diabetes; Anemia; Pain; Abnormal Posture; Alzheimer's Disease.

R51's Minimum Data Set (MDS), dated 09/18/20, documents that R51 requires extensive assistance of 2 staff with bed mobility, toileting and hygiene. It further documents that R51 has 2 stage 3 pressure ulcers.

R51's Braden Assessment, dated 09/18/20, documents R51 is at moderate risk for the development of pressure ulcers.

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S9999	Continued From page 19 R51's Care Plan, dated 09/08/20, documents R51 has a stage 2 pressure ulcer to the sacrum. Interventions include to monitor, document, report to Physician changes in skin status including appearance, color, wound healing, signs/symptoms of infection, wound size and staging. R51's Wound History Report, dated 10/14/20, document R51 had stage 3 pressure ulcers to the left heel and upper left heel. The report documents that both areas were "closed" on 10/01/20 with no other documentation on measurements or assessment of the pressure ulcers identified after this date. R51's Shower Sheets document on 10/12/20 and 10/15/20, red areas to the left heel. On 10/14/20 at 10:41am, V17 (Registered Nurse/RN) stated R51's pressure ulcers to the left heel are healed. On 10/15/20 at 9:26am, R51's left heel was observed to have an area measuring approximately 6cm round with an area in the center measuring approximately 3.5cm x 2cm that is deep red in color and appeared to be a Deep Tissue Injury (DTI) pressure ulcer. R51's posterior left ankle was observed to have a deep red colored area measuring approximately 4cm x 2cm and appeared to be a DTI pressure ulcer. On 10/15/20 at 9:26am, V26 (Certified Nursing Assistant/CNA) stated R51's pressure ulcers to the left heel are most likely due to her boot that she wears. V26 stated she normally puts a long sock on R51 to keep the boot from rubbing R51's skin, but R51 did not have a long sock on that morning when she got R51 out of bed.	S9999		

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R51's Progress notes were reviewed for October 2020 with no documentation identified of R51's pressure areas to the left heel prior to 10/15/20.

R51's Physician Order Sheets for October 2020 were reviewed with no documentation of treatment orders for the red areas to R51's left heel prior to 10/15/20.

On 10/20/20 at 10:14am, V2 (Director of Nurses/DON) stated she would expect the nursing staff to assess the area and notify the resident's physician.

The facility policy and procedure titled "Prevention of Pressure Injuries," dated April 2020, documents to inspect the skin on a daily basis. Evaluate, report and document potential changes in the skin.

The facility policy and procedure titled "Pressure Ulcers/Skin Breakdown Clinical Protocol," dated April 2018, documents the nurse shall describe and document/report the following: full assessment of the pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue, pain assessment, resident's mobility status and current treatments.

2. On 10/07/20 at 10:35 AM V14 unhooked R39's soiled adult brief and tucked it in under the resident, then turned R39 onto her left side and cleansed the fecal material from R39's rectum and buttocks. There was a small open area on R39's right buttock. V17 (Wound Nurse) at first stated she did not think it was open, then looked closer and stated, "That would be a Stage 2."

After V14 finished cleaning R39, V17 cleansed

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the open area on R39's right buttock with wound cleanser, measured it (0.5 cm X 0.5 cm) and then V14 applied zinc oxide protective cream over the area.

R39 also had a round open sore behind her right knee. V14 asked her if she had picked at it and R39 said yes, but the wound was round, with thin layer of skin off of it, and its location was where R39's leg would have bent and rested against the edge of the seat whensitting in her chair. V17 cleansed and measured the wound and stated it was a skin tear measuring 0.6x0.6cm.

R39's MDS dated 10/01/20 documents she is cognitively intact, requires extensive assist with bed mobility, transfers and toileting, and is always incontinent of bowel and bladder.

R39's Care Plan dated 10/07/20 documents, "I have developed an area on right buttock; stage 2. An approach for this care plan, dated 10/08/20 documents: Administer treatments as ordered and monitor effectiveness."

R39's Braden Scale Score for Predicting Pressure Sore Risk dated 10/7/20 documents a score of 14, indicating she is at moderate risk for pressure ulcers.

R39's Physician Order dated 08/19/20 documents: Zinc Oxide 20% to excoriated buttock every shift.

3. On 10/02/20 at 1:05 PM R205 stated she had a sore on her bottom and it is a little painful when she is sitting on it.

On 10/06/20 at 2:50 PM V21 (CNA) assisted R205 to roll over and she had dressing on her

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bottom with curled up edges, making it a ball, causing an area of pressure to that area when she was sitting or lying on it. R205 stated her bottom hurt. V21 straightened the dressing on her coccyx and it was dated 09/30/20, indicating it had been in place for 6 days. The area around the dressing was red.

R205's Physician Order dated 9/30/20 documents: apply DuoDerm to reddened area on coccyx every 72 hours and prn.

R205's Braden Scale for Predicting Pressure Sore Risk dated 09/26/20 documents a score of 16 indicating she is at risk for pressure ulcers.

R205's MDS dated 09/30/20 documents she is cognitively intact, requires extensive staff assist for bed mobility, transfers, and toileting, is incontinent of bowel and bladder, and has no skin impairment.

R205' Care Plan dated 10/08/20 documents: 10/08/2020 03:11 PM Category: Pressure Ulcer: PROBLEM: Resident is at risk for pressure ulcer due to moisture/impaired mobility history of reddened area coccyx. Interventions include: 10/06/2020 APPROACH: DuoDerm as ordered for prevention.

(A)

(Violation 2 of 3)

300.610a)
300.1210b)
300.1210d)6)
300.3240a)

Section 300.610 Resident Care Policies

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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
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.

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:

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

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agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, record review and interview, the facility failed to provide supervision to prevent falling for 3 of 9 residents (R45, R110, R115) reviewed for falls in the sample of 42. This failure resulted in R45 falling 32 times, hitting her head on 05/29/20 causing large bruise to left eye and on 08/09/20 causing bruising to right eye; R110 suffering lacerations to the head after falling backwards in a wheelchair in the facility van; and R115 falling on 12/23/19 suffering multiple rib fractures and internal bleeding.

Findings include:

1. On 10/01/20 at 1:45 PM, R45 was observed sitting up in wheelchair in her room. R45 was alert to self only stating she gets help when she needs it. R45 stated she knows when to use her call light. When R45 was asked if she knew where her call light was, she stated "No, not really." R45's call light was observed tied around the side rail on her left side.

The Physician's Order Sheet (POS), dated 10/01/20, documented the following diagnoses for R45, in part as, difficulty walking, muscle weakness, Chronic Obstructive Pulmonary Disease (COPD), cognitive communication deficit, Gastrointestinal (GI) bleed, anxiety disorder, major depressive disorder (MDD), Hypertension (HTN), osteoporosis (OA), atrial fibrillation, benign paroxysmal vertigo, diabetes mellitus type II, COVID-19 positive (04/20/20), chronic bronchitis and oxygen dependence. It

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documented on 03/19/20 an order for bed alarm.

The Minimum Data Set (MDS), dated 09/04/20, documented R45 was moderately cognitively impaired and required extensive assist of one staff for bed mobility, transfers, locomotion, dressing, toileting, hygiene and bathing; and had balance deficits and was frequently incontinent of both bowel and bladder.

The care plan, dated 08/28/20, documented R45 was identified as being high risk for falls with the following interventions: personal alarm to bed and chair and reminders to not take off. On 08/02/20, reminders/education to ask for assist to clean out drawers. On 07/08/20, non-skid socks/shoes when up in wheelchair. On 07/07/20, alarm checked & working. Post fall monitoring, notify provider if Change of Condition (COC), continue interventions on risk fall care plan, frequent visual checks, new body alarm at all times, medication review and therapy to screen. On 10/14/20 at 11:30 AM, V2 (Director of Nursing/DON) stated she was not aware of what the "Risk fall care plan" was used for or where that information was located in the medical record.

On 03/13/20, R45's Fall risk assessment admission documented score of 3 or no risk. On 05/22/20, the Fall risk assessment quarterly documented a score of 18 which indicated high risk. On 06/09/20 and 09/04/20, it documented a score of 20 which indicated high risk.

On 03/13/20, R45 was admitted to the facility. From 03/16/20 to 05/29/20, nurse's notes and fall reports documented R45 had 15 falls. On 05/29/20 at 10:25 AM, nurse's notes documented R45 was found on the floor in her room with a large bruise to the left eye. From 06/06/20 to

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09/30/20, R45 had 16 additional falls. On 08/09/20 at 8:11 AM, nurse's notes documented R45 was found sitting on top of her bed covers with a large bruise to the right eye. There were no new interventions put into place, only repeated interventions.

2. On 12/23/2019 at 3:29 PM, a nurse's note documented, "Resident is c/o pain to right side rib area. Called and rec'd orders to get x-ray of area. Writer called Biotech to give orders for x-ray they will be out today. Writer also called daughter and made her aware and will call with results to her."

On 12/23/2019 at 3:47 PM, a nurse's note documented, "Addendum from previous note: Writer assessed resident Right side where she was c/o pain. There are no bruising, open area, nor swelling noted to R. Rib area. Writer talked with DON about res c/o pain to this site writer was informed to get x-ray to make sure area was healing properly d/t resident having a previous fall that x-ray indicated that her 9/10 ribs were fx on right side. Resident denied any pain to touch upon assessment to area will con't to monitor for changes."

On 12/24/2019 at 7:00 AM, a nurse's note documented, "Resident c/o pain to R side, prn Tylenol administered did not complain of severe pain for rest of shift, as a professional this nurse did not believe necessary to further assess."

On 12/25/2019 at 6:56 AM, a nurse's note documented, "Resident c/o severe pain on the right side of her rib. vitals checked. BP-200/80, P-58, O2- 96. Exchange called for physician, yet to hear from her."

On 12/25/2019 at 2:22 PM, a nurse's note

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documented, "Resident is hurting in upper and lower back area and rib cage area. resident POA here and wants resident sent to hospital, ok with physician to send resident to the hospital."

On 12/26/2019 at 3:48 AM, a nurse's note documented, "A hospital employee who is residents nurse called at 11:43 PM to inform us that resident has been admitted and will not be returning to the facility tonight. She also said resident has multiple broken ribs and internal bleeding."

The Physician Order Sheet (POS), dated 12/01/19, documented R115 was admitted with the following diagnoses, in part as, cerebrovascular accident (CVA), abnormal gait, hypertension, vascular dementia, macular degeneration, major depressive disorder, muscle wasting and atrophy and chronic clavicle pain/fracture.

The MDS, dated 10/23/19, documented R115 was identified as being severely cognitively impaired and required extensive assist of one staff for toileting; limited assist of one staff for transfers and walking; had a balance deficit and was occasionally incontinent of bladder.

The care plan, dated 12/27/19, documented R115 was identified as being high risk for falls. The interventions dated 12/27/19 were to refer to therapy. On 10/08/19, it documented assist with reminders to use walker and wc; assist with proper fitting shoes and gripper socks. Remind to use call light.

A Facility Event Summary Report, dated 10/08/19 at 2:40 PM, documented Daughter notified staff resident fell in room. Daughter stated she was

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making residents bed and thought resident was sitting in her recliner and heard her fall. Laceration to top of left eye, scratch with bruise to left arm. Neuro checks WNL. MD notified. Resident out with daughter. Educated daughter to ask for assist.

Facility Event Summary Report, dated 10/28/19 at 2:51 PM, Resident observed in her bathroom on the floor. Resident was trying to go to the bathroom and said she got really weak and her legs gave out. Resident was incontinent of stool. Resident had no c/o's of pain at time of the fall. Resident is independent with mobility and wheeled walker. Resident c/o pain to left rib area on 10/30/19. X-ray obtained, and results revealed 9th and 10th rib fractures. MD and POA aware. Investigation sent to IDPH.

On 10/20/20 at 11:30 AM, DON stated there was no investigation done for any falls in the month of December 2019.

3. On 10/01/20 at 2:07 PM R110 had her call light on stating she needed the bed pan. She stated she had just gotten back from the hospital where she had brain surgery. She could not remember how long she has been back at the facility. She stated she could not get up on her own and stated she had fallen in the past but could not remember when.

R110's Face Sheet documents her diagnoses to include Benign Neoplasm of Cerebral Meninges; Unspecified Abnormalities of gait and mobility; and Other Instability, left ankle.

R110's MDS dated 10/07/20 documents she is alert and oriented, requires extensive assist with transfers because she is not steady and only able

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to stabilize with staff assistance during transfers.

R110's Care Plan for the problem labeled "Falls" documents R110 had a fall on 9/16/20 but does not include any new interventions regarding resident safety while being transported to or from the facility in the facility transport van.

R110's Progress Note dated 9/16/20 at 11:30 AM documented: "Nurse received notification from driver that resident had fallen backwards in her w/c (wheelchair) while he was driving her back to the facility. Resident was at a Doctor's appointment previously with Neurosurgeon regarding the brain tumor that was found at previous hospital stay and was returning back to the facility. Resident had a couple of small cuts and bleeding from the back of her head per driver, so he called EMS (Emergency Medical Services) to transport resident to the hospital. Driver also reported that he notified resident's daughter who is POA (Power of Attorney)."

R110's Event Report dated 09/16/20 documents, "(R110) had an unwitnessed fall outside of the facility and injuries included laceration to the back of her head." The Event Report documents the Interdisciplinary Team (IDT) met to review the fall, and R110's Care Plan was reviewed and updated on 09/24/20, but R110 did not return from the hospital until 09/30/20. The Event Report did not include any assessment for the root cause of the fall or inspection of the seatbelts or fasteners that were not tight and allowed R110's wheelchair to fall backwards. R110's Care Plan was not updated with progressive interventions at the time of her fall or when she returned from the hospital.

10/13/20 02:22 PM V24 (Transportation Driver) stated on 09/16/20 he was bringing R110 back to

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the facility from an appointment and when he accelerated from a stop, R110 fell backwards in her w/c and hit her head. V24 stated when he first loaded R110 onto the van she was not at her usual baseline and was throwing herself back and forth in her w/c. He also stated he was not comfortable with the van he was driving, as it was a van from the sister facility, and the straps did not have a ratcheting mechanism he was used to that enabled him to tighten the straps. He stated he attached all four straps to the hooks on the floor to stabilize R110's w/c and he stated they were still attached after she fell backwards in her w/c. He stated he does not know why the straps did not stay tight and keep the w/c from tipping over backwards. He stated he had checked the straps when he first put R110 in the van to return her to the facility, and they were tight at that time.

R110's Hospital Emergency Report dated 09/16/20 at 11:53 AM documents, "She was seen at the Neurosurgery clinic earlier today and upon leaving by ambulance to transport her back to the nursing home her wheelchair was not secured and she fell while in the ambulance." V24 clarified she was being transferred back to the facility in a sister facility's transportation van.

On 10/13/20 at 3:30 PM V1 (Administrator) provided a typed document signed by the administrator from the sister facility where the van had been borrowed from on 09/16/20 to transport R110. The document, undated, stated, "On 09/16/20 an incident was reported that occurred in our van and a resident from (facility). At that time the seatbelts and fasteners were checked, and all were in proper working condition." V1 stated V24 had checked the seatbelts and fasteners at the time of R110's fall, and they were still attached so she does not know what

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happened. She stated the van did not have to be checked by the service department where it was purchased for faulty seatbelts because it was a brand-new van and there was nothing wrong with it. She was unable to state why the straps did not remain secure to prevent R110 from falling backwards when the van accelerated forward.

On 10/20/20 at 11:30 AM, V2 (DON) stated there was no investigation done for any falls in the month of December 2019. She also stated that she was not employed by the facility during that time and was not aware of the incident that occurred on 12/23/19. She further stated that the staff that had documented in the nurse's notes were no longer employed by this facility. An attempt to get staff interviews regarding this incident was unable to be accomplished due to none of the current staff were employed at during this time period. This was verified by V1 and V2.

The policy and procedure titled, "Falls and Fall Risk, managing" was reviewed. It documented under, "Resident-Centered Approaches to Managing Falls and Fall Risk: 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls; 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant." Under, "Monitoring Subsequent Falls and Fall Risk: 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 4. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician

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will help the staff reconsider possible causes that may not previously have been identified. 5. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls."

(A)

(Violation 3 of 3)

300.1210b)
300.1210d)2)
300.3220f)
300.3240a)

Section 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.
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.

Section 300.3220 Medical Care
f) All medical treatment and procedures shall be administered as ordered by a physician. All new

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S9999	Continued From page 33 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. (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review, the Facility failed to perform laboratory tests and administer high risk anticoagulant medication as ordered by the Physician for one of three residents (R113) reviewed for anticoagulant medications in the sample of 42. This failure resulted in R113 being hospitalized for 6 days for monitoring the viscosity of her blood and get her International Normalized Ratio (INR) levels to a therapeutic level. Findings include: R113's Progress Notes dated 05/13/20 at 9:08 PM document she was transferred to the local hospital with a change of condition. R113's Death Certificate dated 05/19/20 documents R113 expired in the hospital on 05/16/20 with the diagnoses of COVID, Pneumonia, and End Stage Renal Disease. R113's Face Sheet documents her diagnoses to include Unspecified Atrial Fibrillation, Presence of Prosthetic Heart Valve, and Acute embolism and thrombosis of unspecified deep veins of lower extremity, bilateral.	S9999		

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R113's Minimum Data Set (MDS) schedule documents R113 was hospitalized from 04/20/20 to 04/26/20. Her admission MDS, dated 12/30/19, which is her only MDS prior to discharge that included a cognitive assessment, documented she was alert and oriented.

R113's Care Plan dated 01/08/2020 documents: Problem: Altered cardio/vascular status related to diagnosis of hypertension, history of myocardial infarction, congestive heart failure, presence of prosthetic heart valve, other chest pain, and hyperlipidemia. The interventions include to do labs as ordered and administer medications as ordered.

Per review of R113's electronic medical record, an Event Report dated 04/20/20 documents: "Medication Error" occurred on 4/20/20 at 3:44 PM. This report was initiated by V35 (Licensed Practical Nurse/LPN) who documented she completed a medication error report for (R113). The evaluation of the incident documents: "Resident admitted to the hospital and placed on heparin drip. Nurse took verbal order for Coumadin and then did not place order on EMAR (Electronic Medication Administration Report). Education will be given to all nurses regarding the importance of PT (Prothrombin Time)/INRs and proper coumadin tracking."

The Medication Error Report documents the description of the error as: Date error began: 04/17/20; Correct order: Coumadin 4 mg daily; Orders were given to continue Coumadin and med was not given."

R113's Progress Notes dated 04/13/20 at 10:10 AM documented her medical doctor (MD) was

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notified of critical lab results of INR, a test that along with PT, measures the time it takes blood to clot. Per this progress note, R113's MD gave an order for R113's anticoagulant medication (Coumadin) to be held and facility to do a daily INR and call MD office with results. R113's progress notes document that INRs were done on 04/14/20 and 04/15/20, and R113's anticoagulant medication continued to be held on those days, and INR was to be repeated on 04/16/20. Review of R113's progress notes document no new orders were documented related to R113's INR that was done on 04/16/20, and no additional INR was done on 04/17/20, 04/18/20 or 04/19/20. There were no new orders to resume R113's anticoagulant medication.

R113's progress note dated 04/20/20 at 10:55 AM documented, "PT/INR results reported to MD office."

R113's progress notes dated 04/20/20 at 11:13 AM document, "Nurse from MD office called stating MD will have to be contacted due to INR being so low."

R113's progress notes dated 04/20/20 at 2:12 PM document, "MD office called back and requested (R113) be sent to hospital to be put on heparin drip to regulate blood viscosity."

R113's Medication Administration Record (MAR) dated 04/01/20 to 04/30/20 documents R113 did not receive her anticoagulant medication on 04/15/20, 04/16/20, 04/17/20, 04/18/20, 04/19/20, or 04/20/20.

R113's Hospital History and Physical Report dated 04/21/20 documents, "Chief Complaint: Subtherapeutic INR (International Normalized

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Ratio). (R113) is a female with multiple medical problems to include end-stage renal disease on hemodialysis, coronary artery disease, congestive heart failure, valvular heart disease status post mechanical mitral and aortic valve replacement on long-term anticoagulation with warfarin. (R113) apparently has not been receiving her warfarin since sometime last week for reasons unclear to the patient. I asked if she inquired why her warfarin was being held, and she tells me, 'I just trust that they know what they are doing.' She is now having to be admitted for heparin drip given the presence of mechanical valves."

R113's Hospital Discharge Instructions dated 04/26/20 document: To continue daily PT/INR draws with results to (Cardiologist's) office in order to monitor her closely. This patient's INR drops quickly and it is important for orders for lab draws and medications to be followed appropriately in order to prevent adverse events such as a stroke or bleeding."

On 10/26/20 at 11:15 AM per phone interview, V2 (Director of Nursing) stated she did review R113's medication error that occurred on 04/17/20, but could not understand exactly what happened, and none of the staff who were involved are employed by the facility anymore. V2 stated if a medication error occurs the facility follows the policy and procedure and notifies the resident's family and physician and follows out whatever orders are given. She stated the facility staff use a PT/INR machine now to perform labs and report the results to the MD for orders regarding Coumadin dose. V2 stated she does not know that there is a specific policy or procedure regarding high risk medications and double-checking orders, but she personally tracks residents who are on Coumadin to ensure the nurses are following through on the

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
	IL6002729	A. BUILDING: ____ B. WING ____	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDWARDSVILLE NSG & REHAB CTR	401 ST MARY DRIVE EDWARDSVILLE, IL 62025

(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 37 lab and medication orders for those residents. The facility's policy, "Adverse Consequences and Medication Errors" revised April 2014, documents: The interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions (ADRs) and side effects. Adverse consequences shall be reported to the Attending Physician and Pharmacist, and to federal agencies as appropriate. 12. In the event of a significant medication-related error or adverse consequences, immediate action is taken, as necessary, to protect the resident's safety and welfare. Significant is defined as: b. Requiring hospitalization or extending a hospitalization. (B)	S9999		