STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005961	A. BUILDING: _____ B. WING _____	C 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD NURSING & REHAB CENTER	152 WILMA DRIVE MARYVILLE, IL 62062

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S 000	Initial Comments Facility Report Investigation to Incident of 7/8/19/IL113932 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.1010h) 300.1210b) 300.1210d)3)6) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B) 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. Restorative measures shall include, at a minimum, the following procedures:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to perform ongoing assessments, failed to recognize a change of condition and failed to notify the physician/nurse practitioner of all pertinent information regarding R2's anticoagulant therapy for Deep Vein Thrombosis after R2 fell.

This failure has the potential to effect 8 of 8 residents (R2, R7, R8, R9, R10, R11, R12 and R13) reviewed for ongoing assessment of potential risk factors for anticoagulant use in the sample of 13.

Finding include:

R2's Face Sheet, undated, documents R2 has diagnoses of Acute embolism (blockage of blood

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S9999	Continued From page 2	S9999		

vessel) and thrombosis (formation of a blood clot inside a blood vessel) of unspecified deep veins of unspecified lower extremity, Unspecific lack of coordination, Muscle weakness, Abnormal posture, and Cognitive communication deficit.

R2's Physician Order (PO), dated 6/28/19, written by V9, Nurse Practitioner (NP), documented an order for left lower leg venous doppler (a diagnostic test to check the circulation in the large vein in the legs).

R2's Venous Doppler Results, dated 06/29/19 documented R2 had a deep vein thrombosis (blood clot) noted in her left lower extremity.

R2's PO, dated 6/29/19, documents R2 should receive "Lovenox (blood thinner) 1mg (milligrams) /kg (kilograms) Sub q (subcutaneous - injection under the skin), BID (twice daily) until INR (international normalized ratio - a laboratory measurement of how long it takes blood to form a clot) between 2-3 and Coumadin 10 mg po (by mouth daily times 2 days. Day 3: Coumadin 5 mg obtain PT/INT (prothrombin time- a blood test that measures the time it takes for the liquid portion of blood to clot)/ INT call MD (medical doctor) with results."

R2's Medication Administration Record (MAR), dated 7/1/19, documents increase of Coumadin from 5mg to 6mg every evening, in addition to, the original order of Lovenox twice daily.

R2's Nurse's Notes dated from 6/29/19-7/8/19 does not document R2 had any bruising, bleeding or injuries. There was no documentation in R2's medical record that she had fallen, sustain injury, or bruises prior to 7/8/19.

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S9999	Continued From page 3	S9999		

R2's Comprehensive CNA (Certified Nurse's Assistant) Shower Review Sheets, dated 7/1/19 and 7/4/19, document, "To perform a visual assessment of a resident's skin when giving the resident a shower. Report any abnormal looking skin (as described below) to the charge nurse immediately. Forward any problems to the Director of Nurses (DON) for review. Use this form to show the exact location and description of the abnormality. Using the body chart below, describe and graph all abnormalities by number." There were no skin issues including bruising or injuries noted on R2's 7/1/19 and 7/4/19 shower review sheets.

On 7/30/19 at 8:30 AM, V14 (CNA), stated that she was the one who signed the shower sheet and it was correct. V14 stated that R2 was set-up help only and V14 did not observe R2's skin.

R2's Nurse's Note dated 7/8/19 at 11:15 PM documents R2 was attempting to sit on the bed, bounced up and hit her right eyebrow area on headboard, then rolled out of bed. The area to right eye was cleaned and steri-strips applied, bleeding was controlled. There was no documentation in this Nurse's Note as to extent of the injury.

R2's Nurse's Note dated 7/8/19 at 11:40 PM, written by V3 documents, "Resting quietly in bed. Neurological checks within normal limits. No sign and/or symptoms of pain or distress. Will continue to monitor." There is no documentation the nurse did any body assessment. The Nurse's Note did not document R2 having any bruising, bleeding, or any other injuries.

R2's Nurse's Note dated 7/9/19 at 1:15 AM written by V 3 documents, "Resting quietly in bed.

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S9999	Continued From page 4	S9999		

Neurological checks within normal limits. No sign and/or symptoms of pain or distress. Will continue to monitor. Blood Pressure 118/78, Temperature 97.1, Respiration 20, and Pulse 66." The is no documentation the nurse did any body assessment. The Nurse's Note did not document R2 had any bruising, bleeding or any other injuries.

R2's Nurse's Note dated 7/9/19 at 3:30 AM written by V3 documents, "Neurological checks are within normal limits. Denies pain or distress. Will continue to monitor." There is no documentation the nurse assessed R2's body or R2 had any bruising, bleeding, or any other injuries.

R2's Nurse's Note dated 7/9/19 at 4:45 AM documents, "Resting quietly in bed. No sign and/or symptoms of pain or distress. Neurological checks within normal limits." There is no documentation of any bruising, bleeding, or any other injuries noted.

R2's Nurse's Note dated 7/9/19 at 5:35 AM documents, "Resident was cold, clammy but states 'I'm hot' labored breathing noted." The Nurse documented that her (peripheral capillary oxygen saturation (spO2)- estimate of amount of oxygen in the blood) was 52% room air, Pulse 38. unable to obtain blood pressure. Call to 911." There is no documentation of any bruising, bleeding, or any other injuries noted.

R2's Nurse's Note dated 7/9/19 at 5:38 AM documents the ambulance arrived, transported R2 to local hospital for evaluation.

R2's Hospital History and Physical Records, dated 7/9/19, documents R2 arrived at the

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ELMWOOD NURSING & REHAB CENTER	152 WILMA DRIVE MARYVILLE, IL 62062

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S9999	Continued From page 5	S9999		

emergency department at 6:07 AM with a history of Deep Vein Thrombosis (DVT) and anticoagulant therapy for an evaluation for altered mental status. It documented R2 had a fall at the nursing home on 7/8/19 and had become less aware, having difficulty breathing, and not following commands. This report documents that R2 had diffuse ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising). The report documents she had extensive bruising over her abdomen and a laceration above her right eye. R2 was taken to CAT (Computerized Axial Tomography-special x-ray test that produce cross-sectional images of the body using x-ray and a computer) scan to evaluation for an intercranial hemorrhage. Upon transporting back to the emergency department, R2 expired at 6:38 AM.

R2's Electronic Death System Form, dated 7/15/19, written by V8, Physician, documents that R2 had a fall at the nursing home attempting to walk. The Form documented the immediate cause of death was traumatic cerebral hemorrhage. The Form documented "Deep Vein Thrombosis" as a condition to leading to the cause of death with R2 being on anticoagulants listed as a significant condition contributing to R2's death.

On 7/17/19 at 12:04 PM V3, Licensed Practical Nurse (LPN), V3 confirmed she was nurse on duty the night R2 fell. V3 stated that R2 had a "scratch" above her right eyebrow area, she cleaned the area then notified V9, Nurse Practitioner (NP). V3 stated that V9 told her to start neuro checks and incident report. V3 stated that R2 was her normal self until around 5-5:15 AM. V3 stated that she noticed R2's color off, her breathing was not normal, oxygen level was low,

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S9999	Continued From page 6	S9999		

and R2 was cool to the touch. V3 stated that R2 had bruising on her abdomen, "both sides, all sizes, looked like circles from shots." V3 stated that she documented those bruises on R2 body assessment. There is no documentation noting those bruises.

On 7/17/19 at 1:07 PM, V4 (CNA), stated that on 7/8/19, R2 "plopped" on the bed, hitting her head on the headboard and rolled onto the floor. V4 stated she and V10 got R2 off the floor. V4 stated R2 vomited several times "projectile" brown vomit with red chunks during the night. V4 stated she made V3 aware. V4 stated V3 told R2 she couldn't give her any more water since she was vomiting. V4 stated eventually R2 became pale.

On 7/18/19 at 11:05 AM V4, (CNA), stated that R2 had dark purple bruising on her (whole) abdomen. V4 stated that those bruises were there before the fall. V4 could not recall when she noticed the bruises but R2's bruises were there before R2 fell on 7/8/19.

On 7/30/19 at 7:57 AM V4, (CNA), stated that she was not sure of the times of the vomiting. She stated that it was a little while after R2 fell. V4 stated that R2 vomited at least three times throughout the night. And each time, V4 told V3. V3 would go in and check on R2, however; she didn't stay in the room.

On 7/30/19 at 8:30 AM, V3 (LPN), stated, "I thought about it. I didn't document the bruises on her abdomen because it was already on her weekly skin assessment. I only documented the new one to her head." V3 also stated that she didn't recall telling V9, (NP) about R2 being on anti-coagulants the night she fell. V3 also stated that she does not know about the emesis V4,

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S9999	Continued From page 7	S9999		

(CNA) is referring too."(V4) didn't tell me about (R2) vomiting."

On 7/17/19 at 3:15 PM V8, Attending Physician, stated that "Any nurse should know that if a resident is on an anti-coagulant and hit their head, should be sent out to the emergency room (ER)." V8 stated, "That's standard of practice isn't it? If they would have called me, I would have sent her out."

On 7/18/19 at 10:20 AM V9, NP, stated that the facility called at 12:18 AM on 7/9/19 regarding R2's fall and again at 6:02 AM reporting they were sending R2 out to the ER due to a change in condition. V9 stated that she did not know R2 was on an anti-coagulant and if so, she would have ordered R2 to be sent out to the ER for an evaluation.

On 7/18/19 at 2:00 PM V2, Director of Nurses (DON), stated that the facility does not have a policy on Anti-Coagulation Therapy.

On 7/23/19 at 4:00 PM, V2 (DON) stated she would expect the CNA's and nurses to observe for bruising, excessive bleeding, and to make sure labs are done on time. V2 stated she would expect the nurses to notify the medical doctor of any injuries sustained while on a blood thinner. V2 stated that no one had reported any bruising on R2's abdomen to her.

On 7/23/19, V2 provided a list of residents who currently are in the facility and are on anticoagulation therapy. The following residents are on this list: R7-R13.

(A)

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