STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003628	A. BUILDING: _____ B. WING _____	C 06/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENWOOD HEALTHCARE & REHAB.	19330 SOUTH COTTAGE GROVE GLENWOOD, IL 60425

(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	Final Observations Statement of Licensure Violations; 300.610a) 300.1210b) 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 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 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/23/15

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 Based on interview and record review, the facility failed to follow physician orders, the policy for drawing coumadin levels, and the procedure for entering physician telephone orders for 1 of 3 residents (R1) reviewed for physician orders and medication administration in the sample of 5. This failure resulted in R1 receiving 5 milligrams of the blood thinner Coumadin for 2 days when the level was higher than the recommended limit. R1 had nosebleeds and had to be transferred to the hospital and admitted to the intensive care unit for blood transfusions and intravenous vitamin K to reverse the high coumadin level. Findings include: On 6/8/15 at 8:30am, by phone, Z4 (Family) stated R1's blood got so thin, it caused a nosebleed. Closed record documents R1 was admitted to the facility from the hospital on 1/24/15 with the diagnoses of end stage kidney disease, renal dialysis, lower extremity blood clots, femur fracture, coronary artery disease, sacral pressure ulcer, diabetes, and peripheral vascular disease. R1 was transferred to the hospital 10 days later on 2/03/15 because of a nosebleed, a high coumadin level, and worsening circulation to the feet. Coumadin Lab results document elevated levels: 1/30/15 8.66 (normal range 2-3), hold coumadin 1/30/15 and 1/31/15, resume coumadin on 2/1/15, draw a level on 1/31/15. On 1/31/15 5.66, hold coumadin 1/31/15 and 2/1/15, draw a level on 2/2/15. Progress Note documents R1's coumadin level is elevated at 5.65, new orders given to hold coumadin until Monday 2/2/15 and	S9999		

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S9999	Continued From page 2	S9999		

redraw 2/2/15. There are no lab results for 2/2/15. February 2015 Medication Administration Record (MAR) documents R1 received coumadin 5 mg on 2/1/15 and 2/2/15 at 6pm. Physician Orders document draw a coumadin level on Monday (2/2/15) and Coumadin 5mg by mouth every evening, on hold 1/30/15 2:40pm to 2/1/15 2:38pm and on hold 2/3/15 4:02pm to 2/4/15 1:24am. Progress Note 2/3/15 3:58pm, documents R1 was observed with nose bleeds off and on throughout the shift, Vitamin K 2.5 mg given orally, and an abnormal coumadin level is noted (without a specific value). Lab results 2/3/15 document an elevated coumadin level of 7.48. Notation to the bottom of the lab report documents R1 was sent to the hospital. R1's facility records do not contain a Coumadin Flow sheet.

Hospital Physician Consult 2/4/15 documents R1 was discharged to this facility on 1/24/15 after a filter placement for the blood clots and being started on Coumadin, a blood thinner. R1 was admitted to the intensive care unit and received blood transfusions for a low blood level of 5.5 (normal range for R1 8-9) and intravenous vitamin K to reverse the elevated coumadin level of greater than 11 (normal range 2-3). R1 is diagnosed with elevated coumadin level, muscle hematoma, and retroperitoneal bleed.

On 6/8/15 at 12pm, E3(Nurse) stated staff follow the anticoagulation policy and Coumadin is given in the evening.

The following interviews took place on 6/9/15:
At 10:40am, Z3(Nurse Practitioner) stated R1 was on Coumadin for blood clots in the legs.
At 2:15pm, Z3 stated R1's coumadin level should have continued to decrease if coumadin was not

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S9999	Continued From page 3	S9999		

given on 2/1/15 and 2/2/15. R1's level should have been checked as ordered. Checking the coumadin level a day later and after receiving 5 mg for 2 days in a row with an already elevated level, Z3 would expect the level to be even higher, increasing R1's risk of bleeding. On 2/3/15, Z3 ordered oral vitamin K to counteract the high coumadin level. R1 bled because the coumadin level was very high. Z3 stated she did not know R1 received the 2 doses of coumadin when they should have been held.

At 3:10pm, E2(Director of Nursing) stated nurses write up a lab requisition when labs are ordered. E2 asked why R1's coumadin level was not drawn on 2/2/15 and the lab did not know why. E2 stated when a nurse takes a telephone order from a physician, they are responsible for entering it into the computer as an order. If the order is to hold a medication, the order automatically populates to the Medication Administration Record (MAR) and an "H" is recorded in the box for the days the medication is not to be given. A held medication will not appear on the screen during administration times. E2 stated she will look for R1's Coumadin Flowsheet.
At 3:15pm, by phone, E6(Nurse) stated the most recent order overrides the last order. E6 remembers R1's lab order but does not remember if the order to hold Coumadin was entered into the computer. E6 stated nurses are to wait for the next coumadin level before giving coumadin in the evening.
At 3:35pm, E7(Nurse) stated R1 had nosebleeds on and off throughout the day shift 2/3/15. The nosebleeds would stop and start, but were not uncontrollable. E7 stated R1 had an abnormally high coumadin level, Z3 ordered oral vitamin K, E7 gave the vitamin K, and R1 was sent to the hospital. E7 stated if coumadin was scheduled on

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S9999	Continued From page 4 the MAR 2/2/15, it was administered. E7 reviewed the February 2015 MAR and confirmed R1 received 5 mg of coumadin on 2/2/15 and E7 confirmed the computer initials. At 4pm, by phone, E8(Nurse) stated if R1 had coumadin scheduled and the initials are on the MAR, then coumadin was given on 2/1/15. Anticoagulation Therapy Policy - All residents on anticoagulation therapy shall have their medications monitored monthly, unless otherwise ordered by a physician. All residents on Coumadin should have an order for a monthly prothrombin time (unless ordered sooner by MD). The facility does not have a policy regarding telephone orders. (A)	S9999		

Imposed Plan of Correction
NAME OF FACILITY: Glenwood Healthcare & Rehab
DATE AND TYPE OF SURVEY: June 6, 2015
Complaint Investigation:
1592891/IL0077603

Attachment B
Imposed Plan of Correction

300.610a)
300.1210b)
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

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

Section 300.3240 Abuse and Neglect

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

This will be accomplished by:

I. Provide education for nursing staff on facility's policy and procedures for placing medications on hold, monitoring lab values and to include documentation of INR flow sheets.

II. Director of Nursing or Designee will conduct daily audits of anti-coagulant binders to ensure compliance.

III. Director of Nursing will be responsible for achieving and maintain compliance.

IV. Facility Administrator to provide oversight for continued compliance.

Date of completion: Ten days from receipt of the Imposed Plan of Correction

7/29/2015/JP