

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000335	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/09/2017
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NAME OF PROVIDER OR SUPPLIER MANORCARE OF WESTMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 512 EAST OGDEN AVENUE WESTMONT, IL 60559
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S 000	<p>Initial Comments</p> <p>Annual Licensure and Certification survey.</p> <p>Incident Report Investigation of January 27, 2017 / IL 91431</p> <p>STATEMENT OF LICENSURE VIOLATIONS:</p>	S 000		
S9999	<p>Final Observations</p> <p>300.1210b) 300.1220b)2) 300.1620a) 300.1630c) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p>	S9999	<p>Attachment A</p> <p>Statement of Licensure Violations</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>Section 300.1620 Compliance with Licensed Prescriber's Orders</p> <p>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. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.</p> <p>Section 300.1630 Administration of Medication</p> <p>c) Medications prescribed for one resident shall not be administered to another resident.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>These regulations are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to follow physician orders and failed to ensure residents remained free of significant medication errors.</p> <p>This failure resulted in R1 receiving Coumadin 2 MG (milligrams) for 12 days without a physician order and was admitted to the hospital for a (GI) gastrointestinal bleed.</p> <p>This applied to 2 of 3 residents (R1 and R2) reviewed for anticoagulation medication errors in the sample of 22.</p> <p>The findings include:</p> <p>1). R1's face sheet showed 76 year old R1 was admitted with diagnoses including colon cancer, left hemicolectomy and alcoholic cirrhosis of the liver. R1's order summary report on the date of admission did not include an order for the anticoagulation medication Coumadin.</p> <p>R1's progress note dated January 12, 2017 showed upon admission, R1 was alert, oriented to person place and time and was verbally responsive.</p> <p>On January 14, 2017, an order was transcribed into the medication profile of R1 for Coumadin 2 MG to be given at bedtime for anticoagulation and an order to draw labs for PT (Prothrombin time) and INR (international normalized ratio) testing "in the morning for monitoring lab until January 16, 2017."</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>R1's January 1-31, 2017 Medication Administration Record showed R1 received Coumadin 2 MG at 9:00 PM from January 14 through January 25, 2017 (total of 12 days).</p> <p>R1's Order Recap Report from January 26 through January 27, 2016 showed the Coumadin medication was discontinued on January 27, 2017 at 6:19 PM as R1 was transferred out of the facility.</p> <p>R1's progress notes dated January 26, 2017 at 2:37 PM showed "this morning pt (patient) seemed not like herself. She is awake and alert but not talking much. Not always responding when asking direct questions...spoke with doctor...do stat labs...will come to see pt."</p> <p>R1's progress notes dated January 27, 2017 at 12:02 AM showed "patient was alert, nonverbal, and slow responds...was seen by doctor...in evening...6:15 PM noted bleeding on diaper. When assessed it was rectal bleed...called doctor...send to hospital...admitted the patient and diagnosis is GI (gastro-intestinal) bleed..."</p> <p>R1's physician progress notes untimed and dated January 26, 2017 described R1 as "dazed and nonverbal. Yes and no answers since morning."</p> <p>The document titled "State Report of Patient Incident" which was reported by the facility to Illinois Department of Public Health (IDPH) on January 27, 2017 described the incident as "Coumadin given in error, resident sent to hospital."</p> <p>On January 31, 2017, at 12:14 PM, E1 (Administrator) stated she was looking into re-hospitalization of resident and was informed</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>Z1 (Attending physician) had called and questioned when R1 was on Coumadin, because it wasn't something the provider would have ordered based on the resident's comorbidities. E1 added the medication was given from January 14-25, 2016 in error and the resident it was intended for was R3.</p> <p>On January 31, 2017 at 12:48 PM, E2 (Director of Nursing) stated Z1 (Attending physician) called from the hospital, reported R1 had an elevated INR and asked if R1 was on Coumadin, which prompted an investigation. E2 stated R1 received Coumadin from January 14 through January 24, 2017. E2 added the error occurred because E4 (nurse) transcribed the order "late".</p> <p>On January 31, 2017 at 2:55 PM, E4 stated she inadvertently wrote the orders too close to R1's name on E4's report sheet, did not go back to verify if R1 was on Coumadin and therefore created the error.</p> <p>On February 1, 2017 at 2:11 PM, R1 stated that Z1 (Attending physician) stated the medication was not ordered for R1. R1 remembered taking it but not knowing why, added that when asked if R1 was on medication at home, R1 responded "no". R1 continued to state that at the hospital, R1 had no knowledge how she got there, was told that R1 wasn't herself and expressed the experience was very scary.</p> <p>R1's final report from the hospital stay dated January 27, 2017 showed R1 presented with "loose stools looked dark in color and her INR was 9.5." R1 was positive for fecal occult test. The diagnostic impression showed gastrointestinal bleed, likely lower gastrointestinal bleed; anemia, likely secondary to gastrointestinal</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>bleed and R1 was on anticoagulation for unknown reason.</p> <p>On February 8, 2017 at 11:25 AM, Z1 (Attending physician) stated when R1 was admitted to the facility, R1's transfer paperwork did not include orders for Coumadin. Z1 went on to say that Z1 did not provide R1 an order for Coumadin nor was she aware R1 received Coumadin for 12 days.</p> <p>On February 8, 2017 at 11:35 AM, Z5 (pharmacist) stated the biggest fear of someone receiving anti-coagulation medication in error would be internal bleeding, diarrhea and fatigue.</p> <p>Lexi-Comp's drug Reference handbooks, 12th Edition shows Coumadin (warfarin) is an Anticoagulant. It is a High alert medication. "The Institute for Safe Medication Practice (ISMP) includes this medication among its list of drugs which has a heightened risk of causing significant patient harm when used in error." It further states "as with all anticoagulants, bleeding is the major adverse effect of warfarin. Hemorrhage may occur at virtually at any site."</p> <p>2). R2's face sheet showed R2 was admitted on December 28, 2017 with diagnoses that included acute hematogenous and atrial fibrillation.</p> <p>R2's medication review report sheet displayed physician orders beginning December 28, 2016 through January 2017. R2 was ordered Coumadin in varying doses related to atrial fibrillation.</p> <p>On January 9, 2017, review of physician written orders showed to discontinue R2's Heparin and decrease Coumadin to 11 MG at bedtime. R2's</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>MAR showed R2 received Heparin 1 ML (milliliter) on the evenings of January 9-10 (2 doses), and Coumadin 12.5 MG on January 9, 2017 (1 dose).</p> <p>R2's progress note dated January 9, 2017 at 3:22 PM showed: diagnosis of acute DVT (deep vein thrombosis) right leg with the plan to decrease Coumadin to 11.0 MG at bedtime daily and D/C (discontinue) Heparin.</p> <p>R2's progress note dated January 10, 2017 at 8:04 PM showed orders written on January 9, 2017 to discontinue Heparin and decrease Coumadin was not carried out on January 9, 2017; physician was informed.</p> <p>On February 8, 2017 at 1:03 PM, Z4 (nurse practitioner) stated she was unable to recall if she had been informed the orders for R2 had not been carried out. Z4 stated the failure to reduce the Coumadin and discontinue of the Heparin, could cause Z4 to make decisions to further decrease the Coumadin based on the lab results.</p> <p>On February 8, 2017 at 11:35 AM, Z5 (pharmacist) stated the biggest concern of someone receiving anti-coagulation medication in error, would result in internal bleeding, diarrhea and fatigue.</p> <p>The facility provided guidelines for oral anticoagulation therapy dated 2015, which showed the following: Anticoagulation effect can be expected within 36-72 hours with peak effect occurring within 5-7 days; INR is monitored daily until stable and therapeutic level is achieved; and resident education is important in anticoagulation therapy.</p> <p>Lexi-Comp's drug Reference handbooks, 12th</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>Edition shows Heparin is an Anticoagulant. It is a High alert medication. "The Institute for Safe Medication Practice (ISMP) includes this medication among its list of drugs which has a heightened risk of causing significant patient harm when used in error." It further states "use with caution as hemorrhage may occur."</p> <p>(B)</p> <p>300.615e)</p> <p>Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record information</p> <p>In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act).</p> <p>This regulation is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to initiate criminal background checks within 24 hours of a resident's admission.</p> <p>This applies to 10 residents (R23, R26, R31, R36, R37, R49-R53) in the supplemental sample reviewed for criminal background verification.</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>The findings include:</p> <p>R23 and R53 were admitted to the facility on January 31, 2017. The facility's records showed R23 and R53's criminal background checks were initiated on February 8, 2017.</p> <p>R26, R37, R49 and R50 were admitted to the facility on February 3, 2017. The facility's records showed R26, R37, R49 and R50's criminal background checks were initiated on February 8, 2017.</p> <p>R31 and R51 were admitted to the facility on February 2, 2017. The facility's records showed R31 and R51's criminal background checks were initiated on February 8, 2017.</p> <p>R36 was admitted to the facility on February 5, 2017. The facility's records showed R36's criminal background check was initiated on February 8, 2017.</p> <p>R52 was admitted to the facility on February 1, 2017. The facility's records showed R52's criminal background check was initiated on February 8, 2017.</p> <p>On February 8, 2017 at 3:00 PM, E25 (Business Office Manager) said, "The person who used to do the background checks does not work here anymore, and the back up person transferred to another facility, so no one was doing the background checks."</p> <p>(C)</p>	S9999		
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