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
	IL6005615	A. BUILDING: ____ B. WING ____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME, THE	6901 NORTH GALENA ROAD PEORIA, IL 61614

(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
S 000	Initial Comments Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1620a) 300.1630b) 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 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a	S9999	Attachment A Statement of Licensure Violations	

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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.

Section 300.1630 Administration of Medication

b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available , a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility.

These Regulations were not met as evidenced by:

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Based on interview and record review, the facility failed to accurately transcribe a physician's order for one of 15 residents (R27) reviewed for medications in the sample of 15. As a result, R27 was administered an excessive dosage of R27's Lasix (diuretic) medication causing weakness, dehydration and hypokalemia, and subsequently requiring R27 to be hospitalized.

Findings include:

The facility's Medication and Treatment Orders policy (Revised April 2014) documents the following: "Orders for medications and treatments will be consistent with principles of safe and effective order writing."

R27's electronic facesheet indicates that R27 was readmitted to the facility on 2/9/17, and R27's electronic diagnoses document R27's diagnoses to include the following: Viral Pneumonia, Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia, Congestive Heart Failure, Emphysema and Chronic Lymphocytic Leukemia.

R27's Five Day Final Investigation report dated 2/24/17 documents the following: "(E1, Administrator) notified by (E2, Director of Nursing) that during this morning's (2/16/17) medication pass, it was noted that there had been a transcription error of a physician's order on 2/15/17, for (R27's) Lasix dose. Fax order received...for the following: give additional 40 mg (milligrams) daily x 3 days...Transcribed as Lasix 40 mg t.i.d. (three times daily) x 3 days."

R27's faxed order dated 2/15/17 received from (Z4, Advanced Practice Nurse) documents the

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following: "Noted weight gain. Give additional 40 mg (milligrams) daily x 3 days (in addition to her 80 mg). Continue daily weights."

R27's Physician Order dated 2/9/17 documents the following order: "Lasix 80 mg tablet one tab daily at 8:00 AM." R27's February 2017 Medication Administration Record indicates R27's Lasix 80 mg dose was administered as ordered on 2/16/17.

R27's Physician order dated 2/10/17 documents the following order: "Metolazone (diuretic) 2.5 mg tablet one time daily starting 2/10/17." R27's February 2017 Medication Administration Record indicates R27 was administered R27's Metolazone 2.5 mg dose as ordered on 2/16/17.

R27's "mistranscribed" Physician Order dated 2/16/17 and documents the following: "Lasix 40 mg three times daily for three days starting 2/16/17 at 9:00 AM, 1:00 PM and 5:00 PM." R27's February 2017 Medication Administration Record indicates R27 was administered 40 mg of Lasix on 2/16/17 at 9:00 AM, 1:00 PM and 5:00 PM.

R27's Clinical Notes dated 2/16/17 and timed 5:57 PM documents, "(R27) back from appointment and eating in the dining room. Vitals are stable, denies pain at this time. Alert and Oriented, able to make needs known. No complaints at this time."

R27's Clinical Notes dated 2/17/17 at 4:06 AM documents, "Resting comfortably in bed. Went to see lung doctor says she is not feeling good."

R27's Clinical Notes dated 2/17/17 at 9:42 AM documents, "Hospital called with lab values

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Potassium 2.7 milliEquivalents per liter (mEq/L, indication of a critically low value)...(Z5, R27's Physician) advised us to send (R27) to hospital. (R27) received Lasix 80 mg yesterday AM and 40 mg t.i.d. (three times daily) yesterday in addition to Metolazone this morning...Weight down to 149 pounds from 159 pounds two days ago. (R27) very weak. Shaky. Sending to (local emergency room)."

R27's local Emergency Department documentation dated 2/17/17 documents the following: "(R27) complains of generalized weakness and fatigue. (R27) also states she has dizziness and lightheadedness...Clinical Impression: Hypokalemia (low potassium), Weakness...Potassium was 2.7 mEq/L on labs obtained prior to ER (emergency room) visit. With high dose of diuretics, this would explain her hypokalemia."

R27's local hospital laboratory results form documents the following: On 2/8/17, R27's potassium was 4.6 mEq/L with the following parameters: normal range 3.5 - 5.1 mEq/L. On 2/17/17, R27's potassium was 2.7 mEq/L. On 2/8/17, R27's BUN (Blood Urea Nitrogen) was 29 milligrams per deciliter (mg/dL) with the following normal parameters: 7 - 25 mg/dL. On 2/17/17, R27's BUN was 47 mg/dL.

According Tietz Textbook of Clinical Chemistry (4th Ed.) (2006). Blood Urea Nitrogen (BUN), Serum. Retrieved on 3/9/17 from http://www.mayomedicallaboratories.com/test-catalog/Clinical+and+Interpretive/81793, "Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss)."

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On 3/8/17 at 10:12 AM, E1 Administrator, stated that R27 is still hospitalized and E18, Registered Nurse, who incorrectly transcribed R27's Lasix order, no longer works at the facility.

On 3/8/17 at 11:01 AM, Z5, R27's Physician, stated that R27 was admitted to the hospital as a result of the medication error that occurred on 2/16/17. Z5 stated, "She received two extra doses of Lasix which caused dehydration and a significant weight loss, and that caused her weakness. The morning after (the medication error) she couldn't even stand up. The weakness and dehydration was related to the extra Lasix doses over-diuresing her." Z5 then verified that on 2/17/17, R27's serum potassium level was 2.7 mEq/L (normal range 3.5 - 5.1 mEq/L), a critically low level, and stated, "Lasix is widely known to cause a fall in a resident's potassium."

(B)

Section 300.7040 Activities

e) Activities shall be adapted, as needed, to provide for maximum participation by individual residents. If a particular resident does not participate in at least an average of 4 activities per day over a one-week period, the unit director shall evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team.

This Regulation was not met as evidenced by:

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Based on observation, interview and record review, the facility did not evaluate or modify activities when attendance did not average four activities per day over a one week period for one of 13 residents (R11) reviewed for activities in the sample of 15.

Findings include:

On 3/7/17 at 9:30 AM, R11 was sitting in a wheelchair at a dining room table. Across the room an exercise activity began. R11 was not invited to the activity. R11 began to yell out and E13 (Unit Director) walked over to R11 and asked if he wanted some nuts. E13 then placed nuts in front of R11 and walked away. R11 did not eat the nuts and continued to sit at the table rubbing his head with his hand. On this same date at 9:50 AM, E10 Certified Nurse's Assistant (CNA) and E11 CNA pushed R11 in a wheelchair to R11's room to lay down.

R11's activity participation calendar documents R11 participated in less than four activities on 2/20/17, 2/21/17, 2/22/17, 2/23/17, 2/24/17 for the week of 2/19/17 - 2/25/17 and participated in less than four activities on 2/26/17, 3/1/17, 3/2/17, and 3/4/17 for the week of 2/26/17 - 3/4/17.

On 3/8/17 at 11:20 AM, E17 (Activity Director) stated that E17 is responsible for scheduling the activities for the unit on which R11 resides. E17 stated each resident should be participating in at least four activities a day. E17 stated if a resident is not attending four activities a day, then the facility should re-evaluate the activity participation of the resident and possibly make them a one-on-one for activities. E17 confirmed that R11

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did not participate in at least four activities per day for the weeks of 2/19/17 - 2/25/17 or 2/26/17 - 3/4/17. E17 stated R11's activity participation should have been re-assessed.

The facility's Activity's policy dated 12/3/2007 documents, "Activities are adapted, as needed to provide for maximum participation by individual residents. If a particular resident does not participate in at least an average of 4 activities per day over a one-week period, the (unit director) will evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team."

(AW)

Section 300.7050 Staffing

d) Nurses, CNAs, and social service and activities staff who work on the unit at least 50 percent of the time that they work at the facility shall participate in a minimum of 12 additional hours of orientation within the first 45 days after employment, specifically related to the care of persons with Alzheimer's disease and other dementia. This orientation shall be defined in facility policies and procedures; shall be in a form of classroom, return demonstration, and mentoring; and shall define to new staff the elements contained in Section 300.7050(e)(1)-(10).

e) Nurses, CNAs, and social services and activities staff who work on the unit at least 50 percent of the time that they work at the facility

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shall attend at least 12 hours of continuing education every year, specifically related to serving residents with Alzheimer's disease and other dementia. (Completion of the 12 hours of orientation in accordance with subsection (d) of this Section may be counted as continuing education for the year in which this orientation is completed.)

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to ensure that facility staff that work at least 50 percent of their scheduled work time on the Dementia Unit received 12 hours of Dementia training. This failure has the potential to affect three of three residents (R9, R11, and R24) reviewed for Dementia Care on the sample of 15 and ten residents (R4, R12, R14 and R30 through R36) on the supplemental sample.

Findings include:

The facility's Dementia Unit Staff Education policy dated 12/3/2017 documents, "All nurses, certified nursing assistants, social service, and activities associates who work in (the dementia unit) at least 50 percent of the time that they work at (the facility) must participate in a minimum of 12 additional hours of orientation within the first 45 days after employment and at least 12 hours of continuing education every year, specifically related to the care of persons with Alzheimer's disease and other related dementia."

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The facility's Health Center Room Occupancy Chart documents R4, R9, R11, R12, R14, R24, and R30 through R36 reside on the Dementia unit. During the facility tour on 3/6/17 at 10:00 AM R4, R9, R11, R12, R14, R24, and R30 through R36 were present on the Dementia unit.

The facility's education attendance record documents that E20 Activity Assistant, E21 Activity Assistant, E22 Activity Assistant, E23 Certified Nurse's Assistant, E24 Licensed Practical Nurse (LPN), and E25 LPN attended four hours of Dementia training. The facility's education attendance record documents that E14 Certified Nurse's Assistant (CNA) attended 5.75 hour of Dementia training.

The facility's hire date record documents E20 was hired on 12/12/16, E21 was hired on 12/5/16, E22 was hired on 1/9/17, E14 was hired on 12/14/15, E23 was hired on 12/12/16, E24 was hired on 10/17/16, and E25 was hired on 8/8/16.

On 3/9/17 at 10:50 AM, E13 (Unit Director) confirmed the hours of Dementia training and dates of hire for E20, E21, E22, E23, E24, E25, and E14. E13 stated E14, E20, E21, E22, E23, E24, and E25 should have had 12 hours of Dementia training. E13 stated E13 provided these employees with the four hours of initial training, but these employees did not receive the rest of their Dementia training as required.

(AW)

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE

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FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.615 DETERMINATION OF NEED SCREENING AND REQUEST FOR RESIDENT CRIMINAL HISTORY RECORD INFORMATION

Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information

e) 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)

f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.

These Regulations were not met as evidenced by:

Based on record review and interview, the facility failed to conduct criminal background checks

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within twenty four hours of the resident's admission for one of one resident (R20) reviewed for background checks in the sample of 15 and one resident (R29) on the supplemental sample.

Findings include:

The facility's Resident Background Screening Policy, no date, states, "Prior to or within the initial 24 hours of move-in residents of the Care Center will be screened on the Illinois Sex Offender Registration website, the Illinois Department of Corrections registered sex offender database and a request for criminal history record information in accordance with the Uniform Conviction Information Act (UCIA) will be made."

R20's electronic medical record documents that R20 was admitted to the facility on 2/24/17. R20's background check used for this admission was dated 3/07/16. R20 discharged from the facility care center to an apartment in the facility assisted living on 10/29/16.

R29's electronic medical record documents that R29 was admitted to the facility on 2/24/17. R29's background check used for this admission was dated 8/12/16. R29 was discharged from the facility care center to her daughter's home on 9/29/16.

On 3/08/17 at 2:00 PM, E15 (Social Service Director) stated: "(R20) was at the facility and discharged on 10/29/16. I (E15) used the background check done on 3/07/16 for (R20's) readmission on 2/24/17. (R29) was at the facility and discharged on 9/20/16 to (R29's) daughter's home. I (E15) used the background check done on 8/12/16 for (R29's) readmission on 2/24/17. I'm (E15) not sure what our policy says, but I think

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we can use the background check for a year. I would not be aware of any criminal activity of a resident after they have left our care center."

(AW)

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.625 IDENTIFIED OFFENDERS

Section 300.625 Identified Offenders

j) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care.

k) The facility shall incorporate the Identified Offender Report and Recommendation into the identified offender's care plan. (Section 2-201.6(f) of the Act)

These Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to develop a care plan regarding a

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resident's criminal history status for one of nine residents (R28) reviewed for background checks on the supplemental sample.

Findings include:

The facility's Assessments and Care Planning Policy dated 9/2013, states, "The Community's Interdisciplinary Team, in coordination with the resident, their family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Interim care plan will be developed within twenty-four (24) hours of admission/move in and will be effective until the comprehensive care plan is completed in conjunction with initial care planning.

R28's electronic medical record documents that R28 was admitted to the facility on 3/06/17.

R28's Uniform Conviction Information Act (UCIA) criminal history check dated 3/06/17 documents, "Multiple hits - fee fingerprints requested."

R28's current care plan dated 3/07/17 does not include a care plan addressing R28's, "Multiple Hits," from R28's UCIA criminal history check.

On 3/07/17 at 10:00 AM, E7 (MDS Coordinator) stated that E7 was unaware that R28's UCIA check was not cleared. E7 stated, "I (E7) don't know who does the background checks and am not sure how it would be brought to my attention. I haven't had one like this before."

On 3/07/17 at 2:00 PM, E15 (Social Services) stated, "(R28) has several "hits" on the Illinois State Police Report (UCIA). I didn't know that it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005615	A. BUILDING: ______ B. WING ______	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME, THE	6901 NORTH GALENA ROAD PEORIA, IL 61614

(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 14 would need to be care planned. I don't do care plans." (B)	S9999		