STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145739	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LUTHERAN HOME FOR THE AGED	800 WEST OAKTON STREET ARLINGTON HTS, IL 60004

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interview, and record review, the facility failed to follow their policy regarding investigating injuries of unknown origin. This applies to 1 of 3 residents (R4) reviewed for injuries of unknown origin in the sample of 7. The findings include: An incident report dated 4/29/20 states, {R4} Alert, and oriented times one to two, complains of pain to left knee on 8/10 . Doctor paged with new order for x-ray of left hip, knee, and femur. Results came back with a spiral fracture shaft of femur with overlap of fracture fragments . There was no known incidents. Her complaint of pain in her left knee area was first noted on 4/14/20 when {R4} experienced a medical event with low Blood pressure and lethargy. Doctor was made aware. Prior to complaints of pain resident was able to transfer with stand by assistance, was noted to transfer herself without any assistance or calling for help. After our investigation it is determined the nature of this fracture is accidental with possibility of an unwitnessed fall or incident. The Hospice Note dated 4/19/20 states, Clinician called out due to increase in swelling in Left Lower Extremity (LLE) and Left Labia. Upon assessment {R4's} LLE was turned outward on the bed. Very painful to touch, unable to straighten leg. There is bruising noted from mid thigh area down to knee on lateral side of leg. Possible fracture or dislocation. The facility policy entitled Abuse and Neglect of a Resident date 11/26/2019 states: Injuries of Unknown Origin : an injury should be classified as an injury of unknown sourcewhen both of the following conditions are met: -The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and -The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. -Bruising of unknown origin. The policy also states, Investigations for potential, injuries of unknown source will include interviews with associates, resident and families. Inquiries will include but are not limited to: When was the injury discovered? When was the resident last seen injury free? The time period between injury free and injury discovery will become the target of further inquiry . On 8/20/20 at 1:00PM V2 confirmed that the facility did not view R4's thigh bruising and swelling as an injury of unknown origin until they got the x-ray results on 4/29/20 showing that R4 had a fractured femur.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to investigate an injury of unknown origin within 5 days of the injury being noticed. This applies to 1 of 3 residents (R4) assessed for injuries of unknown origin in a sample of 7. The findings include: On 8/19/20 at 12:15PM, R4 was seated in her wheelchair in the dining room feeding herself lunch. R4 was clean and well groomed and pleasantly confused when spoken to. R4 stated that she hurt her left leg when she fell while having a [MEDICAL CONDITION]. An incident report dated 4/29/20 states, {R4} Alert, and oriented times one to two, complains of pain to left knee 8/10 . Doctor paged with hew order for x-ray of left hip, knee and femur. Results came back with a spiral fracture shaft of femur with overlap of fracture fragments . There was no known incidents. Her complaint of pain in her left knee area was first noted on 4/14/20 when {R4} experienced a medical event with low Blood pressure and lethargy. Doctor was made aware. Prior to complaints of pain resident was able to transfer with stand by assistance, was noted to transfer herself without any assistance or calling for help. After our investigation it is determined the nature of this fracture is accidental with possibility of an unwitnessed fall or incident. R4's EMR (Electronic Medical Record) nurse's notes(NN) dated 4/14/20 state, At 2:20PM patient 's face turned blue. vital signs was B/P -87/48 P -74, shallow breathing, Temp 97.4, SO2 95%. Notified Hospice about patient's condition, {V11- R4's Physician} was notified Patient was put by transfer to bed Patient's left knee was swollen and hard touch, verbalized pain when touched . NN dated 4/19/20 state, Pain when turned and repositioned . Noted increased swelling left leg and left pubic swelling ,discoloration on left lateral thigh. Hospice notified. Will send nurse to evaluate. The Hospice Note dated 4/19/20 states, Clinician called out due to increase in swelling in Left Lower Extremity (LLE) and Left Labia. Upon assessment {R4's} LLE was turned outward on the bed. Very painful to touch, unable to straighten leg. There is bruising noted from mid thigh area down to knee on lateral side of leg. Possible fracture or dislocation. R4's X-ray report dated 4/29/20 states, Spiral Fracture shaft of femur with overlap of fracture fragments. (An investigation into R4's injury was not started until the facility received this information- 10 days after the initial bruising was documented and 15 days after the initial pain was documented.) On 8/20/20 at 11:20AM, V11 stated, I was notified on 4/21and from their description I thought it could be a blood clot. I don't recall hospice talking to me about it. I don't recall hearing that it was externally rotated. I saw her on 4/30 and I don't think it was more than a week since I heard about the leg. We were focused on comfort measures. On 8/20/20 at 12:30PM, V10 (Hospice Case Manager) stated, After (Hospice RN) saw her she contacted the POA and spoke with the facility. She updated the nurse with what she saw but the daughter did not want any treatment. She was in a declining state. Every time we go in we do an assessment. Prior to this the resident was able to sit in her wheelchair and transfer with assist. On 4/14 she had a sharp decline- turning blue and was transferred to the bed before we ever got there. We tell the facility what we see and it is up to them to do an internal investigation. They said they did that but not until after they got the x-ray results on 4/29/20. On 8/19/20 at 1:40PM, V2 (Director of Nursing) stated, {V11} thought it might be a blood clot so we were in the process of ruling out a blood clot. We were not viewing it as an injury. {V11} did not want to do anything so there was nothing we could do at that point. There was no reason to do an investigation when we thought it was a blood clot. Hospice was taking the lead on that and they told {V11} and she just agreed with them and let them do what was needed. On 8/20/20 at 1:00PM V2 stated that she did not find any documentation from hospice in R4's EMR stating that the left leg swelling and discoloration could be a blood clot. Also V2 stated that the left thigh would be a strange location to find a blood clot. The facility policy entitled Abuse and Neglect of a Resident date 11/26/2019 states: Injuries of Unknown Origin : an injury should be classified as an injury of unknown sourcewhen both of the following conditions are met: -The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and -The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. -Bruising of unknown origin The same policy also states, Within five (5) working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation will be sent to the Department of Public Health.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow doctors orders for R1. This applies to 1 of 3 residents (R1) reviewed for physician orders [REDACTED]. The findings include: R1's medication record for July 2020 shows, PT with INR (Prothombin time/International Ratio- lab test to measure/dose [MEDICATION NAME] (blood thinner) levels) scheduled for July 22, 2020. R1's nurses notes dated July 20, 2020 shows, .Continue to hold [MEDICATION NAME] until further

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) orders D/C (discontinue) INR on 7/22 . The [MEDICATION NAME] flow sheet for R1 (rolling date) does not show the order to hold the [MEDICATION NAME] or to discontinue the PT/INR ([MEDICATION NAME]/international ratio) on July 22, 2020. The same form shows, 7/14/2020 Current [MEDICATION NAME] order: HOLD, PT/INR results: 26.6/2.6, New [MEDICATION NAME] Order: 1.5 milligram daily, Date of next PT/INR: 7/22/20. The next entry on the [MEDICATION NAME] flow sheet is July 22, 2020 after the PT/INR was drawn but it was discontinued and not to be drawn. R1's nurses notes dated July 22, 2020 written by V6 Registered Nurse (RN) shows, .PT/INR ([MEDICATION NAME] Time/International Ratio- laboratory test done to measure/dose [MEDICATION NAME] levels) was collected at 1800 (6:00PM). MD (Medical Doctor) was informed the labs result will be available around 2000 or 2100 (8:00PM or 9:00PM). Ask MD permission to page him when PT/INR result is ready. According to MD nurse on duty should page him in the morning with PT/INR result. According to nursing supervisor on duty need to page medical director with PT/INR result. Endorse all messages to next shift nurse. R1's nurses notes dated July 22, 2020 shows, PT/INR results relayed to medical director (V5) on call. New orders placed and carried out. On August 20, 2020, at 10:53 AM, V6 RN stated, she did get the response to not call V4 R1's primary care physician (PCP) until the next morning with the PT/INR result but the nursing supervisor told her to tell the next nurse on shift to call the medical director if the PT/INR was abnormal. So that is what she relayed to the next nurse. On August 20, 2020, at 9:50 AM, V7 RN stated, she had gotten report from V6 RN to not call V4 R1's PCP with the PT/INR results and to call V5 Medical Director with the results. She called V5 and couldn't remember if she talked to him or not but whoever she talked with gave her the order for [MEDICATION NAME]. She also stated, that she looked at the [MEDICATION NAME] flow sheet that showed R1 was still receiving [MEDICATION NAME] daily and reported that to whoever she talked to on the phone. (The [MEDICATION NAME] flow sheet was never updated with [MEDICATION NAME] being held on July 19, 2020. The Medication Administration Record [REDACTED]. On August 20, 2020, at 2:03 PM, V12 Nursing Supervisor stated, he was not aware of the PT/INR being discontinued on July 22, 2020 or the whole situation. Actually V6 RN and I had a conversation, she informed me that V4 R1's PCP doesn't want to be bothered at this time. So what if the results come back later? What will we do with the results? We need to take care of results from the PT/INR I told her, if that is the case, we need to inform V5 Medical Director. Instructed her to call V5. He also stated, he felt that having a PT/INR drawn and getting results should be relayed to a doctor in order to dose [MEDICATION NAME] (without knowing an order was given to discontinue the PT/INR and to not call with results until the morning). On August 20, 2020, at 12:13 PM, V5 Medical Director stated, the original order to discontinue the PT/INR on July 22, 2020 should have been canceled and never drawn. He stated, the facility should have called him directly on July 22, 2020. The facility called his on-call partner who has an obligation for V5's patients in his practice and not another doctor's patients. I never received a call that night from the facility. I would have never given the [MEDICATION NAME] order. He stated, he would have asked questions about the patient and knew what was going on before giving an order. I would never cancel out another doctor's order. The facility's physician orders- obtaining and transcribing policy dated February 11, 2006 shows, Policy Statement: To ensure that physician orders [REDACTED]. In implementing this policy, the following shall apply. 1. All orders for medications, tests, and treatments shall be written on the physician's orders [REDACTED]. 2. The licensed nurse who takes a verbal or telephone order must use the following procedure and is responsible for verifying all orders. a. Record the order, b. Read back and verify the complete order to the prescribing practitioner, c. Write/enter the name of the prescribing practitioner, d. Sign their own name as the licensed or registered person receiving the order, e. Transcribe order to appropriate documentation (MAR, TAR (Medication Administration Record. Treatment Administration Record)) . f. Verify allergies and compare to order, g. Update care plan to reflect change in plan of care, h. update consent forms if necessary, i. Contact residents Healthcare Power of Attorney as appropriate .
F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to discontinue a previously scheduled laboratory test for R1 to prevent an unnecessary laboratory test being done. This applies to 1 of 3 residents (R1) reviewed for medications/lab results in the sample of 7. The findings include: R1's medication record for July 2020 shows, PT with INR (Prothombin time/International Ratio- lab test to measure/dose [MEDICATION NAME] (blood thinner) levels) scheduled for July 22, 2020. R1's nurses notes dated July 20, 2020 shows, .Continue to hold [MEDICATION NAME] until further orders D/C (discontinue) INR on 7/22 . The [MEDICATION NAME] flow sheet for R1 (rolling date) does not show the order to hold the [MEDICATION NAME] or to discontinue the PT/INR ([MEDICATION NAME]/international ratio) on July 22, 2020. The same form shows, 7/14/2020 Current [MEDICATION NAME] order: HOLD, PT/INR results: 26.6/2.6, New [MEDICATION NAME] Order: 1.5 milligram daily, Date of next PT/INR: 7/22/20. The next entry on the [MEDICATION NAME] flow sheet is July 22, 2020 after the PT/INR was drawn but discontinued. R1's medication record for July 2020 shows, a PT/INR was drawn on July 22, 2020. On August 19, 2020, V8 Registered Nurse stated, maybe did not because able to draw the blood when asked if she discontinued the PT/INR as ordered by R1's physician on July 20, 2020. On August 19, 2020, V2 Director of Nursing stated, the PT/INR was never discontinued. Never should have drawn INR on July 22, 2020. The facility's physician orders- obtaining and transcribing policy dated February 11, 2006 shows, Policy Statement: To ensure that physician orders [REDACTED]. In implementing this policy, the following shall apply. 1. All orders for medications, tests, and treatments shall be written on the physician's orders [REDACTED]. 2. The licensed nurse who takes a verbal or telephone order must use the following procedure and is responsible for verifying all orders. a. Record the order, b. Read back and verify the complete order to the prescribing practitioner, c. Write/enter the name of the prescribing practitioner, d. Sign their own name as the licensed or registered person receiving the order, e. Transcribe order to appropriate documentation (MAR, TAR (Medication Administration Record. Treatment Administration Record)) . f. Verify allergies and compare to order, g. Update care plan to reflect change in plan of care, h. update consent forms if necessary, i. Contact residents Healthcare Power of Attorney as appropriate .