STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145890	A. BUILDING _____ B. WING _____	C 12/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINVIEW	**1001 A JEFFERSON STREET ELDORADO, IL 62930**

(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) COMPLETION DATE
F 505	Continued From page 7 2. On 11/27/06 E2 (DON) and E7 (Quality Assurance Nurse) reviewed records of new admissions in the past three weeks. The focus was to determine if physician orders were followed, lab tests, results, and treatments are completed and followed through. 3. On 11/29/06 , the facility contacted the pharmacy and medical consultant. Nursing shift supervisors were implemented on the 3-11 shift to enhance a nursing shift reporting system. 4. E2 is meeting with a medical records consultant on 12/13/06, to devise an approach to streamline the paper work during the admission process. 5. An inservice was held on 12/12/06 for nursing staff to review the admission process, and focus on timely reporting and scheduling of procedures ordered by the physicians.	F 505		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 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	F9999		

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F9999	Continued From page 8 of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by:	F9999		

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F9999	Continued From page 9 Based on record reviews and interviews the facility failed to obtain weekly Pro-Time levels for a period of 25 days to monitor the blood clotting time for 1 of 5 residents (R4) receiving Coumadin Therapy. R4 was admitted to the hospital with Hypoprothrombinemia, Lower Gastrointestinal Bleeding secondary to the Hypoprothrombinemia, and a Pro-Time level result that was at a high critical level. R4 required two units of fresh frozen plasma and Vitamin K during the hospitalization. The facility also failed to obtain and report the results of a B-Mode Doppler test that had been ordered by a physician to determine if the anti-coagulant (blood thinning) medication, Coumadin, was effective in preventing blood clots for R4. Findings include: 1. R4 was admitted to the facility on 10/28/06 following left hip surgery. The physician order sheet dated 10/28/06, states R4 is to receive Coumadin 3 milligrams daily for four weeks, and to check R4's blood Pro-Time level weekly for the next four weeks and report the levels to Z1 (Surgeon). During an interview with E2 (DON) at 3:05 PM on 12-04-06, she stated nurses E4 (LPN), E5 (RN) and E6 (LPN) wrote this order in R4's medical record on 10-28-06 then left a note for E3 (medical records clerk) to schedule with the laboratory a time for R4's Pro-Time (Prothrombin Time) level to be drawn and tested. E2 stated E3 was on vacation when the nurses left this note. E3 did not return to the facility from vacation until after 11/8/06. This was two days after the second Pro-Time should have been drawn and tested. R4 did not have a Pro-Time drawn for twenty five days until 11/22/06. A	F9999		

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F9999	Continued From page 10 discharge summary note dated 11/29/06 states "R4 was admitted to the hospital emergency room 11/22/06, with a diagnosis of rectal bleeding and a pro time was drawn." The Laboratory Cumulative Report dated 11/22/06 indicates R4's Pro-Time was 129.0 seconds. The normal reference range is 11.0 -15.0 seconds. R4's International Normalization Ratio (INR) was 76.4. The normal reference range is 1.5 - 4.5. The report states these levels are high and critical. On 11/25/06, the Laboratory Cumulative Report indicates R4's Prothrombin time was still elevated at 15.3 seconds after 3 days of medical intervention in the hospital. The INR level for R4 on 11/25/06 was 1.64. During an interview with Z3 (consulting physician) on 12/5/06 at 2:35 PM he stated that on 11/25/06 a colonoscopy was performed on R4. Z3 stated there was no active bleeding noted. A couple of tiny mucosa covered with blood clots were noted and possibly the site of bleeding. Z3 also stated, "R4's INR was extremely high when she came to the hospital." The Discharge Summary Report indicates R4 was hospitalized for seven days, 11/22/06 through 11/29/06, before returning to the facility. The final diagnosis during this hospitalization is Hypoprothrombinemia, Gastrointestinal Bleeding Secondary to hypoprothrombinemia, Congestive Heart Failure and Hypertension. During the hospital stay R4 received Vitamin K and two units of fresh frozen plasma. The October 2006 medication administration record indicates that R4 received 3 milligrams of coumadin daily from 11/1/06 until 11/21/06. This was confirmed by reviewing the medication administration record dated 11/1/06 through 11/21/06, and also during an investigation conducted by E2 dated 11/29/06.	F9999		

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F9999	Continued From page 11 During an interview with Z2 (Physician) on 11/06/06 at 2:39 PM, he stated he has never had a patient who's blood was as thin as R4's. Z2 stated he contacted a hematologist because R4's blood was so thin. The hematologist recommended fresh frozen plasma because it would help the blood clot faster. Vitamin K was also given. Z2 stated most people with thin blood can use vitamin K and nothing more. The physician order sheet dated 10/28/06 states "R4 is to have a B-Mode Doppler on the left lower extremity in three weeks." The nurses note dated 11/13/06 at 9:00 AM, states "R4 left the facility for the Doppler Study." Per interview with E2 (DON), on 12/5/06 at 10:50 AM, she stated the facility has not and does not have the results of the Doppler Study. On 12/4/06 at 3:05 PM, E2 stated it is standard procedure for Z1 to order a Doppler Study for patients like R4 who have had hip surgery. E2 also stated Z1 usually discontinues coumadin therapy if the results of the Doppler Study are negative. The nurses notes dated 11/13/06 at 9:00 AM state R4 left the facility to have a Doppler test on the left lower extremity. The medication administration record dated from 11/1/06 - 11/21/06 indicates R4 received 3 milligrams of Coumadin until 11/22/06. R4 was admitted to the hospital on 11/22/06 with a Prothrombin Time of 129 seconds and an International Normalization Ratio (INR) of 76.40. This was noted on a Discharge Summary Report dated 11/22/06. The Laboratory Cumulative Report Dated 11/22/06 indicates a normal range for the Prothrombin Time is 11.0 - 15.0. This report states a prothrombin time of 129 seconds is high and critical The INR of 76.4 is also listed as high and critical on the Laboratory Cumulative Report of	F9999		

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F9999	Continued From page 12 11/22/06. On 12/6/06 at 2:19 PM, Z1 stated the elevated prothrombin time and INR are potentially life threatening and worrisome. He also stated he has not been notified of the results of the B- Mode Doppler test. On 12/8/06 at 9:00 AM, Z1 stated he would have discontinued R4's coumadin therapy when he received the results of a negative B-Mode Doppler Test. (A)	F9999		