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	145876	A. BUILDING _____ B. WING _____	C 10/16/2008

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HELIA HEALTHCARE OF URBANA	**907 NORTH LINCOLN URBANA, IL 61801**

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F 000	INITIAL COMMENTS Complaint Investigation #0864513 (IL37677)--F224, F273, F329, F333. Incident Report Investigation of 9/29/08 (IL37730) --F323. A partial extended survey was conducted.	F 000		
F 224 SS=J	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility neglected to have a policy in place to ensure staff monitored for adverse consequences for 1 of 6 residents receiving anticoagulant therapy (R3). The facility neglected repeatedly to follow up on PT(Prothrombin Time) and INR (International Normalized Ratio) laboratory test results with the Physician, resulting in Hemorrhaging of R3's Left Leg. This neglect resulted in an Immediate Jeopardy. While the immediacy was determined to be removed on 10/3/08, the facility remains out of compliance at a Severity Level 2 as they are still monitoring the implementation and effectiveness of the Anticoagulant Policy put into place. Findings include: E2, Director of Nurses (DON), was interviewed	F 224		11/7/08

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

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F 224	Continued From page 1 on 10/3/08 at 9:45am. When asked for the facility policy on Anticoagulation Therapy, E2 stated, "We did not have an Anticoagulant policy until today[10/3]." When asked if the policy had been implemented, E2 stated, "It's partially implemented at this point." The POS (Physician Order Sheet) dated 9/1-9/30/08 states R3 has diagnoses of Anemia, History of Cerebrovascular Accident, Erosive Esophagitis and Peripheral Vascular Disease. There is a undated Telephone Physician's Order for "Coumadin 3 mg[milligrams] po[by mouth] qd[every day]. [Recheck] PT/INR in 1 week[8/4/08]." There are no laboratory test results for a PT/INR in R3's record until 8/19/08. The laboratory report dated 8/19/08 states the PT was 32.6 seconds with normal being 10.0-13.0 seconds and the INR was 5.2 with therapeutic range being 2.0-3.0. Z3, Laboratory Dispatcher, was interviewed on 10/3/08 at 1:45pm. Z3 confirmed there was no PT/INR done for R3 until 8/19/08. There is a Telephone Physician's Order dated 8/19/08 to "Discontinue current Coumadin Order. Do PT/INR on 8/21/08." There is a Telephone Physician's Order dated 8/27/08 to "Start Coumadin 3mg po daily and recheck PT/INR in 1 week." The laboratory report dated 9/8/08 states the PT was 25.0 seconds with normal being 10.0-13.0 and the INR was 3.3 with the therapeutic range being 2.0-3.0. There is an entry on the report which states, "Faxed 9/8/08, 9:20pm."	F 224		

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F 224	Continued From page 2 The nurses notes dated 9/8/08 with no time documented state, "Faxed PT/INR." There is no documentation in the nurses notes from 9/8-9/18/08 of any followup with Z1, MD, about the PT/INR results of 9/8/08. Z1, MD, was interviewed on 10/7/08 at 12:35pm. When asked if staff had followed up by calling to make sure he got the faxed INR result on 9/8/08, Z1 stated he did not know. When asked how he would have responded if he was called and given the INR level of 3.3, Z1 stated, "I would have repeated the PT/INR in 3 or 4 days, as 3.3 is not too much above where I wanted [R3's] level to be." Z1 stated it's okay for staff to fax laboratory results to him, but he also wants a phone call for the PT/INR results. The Nurses Notes dated 9/18/08 at 5:30am state, "Lg[large] skin tear reopened on L[left] lower calf. Large amt[amount] bright red blood...." R3 was transferred to the Emergency Room. The Emergency Room Report dated 9/18/08 at 6:30am states R3 has the following diagnoses: Abrasion Left Leg, Hemorrhage Left Leg and Coagulapathy Secondary to Warfarin (Coumadin). The report documents a surgical pressure dressing was applied to R3's left leg and 2 Units of Fresh Frozen Plasma was administered to R3. The hospital laboratory report dated 9/18/08 states the PT was 107.5 seconds with normal being 9.2-12.8 seconds and the INR was 8.2 with therapeutic range being 2.0-3.0. Z2, Emergency Room Physician, was interviewed on 10/8/08 at 4:00pm. When asked if R3's high	F 224		

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F 224	Continued From page 3 PT/INR results were life threatening, Z2 stated, "Theoretically it could have been life threatening if she smacked her head, but some people have levels that high and are okay. It could be life threatening if she [R3] had developed bleeding in her head , nosebleed, but there were no signs...." Z1, MD, was interviewed on 10/7/08 at 12:35pm. When asked if in his opinion R3's INR result of 8.2 and PT of 107.5 seconds on 9/18/08 were life threatening, Z1 stated, "At that stage not life threatening. She [R3] was at risk of bleeding at that point, very high risk." The Immediate Jeopardy situation was identified on 10/9/08 at 7:45am. The Immediate Jeopardy was determined to have begun on 9/18/08 when the facility neglected to have a Anticoagulant Policy to ensure monitoring and follow up of PT/INR laboratory test results, resulting in Hemorrhaging of R3's Left Leg. E1, Administrator and E19, Corporate Nurse, were notified of the Immediate Jeopardy on 10/9/08 at 8:50am. The surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy: 9/18/08: R3 was transported and treated in the Emergency Room where the hemorrhage was stopped. 10/2/08: A Coumadin Log was initiated for each nursing unit. Each resident receiving Coumadin was placed on an individual monitoring sheet. 10/3/08-A new policy on Anticoagulant Therapy	F 224		

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F 224	Continued From page 4 was written and implemented. All nursing staff was inserviced by E2, DON, before being allowed to work, including Agency nurses. All nurses have been provided a copy of the policy. 10/3/08-The DON will be responsible for monitoring all residents receiving Anticoagulants, including laboratory results, and followup with the Physician. 10/6/08-The record of residents receiving Coumadin were reviewed.	F 224		
F 273 SS=D	483.20(b)(2)(i) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to complete comprehensive assessments within 14 days of admission for 2 of 3 sampled residents (R11, R10). Findings include: 1. The facility Admission Face Sheet documents that R11 was admitted to the facility on 9/9/08. The MDS (Minimum Data Set) was dated as being done on 9/11/08. The September 2008 POS(Physician Order Sheet) states R11 has	F 273		11/7/08

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F 273	Continued From page 5 diagnoses of Diabetes, Alzheimer's, Hypertension, Peripheral Neuropathy, Congestive Heart Failure and Chronic Obstructive Lung Disease. The MDS was not completed in the following areas on 10/9/08: Mood and Behavior Pattern(Section E); Psychosocial Patterns (Section F); Physical Functioning and Structural Problems (Section G); Continence in Last 14 days (Section H); Disease Diagnoses(Section I); Health Conditions (Section J); Oral/Nutritional Status (Section K); Skin Condition (Section M); Activity Patterns(Section N) and Special Treatments and Procedures. Medications (Section O) was completed but was not accurate. The MDS stated that R11 received no injections, but R11 had Lovenox given subcutaneously from 9/9/08 -10/6/08. There were no RAP's(Resident Assessment Protocols) completed for R11. E3, Care Plan Coordinator, was interviewed on 10/9/08 at 9:55am. When asked why R11's MDS and RAP's were not completed E3 stated, "I thought the MDS and RAP's were done." E3 confirmed that R11's MDS and RAP's were not done. 2. The facility Admission Face Sheet documents that R10 was admitted to the facility on the evening of 9/15/08. The September 2008 POS states R10 has diagnoses of Pneumonia, diabetes, Hypertension, Peripheral Vascular Disease, Seizure Disorder, Atrial Fibrillation and Congestive Heart Failure. The MDS is dated as completed on 9/16/08. The RAP's were not completed until 9/22/08.	F 273		
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident	F 323		11/5/08

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F 323	Continued From page 6 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to assess for the most appropriate transfer method to ensure a safe transfer for 1 of 1 sampled residents with a Left Below the Knee Amputation (R12). The facility failed to transfer R12 in a safe manner by using the sit to stand mechanical lift with only one staff assist resulting in a Fractured Left Hip. Findings include: The Physician Order Sheet dated 10/1-10/31/08 states R12 has diagnoses of Dementia, Agitation, Left Below the Knee Amputation and Osteoporosis. The Minimum Data Set (MDS) dated 9/17/08 states that R12 has cognitive problems and behaviors including resisting care, anger, socially inappropriate, physically and verbally abusive. The assessment states R12 requires total assist of 2 with transfer/toilet use, total assist with dressing, hygiene, extensive assist with eating/bed mobility and does not ambulate. The facility assessed R12 as a high fall risk on 12/31/07 and 10/8/08. The care plan dated as reviewed on 7/2/08 and 10/08 identifies that R12 is "dependent on staff for all ADL's [Activities of Daily Living] related to	F 323		

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F 323	Continued From page 7 cognitive deficits, generalized weakness and L[left] BKA[Below Knee Amputation]." The care plan also identifies that R12 "requires use of mechanical lift due to nonambulatory status and cannnot bear weight." The care plan has the following approaches: "Ongoing inservicing of all staff that use the mechanical lift"; "2 staff assist at all times for mechanical lift transfers"; "Assessment for continued need to use mechanical lift"; "Provide 1-2 assists with transfers and toileting. Mechanical lift used for all transfers." The care plan does not specify what type of mechanical lift is to be used, the type of sling to be used during a transfer and whether 1 or 2 assists (staff) are to be used for the transfer. E3, Care Plan Coordinator, was interviewed on 10/10/08 at 10:35am. When asked what type of assessment she did to determine what mechanical lift was appropriate for R12, E3 stated, "I did not do any assessment. Whatever they have been doing is what I go by." E3 stated R12 had been using the sit to stand mechanical lift. E3 stated, "I asked all the CNAs [Certified Nurse Aides] how they had been transferring [R12]. I have watched them transfer [R12], [R12] stood on her good leg and will hold onto the lift handles." E3 stated she watched 1 transfer with R12 and did not see R12 "fight." E3 stated R12's behaviors are related to her "mood." E2, Director of Nurses (DON), was interviewed on 10/10/08 at 10:50am. When asked how R12 was being transferred prior to the hip fracture, E2 stated, "with the sit/stand mechanical lift." When asked for an assessment for the use of the lift, E2 stated therapy had done an assessment in the past.	F 323		

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F 323	Continued From page 8 The Occupational Therapy Evaluation dated 2/28/08 states the reason for the referral was "recent hospitalization" with diagnoses of Congestive Heart Failure and Muscle Weakness. R12's rehabilitation potential was documented as poor and R12 was "not appropriate for further OT[Occupational Therapy]." Z7, Occupation Therapist, was interviewed on 10/10/08 at 2:05pm. When asked if he had done a transfer assessment for R12, Z7 stated he did not remember doing the evaluation and does not know if he watched a transfer but believed that the evaluation should document total body mechanical lift not standing mechanical lift. Z7 stated in his professional opinion a sit to stand mechanical lift should not be used on R12 because she only has 1 leg, unless R12 has a prosthesis she uses. Z7 was reinterviewed on 10/14/08 at 9:45am after faxing (facsimile) the Occupational Therapy Evaluation dated 2/28/08 for Z7 to review. After reviewing the evaluation Z7 stated that R12's Left Below the Knee Amputation was not listed on the evaluation and questioned when the amputation was done and if R12 had the amputation at the time of the evaluation. Z7 stated after reviewing the evaluation that nursing told him R12 transferred with a sit to stand mechanical lift, was in bed during the evaluation, was total assist with ADLs and not someone therapy would benefit. Z7 stated he still believed the sit to stand mechanical lift would not be safe to transfer R12 because R12 is a Left Below the Knee Amputation. E2, DON, was interviewed on 10/14/08 at 9:50am. and 11:00am. E2 stated R12's amputation was done in November of 2005 and	F 323		

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F 323	Continued From page 9 R12 has never had a prosthesis. E2 stated R12 is non ambulatory because of the amputation but did bear weight on the remaining leg (right).When asked what kind of sling was used for the sit to stand mechanical lift E2 stated, "The standard sling, a belt which goes around the waist." E2 stated there is another sling for the sit to stand lift which crisscrosses through the legs, but that sling was not used for R12. The "Operation Manual" from the mechanical lift company contains the following information (in part): The sit to stand mechanical lift "was designed specifically for assisting ...residents to a standing position.... Because the [sit to stand lift] is an assistive device it should only be used with residents...that can bear the requisite amount of weight as determined by your facility. It also requires that residents...possess more advanced motor skills than the [total body mechanical lift]. It is important to determine the appropriateness of this piece of equipment for a particular resident...." "The standard belt is used for residents... that have consistent and reliable motor functions." Z10, Vice President of the Mechanical Lift Company was interviewed on 10/14/08 at 9:30am. When asked if the sit to stand mechanical lift was safe to be used for a resident with a below the knee amputation, Z10 stated, "They would have to be assessed with the [sit to stand lift] and would have to be able to stand." Z11, Salesman of Mechanical Lift, was interviewed on 10/17/08 at 9:05am. When asked	F 323		

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F 323	Continued From page 10 if the sit to stand mechanical lift was safe to be used with a resident (R12) with cognitive/behavior problems and a Below the Knee Amputation, Z11 stated, "My only concern is the potential if you lose weight bearing [during the transfer] the resident will swing to the affected side." Z11 stated with a resident that has both legs if they lose weight bearing during the transfer their shin goes into the shin support area of the lift, but with only 1 leg there would be a "tipping issue." Z11 stated, "I recommend having a second person for the transfer. I recommend the second person stand on the [resident's] afflicted side and when they lose weight bearing they can stabilize the resident. Z11 stated he tells all of his facilities to use 2 assists when using the sit to stand lift to transfer a resident with only 1 leg. E16, CNA, was interviewed on 10/9/08 at 3:45pm. E16 stated she got R12 up by herself with the sit to stand mechanical lift on Saturday, 9/27/08(am). E16 stated R12 did fine and was in a good mood. E12, CNA, was interviewed on 10/9/08 at 3:20pm. E12 stated she changed R12 after breakfast and lunch using the sit to stand mechanical lift. E12 stated she put R12 to bed after lunch with the lift by herself. E12 stated R12 was fine and had no complaint of pain on Saturday 9/27/08. E15, CNA, was interviewed on 10/9/08 at 3:35pm. E15 states she transfers R12 with the sit to stand lift but never by herself because R12 will "fight." E15 stated R12 was fine Saturday (9/27) morning when she and E12 changed R12 using the sit to stand lift.	F 323		

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F 323	Continued From page 11 E14, CNA, was interviewed on 10/9/08 at 2:25pm. E14 stated when she came to work at 2:30 she saw R12 sitting in the wheelchair sleeping in the television room. E14 stated R12 was complaining of pain and holding her side at supper that night. When asked how she transferred R12 on Saturday 9/27/08 evening after supper, E14 stated she and E9, CNA, transferred R12 by lifting her under the arms and holding onto the back of her pants. E14 stated when they put her to bed R12 was "reaching for her leg" and saying "Don't do that" as they tried to remove R12's pants. E14 stated R12 kept saying "Hold me Hold me." E14 stated she has never seen anyone use the sit to stand mechanical lift for R12. E14 stated she did not think the lift would work since R12 only has 1 leg. E9, CNA, was interviewed on 10/9/08 at 1:00pm. E9 confirmed that she and E14 transferred R12 to bed after supper on 9/27/08 by lifting her under the arms and holding onto the back of the pants. E9 stated R12 was in so much pain she did not think R12 would hold onto the sit to stand lift during a transfer. E9 stated she and E14 pulled R12's pants down and R12 was "screaming in pain" saying "Hold me Hold me." E9 stated "that's not [R12], I knew something was wrong." E18, CNA, was interviewed on 10/10/08 at 2:10pm. E18 confirmed she was in the room when E15 and E14 transferred R12 to bed on 9/27/08 after supper and R12 was "hollering" about her leg. E18 stated R12 is always a 2 person transfer and she has never seen R12 transferred with the sit to stand lift. The Nurses Notes dated 9/28/08 state R12 was	F 323		

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F 323	Continued From page 12 transferred to the hospital with left hip pain. The Emergency Room Report dated 9/29/08 states R12 had a Left Hip Fracture. The X-ray Report dated 9/29/08 states, "...intertrochanteric fracture of the left femur with avulsion of the lesser trochanter. There is some impaction of the bone fragments...."	F 323		
F 329 SS=J	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	F 329		11/5/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 13 failed to monitor for adverse consequences for 3 of 6 sampled residents receiving Anticoagulant therapy (R3, R8, R5). The facility repeatedly failed to follow up on PT (Prothrombin Time) and INR (International Normalized Ratio) laboratory test results with the Physician, resulting in Hemorrhaging of R3's left leg. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 10/3/08, the facility remains out of compliance at a Severity Level 2 as they are continuing to implement a policy and provide staff education on monitoring of anticoagulant therapy. Findings include: 1. The POS(Physician Order Sheet) dated 9/1-9/30/08 states R3 has diagnoses of Anemia, History of Cerebrovascular Accident, Erosive Esophagitis and Peripheral Vascular Disease. The MDS (Minimum Data Set) dated 8/18/08 states R3 has cognitive problems, behaviors, requires limited assist with transfers/bed mobility and extensive assist with dressing, and hygiene. The care plan dated as reviewed on 8/26/08 states R3 has the potential for side effects related to Coumadin therapy with the following approaches identified: "Perform labs[laboratory test] as ordered and report results to physician"; "Notify MD[Medical Doctor] of abnormal labs...immediately"; "Assess [R3] for blood in urine or stools, bleeding from gums, or prolonged bleeding of any kind." There is a undated Telephone Physician's Order for "Coumadin 3 mg[milligrams] po[by mouth] qd [every day]. [Recheck] PT/INR in 1 week[8/4/08]." E7, LPN(Licensed Practical Nurse) was	F 329		

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F 329	Continued From page 14 interviewed on 10/7/08 at approximately 10:30am. When asked the date she took the telephone order for R3's Coumadin, E7 stated, "I took the order on 7/28 or 7/31." The POS dated 8/1-8/31/08 has an entry dated 7/28/08 for "Coumadin 3mg po q day." The undated MAR (Medication Administration Record) has an undated entry for "Coumadin 3mg po q day" initialed as being given on 7/31/08 to R3. The MAR dated 8/1-8/31/08 has an entry dated 7/28/08 for "Coumadin 3mg po q day." The Coumadin was initialed as being given every day except 8/3/08, 8/15/08 and 8/18/08 until it was discontinued on 8/19/08. There is no laboratory test results for a PT/INR in R3's record until 8/19/08. The laboratory report dated 8/19/08 states the PT was 32.6 seconds with normal being 10.0-13.0 seconds and the INR was 5.2 with therapeutic range being 2.0-3.0. Z3, Laboratory Dispatcher, was interviewed on 10/3/08 at 1:45pm. Z3 confirmed there was no PT/INR done for R3 until 8/19/08. Z3 stated there was a Hemoglobin and Hematocrit done on 8/4/08 but no PT/INR. Z1, MD, was interviewed on 10/7/08 at 12:35pm. When asked about R3's INR result of 5.2 on 8/19/08, Z1 stated, "It's a little high, not a major risk, but I don't want it[INR] to be that high." Z1 stated he wanted R3's INR to be "between 2.0-3.0." There is a Telephone Physician's Order dated 8/19/08 to "Discontinue current Coumadin Order. Do PT/INR on 8/21/08."	F 329		

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F 329	Continued From page 15 There is a Telephone Physician's order dated 8/22/08 to "Repeat PT/INR on Monday[8/25]. Keep Coumadin on hold. Call [Z1,MD] with results." The laboratory report dated 8/25/08 states the Hemoglobin was 8.4 with normal being 11.8-14.3 and the Hematocrit was 25.1 with normal being 34-45. The report documents the PT was 17.2 seconds with normal being 10.0-13.0 and the INR was 1.7 with the therapeutic range being 2.0-3.0. There is an entry dated 8/25/08 on the laboratory sheet which states, "Faxed [facsimile]." Another entry states, "Called [Z1] on 8/27/08 at 3:15pm. Order to start Coumadin 3mg po and [recheck] PT/INR in 1 wk[week]." There is a Telephone Physician's Order dated 8/27/08 to "Start Coumadin 3mg po daily and recheck PT/INR in 1 week." The laboratory report dated 9/4/08 states the PT was 21.8 seconds with normal being 10.0-13.0 and the INR was 2.6 with the therapeutic range being 2.0-3.0. The laboratory report dated 9/8/08 states the PT was 25.0 seconds with normal being 10.0-13.0 and the INR was 3.3 with the therapeutic range being 2.0-3.0. There is an entry on the report which states, "Faxed 9/8/08, 9:20pm." The nurses notes dated 9/8/08 with no time documented state, "Faxed PT/INR," There is no documentation in the nurses notes from 9/8-9/18/08 of any followup with Z1, MD, about the PT/INR results of 9/8/08. E4, RN (Registered Nurse) was interviewed on	F 329		

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F 329	Continued From page 16 10/7/08 at 11:45am. When asked if she had called the PT/INR result of 9/8/08 to the Physician, E4 stated, "[R3] has been on Coumadin" and did not know if she had called the Physician. E4 then refused to talk any further with the surveyor and stated she would "Call her attorney and consult with him." E7, LPN, was interviewed on 10/7/08 at 10:30am. When asked if she had called PT/INR results of 9/8/08 to the Physician, E7 stated she did not remember. Z1, MD, was interviewed on 10/7/08 at 12:35pm. When asked if staff had followed up by calling to make sure he got the faxed INR result on 9/8/08, Z1 stated he did not know. When asked how he would have responded if he was called and given the INR level of 3.3, Z1 stated, "I would have repeated the PT/INR in 3 or 4 days, as 3.3 is not too much above where I wanted [R3's] level to be." Z1 stated it's okay for staff to fax laboratory results to him, but he also wants a phone call for the PT/INR results. The Nurses Notes dated 9/18/08 at 5:30am state, "Lg [large] skin tear reopened on L[left] lower calf. Large amt[amount] bright red blood...." R3 was transferred to the Emergency Room. E5, LPN, was interviewed on 10/7/08 at 10:55am. E5 stated she applied pressure to R3's left calf, but the area was still bleeding and there was "quite a bit of blood", so she sent R3 out to the hospital. When asked if she had called the Physician with the laboratory result of 9/8/08, E5 stated, "I did not call the doctor if it's not documented." The Emergency Room Report dated 9/18/08 at 6:30am states R3 has the following diagnoses:	F 329		

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F 329	Continued From page 17 Abrasion Left Leg, Hemorrhage Left Leg and Coagulapathy Secondary to Warfarin (Coumadin). The report documents a surgical pressure dressing was applied to R3's left leg and 2 Units of Fresh Frozen Plasma was administered to R3. The hospital laboratory report dated 9/18/08 states the PT was 107.5 seconds with normal being 9.2-12.8 seconds and the INR was 8.2 with therapeutic range being 2.0-3.0. Z2, Emergency Room Physician, was interviewed on 10/8/08 at 4:00pm. When asked if R3's high PT/INR results were life threatening, Z2 stated, "Theoretically it could have been life threatening if she smacked her head, but some people have levels that high and are okay. It could be life threatening if she [R3] had developed bleeding in her head, nosebleed, but there were no signs...." Z1, MD, was interviewed on 10/7/08 at 12:35pm. When asked if in his opinion R3's INR result of 8.2 and PT of 107.5 seconds on 9/18/08 were life threatening, Z1 stated, "At that stage not life threatening. She [R3] was at risk of bleeding at that point, very high risk." The Immediate Jeopardy situation was identified on 10/7/08 at approximately 2:30pm. The Immediate Jeopardy was determined to have begun on 9/18/08 when R3 went to the hospital with Hemorrhaging of the Left Leg due to lack of monitoring of anticoagulant therapy. E1, Administrator, and E2, Director of Nurses (DON), were notified of the Immediate Jeopardy on 10/7/08 at 3:55pm The surveyor confirmed through interview and	F 329		

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F 329	Continued From page 18 record review that the facility took the following actions to remove the Immediate Jeopardy: 9/18/08: R3 was transported and treated in the Emergency Room where the hemorrhage was stopped. 10/3/08-A new policy on Anticoagulant Therapy was written and implemented. All nursing staff was inserviced by E2, DON, before being allowed to work, including Agency nurses. All nurses have been provided a copy of the policy. 10/3/08-The DON will be responsible for monitoring all residents receiving Anticoagulants, including laboratory results, and followup with the Physician. 10/6/08-The record of residents receiving Coumadin were reviewed. 2. The POS dated September 2008 states that R8 has a diagnosis of Mitral Valve Replacement. The POS has a Physician's Order dated 8/15/08 for Coumadin 11mg daily, Recheck PT/INR in 1 week (8/21). The laboratory report dated 8/18/08 states the PT was 17.7 seconds with normal being 10.0-13.0 seconds and the INR was 1.8 with the therapeutic range being 2.0-3.0. There is a Physician's Order dated 8/21/08 to Repeat PT/INR on 8/22/08. The PT/INR laboratory results for 8/22/08 or any date after 8/18/08 were not found in R8's record and there was no documentation in the Nurses Notes for August/September 2008 of any	F 329		

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F 329	Continued From page 19 followup regarding the PT/INR. E2, DON, was interviewed on 10/8/08 at 9:50am and 10:25am. When asked about R8 not having any laboratory reports in the record since 8/18/08 and being on 11mg of Coumadin, E2 stated she has a laboratory slip showing that R8's PT/INR was drawn on 8/22/08, but confirmed there were no results in R8's record. E2 confirmed there was no documentation in the nurses notes to indicate any follow up was done regarding the PT/INR ordered on 8/22/08. E2 stated that R8 also had a PT/INR drawn on 10/6/08. E2 stated she would ask the laboratory to print the results for 8/22 and 10/6 and fax them to the facility. E2 stated R8 went to the hospital in September. E2 stated she talked with the hospital today(10/8) and was told they did do a PT/INR on 9/19/08, addressed it with the Physician and would fax the results to the facility. E2 provided laboratory results for R8 as follows on 10/8/08: The laboratory report dated 8/22/08 stated the PT was 18.6 seconds with normal being 10.0-13.0 and the INR was 2.0 with therapeutic range being 2.0-3.0. The hospital laboratory report dated 9/19/08 stated the PT was 44.7 seconds with normal being 9.2-12.8 and the INR was 3.6 with the therapeutic range being 2.0-3.0. This report was not in R8's record at the facility and E2 was not aware the laboratory test had been done until 10/8/08 when she called the hospital for follow up. The laboratory report dated 10/6/08 stated the PT	F 329		

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F 329	Continued From page 20 was 33.7 seconds with normal being 10.0-13.0 and the INR was 5.5 with therapeutic range being 2.0-3.0. There is a Physician's Order dated 10/6/08 to "Hold Coumadin 10/6 and 10/7" and Recheck PT/INR on 10/8/08. 3. The October 2008 POS states R5 has a diagnosis of Chronic Atrial Fibrillation. The hospital laboratory report dated 9/23/08 states R5's PT was 120 seconds on 9/22/08 and 107.5 seconds on 9/23/08 with normal being 9.2-12.8 seconds. The INR on 9/23/08 was 8.2 with the therapeutic range being 2.0-3.0. The hospital laboratory report dated 9/24/08 states R5's PT was 30.3 seconds and the INR was 2.5. The September 2008 POS has a Physician's Order dated 9/25/08 for Coumadin 3 mg daily. The hospital "Medication Reconciliation Orders" dated 9/25/08 has an order for PT/INR in 1 week (10/1). There are no laboratory test results in R5's record for the PT/INR ordered to be done on 10/1/08. The nurses notes for October 2008 do not document any follow up on the laboratory test. E2, DON, was interviewed on 10/8/08 at 11:05am. When asked if the PT/INR to be drawn on 10/1/08 had been done, E2 stated, "It was drawn on Monday 10/6/08 and we still don't have the results." E2 stated she had called the laboratory 3 different times for the results. E2 stated when she went through the laboratory book on 10/6 she found that the INR/PT had not been drawn for R5. E2 stated an audit for laboratory tests and getting results on the chart	F 329		

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F 329	Continued From page 21 was started on 10/3/08 and finished 10/6/08. E2 confirmed that R5's "chart was audited on 10/2 and it was not caught that the [PT/INR] had not been drawn."	F 329		
F 333 SS=J	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to have a Physician's Order to administer Anticoagulants (Coumadin) to 1 of 6 sampled resident's receiving anticoagulant therapy (R2). The facility repeatedly administered a daily anticoagulant without a Physician's Order, failed to monitor for side effects and had no diagnosis to support the administration of the medication for a period of 2 months. These failures resulted in a significant medication error which placed R2 at high risk for bleeding especially gastrointestinal bleeding. These failures resulted in an Immediate Jeopardy. While the immediacy was determined to be removed on 10/2/08, the facility remains out of compliance at a Severity Level 2 as the facility is continuing to provide staff education and monitoring of anticoagulant therapy. Findings include: The History and Physical dated 6/6/08 states that R2 has diagnoses of Hypertension, Hyperlipidemia, Dementia and Anemia. The laboratory report dated 6/4/08 states that R2's stool was positive for occult blood. The report	F 333		11/5/08

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F 333	Continued From page 22 dated 6/5/08 states that R2's Hemoglobin is 9.6 with normal being 11.1-15.3 and the Hematocrit is 28.5 with normal being 32.4-45.1. The MDS(Minimum Data Set) dated 6/14/08 and 9/10/08 state R2 has cognitive impairment, behaviors and requires supervision with transfers/ambulation, and minimal assist with dressing and hygiene. The facility fall assessment dated 7/24/08 identifies R2 as high risk for falls. The care plan dated as reviewed 7/08 and 9/08 does not identify that R2 was receiving Coumadin or have any approaches to monitor R2 for side effects from the anticoagulant therapy. The MAR (Medication Administration Record) dated 8/1-8/31/08 has an undated entry for "Coumadin 3mg [milligrams] po[by mouth] daily." Written under the Coumadin entry is "Reorder 8/9/08." Coumadin 3mg is initialed as being given every day in August except for 8/9/08 and 8/27/08. The POS (Physician Order Sheet) dated 8/1-8/31/08 has no Physician's Order for Coumadin 3mg to be given. There is no Telephone Physician Order in R2's record for Coumadin 3mg to be given. E2, Director of Nurses (DON) confirmed in interview on 10/3/08 at 11:00am that there was no order for Coumadin in R2's chart. E6, LPN (Licensed Practical Nurse) was interviewed on 10/7/08 at 11:00am. When asked if she wrote the Coumadin 3mg on the August 2008 MAR, E6 confirmed she wrote the Coumadin 3mg entry on the MAR. When asked why she wrote Coumadin on the	F 333		

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F 333	Continued From page 23 MAR, E6 stated, "The pills came in from the pharmacy. I just added the Coumadin to the MAR. I did not take the order. It was on 8/1/08 so I thought it[Coumadin order] was missed-did not think I had to go back and get an order. I went strictly from the MAR." When asked if the Coumadin was labeled with R2's name, E2 stated she could not remember if the Coumadin was labeled with R2's name. E6 confirmed that on 8/9/08 she reordered the Coumadin for R2 from the pharmacy. The POS dated 9/1-9/30/08 and 10/1-10/31/08 has an entry dated 8/11/08 for "Coumadin 3mg tablet. Take 1 tablet by mouth once daily." The MAR dated 9/1/08-9/30/08 has an entry dated 8/11/08 for "Coumadin 3mg tablet. Take 1 tablet by mouth once daily." The Coumadin was initialed as being given every day in September. The October MAR documents that Coumadin 3mg was given on 10/1/08 and discontinued on 10/2/08. The Nurse's Notes dated 10/2/08 at 12:40pm states, "[Z1, Physician] called requesting for [information] as to reason why [R2] placed on Coumadin on 8/1/08, [Z1] states that he is unaware of Coumadin reasoning...." The Physician Progress Note dated 10/2/08 states, "[R2] has received Coumadin since 8/08, med [medication] error.... [Discontinue] Coumadin. No adverse outcome identified. [R2] has anemia but it's chronic. H [Hemoglobin] and H[Hematocrit] has been stable since 6/06 without any drop with Coumadin action." Z1, Physician, was interviewed on 10/7/08 at	F 333		

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F 333	Continued From page 24 12:35pm. When asked if R2 receiving Coumadin without an order or monitoring for side effects could be life threatening for R2, Z1 stated, "It could have been life threatening, consequence being high risk of bleeding, especially gastrointestinal bleeding. [R2] was definitely at risk for bleeding and worsening of anemia due to lack of monitoring and her [R2's] age." E2, DON, was interviewed on 10/3/08 at 11:00am. When asked how the Coumadin was obtained without a Physician's Order E2 stated, "[E6] circled the medication on 8/9/08 because there wasn't any [Coumadin] and the Pharmacy has a refill sheet. The pharmacy called back and checked with [E7, LPN] to verify that order." E2 stated the POSs and MARs are checked for accuracy and signed by staff as they are checked every month. The MARs and POSs are checked for accuracy again the night before staff start using the ones for the next month. E2 stated R2's August POS and MAR were to have been double checked by the night nurse (E8) the night before using them (7/31/08). E2 stated E8 would have had both the old (July) and new (August) MARs and should have been checking both. E8, LPN, was interviewed on 10/7/08 at 11:55am. E8 stated she would look at the previous months POS when checking for accuracy. When asked if not having a check mark by the Coumadin entry on R2's September POS meant anything, E8 stated, "It makes me think I questioned the Coumadin, but I do not remember what I did. Usually I'll leave [E2] a note, but do not remember what I did." Z3, Pharmacy Supervisor, was interviewed on 10/7/08 at 2:00pm. When asked how the facility	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145876	A. BUILDING _____ B. WING _____	C 10/16/2008

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F 333	Continued From page 25 obtained the Coumadin without a Physician's Order, Z3 stated the pharmacy received a facsimile [fax] from the facility on a refill sheet for Coumadin 3mg daily, which is considered to be the order. Z3 stated the pharmacy fills the medication according to how the nurse wrote the medication on the refill sheet. Z3 stated if the refill sheet is not signed by the nurse the pharmacy will check with a nurse to verify when the order was faxed." Z3 stated the pharmacy verified the Coumadin refill request with E7, LPN. The pharmacy refill sheet dated 8/9/08 states "[R2] Coumadin 3mg po daily" and documents the nurse as E7. The refill sheet dated 9/9/08 has a pharmacy label which identifies "Warfarin Sodium [Coumadin] 3mg tab[tablet]." E7, LPN, was interviewed on 10/3/08 at 11:20am. When asked if she checked to see if there was an order for the Coumadin when pharmacy called on 8/11/08, E7 stated she "does not remember pharmacy calling or being asked to confirm the order." The Immediate Jeopardy situation was identified on 10/7/08 at approximately 2:30pm. The Immediate Jeopardy was determined to have begun on 8/1/08 when R2 began receiving Coumadin without a Physician's Order or monitoring. E1, Administrator, and E2, DON, were notified of the Immediate Jeopardy on 10/7/08 at 3:55pm. The surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy:	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 333	Continued From page 26 10/2/08: The facility notified the Physician of the medication error and R2's Coumadin was discontinued. 10/2/08: The Physician reviewed R2's medications and examined her.	F 333		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)1) 300.1220b)7) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 27 a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial 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. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 7) Coordinating the care and services provided to residents in the nursing facility. Section 300.3240 Abuse and Neglect a) An owner, licensee, admministrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: I. Based on interview and record review the facility neglected to have a policy in place to ensure staff monitored for adverse consequences for 3 of 6 residents receiving	F9999		

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F9999	Continued From page 28 anticoagulant therapy (R3, R5, R8). The facility neglected repeatedly to follow up on PT (Prothrombin Time) and INR (International Normalized Ratio) laboratory test results with the Physician, resulting in Hemorrhaging of R3's Left Leg. II. Based on record review and interview the facility failed to have a Physician's Order to administer Anticoagulants (Coumadin) to 1 of 6 sampled residents receiving anticoagulant therapy (R2). The facility repeatedly administered a daily anticoagulant without a Physician's Order, failed to monitor for side effects, and had no diagnosis to support the administration of the medication for a period of 2 months. These failures resulted in a significant medication error which placed R2 at high risk for bleeding especially gastrointestinal bleeding. Findings include: E2, Director of Nurses (DON), was interviewed on 10/3/08 at 9:45am. When asked for the facility policy on Anticoagulation Therapy, E2 stated, "We did not have an Anticoagulant policy until today[10/3]." When asked if the policy had been implemented, E2 stated, "It's partially implemented at this point." 1. R3's POS (Physician Order Sheet) dated 9/1-9/30/08 states R3 has diagnoses of Anemia, History of Cerebrovascular Accident, Erosive Esophagitis and Peripheral Vascular Disease. The MDS (Minimum Data Set) dated 8/18/08 states R3 has cognitive problems, behaviors, requires limited assist with transfers/bed mobility and extensive assist with dressing, and hygiene.	F9999		

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F9999	Continued From page 29 The care plan dated as reviewed on 8/26/08 states R3 has the potential for side effects related to Coumadin therapy with the following approaches identified: "Perform labs [laboratory test] as ordered and report results to physician"; "Notify MD [Medical Doctor] of abnormal labs...immediately"; "Assess [R3] for blood in urine or stools, bleeding from gums, or prolonged bleeding of any kind." There is a undated Telephone Physician's Order for "Coumadin 3 mg [milligrams] po [by mouth] qd [every day]. [Recheck] PT/INR in 1 week [8/4/08]." E7, LPN (Licensed Practical Nurse) was interviewed on 10/7/08 at approximately 10:30am. When asked the date she took the telephone order for R3's Coumadin, E7 stated, "I took the order on 7/28 or 7/31." The POS dated 8/1-8/31/08 has an entry dated 7/28/08 for "Coumadin 3mg po q day." The undated MAR (Medication Administration Record) has an undated entry for "Coumadin 3mg po q day" initialed as being given on 7/31/08 to R3. The MAR dated 8/1-8/31/08 has an entry dated 7/28/08 for "Coumadin 3mg po q day." The Coumadin was initialed as being given every day except 8/3/08, 8/15/08 and 8/18/08 until it was discontinued on 8/19/08. There are no laboratory test results for a PT/INR in R3's record until 8/19/08. The laboratory report dated 8/19/08 states the PT was 32.6 seconds with normal being 10.0-13.0 seconds and the INR was 5.2 with therapeutic range being 2.0-3.0. Z3, Laboratory Dispatcher, was interviewed on	F9999		

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F9999	Continued From page 30 10/3/08 at 1:45pm. Z3 confirmed there was no PT/INR done for R3 until 8/19/08. Z3 stated there was a Hemoglobin and Hematocrit done on 8/4/08 but no PT/INR. There is a Telephone Physician's Order dated 8/19/08 to "Discontinue current Coumadin Order. Do PT/INR on 8/21/08." There is a Telephone Physician's order dated 8/22/08 to "Repeat PT/INR on Monday[8/25]. Keep Coumadin on hold. Call [Z1,MD] with results." The laboratory report dated 8/25/08 states the Hemoglobin was 8.4 with normal being 11.8-14.3 and the Hematocrit was 25.1 with normal being 34-45. The report documents the PT was 17.2 seconds with normal being 10.0-13.0 and the INR was 1.7 with the therapeutic range being 2.0-3.0. There is an entry dated 8/25/08 on the laboratory sheet which states, "Faxed [facsimile]." Another entry states, "Called [Z1] on 8/27/08 at 3:15pm. Order to start Coumadin 3mg po and [recheck] PT/INR in 1 wk[week]." There is a Telephone Physician's Order dated 8/27/08 to "Start Coumadin 3mg po daily and recheck PT/INR in 1 week." The laboratory report dated 9/4/08 states the PT was 21.8 seconds with normal being 10.0-13.0 and the INR was 2.6 with the therapeutic range being 2.0-3.0. The laboratory report dated 9/8/08 states the PT was 25.0 seconds with normal being 10.0-13.0 and the INR was 3.3 with the therapeutic range being 2.0-3.0. There is an entry on the report	F9999		

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F9999	Continued From page 31 which states, "Faxed 9/8/08, 9:20pm." The nurses notes dated 9/8/08 with no time documented state, "Faxed PT/INR." There is no documentation in the nurses notes from 9/8-9/18/08 of any followup with Z1, MD, about the PT/INR results of 9/8/08. E4, RN (Registered Nurse) was interviewed on 10/7/08 at 11:45am. When asked if she had called the PT/INR result of 9/8/08 to the Physician, E4 stated, "[R3] has been on Coumadin" and did not know if she had called the Physician. E4 then refused to talk any further with the surveyor and stated she would "Call her attorney and consult with him." E7, LPN, was interviewed on 10/7/08 at 10:30am. When asked if she had called PT/INR results of 9/8/08 to the Physician, E7 stated she did not remember. Z1, MD, was interviewed on 10/7/08 at 12:35pm. When asked if staff had followed up by calling to make sure he got the faxed INR result on 9/8/08, Z1 stated he did not know. When asked how he would have responded if he was called and given the INR level of 3.3, Z1 stated, "I would have repeated the PT/INR in 3 or 4 days, as 3.3 is not too much above where I wanted [R3's] level to be." Z1 stated it's okay for staff to fax laboratory results to him, but he also wants a phone call for the PT/INR results. When asked about R3's INR result of 5.2 on 8/19/08, Z1 stated, "It's a little high, not a major risk, but I don't want it [INR] to be that high." Z1 stated he wanted R3's INR to be "between 2.0-3.0." The Nurses Notes dated 9/18/08 at 5:30am state,	F9999		

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F9999	Continued From page 32	F9999		

"Lg [large] skin tear reopened on L [left] lower calf. Large amt [amount] bright red blood...." R3 was transferred to the Emergency Room.

E5, LPN, was interviewed on 10/7/08 at 10:55am. E5 stated she applied pressure to R3's left calf, but the area was still bleeding and there was "quite a bit of blood," so she sent R3 out to the hospital. When asked if she had called the Physician with the laboratory result of 9/8/08, E5 stated, "I did not call the doctor if it's not documented."

The Emergency Room Report dated 9/18/08 at 6:30am states R3 has the following diagnoses: Abrasion Left Leg, Hemorrhage Left Leg and Coagulapathy Secondary to Warfarin (Coumadin). The report documents a surgical pressure dressing was applied to R3's left leg and 2 Units of Fresh Frozen Plasma were administered to R3. The hospital laboratory report dated 9/18/08 states the PT was 107.5 seconds with normal being 9.2-12.8 seconds and the INR was 8.2 with therapeutic range being 2.0-3.0.

Z2, Emergency Room Physician, was interviewed on 10/8/08 at 4:00pm. When asked if R3's high PT/INR results were life threatening, Z2 stated, "Theoretically it could have been life threatening if she smacked her head, but some people have levels that high and are okay. It could be life threatening if she [R3] had developed bleeding in her head, nosebleed, but there were no signs...."

Z1, MD, was interviewed on 10/7/08 at 12:35pm. When asked if in his opinion R3's INR result of 8.2 and PT of 107.5 seconds on 9/18/08 were life threatening, Z1 stated, "At that stage not life

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F9999	Continued From page 33	F9999		

threatening. She [R3] was at risk of bleeding at that point, very high risk."

2. R8's POS dated September 2008 states that R8 has a diagnosis of Mitral Valve Replacement. The POS has a Physician's Order dated 8/15/08 for Coumadin 11mg daily, Recheck PT/INR in 1 week (8/21).

The laboratory report dated 8/18/08 states the PT was 17.7 seconds with normal being 10.0-13.0 seconds and the INR was 1.8 with the therapeutic range being 2.0-3.0.

There is a Physician's Order dated 8/21/08 to Repeat PT/INR on 8/22/08.

The PT/INR laboratory results for 8/22/08 or any date after 8/18/08 were not found in R8's record and there was no documentation in the Nurses Notes for August/September 2008 of any followup regarding the PT/INR.

E2, DON, was interviewed on 10/8/08 at 9:50am and 10:25am. When asked about R8 not having any laboratory reports in the record since 8/18/08 and being on 11mg of Coumadin, E2 stated she has a laboratory slip showing that R8's PT/INR was drawn on 8/22/08, but confirmed there were no results in R8's record. E2 confirmed there was no documentation in the nurses notes to indicate any follow up was done regarding the PT/INR ordered on 8/22/08. E2 stated that R8 also had a PT/INR drawn on 10/6/08. E2 stated she would ask the laboratory to print the results for 8/22 and 10/6 and fax them to the facility. E2 stated R8 went to the hospital in September. E2 stated she talked with the hospital today (10/8) and was told they did do a PT/INR on 9/19/08, addressed it

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F9999	Continued From page 34 with the Physician and would fax the results to the facility. E2 provided laboratory results for R8 as follows on 10/8/08: The laboratory report dated 8/22/08 stated the PT was 18.6 seconds with normal being 10.0-13.0 and the INR was 2.0 with therapeutic range being 2.0-3.0. The hospital laboratory report dated 9/19/08 stated the PT was 44.7 seconds with normal being 9.2-12.8 and the INR was 3.6 with the therapeutic range being 2.0-3.0. This report was not in R8's record at the facility and E2 was not aware the laboratory test had been done until 10/8/08 when she called the hospital for follow up. The laboratory report dated 10/6/08 stated the PT was 33.7 seconds with normal being 10.0-13.0 and the INR was 5.5 with therapeutic range being 2.0-3.0. There is a Physician's Order dated 10/6/08 to "Hold Coumadin 10/6 and 10/7" and Recheck PT/INR on 10/8/08. 3. R5's October 2008 POS states R5 has a diagnosis of Chronic Atrial Fibrillation. The hospital laboratory report dated 9/23/08 states R5's PT was 120 seconds on 9/22/08 and 107.5 seconds on 9/23/08 with normal being 9.2-12.8 seconds. The INR on 9/23/08 was 8.2 with the therapeutic range being 2.0-3.0. The hospital laboratory report dated 9/24/08 states R5's PT was 30.3 seconds and the INR was 2.5. The September 2008 POS has a Physician's	F9999		

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F9999	Continued From page 35 Order dated 9/25/08 for Coumadin 3 mg daily. The hospital "Medication Reconciliation Orders" dated 9/25/08 has an order for PT/INR in 1 week (10/1). There are no laboratory test results in R5's record for the PT/INR ordered to be done on 10/1/08. The nurses notes for October 2008 do not document any follow up on the laboratory test. E2, DON, was interviewed on 10/8/08 at 11:05am. When asked if the PT/INR to be drawn on 10/1/08 had been done, E2 stated, "It was drawn on Monday 10/6/08 and we still don't have the results." E2 stated she had called the laboratory 3 different times for the results. E2 stated when she went through the laboratory book on 10/6 she found that the INR/PT had not been drawn for R5. E2 stated an audit for laboratory tests and getting results on the chart was started on 10/3/08 and finished 10/6/08. E2 confirmed that R5's "chart was audited on 10/2 and it was not caught that the [PT/INR] had not been drawn." 4. The History and Physical dated 6/6/08 states that R2 has diagnoses of Hypertension, Hyperlipidemia, Dementia and Anemia. The laboratory report dated 6/4/08 states that R2's stool was positive for occult blood. The report dated 6/5/08 states that R2's Hemoglobin is 9.6 with normal being 11.1-15.3 and the Hematocrit is 28.5 with normal being 32.4-45.1. The MDS (Minimum Data Set) dated 6/14/08 and 9/10/08 state R2 has cognitive impairment, behaviors and requires supervision with transfers/ambulation, and minimal assist with	F9999		

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F9999	Continued From page 36 dressing and hygiene. The facility fall assessment dated 7/24/08 identifies R2 as high risk for falls. The care plan dated as reviewed 7/08 and 9/08 does not identify that R2 was receiving Coumadin or have any approaches to monitor R2 for side effects from the anticoagulant therapy. The MAR (Medication Administration Record) dated 8/1-8/31/08 has an undated entry for "Coumadin 3mg [milligrams] po[by mouth] daily." Written under the Coumadin entry is "Reorder 8/9/08." Coumadin 3mg is initialed as being given every day in August except for 8/9/08 and 8/27/08. The POS (Physician Order Sheet) dated 8/1-8/31/08 has no Physician's Order for Coumadin 3mg to be given. There is no Telephone Physician Order in R2's record for Coumadin 3mg to be given. E2, Director of Nurses (DON) confirmed in interview on 10/3/08 at 11:00am that there was no order for Coumadin in R2's chart. E6, LPN (Licensed Practical Nurse) was interviewed on 10/7/08 at 11:00am. When asked if she wrote the Coumadin 3mg on the August 2008 MAR, E6 confirmed she wrote the Coumadin 3mg entry on the MAR. When asked why she wrote Coumadin on the MAR, E6 stated, "The pills came in from the pharmacy. I just added the Coumadin to the MAR. I did not take the order. It was on 8/1/08 so I thought it [Coumadin order] was missed-did not think I had to go back and get an order. I went strictly from the MAR." When asked if the Coumadin was labeled with R2's name, E2 stated she could not remember if the Coumadin was labeled with R2's	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145876	A. BUILDING _____ B. WING _____	C 10/16/2008

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F9999	Continued From page 37	F9999		

name. E6 confirmed that on 8/9/08 she reordered the Coumadin for R2 from the pharmacy.

The POS dated 9/1-9/30/08 and 10/1-10/31/08 has an entry dated 8/11/08 for "Coumadin 3mg tablet. Take 1 tablet by mouth once daily."

The MAR dated 9/1/08-9/30/08 has an entry dated 8/11/08 for "Coumadin 3mg tablet. Take 1 tablet by mouth once daily." The Coumadin was initialed as being given every day in September. The October MAR documents that Coumadin 3mg was given on 10/1/08 and discontinued on 10/2/08.

The Nurse's Notes dated 10/2/08 at 12:40pm states, "[Z1, Physician] called requesting for [information] as to reason why [R2] placed on Coumadin on 8/1/08, [Z1] states that he is unaware of Coumadin reasoning...."

The Physician Progress Note dated 10/2/08 states, "[R2] has received Coumadin since 8/08, med [medication] error.... [Discontinue] Coumadin. No adverse outcome identified. [R2] has anemia but it's chronic. H [Hemoglobin] and H[Hematocrit] has been stable since 6/06 without any drop with Coumadin action."

Z1, Physician, was interviewed on 10/7/08 at 12:35pm. When asked if R2 receiving Coumadin without an order or monitoring for side effects could be life threatening for R2, Z1 stated, "It could have been life threatening, consequence being high risk of bleeding, especially gastrointestinal bleeding. [R2] was definitely at risk for bleeding and worsening of anemia due to lack of monitoring and her [R2's] age."

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F9999	Continued From page 38 E2, DON, was interviewed on 10/3/08 at 11:00am. When asked how the Coumadin was obtained without a Physician's Order E2 stated, "[E6] circled the medication on 8/9/08 because there wasn't any [Coumadin] and the Pharmacy has a refill sheet. The pharmacy called back and checked with [E7, LPN] to verify that order." E2 stated the POSs and MARs are checked for accuracy and signed by staff as they are checked every month. The MARs and POSs are checked for accuracy again the night before staff start using the ones for the next month. E2 stated R2's August POS and MAR were to have been double checked by the night nurse (E8) the night before using them (7/31/08). E2 stated E8 would have had both the old (July) and new (August) MARs and should have been checking both. E8, LPN, was interviewed on 10/7/08 at 11:55am. E8 stated she would look at the previous months POS when checking for accuracy. When asked if not having a check mark by the Coumadin entry on R2's September POS meant anything, E8 stated, "It makes me think I questioned the Coumadin, but I do not remember what I did. Usually I'll leave [E2] a note, but do not remember what I did." Z3, Pharmacy Supervisor, was interviewed on 10/7/08 at 2:00pm. When asked how the facility obtained the Coumadin without a Physician's Order, Z3 stated the pharmacy received a facsimile [fax] from the facility on a refill sheet for Coumadin 3mg daily, which is considered to be the order. Z3 stated the pharmacy fills the medication according to how the nurse wrote the medication on the refill sheet. Z3 stated if the refill sheet is not signed by the nurse the pharmacy will check with a nurse to verify when	F9999		

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F9999	Continued From page 39 the order was faxed." Z3 stated the pharmacy verified the Coumadin refill request with E7, LPN. The pharmacy refill sheet dated 8/9/08 states "[R2] Coumadin 3mg po daily" and documents the nurse as E7. The refill sheet dated 9/9/08 has a pharmacy label which identifies "Warfarin Sodium [Coumadin] 3mg tab[tablet]." E7, LPN, was interviewed on 10/3/08 at 11:20am. When asked if she checked to see if there was an order for the Coumadin when pharmacy called on 8/11/08, E7 stated she "does not remember pharmacy calling or being asked to confirm the order." (A)	F9999		