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| F 333 | Continued From page 25<br>Exelon patch had been changed and the Lactinex given, even though they were not given.<br><br>4. The POS dated 11/16-12/15/09 states R2 has diagnoses of Dementia and Psychosis.<br><br>The Physician's Order dated 12/11/09 states Risperidone 0.5mg every HS.<br><br>The "Medication Incident/Error Report" dated 12/28/09 states the Risperidone was "omitted" on 12/16, 12/19, 12/21-12/27/09. The report states the medication was not in the medication cart and that the pharmacy never sent the medication.<br><br>The MAR dated 11/16/09-12/15/09 and 12/16/09-1/15/09 documents the Risperidone is initialed as if given.<br><br>E7, RN, Unit Manager, stated on 2/16/10 at 9:25am stated the Risperidone was found on 12/29/09 in the top drawer of the medication cart. E7 stated there should have been 18 tablets of the Risperidone out of the bottle of medication, but there were only 13 tablets gone from the bottle. E7 stated R2 did not receive 5 doses of the Risperidone and she was unable to tell which nurses did not give the medication since all had initialed the Risperidone as if it had been given. | F 333 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>300.1010h)<br>300.1210a)<br>300.1210b)2)<br>300.1210b)3)<br>300.3220f) | F9999 | | |

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300.3240a)

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.

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 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:
2) All treatments and procedures shall be administered as ordered by the physician.
3) Objective observations of changes in a resident' 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.

300.3220 Medical and Personal Care Program

f) All medical treatment and procedures shall be administered as ordered by a physician. All new

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physician orders shall be reviewed by the facility's Director of Nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

300.3240 Abuse and Neglect

a) An owner, licensee, administrator, 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:

A. Based on interview and record review the facility neglected R7 by failing to implement existing policies on Falls, Lab[Laboratory] and Diagnostic Test Results, Laboratory Testing, Orders for Anticoagulants, Anticoagulants and Change in Resident's Condition or Status for 1 of 4 sampled residents on Anticoagulants(R7). The facility neglected R7 by failing to notify the Physician in a timely manner of high laboratory values, neglected to identify a fall, to notify the Physician/Nursing staff of the fall and implement post fall monitoring. The facility neglected R7 by failing to assess and monitor significant bruising as a side effect of anticoagulant therapy and a fall. The facility neglected to notify the Physician of the significant bruising in a timely manner, and continued to administer anticoagulants to R7. These failures resulted in Acute Posthemorrhagic Anemia, Hypovolemia, Shock, Coagulopathy and Hematoma of the Lower Limb for R7. R7 died on 2/4/10.

B. The facility failed to hold Coumadin for R12 according to the Physician's order for an INR of

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| F9999 | Continued From page 28<br>10.5.<br><br>Findings include:<br><br>A. R7<br>1. The facility "Anticoagulation-Clinical Protocol" states the nurse will "assess and document/report......recent labs, including therapeutic dose monitoring" and the "staff should use a warfarin[coumadin] flow sheet ...... to follow trends in anticoagulant dosage and response."<br><br>The facility "Lab and Diagnostic Test Results-Clinical Protocol" states, "If staff who first receive or review lab....tests results cannot follow the remainder of the procedure for reporting and documenting the results... another nurse in the facility...... should follow or coordinate the procedure." The protocol states, "If a test was obtained to monitor the blood level of a medication and the level is reported as high(above therapeutic range) or toxic, the nurse will notify the physician promptly and will not give the next dose until the situation has been reviewed with the physician."<br><br>The facility "Policy and Procedure" titled "Laboratory Testing" states, "Lab results received by telephone are directed to the nurse on the appropriate unit. All results are faxed to the facility after the results have been obtained from the lab. The lab will also provide a written copy of lab results through the mail. The nurse notifies the physician of any abnormal results within the current shift. The nurse initials the original lab results after notifying the physician and the files it.....in the chart." | F9999 | | |

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| F9999 | Continued From page 29<br>The Physician Progress Note dated 1/18/10 states R7 is on anticoagulant therapy for a diagnoses of Post Pulmonary Embolism and Right Deep Vein Thrombosis.<br><br>There is a Physician's Order dated 1/17/10 for "Coumadin 5 mg[milligrams] take 1 tablet every evening" and "PT[Prothrombin Time]/ INR on 1/19/10......"<br><br>There were no laboratory results in R7's record for the PT/INR ordered to be done on 1/19/10. E7, RN(Registered Nurse) Unit Manager, stated on 2/16/10 at 10:30am she would call the laboratory and have the results faxed to the facility.<br><br>The laboratory results for the PT/INR dated 1/20/10 stated that R7's Protime was 56.3 seconds with normal being 10.4-13.0 Seconds. The report states the INR was 5.5 with the range for the prevention of pulmonary emboli being 2.0-3.0. The report states that the PT/INR was called to E6, LPN(Licensed Practical Nurse) on 1/20/10 at 10:13am. E6 stated on 2/16/10 at 11:40am she remembered taking a call from the laboratory with INR results of 5.5. E6 stated she was the nurse supervisor that day and she would not have called the laboratory results to the Physician. E6 stated she wrote a note for the nurse on the unit and left the note on the desk where the nurse would see it.<br><br>E8, RN, stated on 2/16/10 at 2:00pm that she never found a note or saw a report of R7's PT/INR which was drawn on 1/20/10.<br><br>Z1, Nurse Practitioner, stated on 2/16/10 at 11:35am that she did not recall being called with | F9999 | | |

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| F9999 | Continued From page 30<br>R7's PT/INR result of 1/20/10. Z1 stated if she had been called, she would have given an order to hold the Coumadin for 2 days and then recheck the PT/INR.<br><br>E7, RN, Unit Manager, stated on 2/16/10 at 3:15pm there was no Physician's Order in R7's record to hold the Coumadin on 1/20/10. E7 stated there was no documentation in the Interdisciplinary Progress Notes of the Physician being notified of R7's PT/INR on 1/20/10.<br><br>The MAR(Medication Administration Record) dated 1/18/10 to 2/17/10 documents that R7's Coumadin 5mg was initialed as being given from 1/20-1/28/10.<br><br>2. The facility "Orders for Anticoagulants" states, "Should a resident receiving an anticoagulant fall or sustain a head injury, the Attending Physician must be notified......"<br><br>The facility "Change in a Resident's Condition or Status" states, "The ....Charge Nurse will notify the resident's Attending Physician ...... when there has been an accident or incident involving a resident....."<br><br>The facility "Falls-Clinical Protocol" states, "The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events.... "<br><br>There is no documentation of R7's fall on 1/25/10 in the Interdisciplinary Progress Notes, except for a Late Entry note dated 1/25/10. There is no documentation of any post fall monitoring in the notes for the fall of 1/25/10. | F9999 | | |

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The Interdisciplinary Progress Note dated 1/25/10 and identified as a "Late Entry" states, "[R7] was sitting in lounge area CNA[Certified Nurse Aide] ran toward [R7]. CNA slid under [R7] and pulled her onto her lap.......[R7] denied pain.....did not hit head....did not hit w/c[wheelchair] or w/c pedals. [R7] talking and laughing with staff......able to move arms and legs without a problem or pain....Body check done with no areas of redness noted.....". Z3, Agency RN, stated on 1/17/10 at 1:25pm that she made the late entry in R7's Interdisciplinary Progress Notes several weeks after the incident. Z3 stated she did not document the fall in R7's record and did not notify R7's Physician of the fall.

E2, DON(Director of Nursing), stated on 2/17/10 at 11:10am there was no Physician notification or documentation of R7's fall on 1/25/10, because Z3, RN did not consider it a fall. E2 stated the incident report was done the day we found the bruises(1/29). E2 stated it was through the investigation of the bruises that we found out R7 had fallen on 1/25/10. E2 stated the CNA's knew about R7's fall because they saw it happen, but no one else knew of the fall.

3. The facility "Falls-Clinical Protocol" states, "The staff with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications.....have been ruled out.....Delayed complications such as late fractures and major bruising may occur hours or several days after a fall...."

The facility "Orders for Anticoagulants" states, "Should a resident receiving an anticoagulant fall

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| F9999 | Continued From page 32<br>or sustain a head injury,.......the resident observed closely for bleeding, changes in mental status. Nursing Services must notify the physician if the resident has any signs or symptoms of internal bleeding......such as excessive bruising..."<br><br>The facility "Anticoagulation-Clinical Protocol" states, "The staff...will monitor for possible complications in individuals who are being anticoagulated.......If an individual on anticoagulation therapy shows signs of excessive bruising......the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant..."<br><br>The Nurses's Daily Summary Sheet from 1/17-1/29/10 all document either "Skin intact" or are blank except for the sheets dated 1/17/10, 1/19/10 and 1/29/10.<br><br>The Nurse's Daily Summary Sheet documents that E4, RN, worked 7am-11pm on 1/26/10 and 7am-3pm on 1/28/10. E4 stated on 2/17/10 at 10:45am that she did not check R7's arms and legs for bruising when she worked as she did not know R7 had had a fall.<br><br>The Nurse's Daily Summary Sheet documents that E8, RN, worked 3pm-11pm on 1/28/10. E8 stated R7 had no bruising when she worked.<br><br>The Nurse's Daily Summary Sheet documents that E5,LPN, worked 3pm-11pm on 1/27/10 and 7am-3pm on 1/29/10. E5 stated on 2/17/10 at 10:15am the CNA's reported to her that R7 had bruising. E5 stated R7 had a 4-5cm(centimeter) bruise on the right lower leg and a 4 1/2 to 5 inch by 3 inch bruise on the right hip. E5 stated she | F9999 | | |

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talked with the CNA's and found out R7 had a fall on 1/25/10 so did not notify the Physician of R7's bruising. When asked why she did not document R7's bruising in the record, E5 stated, she documented the bruises on the "shower sheet." E5 stated she did not check R7's bruises on 1/29/10. E5 stated R7 had bruising on the hands on 1/29/10 but she did not "pull [R7's] pants down to see if she still had bruising" on the right hip and leg.

There is no documentation of any bruising in the Interdisciplinary Notes from 1/17-1/28/10.

The Interdisciplinary Note dated 1/29/10 states, "CNA informed this nurse at 6pm that [R7] had some bruising. Bruise extended from right hip all the way down to left side of ankle. Hip had large knot area with scabs in middle..... Right hand was also bruised....Dr[Doctor]......notified........order given to send to ER[Emergency Room]."

The Emergency Department Provider Notes dated 1/29/10 state, "[R7] fell....and her right leg has progressively increased in size with diffuse ecchymosis.....It does appear [R7] struck her head...."

The History and Physical dated 1/29/10 lists R7's diagnoses as "Shock, Acute Posthemorrhagic Anemia, Hypovolemia, Coagulopathy, Acute Kidney Failure, Unspecified, Hematoma of Lower Limb and Diabetes."

Z5, Emergency Room Physician, stated on 2/18/10 at 10:10am that R7's diagnoses of Hypovolemia, Shock, Acute Posthemorrhagic Anemia and Coagulopathy were "directly related to [R7's] high INR," there was a large amount of

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blood lost in the leg . Z5 stated the high INR was "totally related to the incredible amount of blood loss in the leg." Z5 stated it "took a lot of fluid and blood to fix [R7's] anemia/shock which resulted in CHF[Congestive Heart Failure]" for R7. Z5 stated the "treatment came with risks as well as created them because of the CHF."

The Medical Death Certificate dated 2/16/10 states that R7 died on 2/4/10. The death certificate states R7's cause of death was "Cardiopulmonary Arrest, Respiratory Failure and Hypovolemic Shock".

B. R12
The Physician Order Sheet dated 12/17/09 to 1/16/10 states that R12 has a diagnosis of Atrial Fibrillation.

The Physician's Order dated 12/17/09 states to give Coumadin 6mg every evening.

The Laboratory Report dated 12/18/09 states R12's Protime was 100.8 with normal being 10.4-13.0 seconds and the INR was 10.5 with the range for prophylaxis being between 2.0-3.0. The report documents the laboratory called the PT/INR to Z6, LPN, on 12/18/09 at 8:57am.

The Physician's Order dated 12/18/09 states to give "5mg Vitamin K po[by mouth] now. Hold Coumadin. PT/INR in am 12/19/10."

The MAR dated 12/17/09-1/16/10 documents Coumadin 6mg was initialed as being given on 12/18/09 and 12/19/09 instead of being held as ordered by the Physician. The MAR does not document that the Vitamin K was given. Vitamin K 5mg is not written on the MAR.

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| F9999 | Continued From page 35<br><br>Z1, Nurse Practitioner, stated on 2/19/10 at 12:00pm that Vitamin K is only given if the INR is over 10.0. When asked how great the risk of bleeding was for R12, Z1 stated R12 was at risk for bleeding especially if she had fallen.<br><br>The Medication Incident/Error Report dated 12/20/09 states there were new orders to give Vitamin K related to an INR of 10.5 and PT of 100.8 seconds. There were orders to hold the Coumadin and recheck the PT/INR on 12/19/09. The report documents that Coumadin 6mg was given on 12/18 and 12/19 "without current orders." The report documents to prevent a future reoccurrence of the error staff are to "check MAR for orders [and] [followup] with lab[laboratory] results in a timely manner."<br><br>The Physician's Order dated 12/20/09 states, "MD[Medical Doctor] acknowledges med[medication] error. PT/INR [and] CBC[Complete Blood Count] stat[now], Call [with] results." The Laboratory Report dated 12/20/09 states R12's INR was 3.2 with the prophylaxis range being between 2.0-3.0.<br><br>E2, DON, stated on 2/23/10 at 3:40pm that Z6, LPN, took the order for the Vitamin K and to hold the Coumadin(12/18,12/19) but never transcribed the order to the MAR. E2 stated it looks like the Coumadin was never marked on the MAR to be held, so E12, RN gave the Coumadin on 12/18 and Z7,LPN, gave the Coumadin on 12/19. E2, DON, stated on 2/19/10 at 12:30pm that even though the Vitamin K was not documented as being given to R12, that Z1 thought it had been given because R12's INR came down even though the Coumadin was given instead of being | F9999 | | |

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