STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146090	A. BUILDING _____ B. WING _____	03/30/2010

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HAWTHORNE INN OF DANVILLE	3222 INDEPENDENCE DRIVE DANVILLE, IL 61832

(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
F9999	Continued From page 33 LICENSURE VIOLATIONS 300.686a) 300.1210a) 300.1210b)2)3) 300.3240a) Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Drugs a) A resident shall not be given unnecessary drugs in accordance with Section 300.Appendix F. In addition, an unnecessary drug is any drug used: 1) in an excessive dose, including in duplicative therapy; 2) for excessive duration; 3) without adequate monitoring; 4) without adequate indications for its use; or 5) in the presence of adverse consequences that indicate the drugs should be reduced or discontinued. (Section 2-106.1(a) of the Act) 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:	F9999		

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F9999	Continued From page 34 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. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on record review and interview the facility failed to monitor the Prothrombin Time (PT) and International Normalized Ratio (INR) for one of five residents sampled for anticoagulant therapy (R1). The facility failed to follow physicians orders for Coumadin administration and failed to monitor PT/INR levels as ordered by the physician. R1 was admitted to the hospital two times within three weeks with a Critical INR level of greater than 9.0. R1 also suffered Gastrointestinal bleeding, bruising to upper and lower extremities, bruising to the chest and lacerations to the right foot with "profuse" bleeding. Findings include: The facility discharge record for R1 shows initial admission date of 7/23/09 with diagnoses including: Morbid Obesity, Atrial fibrillation,	F9999		

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F9999	Continued From page 35 pacemaker, Diabetes Type II, Chronic Kidney Disease stage IV and fractured ankle. The care plan for R1 dated 11/5/09 includes the following: Problem: Resident has potential for bleeding r/t (related to) anticoagulant therapy - see MAR (medication administration record). Goal: Therapeutic lab results and no abnormal bleeding through next review. Approach: Obtain and monitor PT/INR..as ordered. Special instructions: Contact physician if the INR equals or is more than 3.5 unless otherwise ordered by physician. Approach: Administer medication as prescribed - see MAR Approach: Monitor for and report s/s (signs/symptoms) of weakness, fatigue, dyspnea upon exertion, angina, chest pain, cardiac changes. Approach: Monitor for s/s of bleeding and report: easy bruising, hematoma, black tarry stools, small pinpoint rashes, bloody sputum/emesis, nosebleeds, hematuria. Approach: BE AWARE: Vitamin K reverses anticoagulant effect of Warfarin/Coumadin. Problem: Potential for shortness of breath, hypoxia, respiratory failure and cardiovascular collapse r/t.....**Requires oxygen.** Takes prednisone.... Goal: (Patient will be) without respiratory distress and without s/s of hypoxia, respiratory failure or cardiovascular collapse through next review. Approach: Monitor for s/s of hypoxia: agitation, anxiety, restlessness, changes in mentation of level of consciousness, cyanosis Approach: Monitor for side effects of Prednisone: hypertension, edema, GI (gastrointestinal)	F9999		

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F9999	Continued From page 36 irritation.....Report severe abdominal pain or tarry stools. Approach: O2 (oxygen) saturation every shift. Problem: Resident is at risk for falls r/t dx (diagnosis) of weakness, debility with deconditioning.....S/P (status post) left ankle fracture with ORIF (open reduction internal fixation) d/t (due to) fall.....PRN (as needed) hypnotic, narcotic and anti-anxiety medication use. Goal: Resident will remain free from injury r/t falls during this quarter. Approach: Monitor for side effects of anti-anxiety, narcotic and hypnotic medications. Approach: Communicate changes in resident's status, condition or behaviors during your shift to the nurse, and during shift reports. Physicians order dated 9/22/09 by Z2 (attending physician) increased R1's Coumadin dosage and specified to obtain a PT/INR in one week. This order was signed off on 9/23/09 by E9 (Registered Nurse). The MAR's (Medication Administration Records) for September 1 - September 30, 2009 and October 1 - October 31, 2009 show this medication was not increased as ordered by Z2 until 10/1/09 when the pharmacy issued a new MAR. A PT/INR was drawn on 9/28/09, two days earlier than ordered and prior to the increase in the Coumadin dose. The lab report dated 9/28/09 shows an INR value of 3.71 and PT of 25.6. This lab report lists the PT as 'high' and the INR at a 'high risk' level. There is nothing on the bottom of the fax to indicate Z2 (attending physician) received the fax. On 3/25/10 3:30 pm E3 (Director of Nursing/DON) stated, "I can't find	F9999		

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F9999	Continued From page 37 anything else," when asked if R1's medical record contained a fax showing Z2 had received the PT/INR results of 9/28/09. On 3/11/10 at 12:05 pm, Z2 (attending physician) stated, "I don't remember them sending me INR results of 3.71 on 9/28/09. If there is no documentation from me on the bottom of the fax like 'noted' or new orders written, then I did not receive it." On 3/10/10 at 2:30 pm E3 (DON) stated, "The nurse (E9) was given disciplinary action for not following procedure for transcription of medication orders. It (disciplinary action) was done after (R1) went to the hospital (10/26/09) with the increased INR." On 3/24/10 at 12:55 pm E3 (DON), when asked why the PT/INR was drawn on 9/28/09 instead of 9/30/09, stated, "Well, to me a week translates into 5-7 days, not literally one week." On 3/11/10 at 12:05 pm Z2 (attending physician) stated, "I was not told of the Coumadin medication error. I would have ordered another PT/INR. Was the facility aware? The only medication errors the facility has called me about are antibiotics which is unacceptable. Coumadin is more serious. I don't trust monthly PT/INR's. My personal policy is every two weeks for someone on Coumadin. I depend on the facility to follow my orders. It is a check and balance system. They get the labs as ordered and it reminds me to order the next one. If they don't follow my orders and someone gets hurt they are negligent." On 3/10/10 at 2:30 pm E3 (DON) stated, "(I) am	F9999		

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F9999	Continued From page 38 trying to find the investigation (done after R1 was admitted to the hospital with critical levels of INR). (I) found out during the course (of my investigation) the Coumadin was not transcribed. We have a new pharmacy consultant too. (The) Pharmacy didn't catch the error." The facility policy for medication transcription provided by E3 (DON) is undated and not titled but states, "The following procedure must be implemented: 1. The facility staff is responsible for maintaining the Medication Administration Record (MAR). Complete all transcriptions on residents physician orders sheets, MAR, treatment sheet and PRN (as needed) sheets. To identify a prescription that has had a change in time of administration or a change in frequency of administration, a change of direction sticker should be affixed to the label and/or card." On 10/1/09 the physicians orders from Z2 (attending physician) ordered Cipro to be given to R1 for a urinary tract infection. On 10/2/09 the consultant pharmacy sent the facility a notice titled "Possible Drug Interaction" regarding co-administration of Cipro (Ciprofloxacin) and Coumadin which states "Co-Administration of the above medications (Cipro and Coumadin) may increase the effects of Warfarin. Please monitor." The State Operations Manual updated 8/1/08 under the section "Common Medication-Medication Interactions in Long Term Care" states "Warfarin (Coumadin) with fluoroquinolones such as ciprofloxacin, levofloxacin, ofloxacin" can have "Increased effects of warfarin, with potential for bleeding." The Medication Administration Record (MAR) shows R1 continued to receive the Cipro and Coumadin until 10/8/09.	F9999		

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F9999	Continued From page 39 On 3/10/10 at 2:30 pm E3 (DON) confirmed the MAR was correct and R1 received the Cipro from 10/1/09 through 10/8/09. At this time E3 (DON) stated she did not know if the information was passed on to the attending physician. The "Lexi-Comp Drug Information Handbook for Nursing, 10th edition, 2009" under Warfarin (Coumadin) Adverse Reactions - Bleeding is the major adverse effect of warfarin. Hemorrhage may occur at virtually any site." On 3/11/10 at 12:05 pm Z2 (attending physician) stated, "I was not told of the possible interactions with the Cipro and Coumadin. If the facility knew they didn't pass it on. I could have changed meds." On 3/24/10 at 2:15 pm Z7 (pharmacist) stated, "There are five levels of medication interactions we look at with Warfarin and other drugs. Level one is the worst and we won't even send the medication until approved by the physician. Level II we would definitely send a fax to the facility. Cipro is a severity level II so we will fax the facility, call the facility or both depending on the pharmacist. The facility then notifies the physician." On 10/7/09 Z6 (wound clinic physician) physicians order from the wound clinic contained an order for Doxycycline to be given for 14 days for a urinary tract infection. The "Lexi-Comp Drug Information Handbook for Nursing, 10th edition, 2009" lists Doxycycline as a Tetracycline derivative and states under the section "Drug Interactions-Increased	F9999		

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F9999	Continued From page 40 Effect/Toxicity: Increased prothrombin time with coumarin (coumadin) derivatives." No pharmacy consult was found in R1's medical record regarding potential interactions with coumadin and Doxycycline. E3 (DON) confirmed on 3/10/10 at 2:30 pm she (E3) was unable to find a consult from the pharmacy regarding potential interactions with co-administration of Doxycycline and Coumadin on R1's medical record. On 3/24/10 at 2:15 pm Z7 (pharmacist) stated, "Doxycycline is a level three severity. We don't typically fax these to facilities." A document located in R1's medical record dated Saturday, 10/24/09 shows a fax was sent to Z2's office from the facility requesting "(R1) has c/o (complaints of) nosebleeds and requested that I check her INR.....Could we order an INR? She does have some bruising on her hands and abdomen.." There is no documentation the facility called the physician or on-call physician over the weekend. On 3/24/10 at 12:55 pm E3 (DON) stated (regarding faxing the physician on the weekend and not calling the on call physician) "The expectation? Well in hindsight yes (nurse should have called the physician) but in the moment it would depend on the length of time she had the nosebleed, how much blood was noted or were there any other problems." On 3/25/10 at 2:35 pm Z8 (Medical Director) stated, "Usually they call the on call physician.	F9999		

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F9999	Continued From page 41 Sometimes it is difficult to get ahold of attendings so typically they call the on call person." There are no nursing notes regarding the nosebleed or request for PT/INR. On 3/24/10 at 12:55 pm E3 (DON) stated, "Yes, I have to say a nosebleed in a resident on Coumadin is noteworthy and should have been in the nurses notes." At the time of interview E3 also stated she was looking in other areas of the electronic record and found no documentation of a nosebleed under "observation" or "event" reports. On Monday 10/26/09 at 12:22 pm Z2's office faxed the following physicians order to the facility "PT/INR stat today. Fax or call results." No lab results were found in the medical record of R1 for this stat PT/INR order. On 3/10/10 at 2:30 pm E3 (Director of Nursing) stated she (E3) was unable to find any PT/INR results from 9/28/09 - 10/26/09 prior to R1 being sent to the hospital at 6:05 pm on 10/26/09. On 10/26/09 R1 was sent to the hospital with the admission "History and Physical" by Z4 (hospital physician) stating "In the emergency department, it was found that the patient had an INR of greater than 9.0.....However given heme-positive stools (blood in stools) with her supratherapeutic (high) INR she (R1) was given a total of 20 mg of Vitamin K IM (intramuscular).....According to the ICU (Intensive Care Unit) nurse, the patient (R1) had 3 episodes of 30-60 ml (milliliters) of blood-tinged mucousy emesis." On 3/25/10 at 2:35 pm Z8 (Medical Director)	F9999		

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F9999	Continued From page 42 stated, "A critical PT/INR is just that - critical. A critical PT/INR predisposes the patient to bleeding. You would usually see some type of bleeding, usually GI (Gastrointestinal) before someone dies." The "Lexi-Comp Drug Information Handbook for Nursing, 10th edition, 2009" lists one of the uses of Vitamin K as "Prevention and treatment .....caused by coumarin induced-derivatives or other drug induced Vitamin K deficiency." The hospital laboratory results dated 10/26/09 list the INR as greater than 9.0 and labels this value as a "critical" result. R1 returned to the facility on 11/2/09 with additional diagnosis on the discharge summary from the hospital of Gastrointestinal Hemorrhage (GI bleed) added to the cumulative diagnoses list. On 11/3/09 "In-Service Education/Meeting Report" shows E3 (DON) presented an inservice titled "Anticoagulants for Healthcare Professionals." The in-service "Anticoagulants: Summary" states "(Anticoagulants) Effective medications IF used correctly (e.g. correct dose, duration of therapy and clinical/laboratory monitoring); All patients receiving these agents MUST be diligently and continuously monitored for signs and symptoms of bleeding; Warfarin: conservative increases in dose, frequent INR monitoring, numerous drug, food and nutrient interactions; Injectables: careful attention to dose and duration of therapy (especially when used concomitantly with warfarin)." R1's medical record contains a fax dated 11/4/09 showing the PT/INR results were faxed to the Z2	F9999		

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F9999	Continued From page 43 (attending physician). At that time the facility requested a weekly PT/INR order for R1. On 11/4/09 the Z2 (attending physician) ordered "weekly PT/INR." On 3/10/10 at 2:30 pm E3 (Director of Nurses) stated she was "unable to locate a PT/INR for (R1) on 11/11/09 or 11/12/09." On 11/2/09 Z2's physician orders state Cefpodoxime 100 mg twice daily. The "Lexi-Comp Drug Information Handbook for Nursing, 10th edition, 2009" lists Cefpodoxime as a cephalosporin antibiotic and states "Cefpodoxime: Physical Assessment.....Monitor laboratory tests (prothrombin time)....adverse effects (eg <example given>: hemolytic anemia.....and bleeding.)" Under the section "Adverse Reactions: Reactions reported with other cephalosporins: ....renal dysfunction....hemolytic anemia, hemorrhage...." On 3/10/10 at 2:30 pm E3 (DON) and on 3/24/10 at 2:15 pm Z7 (pharmacist) confirmed no co-administration alert had been sent to the facility. The nurses notes show R1 was sent to the hospital on 11/17/09 at 8:25 am after a fall which occurred at 12:55 am. The nurses notes dated 11/17/09 at 8:02 am state, "Resident (R1) assess <sic> this a.m. noted on left knee skin tear freely bleeding.....on right leg redden/molted <sic> edemous <sic>, right foot 3rd, 4th, 5th toes under side deep laceration<sic>, unable to measure d/t (due to) profuse bleeding. (R1) tearful d/t pain of right foot, noted left hand/arm blacken bruse <sic>. bruses <sic> on bil (bilateral/both) upper lateral chest area.....O2 (oxygen) at 6 L (liters) nc (nasal cannula) sat (saturation) 95%.....(R1)	F9999		

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F9999	Continued From page 44 stated was confused at time of fall last nite. (Z2) called order received. (Z3/family) called and informed of patient to go to er (emergency room) for eval (evaluation) and tx (treatment)." The hospital "History and Physical" dated 11/17/09 by Z5 (hospital physician) states, "...presented to the ED (emergency department) today for repair of laceration to her right foot after incurring a fall last night, falling out of bed. While in the ER (emergency room), her INR was checked and found to be supratherapeutic at 9.0.....Of note, the patient was recently treated for UTI (urinary tract infection) at the nursing home." The hospital laboratory results dated 10/17/09 list the INR as greater than 9.0 and labels this value as a "critical" result. The hospital "Discharge Summary" dated 11/21/09 by Z4 (hospital physician) states "....INR was checked and it was found to 9.0. (R1) was admitted. (R1) received Vitamin K 10 mg IM (intramuscular) along with 2 units of fresh frozen plasma after which INR on the day of discharge was noted to be 3.2." On 3/10/10 at 2:30 pm E3 stated ,"I am trying to find the investigations (related to the two hospitalizations with critical INR levels). I can't remember (what happened) each time. I did look into the incidents but can't find the reports." On 3/18/10 at 10:00 am E3 (DON) and at 10:15 am E1 (Administrator) stated the medication and pharmacy errors were discussed in the quarterly Quality Assurance meeting.	F9999		

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F9999	Continued From page 45 The "Quality Assurance Committee Policy" dated 12/02 under "Purpose" states: 'The Quality Assurance Committee is utilized to; Identify areas of concern; Involve staff in the development of action plans related to monitoring results, thereby enhancing staff commitment to and involvement in measures to promote compliance; Evaluate the effectiveness of past and present actions taken to remedy deficiencies; Provide facility with objective information to guide decision making; Pharmacy Committee.....will be incorporated into Quality Assurance Committee." On 3/18/10 at 2:00 pm. E1 (Administrator) provided The "Quarterly Quality Assurance Summary - Fourth Quarter 2009." Under the Section "Medical Director Reported: No concerns at this time." Under the section "DON Reported: Medication Error Review - Problem: Three medication errors, no pattern or severe harm, Coumadin and monitoring was involved in one of the errors. Correction: At time of the error report. Monitored: Observed daily by DON." Under the section "Consultant Pharmacist Reported: Pharmaceutical Review (October - December 2009). Patterns/Trend on Overall Medication and Psychopharmacological Medication Utilization: No negative patterns or trends were observed during the period. Action Plan: No action plan is required at this time." R1 did not return to the facility after discharge from the hospital. The facility was unable to find an investigation into the incident. (A)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146090	A. BUILDING _____ B. WING _____	03/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE INN OF DANVILLE	**3222 INDEPENDENCE DRIVE DANVILLE, IL 61832**

(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