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F 363	Continued From page 43 ladle to serve. A serving of ground meat using the 3 ounce dipper was noticeably larger. R22 consumed 100 percent of the Mechanical Soft meat served at the noon meal.	F 363		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility multi bed resident bedrooms do not provide 80 square feet per resident in 21 of 32 resident rooms. The findings include: The previous survey dated 10/16/2009 documents a deficiency for undersized rooms. Administrator E1 provided a November 16, 2009 document from the Department for a Waiver of Title 19 rooms. The facility currently has thirty two resident rooms set up for use. This includes 21 undersized rooms: room numbers 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 20, 21, 22, 23, 24, 25, 26, 27, and 28. These rooms provide 75.5 square feet of space per resident. The facility license is for 78 beds. There are currently only 32 resident rooms set up. Rooms Rooms 31, 32, 33, and 34 are being used for offices. These rooms provide 75.5 square feet per bed. Room 18 and the room next to 18 is used as a Physical Therapy Room. Room 13 is	F 458		

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F 458	Continued From page 44 now being used as a Director of Nursing Office.	F 458		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210a) 300.1210b)3) 300.1610a)1) 300.1610a)2) 300.1620a) 300.1620c) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not	F9999		

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F9999	Continued From page 45 limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 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 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and	F9999		

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F9999	Continued From page 46 disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. 2) Medication policies and procedures shall be developed with the advice of a pharmaceutical advisory committee that includes at least one licensed pharmacist, one physician, the administrator and the director of nursing. This committee shall meet at least quarterly. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. c) Review of medication orders: The staff pharmacist or consultant pharmacist shall review the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical experience and judgment, and Section 300.Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be	F9999		

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F9999	Continued From page 47 done at the facility and shall be documented in the clinical record. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met, as evidenced by the following: Based on record review and interview, the facility neglected to follow policies/procedures to protect 1 resident in a sample of 12 from significant medication error (R14). Staff failed to follow policies including Pharmacy Medication Orders and Resident Charts, Guidelines for Physician Notification of Resident Change in Condition, Notification for Change in Resident Condition or Status, Oral Medication Administration, Medication Administration, Conformance with Physician Medication Orders, and Adverse Drug Reactions and Medication Discrepancy. The facility also failed to have a policy in place regarding administration and monitoring of anticoagulant therapy. Failure to follow these policies resulted in failing to correct an error in transcription with the pharmacy for Coumadin (anticoagulant), failing to note concomitant use of Plavix (antiplatelet), failing to note the discrepancy between the physician's orders and the Medication Administration Records (MARs), failing to monitor for side effects of anticoagulant therapy, and failing to note critical laboratory results (labs) and inform the physician. As a	F9999		

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result, R14 received Coumadin in error for 36 days, experienced bleeding 13 days prior to hospitalization, had a delay in treatment for 2 days following critical labs, and was hospitalized for Gastrointestinal (GI) Bleeding.

Findings include:

1. According to admission records, hospital discharge records, and the initial Physician's Order Sheet (POS), R14 was admitted to the facility on 4/13/10 with diagnoses of Anxiety, Panic Attacks, Hypokalemia, Gastroesophageal Reflux Disease, Depression, Hypertension, and Hemorrhoids. Medication orders included Plavix 75mg (milligrams) daily, but no Warfarin. The assessment for 4/21/10 assesses R14 with no memory problems or cognitive impairment, as independent for most activities of daily living, and usually continent. According to notes dated 7/2/10 by E11 (Social Service Designee), R14 changed physicians in early July, 2010, and Z1 (attending physician) had not seen R14 as yet.

An order dated 6/9/10 on R14's 6/10 POS written by E6 (nurse) states the following: "Continue Coumadin (Warfarin) 9-11-10 (6/11/10) PT (prothrombin time) INR (international normalized ratio) 3 weeks. Continue 3 mg daily dosage." Under the medication column on this POS is "6/9/10 - Coumadin 3mg daily starting 6/11/10." This order and medication entry are crossed out with "error - 6/10/10." The Coumadin order is printed on the 7/10 POS, with a line drawn through it and "error" written on it. The Coumadin order is also printed on the 8/10 POS, prior to the hospitalization, but is not crossed out.

Coumadin is not on the MAR for 6/10. However,

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F9999	Continued From page 49 starting with 7/1/10, the MARs for 7/10 and 8/10 have the Coumadin entry dated 6/10/10, "Warfarin Sodium 3mg tab Sub for : Coumadin 3mg Take 1 tablet by mouth once daily Class: anticoagulant." Each date is initialed by the nurses as given from 7/1/10 through 8/5/10, for a total of 36 days. On 8/6/10, the day R14 went to the hospital, is written "OOF" (out of facility.) Nurses Notes were reviewed from admission on 4/13/10 to 8/10/10. On 7/25/10 at 1:40pm, R14 "c/o (complained of) vaginal bleeding, discomfort, stated has had bleeding for over two weeks but not a month, light red, moderate bleeding. Stated last change of {brief} was light bleeding. Stated would like to see a women gyno doctor. . ." Z2, (on-call associate for Z1) was called, and he ordered CBC (complete blood count) and urinalysis with culture. This order also stated to "contact {Z1} on 7/26/10." There is no evidence that Z2 was informed that R14 was receiving Coumadin. At 5:00pm, a "mod amt (moderate amount) pink thin drainage on {brief}. . . peri-rectal area viewed - small amt dried blood smear on buttocks and rectal area - does not appear vaginal at this time. . . Resident advised to put rectal cream on every HS (bedtime)." No further Nurses Notes addressed any bleeding issues through 8/6/10 at 2:00am. The CBC results dated 7/26/10 show low Hct (hematocrit) and Hgb (hemoglobin) at 30.8% (normal 37 - 52%) and 10.3 (12 - 18 grams/deciLiter) respectively. There is no evidence that Z1 was contacted on 7/26/10 as per order. According to Nurses Notes and telephone order, Z1 was contacted on 7/29/10 regarding CBC and urinalysis, and that R14's "mouth dry, black, hairy tongue. . .complains of	F9999		

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F9999	Continued From page 50 abdominal pain." Z1 ordered antibiotics for the UTI (urinary tract infection), and to "encourage cranberry juice and fluids. Will continue to monitor." According to the Medication Regimen Review sheet, the consultant pharmacist reviewed the record on 6/10/10 and 7/2/10, but noted no irregularities and made no recommendations. On 8/6/10 at 10:00am Nurses Notes state that Z2 (associate physician) was called regarding R14's complaints of "blood in urine, patient states small spots appear in her pad." At 2:15pm, notes state, "CNAs (Certified Nurse Aides) {changed} patient's pad and reported blood 'splurting' out on them when patient was turned to the side. . . noted bloody rectal area. Checked on patient's lab work - PT of > (greater than) 54.3 and INR > 10 (normals 10 - 13 seconds and 2 - 3 respectively per lab sheet) noted on 8/4/10. Patient on Coumadin and Plavix. PT/INR, CBC ordered STAT (immediately)." At 4:30pm, R14 was transported to the hospital where she was admitted for GI bleeding. Review of the lab sheet dated 8/4/10 with the elevated PT/INR shows that it was sent by fax from the lab to the facility at 3:22pm on 8/4/10. There is no indication by date, notes or initials that these labs were faxed or called to the physician, nor did the Nurses Notes address these labs until the above incident on 8/6/10. The hospital History and Physical by Z2 dated 8/6/10 states that R14 was admitted for gastrointestinal bleeding "for several days. Cannot determine duration exactly," and was complaining of "some lightheadedness and	F9999		

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tiredness." The list of nursing home medications include Plavix and Warfarin. Lab results included Hct of 13.6 and Hgb of 4.5, PT of 108, and INR of 11.6. Emergency room treatment included vitamin K IV (intravenous), fresh frozen plasma, and transfusion of 2 units of packed red blood cells.

According to Consultation and Operative Notes by Z3 (gastroenterologist) dated 8/7/10 and 8/8/10 respectively, R14 underwent an upper endoscopy (EGD) and a colonoscopy. Z3 determined that while R14 does have mild gastritis and esophagitis, the source of the bleeding: ". . .rectum was quite hard. . . consistent with a radiation proctitis for cervical cancer. The rectal mucosa was red and friable. . . This was probably the source of the bleeding. . ." The colonoscopy also showed many multiple polyps and diverticuli.

The hospital Discharge Summary dated 8/9/10 dictated by Z1 states the following: "It is believed that if her INR had not become excessive she would probably would not have begun bleeding. So a close eye on her INR would be necessary. It has become apparent that there is no clear reason why is she is on the Coumadin. . . . I am going to switch her over to Plavix, and until I find better information about her past medical history, we will continue with that alone. . ."

R14 returned to the facility on 8/9/10 at 4:15pm with orders including Plavix 75mg daily.

E2 (ADON/Assistant Director of Nursing) was interviewed on 8/11/10 at 12:30pm. E2 stated she became aware of the problem with R14 on 8/6/10 when the CNAs went to help R14 after she

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had diarrhea, and "blood gushed out." E2 stated that was when they looked at R14's chart and found the elevated PT/INR that was done on 8/4/10. E2 stated that the contracting lab had been at the facility and found that R14 was receiving Coumadin without having a PT/INR. So a telephone order was written on 8/4/10 by E7 (MDS/Careplan Coordinator), received from Z2, for "PT/ INR {secondary to} Coumadin therapy." When asked if she was aware that R14 was not supposed to be on Coumadin, E2 stated that she became aware on 8/6/10 when reviewing the chart. E2 stated that E6 (nurse) wrote the order on 6/9/10 on the wrong chart, and faxed the order to the pharmacy. E2 stated that when E6 realized she wrote the order on the wrong chart, E6 "crossed it out on the POS but did not notify pharmacy." E2 stated that staff do not routinely use telephone order slips that are sent to the physician to sign, but instead just write orders on the POS. E2 stated that at the time of the interview, she had not done anything as far as a medication error investigation/report or notification.

Z1 returned the call for interview on 8/11/10 at 2:30pm. Z1 stated that he was not aware that R14 was receiving Coumadin in error until today. Z1 confirmed that he had recently taken on R14 as a patient and that "sometimes a hand-off from another physician is a little sketchy." Z1 stated that he and Z2, who admitted R14, reviewed her case while R14 was in the hospital, and could not see why R14 was on Coumadin. Z1 confirmed that areas of inflammation noted on the EGD and colonoscopy were the source of the bleeding. R14 received blood and plasma in the hospital. Z1 stated that the use of the Coumadin in error, and along with the Plavix, contributed to the GI

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F9999	Continued From page 53 bleeding. Z1 also stated that he was not aware that a PT/INR was done on 8/4/10. Z1 stated that had those elevated results been reported to him (or Z2), Vitamin K would have been ordered, and could have "definitely" avoided the bleeding episode on 8/6/10. E6, when interviewed on 8/12/10 at 10:00am, stated she did not recall the 6/10/10 Coumadin order until reviewing the chart. E6 stated she may have taken the order for someone else, as she does not work that hall very often. E6 confirmed that she did fax the order to the pharmacy when she received the order. E6 stated she did not recall crossing out the order, and did not recall if she notified the pharmacy of the error. The MARs were reviewed for 6/10 and 7/10, and E6 confirmed that she did administer the Coumadin several times in July. Review of facility policies noted the following: Pharmacy Medication Orders revised 10/06 states, "Telephone orders are to be written on the special Physician's Telephone Orders form, and signed by the nurses taking the order. The original is then sent to the physician for signature. . . The Physician's Telephone Orders form must be signed by the physician in accordance with state and federal guidelines. . . . The transcribed order is then communicated to pharmacy via fax of the telephone order or written order." The Guidelines for Physician Notification dated 10/25/05 lists uncontrolled or repeated bleeding episodes, PT three times control, and Significant Medication Errors. The policy for Notification for Change in Resident Condition or Status states that the physician and family must be notified "when there has been. . . .a reaction to medication. . . .abnormal lab findings. . ."	F9999		

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F9999	Continued From page 54 The Oral Medication Administration policy dated 10/07 states that medication is given, "as prescribed by the physician," and to address the "Five Rights of medication administration: right resident, right drug, right time, right route, right dose, prior to administering this or any medication." The Medication Administration policy dated 10/07 states that, "The complete act of administration entails. . . . verifying it with the physician's orders. . . 6. Medications must be identified by using the 5 rights of administration. . . 18. Omit giving a medication if the resident has symptoms suggestive of an undesirable reaction to the drug and report your observations to the physician as soon as practical. . . .23. Report errors in medication administration immediately per policy. 24. Report suspected adverse reaction immediately per policy." The policy Conformance with Physician Medication Orders dated 10/6 states, "1. A physicians's order may be taken by telephone with a telephone order written by the nurse taking the order, or by facsimile (fax). Any telephone order received must be signed by the nurse receiving the order and countersigned by the physician. 2. Telephone orders. . . will be written on the standard telephone order. . . . 3. A complete and accurate list of current medication orders will be maintained on the resident's Physician Order Sheet. . . . 4. The consultant pharmacist shall review the medical record, including physician orders and laboratory test results al least monthly. . . . the consultant pharmacist will determine if there are any irregularities, which would cause potential adverse reactions. . . ." The Adverse Drug Reaction and Medication Discrepancy policy dated 10/06 states that	F9999		

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F9999	Continued From page 55 "Adverse drug reactions and drug errors are to be reported to the resident's physician, documented in the nurses notes, and documented on an Adverse Drug Reaction or Medication Discrepancy Report." The procedure also states that "1. A medication discrepancy/error has been made when one of the following occurs: * wrong medication administered. . . . .*medication administered to the wrong resident. . . .2. Assess the resident for adverse reaction side effects. . . .3. Report suspected drug reaction or medication discrepancy and assessments immediately to the attending physician for treatment options. . . . 7. A Medication Discrepancy Report shall be completed for any of the above occurrences. . . 8. A Medication Discrepancy Error may be completed in instances when medications are administered outside the recommendations of the manufacturer, physician or standards of practice. . . 14. The Medical Director, Consulting Pharmacist and Administrator will review the Medication Discrepancy Report. . ." E8 (Corporate Nurse) confirmed on 8/12/10 at 2:00pm that the facility does not have a policy specific to Coumadin admininstration and monitoring. (A)	F9999		