STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145197	A. BUILDING _____ B. WING _____	C 04/28/2011

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CONCORD NURSING & REHAB CENTER	**9401 SOUTH RIDGELAND AVENUE OAK LAWN, IL 60453**

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F 309	Continued From page 21 present at the monthly QA meeting.	F 309		
F 364 SS=C	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure food was served at preferable temperatures. Findings include: Resident council meetings from February 2011 denotes residents complained of cold food for breakfast and lunch. Surveyor observed noon meal on 4/19/11 and observed trays passed to residents with appropriate amount of food plated. In confidential interview, residents stated the meal was not warm. Surveyor requested a test tray to be sent to the last unit served. At 1:00PM, surveyor had E13(dietary supervisor) check food temps on the test tray and obtained the following: 1 large Swedish meatball 122 degrees vegetable red cabbage 112 degrees	F 364		4/29/11
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS Section 300.1210a) Section 300.1210b)3)	F9999		

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F9999	Continued From page 22 Section 300.3240a) 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 days 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 300.3240 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 staff/physician interviews, the facility failed to provide care and services for 2 of 6 sampled residents (R4, R6) on anticoagulant therapy by not ensuring:	F9999		

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1) R6's physician was made aware of significant and abnormal lab value used for monitoring Coumadin levels Prothrombin time and International Normalized Ratio (PT/INR) in a prompt time frame.

2) Continuous monitoring of resident (R6's) medical condition with abnormal PT/INR values for adverse effects of Coumadin.

3) R6's physician/alternate or medical director was notified immediately of R6's onset of dark brown stools which required immediate medical intervention.

4) a program was in place identifying and tracking residents identified on Coumadin therapy for PT/INR results for 1 of 18 residents (R4) and 1 closed record (R6).

These failures resulted in R6 having a massive Gastrointestinal bleed (GI Bleed) causing cardiopulmonary arrest and brain death. R6 was taken off life support 3 days after transfer to hospital.

These failures had the potential to affect all 18 residents in the facility identified on anticoagulant (Coumadin) therapy.

Findings include:

R6 was readmitted to the facility on 2/18/11 after hospitalization for 11 days due to infection of sacral wound. R6 has a history of Coronary Bypass Surgery, Diabetes Mellitus and Gastrointestinal Hemorrhage. R6 was alert and orientated but required assistance from staff for

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activities of daily living.

R6's Computerized Physician Order Sheet denoted an order for Coumadin 3 mg by mouth once an evening (5 PM) dated 2/18/11. R6's medication flow sheet denotes R6 received 3 mg of Coumadin at 5:00 PM on the following dates: 2/20/11, 2/21/11, 2/22/11, 2/23/11 and 2/24/11.

Physician Order Sheet denotes an order for a PT/INR test on 2/21/11. Review of lab report denotes specimen for PT/INR was collected on 2/21/11 at 4:20 AM. Results were faxed to E3 (LPN) at 2:25 PM. PT results were 41.7 H (Reference range 11.3-18.6) and INR results were 3.4 H (Reference Range 0.8-3.0). Documentation on the lab report denotes the results were faxed to R6's physician on 2/22/11 by E3, one day after receiving results. There is no further documentation on nurse notes or labs that any follow-up was made to R6's physician for further orders for Coumadin.

E3 stated in phone interview on 4/21/11 that she had called R6's physician's office with the PT/INR results and was told to fax the results. E3 stated she does not recall whether reported abnormal levels to oncoming shift.

R6 continued to receive the 3 mg of Coumadin for the next 3 days. R6 was also on Aspirin 325 mg. The Geriatric Dosage Handbook, including Clinical Recommendations and Monitoring Guidelines, identifies Warfarin (Coumadin) as a high alert medication denoting The Institute for Safe Medications Practices includes this medication among its list of drugs which have a heightened risk of causing significant patient

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harm when used in error. Under Warnings/Precautions "concomitant use of aspirin increases Warfarin anticoagulant effect and may cause severe GI irritation."

R6's care plan regarding use of anticoagulant therapy recommends to avoid aspirin and aspirin containing medications. Observe for signs of active bleeding (nosebleeds, bleeding gum, petechiae, purpura, ecchymotic areas, hematoma, blood in urine, blood in stools, hemoptysis, elevated temp, pain in joints, abdominal pain, epistaxis).

Nurse notes from 2/21/11 through 2/26/11 have no documentation of R6 being monitored for any abnormal bleeding.

Documentation on 2/26/11 at 6:32 AM by E6 (LPN) denotes "R6 observed with dark brown stool, history of duodenal and gastric ulcers, vitals within normal range. Z1 (physician) answering service called, awaiting for call back. Endorse to oncoming nurse to follow-up. ADL's performed by staff, resident kept clean. Blood glucose within normal limit."

E6 stated in phone interview on 4/19/11 at 3:00 PM, staff were cleaning up R6, noticed dark brown stools, did not notice any direct bleeding. R6 was alert and not complaining of pain. E6 stated "I had concerns R6 had a history of duodenal ulcers and was on Coumadin and that could be a problem." Called Z1's answering service and told oncoming nurse of observations.

Documentation on 2/26/11 at 9:14 AM by E5 denotes "Staff CNA called writer to R6 room due

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to R6 not responding. Upon entering room, writer noted resident to be unresponsive, diaphoretic, appeared to have mucous substance coming from mouth mucous substance removed. R6 blood sugar was 285, respirations 28, Saturation Pulse Oximeter (SPO) 86 with O2 on at 3 liters, Oxygen increased to 90, pulse 50, blood pressure 62/48, 911 called, report given to ER." Further documentation on 2/26/11 at 1:22 PM denotes "hospital ER called, informed R6 admission to hospital with diagnosis of GI bleed, Anemia, and Cardiac Arrest.

E5 (LPN) stated in interview on 4/20/11, she had not been informed by E6 (night nurse) of R6's dark brown stools or a call was out for Z1. E5 stated she was passing meds down hallway when E8 (CNA) came to get her because R6 was not responding. E5 stated she had not passed meds yet to R6 so had not seen him. E5 stated she went into room and saw R5 unresponsive and diaphoretic, did sternal rub, responded with movement. E5 stated R6 was usually alert and orientated. E5 stated she checked vitals and called 911. E6 stated I thought it was R6's blood sugar or R6 had a seizure. E6 stated she had not noticed any bleeding, did not check diaper. E6 stated paramedics were there within few minutes.

Facility 24 hour report dated 2/26/11 documents "R6 observed with brown stool. History of duodenal and gastric ulcer. Z1 paged, awaiting call back."

There was no further documentation of monitoring R6 vitals or dark brown stools until R6 went out by 911, nor was there documentation whether Z1 had responded to call on 2/26/11.

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Review of Emergency Medical Service (EMS) Sheet denotes 911 was notified and arrived at scene at 8:42 AM. EMS notes denote upon arrival at 8:42 AM, R6 was in bed unresponsive, agonal breathing. R6 went into witnessed full arrest while attempting to obtain vitals. R6 was in asystole entire time treating R6. CPR was performed throughout patient contact.

Emergency Record review denotes R6 arrived in ER at 9:00 AM in cardiac arrest. R6 was resuscitated and placed on ventilator. R6 received 4 units of packed cells and 4 units of fresh frozen plasma, and given Vitamin K 10 mg. R6's lab results of 2/26/11 were: Protime- 127, INRO 12.3, PTT-92, hemoglobin 3.4. R6 was declared brain dead and removed from life support on 3/1/11.

Z4 (ER attending) for R6 on 2/26/11 stated in phone interview on 4/27/11, "I recall R6 coming in by paramedics and saying 'he's so pale is this guy must be sitting in a pool of blood.'" Z4 stated R6 was wrapped in blankets and sheets and when we uncovered R6 he had a large amount of blood from the rectum. Z4 also stated R6 was dead in full arrest when he came in and was resuscitated with fluids, transfusions and medications. Z4 stated R6's Cardiac Arrest was related to blood loss because of GI bleed.

R6's preliminary autopsy diagnosis dated 3/2/11 revealed: a) gastric ulcer (1.5 cm) b) dilated cecum and colon with old blood consistent with recent GI bleed.

R6's death certificate listed R6's cause of death

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F9999	Continued From page 28 as coronary artery disease due to GI Bleed. Z1 stated in phone interview on 4/19/11 that he had not known the facility had faxed the results of R6's PT/INR result of 2/21/11. Z1 stated that if he was aware of the abnormal PT/INR he would of stopped the Coumadin and ordered another PT/INR. Z1 stated on 4/21/11 that because R6 had continued to receive the Coumadin, it contributed to R6's gastrointestinal bleed. On 4/18/11, surveyor requested from E1 (DON) the list of residents on anticoagulants. E1 presented a list of 18 residents identified on Coumadin faxed from the pharmacy on 4/18/11. E1 was asked if there is any program of identifying and tracking residents on anticoagulants, E1 stated "not that I'm aware of." E1 was asked if the facility had a policy or procedure for residents on anticoagulant therapy, E1 presented a fax document from a sister facility dated 4/18/11 titled "Recommendation for Monitoring and Adjusting Doses for Warfarin (Coumadin)" which discusses the variance of Coumadin dose and dosage recommendation of PT/INR results. Facility policy for Physician Notification of Laboratory Results includes: The guidelines were developed to ensure that: 1. All significant laboratory results are relayed to the physician in an appropriate and prompt manner. 2. Medical problems are communicated to the physician in a timely manner. Nurse responsibilities: 1. Notify the appropriate physician of all critical	F9999		

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and alert laboratory results. This should be done via the telephone.

2. Provide the physician with relevant information regarding diagnoses, resident condition, and current medications and dosages.

3. Provide the physician with information regarding recent results.

4. Results which are neither critical nor alert in status should be faxed to the physician (or called at the physician's request).

5. All physician contacts regarding laboratory results should be documented in the resident's record.

6. If the attending physician does not respond to critical and / or alert notifications the medical director should be contacted by telephone for direction.

Facility GUIDELINES for PHYSICIAN NOTIFICATION FOR CHANGE IN CONDITION OVERVIEW INCLUDES:

These guidelines were developed to ensure that:
1. All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and are to be documented in the medical record.
2. Medical care problems are communicated to the attending physician in a timely, concise, and thorough manner.

NURSE RESPONSIBILITIES

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F9999	Continued From page 30 The nurse should not hesitate to contact the attending physician at any time for a problem which is his or her judgment requires immediate medical intervention. Should the physician not be available, the alternate physician should be contacted. If neither of these physicians are available, the Medical Director should be notified. 2. R4's diagnosis includes history of venous thrombosis. R4's current POS denotes an order for Coumadin 5mg 1 tab once an evening. There was also an order dated 10/23/11 for weekly PT/INR every week. Record review reveals the last PT/INR completed on R4 was 12/23/10 with results of Pro-time 36.2 INR 2.89. Pharmacy review form dated 2/9/11 denoted a recommendation from Z2 (pharmacist) for a monthly PT/INR on R4. Z2 stated in phone interview he had made a recommendation for a PT/INR for R4 but recommendation was never followed up on. R4's care plan dated 4/13/11 for complications related to anticoagulant therapy; approach includes "coordinate lab work." (A)	F9999		