STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145890	A. BUILDING _____ B. WING _____	C 01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINVIEW	**1001 A JEFFERSON STREET ELDORADO, IL 62930**

(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
F 333	Continued From page 1 and transcription errors. The 1/10/12 incident report prepared by E1 (Administrator) finds the medication errors began on 12/28 with an order for Coumadin dose change from 4mg to 3mg. The facility's 1/15/12 incident narrative states "The new order was documented on December and January POS' (Physician's Order Sheets) , but only on December's MAR" (Medication Administration Record) The narrative further states "There was a breakdown in our system as the nurse receiving order failed to pull the 4mg Coumadin from med cart. From 12/28/11 until 01/04/12 (R1) received 3mg until an LPN noticed the MAR still read Coumadin 4mg and had been signed for. She then pulled the 3mg Coumadin from cart and sent to pharmacy for return, assuming the order was 4mg. He then received 4mg daily until hospitalization on 1/10/12. Upon arrival to ER (Emergency Room), an INR (International Ratio) of 5.4 was determined." A review of R1's POS and MAR sheets from December and January confirms the confusion of the Coumadin orders and the administration of the incorrect dosage of Coumadin from 1/4/12 to the time R1 was hospitalized on 1/10/12 with the UGI bleed and the INR of 5.4.	F 333		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.1210d)1) 300.1620a) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 2 d) Pursuant to subsection (a), 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 300.1620 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. 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 failed to ensure that residents remain free of significant medication errors for 1 of 3 (R1) residents reviewed for significant medication errors on the sample of 3. This failure resulted in hospitalization and diagnosis of Upper Gastrointestinal (UGI) bleed and correction of coagulopathy for R1. The findings include:	F9999		

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F9999	Continued From page 3	F9999		

R1's admission record states R1 was admitted to the facility on 6/1/10 with diagnoses including: Cardiovascular Accident, Hypertension, Myocardial Infarction, and Atrial Fibrillation. On 1/10/12 Nursing Notes at 9:30am state R1 had foul smelling coffee ground emesis, a distended abdomen and bowel signs times four. A 1:20pm nurses notes finds R1 was admitted to the hospital for observation with diagnosis of UGI bleed. E2 (Director of Nursing) on 1/19/12 at 12:10 pm stated after R1 was admitted to the hospital , E3 (charge nurse) began a review of R1's record. E3 found errors in Coumadin dosage changes, administration of wrong dosage and transcription errors.

The 1/10/12 incident report prepared by E1 (Administrator) finds the medication errors began on 12/28 with an order for Coumadin dose change from 4mg to 3mg. The facility's 1/15/12 incident narrative states "The new order was documented on December and January POS' (Physician's Order Sheets) , but only on December's MAR" (Medication Administration Record) The narrative further states "There was a breakdown in our system as the nurse receiving order failed to pull the 4mg Coumadin from med cart. From 12/28/11 until 01/04/12 (R1) received 3mg until an LPN noticed the MAR still read Coumadin 4mg and had been signed for. She then pulled the 3mg Coumadin from cart and sent to pharmacy for return, assuming the order was 4mg. He then received 4mg daily until hospitalization on 1/10/12. Upon arrival to ER (Emergency Room), an INR (International Ratio) of 5.4 was determined."

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F9999	Continued From page 4 A review of R1's POS and MAR sheets from December and January confirms the confusion of the Coumadin orders and the administration of the incorrect dosage of Coumadin from 1/4/12 to the time R1 was hospitalized on 1/10/12 with the UGI bleed and the INR of 5.4. B	F9999		