STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145652	A. BUILDING _____ B. WING _____	C 04/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HI NURSING HOME	**2406 HARTLAND ROAD WOODSTOCK, IL 60098**

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F 000	INITIAL COMMENTS Complaint Investigation # 1271168 / IL57179 Valley Hi Nursing Home is in compliance with 42 CFR Part 483, Requirements for Long Term Care facilities for this survey.	F 000		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210d)1)2)3) 300.1810c)1)2)3) 300.1810f)1) 300.1810h) 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	F9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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 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

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.
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 300.1810 Resident Record Requirements

c) Record entries shall meet the following requirements:
1) Record entries shall be made by the person providing or supervising the service or observing the occurrence that is being recorded.

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2) All entries into the medical record shall be authenticated by the individual who made or authored the entry. "Authentication", for purposes of this Section, means identification of the author of a medical record entry by that author and confirmation that the contents are what the author intended.
3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports.

f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained.
1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change

h) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a

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resident.

These REQUIREMENTS were not met as evidenced by:

Based on interview and record review the facility failed to follow physician's orders for obtaining laboratory results, failed to follow their Coumadin Log Policy, failed to identify symptoms of Coumadin toxicity, and failed to notify the physician after a resident became unresponsive.

Findings include:

R2 was a long-term resident who was originally admitted to the facility on 8/8/08 according to the facility face sheet. R2 had moderate cognitive impairment (BIMS 9/15) and required extensive assistance with most activities of daily living, according to the most recent Minimum Data Sets (MDS) assessment dated 12/16/11. R2 had multiple diagnoses, including Atrial-Fibrillation (A-Fib), Hypertension and Coronary Artery Disease, according to the MDS. R2 had a physician's order for Coumadin 8 mg daily, according to the February 2012 Physician's Order Sheet (POS). On 2/9/12 R2's PT result was 29.6 (reference range 20.2-30.8) and her INR result was 2.88 (reference range 2.0-3.0) according to the laboratory report. Z1 (R2's physician) wrote "PT INR 1 week" on the 2/9/12 laboratory report. E5 (Nurse) initialed the laboratory report and wrote "noted." In the nursing notes dated 2/9/12, E5 wrote "2 PM Received PT/INR results back from Dr 0 NO." The Coumadin Orders Log form does not have an entry for 2/9/12. The 2/9/12 physician order for a PT/INR in 1 week was not followed through, resulting in R2 not having this

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lab drawn.

E5 (Nurse) was interviewed on 3/28/12 at 10:55 AM regarding R2's physician order dated 2/9/12 for PT/INR in one week. E5 said that she initialed the doctor's order and wrote "noted" on the fax. E5 stated that she did not follow through with scheduling the PT/INR in one week, because she thought the order read "no new coumadin orders." E5 said that she did not record the lab results or any other information on the "Coumadin Orders Log" because it was the end of shift. E5 said she asked the PM shift nurse to double check her work.

On 2/27/12, R2 became unresponsive according to late entry nursing note dated 2/28/12, authored by E6 (Nurse). According to the note, R2 became unresponsive when she was being assisted with a transfer using a mechanical lift. The note also documents that the CNA said R2 had a bowel movement while being showered. According to the nursing note "there was a very large dark stool on shower floor." The nursing note lacks documentation of whether R2's physician was notified of her unresponsive episode and dark stool.

On 2/28/12 R2 again became unresponsive per documentation in the nursing notes. According to the nursing notes, 911 was called after R2 became unresponsive for 1 minute, then became responsive, and then became unresponsive again; R2's blood pressure was 98/71.

R2 was admitted to the Intensive Care Unit directly from the emergency room with Gastrointestinal bleed and Coumadin toxicity,

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according to the hospital records. R2's PT was ">100" (range 9.2 - 12.7 seconds) and her INR was ">10" (standard therapeutic range: 2.0 - 3.0), according to the hospital History and Physical note dated 2/28/12. Fresh blood was noted coming out of R2's vaginal opening, according the a physician consultation note dated 2/28/12. The Emergency Admission Assessment dated 2/28/12 documents that R2 had dry, bloody oral secretions and bloody, dark red diarrhea. R2 died on March 8, 2012. The Cause of Death was Gastrointestinal Bleeding, according to the Certification of Death Record.

E3 (CNA) was interviewed on 3/29/12 at 10:15 AM. E3 stated that she was R2's CNA on 2/27/12 when R2 became unresponsive in the shower room. E3 said that R3 became unresponsive when she and E4 (CNA) were transferring R2 from the shower chair to the wheelchair using a mechanical lift. E3 said that R2 was unresponsive for about 1 minute. E3 said that she immediately called the nurse. E3 said that during R3's shower, she had a large "black and pasty" stool. E3 said that the stool was different from R3's usual stool, which she described as dark green and watery. E3 said that after lunch on 2/27/12 she assisted R2 to bed. E3 said that R2 had dried blood around her nostrils. E3 said that E5 (Nurse) was also in the room and observed the dried blood around R2's nostrils.

E5 (Nurse) was interviewed on 3/28/12 at 10:55 AM. E5 said that she was called to the shower room on 2/27/12 by the CNA. E5 said that R2 was slumped in her wheelchair with her eyes closed. E5 said that she rubbed R2's sternum

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area and R2 became responsive. E5 said that she noticed tarry stool on the shower room floor. E5 said that she told E6 (R2's nurse that day) to make sure she notifies the doctor about R2's tarry stool. E5 was re-interviewed on 3/29/12 at 1:35 PM. E5 said that she saw dried blood around R2's nostrils after lunch on 2/27/12 while R2 was in bed. E5 stated "it looked like maybe the nasal canula scratched her." E5 said that she noted fresh blood coming from R2's nostrils when she was placing the nasal canula into R2's nose. E5 said that she figured that R2's nose was sore. E5 said that she told the CNA (E3) to tell R2's nurse, as she was not R2's nurse that day.

E6 (Nurse) was interviewed on 3/27/12 at 4:00 PM. E6 said that she responded to the CNA's call for help in the shower room on 2/27/12. E6 said that the CNA's reported that R2 had gone limp and lost consciousness while they were transferring her from her shower chair to her wheelchair. E6 said she noted a large, dark brown stool on the floor but did not get a good look at it because it was about 10 feet away. E6 said that she did not notify R2's doctor about R2's loss of consciousness. E6 responded "no reason" when asked why she did not call the doctor. E6 was re-interviewed on 3/29/12 at 1:50 PM. E6 stated that on 2/27/12 the CNA reported to her that R2 had blood around her nose. E6 said that she checked the oxygen "bubbler" to see if it was functioning properly. E6 said she did not find any problems with the bubbler. E6 said she did not see any blood around R2's nose and did not know whether the CNA had wiped it away.

Z1 (R2's Physician) was interviewed on 3/28/12 at 2:15 PM. Z1 stated that he ordered R2's PT/INR

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to be rechecked in 1 week because it was high normal and he wanted to see the trend. Z1 was not aware that R2's PT/INR had not been rechecked as he had ordered on 2/9/12. Regarding R2's episode of unresponsiveness and tarry stool, Z1 said that he would "absolutely expect to be notified if a resident had a tarry stool or became unconscious for any period of time...that's important for me to know." Z1 said that coumadin toxicity could cause bleeding in any area of the body where there was a previous lesion, including the vagina, rectum and nose.

The facility's policy titled "Change in Condition" (10/17/05) states that all changes of condition "must be completely and objectively documented in the medical record" and the physician should be notified.

The facility's policy titled "Coumadin Log Policy" directs staff to record PT/INR and lab results on the log. The Log requires documentation of DATE, PT, INR, CURRENT MEDICATION, NEW ORDER, and next LAB ORDER.

E2 (Director of Nursing) was interviewed on 3/27/12 at 3:00 PM. E2 stated that staff is expected to document on the Coumadin flow sheet (Log). E2 said that any new labs, changes to orders and the next lab draw should all be documented on the flow sheet.

(AA)