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F 501	Continued From page 39 R25 (infection control-F441), R14 (falls and delays in medical treatment F323 and F309), and R16 (anticoagulant medication monitoring-F329). E1 stated on 7-26-12 at 11:00 a.m. that the facility has no guiding operating policy related to employing the use of a Medical Director and in what capacity.	F 501		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210d)3)6) 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	F9999		

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F9999	Continued From page 40 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: 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. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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	F9999		

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the following:

Based on interview and record review the facility failed to maintain the most effective assessed intervention of one to one direct supervision for R14 to minimize the risks of recurring falls and serious injury and failed to provide appropriate post fall interventions for R14. R14 fell twice within a six hour time period. The second fall incident failed to activate the pressure alarm when R14 climbed out of the bed. The facility failed to properly assess and notify the physician of R14's condition relating to behaviors and altered mental status relating to a fall R14 had on 6/18/12. Failure to notify the Physician on R14's behaviors and altered mental status resulted in R14's treatment being delayed for a time period of eight hours. R14 was subsequently diagnosed with a Subarachnoid Hemorrhage, Subdural Hematoma and Skull Fracture relating to the fall he sustained earlier on 6/18/12. R14 is one of five residents reviewed for falls in the sample of 15.

Findings include:

R14's Physician's Order Sheet (POS) dated June 2012 documents the following diagnoses: Non Insulin Dependent Diabetes Mellitus, Anxiety Disorder and Hypertension.

R14's Minimum Data Set (MDS) dated 4/19/12 documents that R14 is severely cognitively impaired and requires one person physical assist for transfers and toileting, and is unable to balance without staff assistance .

R14's Fall Risk Assessment dated 4/12/12,

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F9999	Continued From page 42 5/25/12, 6/17/12 and 6/18/12 documents that R14 was at high risk for falls. R14's Nurses Notes dated 4/12/12 at 1:30 PM on the date of admission to the facility document: "(R14) Has personal alarm due to history of six falls at home in the past week. (R14) has multiple scrapes /bruising from falls. (R14) has stitches above left eye that needs removed and awaiting orders to remove." The Facility's Occurrence Report dated 6/17/12 documents that on 6/17/12 at 6:45 PM "(R14) was sitting in the wheelchair (w/c) at the nursing station holding cane in hands, (R14) went to stand up and staff member went to assist (R14) and (R14) swung cane hitting staff member and fell to the floor landing on right side, staff member braced (R14) during fall, no injuries noted." R14's Nurses Notes dated 6/17/12 at 10:00 PM document: "Staff sits with (R14) 1:1 (one to one) will continue to monitor." Nurses Notes dated 6/17/12 at 10:30 (late entry) document: "(R14) assisted to bed around 10:15 PM and staff heard bed alarm sounding. (R14) up walking in room with belt in hand. (R14) in the doorway with belt, staff quickly ran to (R14) and removed belt from situation and assisted (R14) to wheelchair and (R14) brought to nurses station to monitor." Nurses Notes dated 6/18/12 at 12:12 AM documents "PRN (whenever necessary) Tylenol given at 11:00 PM for restlessness. (R14) sat in w/c at nurses station and was becoming sleepy, staff assisted (R14) to bed at this time. Bed alarm on, will continue to monitor, call light in reach."	F9999		

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The Facility's Occurrence Report dated 6/18/12 documents that on 6/18/12 at 1:15 AM "(R14) climbed out of bed and the bed alarm did not sound, this nurse (E8) LPN (Licensed Practical Nurse) coming down the hall and found (R14) on the floor laying on his back scooting around on the floor. Raised bump noted to crown of head with raised area to back of head and scalp region...." The same Occurrence report documents that the Physician was faxed the information regarding the fall with injury to his office at 2:00 AM on 6/18/12.

R14's Nurses Notes dated 6/18/12 at 4:15 AM document: ".....(R14) continues to be very restless and fidgets almost constantly. Will continue to monitor."

R14's Nurses Notes dated 6/18/12 at 5:30 AM document: "(R14) on toilet and pointed penis at CNA (Certified Nursing Assistant) and attempted to urinate on CNA, then had toilet tissue in hands as if holding a gun and told staff (R14) will shoot them and then (R14) threw tissue at staff. (R14) in hallway with staff monitoring one to one and (R14) raised right leg and kicked this nurse (E8) in stomach. Will continue to monitor."

R14's Nurses Notes dated 6/18/12 at 6:20 AM document: "(R14) complaints of buttocks hurting PRN (whenever necessary) Tylenol given with difficulty. (R14) would not swallow pills and had difficulty getting (R14) to open his mouth. C/D Wing nurse sat with (R14) and reports (R14) attempting to pull out his tongue. Staff sits with (R14) one to one at nurses station."

R14's Nurses Notes show no documented

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evidence of attempts to notify or consult with R14's Physician regarding the behavioral changes in R14 that occurred on 6/18/12 after R14's fall with a known head injury. The only notification of R14's Physician regarding the fall on 6/18/12 is the facility's Occurrence Report dated 6/18/12 that documents that R14's Physician was faxed the information regarding the fall with injury to his office at 2:00 AM on 6/18/12.

On 7/20/12 at 10:30 AM E2, DON (Director of Nurses) stated she had no additional information regarding R14's Physician being personally contacted except what was already written in R14's Nurses Notes.

R14's Nurses Notes dated 6/18/12 at 8:40 AM document R14's Physician was contacted and an order was received to send R14 to the Emergency Room. R14's Nurses Notes at 9:15 AM document an Ambulance was here to transport to Emergency Room.

R14's hospital Radiology Report dated 6/18/12 document: "Acute subdural hematoma with extension into the anterior falx and a component of subarachnoid hemorrhage all described. There is cerebral edema in the right hemisphere and cerebral atrophy is noted. Linear skull fracture is an equivocal finding in this case."

R14's Nurses Notes dated 6/18/12 at 9:30 PM document: "Daughters came to report that their father (R14) died at 8:15 PM.......they said there was so much brain damage that a conscious life could not be sustained....."

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Z4, Physician for R14, stated on 7/24/12 at 11:40 AM, " .... I read the Emergency Room report for (R14). The report stated (R14) had a acute subdural hematoma, subarachnoid hemmorage and skull fracture. I can say the subdural hematoma and skull fracture was the result of trama from the fall. This was part of the reason for his death, I cannot say it was the only reason for death. The trauma from the fall resulted in (R14's) skull fracture and subdural hematoma."

E1, Administrator stated on 7/20/12 at 11:15 AM, "....the staff put (R14) to bed they stopped the one to one on him because he was supposed to be in the bed sleeping. I don't know why the pressure alarm did not sound, they just malfunction at times. .... There is no policy to my knowledge explaining the procedures and time limits for one to one with residents. They usually stop one to one when the resident goes to sleep." E2 DON (Director of Nurses) was present during this interview with E1 and confirmed the facility had no specific policy for one to one with the residents.

On 7/24/12 at 12:15 PM E2, stated the facility did not have any fall policies for residents who are considered high risks.

(A)

300.610a)
300.1210a)
300.1210d)2)
300.1220b)2)3)6)9)

Section 300.610 Resident Care Policies

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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 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

d) Pursuant to subsection (a), general nursing

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care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.
6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel.
9) Participating in the development and

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implementation of resident care policies and bringing resident care problems, requiring changes in policy, to the attention of the facility's policy development group. (See Section 300.610(a).)

Section 300.1810 Resident Record Requirements

c) Record entries shall meet the following requirements:
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.

These regulations are not met as evidenced by the following:

Based on observation, interview and record review the facility failed to monitor anticoagulant therapy for one of 10 residents (R6) from the sample of 15 and (R16) from the supplemental sample, all reviewed for medication monitoring. The facility failed to monitor R6's anticoagulant medication blood levels for 5 consecutive months putting him at high risk for an adverse health event. The facility also failed to monitor R16's anticoagulant medication therapy. Both residents are assessed by the facility as being at high risk for falls and subsequent injury/adverse health events.

Findings include:

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1) According to the July 2012 Physician Order Sheet R6 was admitted to the facility on 12/13/11 with diagnoses which include, Brainstem Cerebral Vascular Accident, Left Hemiplegia, Obesity, Atrial Fibrillation, Pacemaker, and Deep Vein Thrombosis.

On 7/17/12 at 12:30 PM, R6 was assisted in the bathroom by E5 Certified Nurses Aide (CNA) and E6 CNA. R6 was unable to move or use his left arm or leg at all. R6 required the extensive assistance of two CNA's, and use of a safety grab bar on the right side to stand, in order to use the urinal. R6 was very unsteady and several times yelled out that his leg needed to be moved or his arm was stuck. According to R6's weight records R6's weight as of 6/12 was 246 pounds. At this time E6 stated that this was the way that R6 was assisted to use the bathroom on a regular basis, although he required the use of a mechanical full body lift to get out of bed into his wheelchair.

The Minimum Data Set dated 6/11/12 documents that R6 is non-ambulatory, and requires extensive assistance with all activities of daily living. A facility fall risk assessment last done on 6/11/12 documents that R6 is a high fall risk. The facility Plan of Care last updated on 6/14/12 documents that R6 is a high fall risk and lists interventions that include the need for two person assist to use the bathroom and a full mechanical lift into and out of bed. The Physician's Orders dated 7/12 document that R6 receives Coumadin (anticoagulant) 7.5 MG (milligrams) daily at bedtime. Past Physician's Orders written 12/13/11 through 7/12, document that R6 has been on Coumadin since his last admission to the facility dating back to 12/13/11. The laboratory section of

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F9999	Continued From page 50 the medical record documents the last Prothrombin Time (PT) and International Normalized Ratio results (INR) (both are blood tests utilized in monitoring anticoagulant therapy) was 2/9/12. A Physician's telephone order dated 3/8/12 documents that the same dose of medication is to be continued and a recheck of blood levels was to be done on 4/5/12. The Physician Orders from January 2012 through 7/20/12 indicates blood levels were drawn by the laboratory in January and February. There is no documentation that the recheck of blood levels after February 2012 was ever done. On 7/18/12 at 2:30 PM, E7 Unit Secretary and E11Licensed Practical Nurse (LPN) were questioned regarding R6's anticoagulant medication monitoring. E7 stated, "I don't have him on my current list of regular blood tests. He is nowhere, it must not have been done since March." E11 stated, "when we take off an order we usually write it on the desk calendar. I looked back on the date it was supposed to be drawn and it was not written down so it looks like we didn't do it. We also don't have the results from that last PT/INR drawn on 3/8/12 so we don't know what those were. I will call for those results now. I'll also call the doctor and ask him to order a STAT (to be done immediately) blood level, since we don't have any idea what his level might be." E2, Registered Nurse, Director of Nurses (RN/DON) on 7/18/12 at 2:45 PM stated, "no we do not have a policy for tracking or monitoring anticoagulant therapy. Our regular staff doctors generally check them monthly, more often if needed. The cardiology doctors do their own	F9999		

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ordering. It is always different each time. We call with results and they give us the dose and next order for a recheck. We don't always get orders for the lab to draw a PT/INR, when we have a new admission. The orders we get from the hospital don't always include the last lab result or when the next one is due to be drawn. Sometimes the Unit Secretaries have a separate list if the dates don't get written on the calendar, but not always. We must have just missed it."

Z6, Registered Nurse and Office Practice Manager for Z5 Medical Doctor on 7/20/12 at 10:00 AM stated, "this lapse in monitoring (R6's) bleeding times is very critical, I will speak to the doctor about this information." At 10:30 AM, Z6 stated, "I spoke with (Z5). He reviewed the information and he said I could quote him, "This is a very severe, even critical infraction considering this patients medical history. He has had a stroke, a blood clot, an irregular heart beat and he has a pacemaker. This could have resulted in a critical situation for him, even death."

2) According to the admissions face sheet R16 was admitted to the facility on 5/26/12 after a Right Total Hip Arthroplasty. Other pertinent diagnoses include, Coronary Artery Disease, Peripheral Vascular Disease, Obesity and Atrial Fibrillation.

The Minimum Data Set dated 6/23/12 documents that R16 is non-ambulatory and requires extensive assistance with transfers, bed mobility and most activities of daily living. The facility Fall Risk Assessment tool dated 5/26/12 documents that R16 is a high fall risk. The facility's Plan of Care, last updated on 6/15/12 documents falls as

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(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 52 a problem, with Non-weight bearing status on the right side. Nurses Notes dated 5/29/12 document that lab test results were faxed to Z5 Medical Doctor (MD). On 5/31/12 nurses notes document that Z5 wants INR results faxed to him (from lab done 5/29/12). No further documentation involving the results of the 5/29/12 PT/INR is noted in the nurses notes until 6/4/12 at 2:50 PM. The 5/29/12 Nurses Notes state, "Resident has been getting 5 MG of Coumadin daily since 5/26/12. (Z5) had left message for 1.25 MG to alternate with 2.5 MG, order received to draw STAT PT/INR today." Nurses notes dated 6/5/12 document that Z5 gave orders to hold Coumadin and re-check level in two days. Laboratory results for PT/INR dated 5/29/12 document that R16's INR was at the high end of the intensive therapy acceptable range. Results of the PT/INR done on 6/4/12 document that R16's bleeding time was above intensive therapeutic range and was a "Panic Value." As a result, the medication was held through 6/7/12. On 7/19/12 at 2:45 PM, E10 Registered Nurse stated, "we only heard about the orders when (R16's) Son-in-Law came in to visit. He mentioned to the nurses that (Z5) had called (R16's) answering machine at home and left the orders to change the dose and re-check the levels. We wouldn't have known otherwise. No one here followed up after the results were faxed over on 5/30." R16 was again hospitalized for a second Right Hip Revision due to dislocation from 7/9 through 7/12/12. The Hospital, "Inter Agency Transfer Form," dated 7/12/12, documents that R16 was discharged on Coumadin 5 MG daily. There is	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146046	A. BUILDING ______ B. WING ______	07/27/2012

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F9999	Continued From page 53 nothing documented under the area of Follow-up Labs. E9, Unit Secretary, on 7/20 at 2:20 PM stated, "After this second hip revision I happened to be looking through the hospital transcripts and on page 17. I saw when the last PT/INR had been done in the hospital. No follow up had been ordered, and they usually say to re-check in one week, so I scheduled one to be done on 7/18/12, otherwise it wouldn't have happened. The nurse who took off the admission orders knew (R16) was on Coumadin and should have known she needed an order." (B)	F9999		