STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145926	A. BUILDING _____ B. WING _____	C 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMILION MANOR NURSING HOME	**14792 CATLIN TILTON ROAD DANVILLE, IL 61834**

(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 490	Continued From page 84 anticoagulant therapy. Specifically the nursing staff failed to monitor and identify side effects of anticoagulant therapy; failed to notify the Physician in a timely manner of side effects/laboratory results; failed to have a Physician's Order to administer anticoagulants; failed to hold anticoagulants until the Physician responded to laboratory results and failed to implement a Physician's Order in a timely manner for residents receiving anticoagulant therapy. The following nurses were interviewed: Licensed Practical Nurses--E3, E4, E5, E8, E10, E11, E12 and E38; RN's--E7, E25, E37 and E40.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210a) 300.1210b)1)2)3) 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.	F9999		

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F9999	Continued From page 85 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 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. Restorative measures shall include at a minimum the following procedures: b) 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	F9999		

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F9999	Continued From page 86 made by nursing staff and recorded in the resident's medical record. Section 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 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 Regulations are not met as evidenced by: Based on interview and record review the facility neglected to have a policy in place to ensure staff monitor for side effects/laboratory results of anticoagulant therapy, and neglected to implement existing policies on Physician Notification of Resident Change of Condition, Holding of Medications, Physician Orders and Medication Administration for 5 of 5 sampled residents on anticoagulant therapy (R5,R15,R1,R16,R2). The facility neglected to monitor for side effects of anticoagulant therapy (R5,R15,R1); neglected to identify significant bruising as a side effect of anticoagulant therapy (R5), neglected to notify the Physician in a timely manner of side effects/laboratory test results (R5,R15,R16,R1), neglected to have a Physician's Order to administer oral anticoagulant therapy (R15); neglected to	F9999		

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F9999	Continued From page 87 implement Physician's Orders to administer anticoagulants in a timely manner (R15,R2); and neglected to hold oral and subcutaneous anticoagulants until the Physician responded to laboratory results (R5,R15). The facility neglected to implement existing policies and have a policy in place to ensure staff provided care for residents receiving anticoagulant therapy within accepted nursing standards of care, resulting in R5 hemorrhaging into the right leg, and placing R5 and R15 at increased risk of death by hemorrhage. Findings include: 1. The Physician Order Sheet (POS) dated 4/1-4/30/07 states that R5 has diagnoses of Hypertension, Coronary Artery Disease, History of Gastrointestinal Bleeding and Dementia. The Physician's Order dated 3/30/07 states, "Lovenox 40 units sq[subcutaneous] bid[twice daily] until further notice, Coumadin 5 mg[milligrams] p.o.[by mouth] daily. Labs: Protime[Prothrombin Time] and CBC[complete blood count]." The nurses notes dated 4/6/07 (Friday) at 9:20pm and signed by E4, LPN (Licensed Practical Nurse) state, "Two bruises were discovered on [R5's] inner R [right]buttocks and R upper back of thigh, measures 4cm[centimeters] [by] 4cm on buttocks and 10cm long on leg. Both bruises are splotchy and dark purple/red. Aide who found bruises stated that they [bruises] were not present last night (4/5/07). Origin is unknown. [Z1], MD, faxed." When asked why she did not call Z1 about R5's bruises, E4, LPN, stated in interview on 6/13/07	F9999		

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at 2:00pm, "If not an emergency, later on second shift we normally will fax." E4 stated she reported the bruising to the next shift in report. E4 confirmed that she did not call Z1 about R5's bruising on 4/7/07.

When asked if he got the incident report faxed to his office on a Friday evening (4/6) Z1, MD, stated in interview on 6/13/07 at 11:00am that he was not in the office on Friday evening, Saturday(4/7) or Sunday(4/8) to see the incident report on R5's bruising. When asked if he should have been called about R5's bruising, Z1 stated, "Yes" he expected staff to call him, not fax. Z1 stated if he had been called about the bruising, "I would have looked into the anticoagulant and ordered labs[laboratory tests]." Z1 stated that the bruising was "due to the Coumadin." When asked what negative effects a high Protime or INR can have, Z1 stated, "it worsened the swelling and bleeding." Z1 was unsure when he became aware of R5's bruising.

The nurses note dated 4/7/07 at 6:30pm and signed by E10, LPN, states, "Leg continues to be very swollen [with] fluid pockets in under line tissue. Bruises now very dark purple extending from L[left] buttock to under L thigh." E10 stated in interview on 6/14/07 at 3:00 pm that she did not notice any bruising on R5 until R5 was on the Lovenox. When asked if she had called Z1, MD, about the bruising, E10 stated she did not call Z1 about the bruising as he had already been "faxed."

The nurses notes dated 4/8/07(Sunday) at 12:00pm and signed by E7, RN(Registered Nurse) state, "[R5] moaning, yelling, grimacing [and] crying." E7, RN, ADON(Assistant Director

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of Nursing), stated in interview on 6/14/07 at 11:30am that R5 with her body language was acting like she was in pain. E7 stated she medicated R5 for pain. E7 stated that she saw no bruising on the left leg, only on the right. E7 stated R5's left leg was swollen from the knee into the groin. E7 stated she did not call Z1 about R5's bruising.

The nurses notes dated 4/9/07(Monday) at 12:10pm state, "Lab called [with] Alert Protime Value: Protime 43.9, INR[International Normalized Ratio] 12.4." The note documents that Z1's office nurse was called and given the laboratory results.

The Laboratory report dated 4/9/07 states R5's Protime result was 43.9 seconds with the expected range being 11.7-13.7 seconds and the INR was 12.4 with the High Risk range being 2.5-3.5. When asked what the High Risk range of 2.5-3.5 for the INR meant, Z7, Operations Manager of the Laboratory, stated on 6/21/07 at 12:00pm, you have to watch out for side effects(bleeding) at this level. At that level you are at a higher risk for anything to happen. Z7 stated that an INR of 4 is considered to be a "Panic Level" and the laboratory staff will call the result to the facility.

The Medication Administration Record(MAR) for April 2007 documents that R5 was given Coumadin 5mg on 4/7, 4/8 and 4/9 at 2:00pm by staff initialing the box on the MAR. None of the initials in the boxes for 4/7, 4/8 or 4/9 were circled.

The nurses notes dated 4/9/07 at 9:30 pm state Z1 was paged about R5's PT/INR results.

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F9999	Continued From page 90 The Physician's Order dated 4/9/07 states, "Repeat INR and PT Thursday. Hold Coumadin 5mg until results of PT and INR, Hold Lovenox 40 units until after results of PT and INR." The MAR dated April 2007 documents that R5 was given Lovenox 40 units sq on 4/9/07 at 8:00pm by staff initialing the box and documenting the injection site on the MAR. The initials or site are not circled for 4/9/07 at 8:00pm. E3, LPN, stated in interview on 6/14/07 at 2:10pm that she paged Z1 again on 4/9/07 as he did not call back. E3 confirmed that she got the order from Z1 on 4/9/07 at 9:30 pm to hold the Coumadin and Lovenox. When asked if she told Z1 about R5's bruising, E3 stated, "I just took the order from [Z1]. I did not tell him anything about the bruising." E3 stated she filled out the order for the PT/INR and left a note for Social Service but did not do anything with the MAR. After looking at the MAR, E3 stated she did not write the "HOLD" for 4/10, 4/11 or 4/12, stating that was not her writing. E3 stated she told the night nurse about the order. The MAR dated April 2007 documents that R5 was given Lovenox 40 units sq on 4/10/07 at 8:00am by staff initialing the box and documenting the injection site. None of the initials or sites are circled for 4/10/07 at 8:00am. The MAR documents that "HOLD" is written in below the 8:00am time for the dates of 4/10, 4/11 and 4/12/07. The "HOLD" written in for 4/10 is one box lower than the "HOLD" written in for 4/11 and 4/12/07. E2, Director of Nurses(DON), stated in interview on 6/14/07 at 10:45am that staff document they	F9999		

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have given medications by initialing the MAR after giving the medication and staff circle their initials if they do not give the medication.

The nurses notes dated 4/11/07 at 2:10pm states, "At this [time] has dark purple bruising covering entire R buttock [and] extending down entire posterior thigh [and] mid-calf. Also has some yellowish coloring but mostly dark purple. Has soft bulging area[above] L[left] knee." The nurses note dated 4/11/07 at 3:15pm states that R5 was transferred to the hospital.

The Emergency Department QualChart dated 4/11/07 states that R5 was diagnosed with a Distal Femur Fracture(Left), Anemia and Hyperanticoagulation.

The hospital Daily Activity Report dated 4/11/07 states that R5's Protime was greater than 82.3 seconds with the expected range being 9.1-11.3 seconds and the INR was 9.0 with the normal being 0.9-1.1. The report states, "CRITICAL RESULTS CALLED TO" and documents the staff member the results of the Protime and INR were called to. The Report also documents that on 4/11/07 R5's Hemoglobin was 7.6 with normal being 12.0-14.0 and the Hematocrit was 22.5 with normal being 37.0-47.0.

Z1, MD, was interviewed on 6/15/07 at 11:10am. When asked if the reason R5's Protime increased from 43.9 seconds on 4/9/07 to 82.3 seconds on 4/11/07 could be that staff continued to give the Coumadin/Lovenox, Z1 stated, "that would be why it[Protime] increased" as well as the blood in R5's urine. Z1 stated that he would have expected the Coumadin and Lovenox to be held by the nurses with the level that R5's Protime

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F9999	Continued From page 92 was (43.9). When asked how serious a protime of 43.9 or 82.3 was to R5, Z1 stated, "If there was an increase in blood pressure, a potential for a fall or any other active bleeding, it is high, it is serious. We were looking at the need to bring [R5] in for anticoagulant reversal. [R5] did lose a fair amount of blood due to bleeding into the leg. [R5] could have gone into shock. [R5] already had some hemorrhaging into that leg." Z1 stated that R5 was "anemic and some of that blood loss was related to the anticoagulation and bleeding into the leg." Z1 stated that the blood in R5's urine was secondary to the bleeding into the leg. Z1 stated as far as a threat to R5's life, "there is a threat, the higher the protime goes as relates to 43.9 [seconds] versus 82.3[seconds]." The facility did not have a policy addressing Anticoagulation Therapy to ensure the monitoring for side effects laboratory results etc. until 6/18/07. E2, Director of Nurses(DON), confirmed in interview on 6/19/07 at 3:15pm that the facility did not have a policy on Anticoagulant therapy. The facility neglected to follow existing policies as listed below: a. The facility policy titled "Medications-Holding of" states the following: "If the medication is ordered to be withheld write an H in the box designated for that medication dose." "If any medication is not administered as ordered by the Physician report will be called to the Physician ASAP[as soon as possible]". b. The facility policy titled "Physician Orders" states the following:	F9999		

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F9999	Continued From page 93 "All orders including telephone orders must be recorded on the resident's POS." "A licensed nurse is to review all new orders within twenty-four hours. Check each order for completeness. Make sure all necessary information is listed. Call physician if order is incomplete." "Enter all orders on POS. Medication orders are transcribed to resident's MAR." c. The facility policy titled "Medication-Med Pass" states the following: "Nurses are to be aware of indication, contraindications and major side effects of each medication administered". "MAR may be initialed during preparation or immediately after administration." d. The facility policy titled "Changes in Condition or Status of Resident" states the following: "Charge nurse assigned to resident or designee shall be responsible for notifying the resident's attending physician, family and /or responsible party when: There is significant change in the residents physical, mental or emotional status." 2. The POS dated 6/1-6/30/07 states that R15 has diagnoses of Pulmonary Embolism, Multiple Sclerosis, Anemia, Diabetes and Coccyx Pressure Sore. The laboratory report dated 5/8/07 states that R15's Protime was 33.4 seconds with expected range being 11.7-13.7 seconds and the INR was 7.44 with the range for high risk being 2.5-3.5. The report documents "faxed to [E8, LPN] 12:30pm, 5/8/07."	F9999		

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F9999	Continued From page 94 The MAR dated 5/1-5/31/07 documents that Coumadin 4mg one tablet was given on 5/8/07 at 2:00pm by staff initialing the box, even though R15's INR was high. E2, DON, confirmed in interview on 6/19/07 at 3:15pm that Coumadin 4mg was given to R15 on 5/8/07 at 2:00pm as initialed on the MAR. The laboratory report dated 5/8/07 documents the time the Physician office faxed the report back to the facility at the top of the report. The undated Physician's Order written on the laboratory report states, "Hold Coumadin, PT/INR 5/14/07." The POS has a Physician's Order dated 5/8/07 documented as follows: "Faxed order 5/8/07 Hold Coumadin Do PT/INR-5/14/07." When asked what the Physician's Order dated 5/8/07 meant to her, E10, LPN, stated in interview on 6/21/07 at 12:20pm, "Means to me that he wanted the Coumadin held until the PT/INR was drawn on 5/14/07." E10 stated the laboratory results should be called, so the Physician could resume the Coumadin. E10 stated, "You're supposed to wait for his[Physician] order before restarting the Coumadin. He always writes his orders that way." The MAR dated 5/1-5/31/07 documents that R15's Coumadin 4mg was held on 5/9, 5/10, 5/11, 5/12, 5/13 and 5/14. The laboratory report dated 5/14/07 states that R15 had a protime of 13.8 seconds with the expected range being 11.7-13.7 seconds and the INR was 1.44 with the range for oral anticoagulants being 2.0-3.0. The laboratory report states the report was printed on 6/6/07 at	F9999		

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F9999	Continued From page 95 12:36pm. The section of the report titled "Date/Time Reported to Account" states, "5/14/07 1:05:00 PM." There is nothing documented on the laboratory report showing that the report was faxed or called to the Physician. There is no Physician's Order written on the laboratory report and no dates or fax numbers on the report. The MARs dated 5/1-5/31/07 and 6/1-6/30/07 document that R15 was given Coumadin 4mg daily starting on 5/15/07 through 6/5/07 by staff initialing the box on the MAR. There is no Physician's Order on the POS dated for May and June 2007 or in the Physician Telephone Orders for the Coumadin to be restarted on 5/15/07, and no orders for any laboratory work to be done. The nurses notes do not document that the Physician was notified of the laboratory results of 5/14/07 or any orders being received. E2, DON, stated in interview on 6/19/07 at 3:15pm that she was not seeing an order for the Coumadin to be restarted for R15. E2 confirmed that the Coumadin was initialed by staff as being given from 5/15/07-6/5/07 on the MARs. E2 stated she did not see any documentation in the nurses notes that the Physician had been contacted about the laboratory results or restarting the Coumadin for R15. There is a Physician's Order from the Wound Clinic dated 5/29/07 for the antibiotic Ancef 1 gram every 8 hours, to be given intravenous for 10 days and to continue with the wound vacuum to the sacral wound for 2-3 weeks. The form states that the culture of the sacral wound was positive for Staphylococcus Aureus.	F9999		

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F9999	Continued From page 96 The nurses notes dated 6/6/07 at 1:50pm state that the laboratory was called and asked to fax the PT/INR results from 5/14/07, which the nurse then faxed to the Physician's office. The Physician's order dated 6/6/07 states, "Give routine Coumadin dose(4mg) today. Draw PT/INR on 6/7/07." The laboratory report dated 6/7/07 documents that the report was faxed to the facility on 6/7/07 at 12:43pm. The report states that R15's protime was 25.1 seconds with the expected range being 11.7-13.7 seconds and the INR was 4.38 with the High Risk range being 2.5-3.5. There is an undated Physician's order written on the laboratory report to "Hold Coumadin PT/INR 6/11/07," which is signed by the Physician. The POS dated 6/1-6/30/07 does not have a Physician's Order written for the Coumadin to be held or the PT/INR to be done on 6/11/07. E2, DON, stated in interview on 6/19/07 at 3:15pm that the laboratory report dated 6/7/07 was faxed by the Physician to the facility on 6/8/07. E2 stated the fax date and number at the top of the report are when the Physician's office faxed the report back to the facility, which was 6/8/07 at 1:36pm. E2 stated there was no Physician's Order written on the POS to hold the Coumadin on 6/8/07. The MAR dated 6/1-6/30/07 documents that Coumadin 4 mg was given to R15 on 6/7, 6/8 and 6/9/07 at 2:00pm by staff initialing the box on the MAR. The Physician ordered the Coumadin to be held on 6/8/07 at 1:36pm. E2, DON, stated in interview on 6/19/07 at 3:15pm that staff initialed	F9999		

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	145926	A. BUILDING _____ B. WING _____	C 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 97 the Coumadin 4mg as being given to R15 on 6/7, 6/8 and 6/9. E2 stated that staff should have called the Physician with the laboratory results before giving the Coumadin on 6/7/07. The Coumadin was held on 6/10 and 6/11/07 as documented on the MAR. The laboratory report dated 6/11/07 states that R15's Protime was 24.5 seconds with the expected range being 11.7-13.7 seconds and the INR was 4.18 with the High Risk range being 2.5-3.5 seconds. The report is stamped "faxed" with the date 6/11/07 at 2:54pm written in. The Physician's Order dated 6/12/07 at 5:15pm states, "Hold Coumadin PT/INR on 6/14/07." When asked whether he expected to be called for an order to resume the Coumadin on 5/15/07, Z4, MD, stated in interview on 6/21/07 at 1:15pm, "Usually that's the normal thing to do." Z4 did not remember if staff had called/faxed the laboratory report of 5/14 to him. Z4 stated if he had been faxed he would have ordered an INR to be done within a week. When asked about the risk of having an INR of 4.38, Z4 stated, you normally want someone at risk for clots to be at the 2.5-3.0 range. Z4 stated that with an INR of 4.38 R15 was at high risk for bleeding, because R15 was on antibiotics. Z4 stated that R15 had an infection and that is why her Protime/INR's were fluctuating. Z4 stated that antibiotics will interfere with the PT/INR results. Z4 stated he usually will stop the Coumadin while being treated with antibiotics. Z4 stated that R15 is a "paraplegic" and usually will get "Deep Vein Thrombosis." The laboratory report dated 6/14/07 states that R15's Protime was 14.3 seconds with the	F9999		

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F9999	Continued From page 98 expected range for oral anticoagulant being 11.7-13.7 seconds and the INR was 1.54 with the range for oral anticoagulant being 2.0-3.0. There is an undated Physician's Order on the report which states, "Start 3mg daily PT/INR 6/18/07." On the POS there is a Physician's Order dated 6/15/07 to, "[Change] Coumadin to 3mg po [every] day. Repeat PT INR 6/18/07." The MAR has an order dated 6/15/07 for Coumadin 3mg po every day which staff have initialed as being started on 6/16/07. The Coumadin order was not implemented on 6/14 or 6/15/07 as ordered by the Physician. E2, DON, stated in interview on 7/2/07 at 9:50am that the Physician's office faxed the order to start Coumadin 3mg daily to the facility on 6/14/07. E2 confirmed that the order was not written on the POS until 6/15/07 and not implemented until 6/16/07. E2 stated that the Coumadin should have been started on 6/14/07 instead of 6/16/07. The facility did not have a policy addressing Anticoagulation Therapy to ensure the monitoring for side effects/laboratory results etc. until 6/18/07. E2, Director of Nurses(DON), confirmed in interview on 6/19/07 at 3:15pm that the facility did not have a policy on Anticoagulant therapy. The facility neglected to implement existing policies on "Medications-Holding of, Physician Orders, Medication-Med Pass and Changes in Condition or Status of Resident." 3. The Clinical Consultation Report dated 2/17/07 states that R1 has a diagnoses of Atrial Fibrillation with Fast Ventricular Response of Unknown Duration and Congestive Heart Failure.	F9999		

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F9999	Continued From page 99 The report states, "Since the duration of [R1's] atrial fibrillation is not known, [R1] needs to be anticoagulated." The Physician's Order dated 5/3/07 states, "Start Coumadin 2mg daily. PT/INR [one] week." The laboratory report dated 5/10/07 states that R1's Protime was 16 seconds with the expected range being 11.7-13.7 seconds and the INR 1.9 with the range for oral anticoagulant being 2.0-3.0. The report documents that the lab faxed the results to the facility on 5/10/07 at 12:49pm. There is no documentation on the laboratory report or in the nurses notes of the results being faxed/called to the Physician. E8, LPN, stated in interview on 6/19/07 at 10:50am that there is no documentation in R1's chart to indicate that the Physician was notified of the PT/INR results of 5/10/07. E8 confirmed that there was no Physician's Order for laboratory monitoring in R1's chart until 6/18/07. The facility "Clinical Report" dated 6/18/07 states, "We are doing a stat PT/INR today. Can we have an order to draw PT/INR's monthly." The laboratory report dated 6/18/07 states that R1's Protime was 13.2 with the range being 9.2-11.6 seconds and the INR was 1.3 with the oral anticoagulation range being 2.0-3.0. The Physician Order dated 6/19/07 states, "[Increase Coumadin] 2mg qod[every other day], [Coumadin]3mg qod. PT/INR 1 week." The facility did not have a policy addressing Anticoagulation Therapy to ensure the monitoring	F9999		

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F9999	Continued From page 100 for side effects/laboratory results etc. until 6/18/07. 4. The POS dated 6/1-6/30/07 states that R16 has a diagnosis of Atrial Fibrillation. There is a Physician's Order on the POS for a "PT/INR every month"and Coumadin 7.5mg five times a week and Coumadin 5mg twice a week. The laboratory report dated 5/18/07 states that R16's Protime was 15 with the expected range being 11.7-13.7 seconds and the INR was 1.68 with the oral anticoagulant range being 2.0-3.0. There is documentation on the report that the lab sent the report to the facility on 5/18/07 at 12:41 pm. The report documents that the facility faxed the report to the Physician's office on 5/21/07 at 6:55am. The Physician's order dated 5/21/07 states, "Increase to [Coumadin] to 7.5mg, Sunday-Friday and [Coumadin] 5mg on Saturday. Recheck 1 [month]." E40, RN, stated in interview on 6/19/07 at 12:10pm that R16's laboratory report dated 5/18/07 was not faxed to the Physician until 5/21/07. 5. The POS dated 5/1-5/31/07 states that R2 has a diagnosis of Deep Vein Thrombosis. The POS has an order dated 12/15/06 for Coumadin 3.5mg every day. The laboratory report dated 5/15/07 states that R2's Protime was 13.3 seconds with the expected range being 11.7-13.7 seconds and INR was 1.34 with the oral anticoagulant range being 2.0-3.0. The report has an undated	F9999		

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F9999	Continued From page 101 Physician's order to "[Increase] Coumadin 1/2mg qd[every day]". E2, DON, stated in interview on 6/20/07 at 2:30pm that she thought the Physician faxed the laboratory report back to the facility on 5/15/07 based on the date at the top of the report. E2 confirmed that staff did not implement the increase in Coumadin until 5/21/07. There is a Physician's Telephone Order dated 5/21/07 to "Increase Coumadin to 4mg po daily. Repeat Protime/INR in 2 days". The MAR dated 5/1-5/31/07 documents that Coumadin 4mg was given starting on 5/21/07. (A)	F9999		