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F 329	Continued From page 29 antibiotics along with the Warfarin may have contributed to the increase in the P.T. and INR for R1. 2. E2 identified 24 residents (R1 through R24) on Warfarin and at risk for falls on 12-13-11 at 8:30AM. E2 states residents on blood thinning medications are not routinely evaluated for drug interactions with other medications or recurrent falls related to the blood thinning medication. Interview with Z3 (Contract Pharmacy Consultant) on 12-13-11 at 3PM, states he reviews all resident's physician orders and medication regime monthly. Z3 stated he does not routinely evaluate the medication interactions with Warfarin and other meds as he is usually reviewing the meds after they have been discontinued (i.e.. antibiotics). E13 (RN) and E10 (RN) stated on 12-13-11 at 2:45PM and 12:30PM, they were not aware of any drug interactions between Warfarin and other medications. E10 also stated the pharmacist did not review or make recommendations for residents on Warfarin therapy. E13 and E10 stated no indication/precautions were identified on the prescription label by the pharmacy when filling blood thinning medications and other meds that could have a possible interaction. This was confirmed by interview with Z4 (Pharmacist) on 12-14-11 at 8:55AM.	F 329		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b) 300.1210d)3)6) 300.3240a)b)c)	F9999		

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F9999	Continued From page 30 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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. 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. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.	F9999		

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F9999	Continued From page 31 c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. These Requirements are Not Met as evidencied by: Based on interviews and record review the facility neglected to follow the facility's policies named: "Reporting Incident and Accidents" (undated), "Physician Notification Policy" (undated), "Use of the Gait Belt" (undated) and "Fall Monitoring, Review and Prevention" (dated March 2010). This failure to follow the facility policies resulted in an unsafe transfer of a resident in accordance with the plan of care, failure to timely report a resident's fall, failure to monitor a resident's condition after a fall, failure to timely notify a physician related to the resident's fall and injuries and failure to monitor medication interactions contributing to complications from the fall for 1 of 5 residents (R1) reviewed on a blood thinning medication who are at risk for falls in the sample of 5. Fndings include: The facility also neglected to devise a system of communication, training and implementation for staff to immediately know which residents are on blood thinners who are at risk for falls and are prescribed other medications that increase the effect of the blood thinner in order to prevent complications. This neglect has the potential to affect 5 of 5 residents (R1, R2, R3, R4 and R5)	F9999		

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reviewed on blood thinning medications who are at risk for falls in the sample of 5 and 19 residents on the supplemental sample (R6 through R24).

Findings include:

1. R1 was an 85 year old resident with diagnoses including Chronic Lower Extremity Edema and Deep Vein Thrombosis and was on Chronic Coumadin (Warfarin) Therapy since admission according to the admission face sheet dated 10-07-10. According to the Minimum Data Set Assessment (MDS) dated 11-16-11 (Significant Change MDS Assessment), R1 is dependent on 2 staff persons for assistance with bathing, dressing and toilet use. R1 requires total dependence of two plus persons for transfers according to the MDS dated 11-16-11.

R1's December physician's plan of care dated 12-01-11 to 12-31-11, states R1 is to transfer with weight bearing as tolerated and fall precautions. R1's Physical Therapy Evaluation dated 10-11-11 states R1 is nonambulatory at this time and staff are to use a mechanical lift at all times for transferring R1. R1's care plan dated 11-28-11 with an approach dated 09-19-11 regarding fall prevention, states to use a mechanical lift for all transfers with 2 staff members. The Care Plan approach for constipation/ urinary problems dated 11-21-11 states: "place resident back in bed for bedpan use - using bedpan only". R1 was assessed using the facility's "Assessment of Fall Potential" form dated 11-28-11 to be at "High Risk for Falls. R1 had a fall on 11-26-11 from a recliner after an apparent blackout episode.

R1's December physician's plan of care dated

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Dec 01 to 31-.2011, states R1 is to take Coumadin 5mg (Warfarin) Thurs., Sat., and Sun. and Coumadin 2.5 mg daily on Mon., Wed., and Fri. R1 also had a physician's order dated 11-28-11 for Cipro 500mg (Ciprofloxacin) twice a day for 7 days for a Urinary Tract Infection. The Cipro was discontinued on 11-30-11 and Keflex 500mg (Cephalexin) three times a day for 7 days was ordered based on the urine culture results. R1 was also on routine Hydrocodone/APAP (Acetaminophen) 10/325mg every 8 hours. Celexa 20mg (Citalopram/Selective Serotonin Reuptake Inhibitor (SSRI) daily was ordered on 10-31-11 then changed to Cymbalta 30mg (Duloxetine) daily on 11-04-11. R1 also had a physician's order dated 10-07-10 for Acetaminophen 325mg 2 tablets every 4 to 6 hours as needed for pain not to exceed 4 Gm in 24 hours. According to the " Drug Information Handbook for Nursing 2007" the following medications may increase the serum levels/effects of warfarin: acetaminophen, cephalosporins and SSRI's. Z1 (Physician) stated on 12-13-11 at 10AM, the Cipro and Keflex antibiotics along with the Warfarin may have contributed to the increase in the Prothrombin Time (P.T.) and International Normalized Ratio (INR) for R1 on 12-02-11.

According to the facility's "Incident Report" dated 12-02-11 at 6:15AM, R1 reported to E12 (Certified Nursing Assistant-CNA) then to E9 (Registered Nurse) and E4 (RN) that she was dropped to her knees by E5 and E7 (CNAs) during a transfer from the bedside commode to the bed on 12-01-11 in the afternoon. The report stated on 12-02-11 at 6:15AM, R1 was noted to have an extensive bruise and swelling to the right

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posterior lower leg (calf) measuring 25 cm x 22 cm with a fluid filled hematoma 9cm x 11cm. Another bruise was noted to the outer right knee measuring 7 cm x 6 cm with a fluid filled area measuring 5.5cm x 5.7cm. According to interview with E4 on 12-07-11 at 2PM and E12 on 12-13-11 at 2PM, R1 stated the fall occurred on 12-01-11 before supper with E5 and E7 assisting her and not using a mechanical lift or gait belt. E9 stated on 12-07-11 at 3:55PM, R1 complained to E9 on 12-02-11 at 7PM that the back of her right leg had excruciating pain. E9 assessed R1's leg and no new bruises were present. Interview with E5 and E7 on 12-07-11 at 2:55PM and 3:20PM, both stated R1 was transferred from the bed to the bedside commode without the use of a mechanical lift or gait belt on 12-01-11 between 4:30PM and 4:45PM with no problem. When R1 was transferred back from the bedside commode to the bed without the use of a mechanical lift or gait belt by E5 and E7, R1's legs gave out and she was lowered to the floor to her knees. E5 stated R1 was immediately pulled up and placed in bed. E5 and E7 stated they did not report the incident to the charge nurse. E5 stated R1 did not bear weight during the transfer and R1 did not complain of pain at the time. Neither E5 or E7 checked R1 for injuries.

On 12-07-11 at 3:55PM E6 (RN-11PM-7AM shift) stated she became aware of R1's fall incident (on 12-01-11) and large bruises with hematomas on R1's right leg on 12-02-11 at 6:15AM when R1 told E12 (CNA). E6 stated R1 complained at this time of excruciating pain unrelieved by the routine pain medications (Morphine Sulfate 15mg ER and Hydrocodone/APAP 10/325mg) given at 4AM and a Tylenol 325mg -2 tablets given at 12AM. E6

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filled out an incident report and reported the incident and injury to E10 (RN 7AM-3PM shift). E10 stated on 12-08-11 at 12:17PM, she notified Z1 (Physician) between 8AM-8:15AM on 12-02-11 of R1's condition. R1's blood pressure dropped to 90/54, pulse 86, respirations 20 and pulse oxygen was 78%. Z1 ordered to send R1 to the emergency room for evaluation and treatment related to the increased leg pain and decreased oxygen level according to the nursing notes dated 12-02-11 at 8:30AM. According to the nursing notes (late entry) dated 12-02-11 at 6:50AM, a PT and INR lab test (ordered by the physician on 11-18-11) was drawn for R1. The ambulance arrived at 9:10AM and R1 left the facility at 9:15AM. The lab called with R1's PT and INR results after R1 left the facility, with results as follows: INR 14.3 high critical (normal 2-3.0) and PT 60.5 high (normal 16.0-22.6).

According to the Hospital's Emergency Physician's Report dated 12-02-11 at 10:24AM, R1 had been falling frequently. R1 fell out of a recliner on 11-26-11 and sustained skin tears to both elbows and right knee. R1 also hit her head and sustained some superficial lacerations in the right temporal region due to being on anticoagulate therapy according to the report. R1 fell again on 12-01-11 injuring her right knee and sustained a large hematoma on her right knee, R1's PT/INR was elevated to 60.5. R1 had a Cat Scan of the head, xray of the right knees and elbows. All xrays were negative for fractures or intercranial bleeding. The Emergency Physician's Report dated 12-02-11 stated R1's blood pressure suddenly dropped and pulse became thready, she became bradycardic. The emergency room staff was unable to find an

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adequate intravenous line access so an interosseous vascular access was justified. R1 became agonal in her rhythm and stopped breathing. R1 had a Do Not Resuscitate request and death was pronounced at 2:38PM. The Emergency room report lists the following assessment: 1)Frequent Falling, 2) Right Knee injury without fracture 3) Large right lower leg hematoma 4) Excessive Anticoagulation and 5) Unexpected cardiopulmonary arrest.

R1's death certificate states the cause of death was Acute Myocardial Infarction, Atherosclerotic Heart Disease and Recent Fall. This certificate was certified by Z2 (Coroner) on 12-07-11.

E4 (Licensed Practical Nurse) did an investigation on 12-02-11 of R1's incident 12-01-11. E4 determined in the report that the bruise to R1's back of the leg could have been caused by bumping R1's leg on the bed side rail during the transfer. E4 found a mechanical lift was not used in R1's transfer due to R1 wanting to use the bedside commode for a bowel movement. Due to the height differences between E5 and E7, E7 would have to lift harder and the bruise on R1's right leg occurred on E7's side. E4 stated in the report that R1 was sent to the emergency room and per ER nurse stated R1 was to be admitted for "Excessive coagulation and bleeding from somewhere but not sure where".

2. E2 (Director of Nursing) identified 23 current residents (R2 through R24) on Warfarin and at risk for falls on 12-13-11 at 8:30AM. E2 states residents on blood thinning medications are not routinely evaluated for drug interactions with other medications or recurrent falls related to the blood

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thinning medication. Interview with Z3 (Contract Pharmacy Consultant) on 12-13-11 at 3PM, states he reviews all resident's physician orders and medication regime monthly. Z3 stated he does not routinely evaluate the medication interactions with Warfarin and other meds as he is usually reviewing the meds after they have been discontinued (i.e.. antibiotics). E13 (RN) and E10 (RN) stated on 12-13-11 at 2:45PM and 12:30PM, they were not aware of any drug interactions between Warfarin and other medications. E10 also stated the pharmacist did not review or make recommendations for residents on Warfarin Therapy. E13 and E10 stated no indication/precautions were identified on the prescription label by the pharmacy when filling blood thinning medications and other meds that could have a possible interaction. This was confirmed by interview with Z4 (Pharmacist) on 12-14-11 at 8:55AM.

3. The facility policy for "Reporting Incident and Accidents" (undated) states "When an incident/accident occurs, the witness or person discovering the incident must report to the nurse in charge."...."Emergency care should be provided when necessary, either by the nurse or by sending to the Emergency Room for evaluation and possible emergency treatment." "The attending physician must always be notified as soon as possible." R1's drop to her knees on 12-01-11 was not reported to the charge nurse. Fourteen hours later R1 reported the incident to E12. No monitoring of R1's condition after the incident was done by staff. R1's physician was not notified until 16 hours after the incident, according to the nurse's notes dated 12-02-11 at 8:30AM.

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F9999	Continued From page 38 The facility's "Physician Notification Policy" (undated) states "All incidents must be reported to the physician in a timely manner. Head to toe assessment following the fall/incident is a must. Any incident with injury needs to be reported immediately." This policy was not followed. The facility's "Use of the Gait Belt" Policy (undated) was not followed as it states: "1. Gait belts will be used at all times during transfers requiring assistance or supervision..." This policy was not followed on 12-01-11 when E5 and E7 transferred R1 to and from the bed to the bedside commode without the use of a gait belt. The facility's "Fall Monitoring, Review, and Prevention" Policy (dated March 2010) states: "It is the policy of this facility to provide a safe environment for each resident.....The facility will review all falls occurring during the weekly safety meeting..... 3. When resident experiences a "fall", the charge nurse will complete an incident report and an investigation. Staff will ensure the resident's safety and will immediately put any new interventions into place.... 4. Further investigation will be completed by the charge nurse, ADON or another designated nurse. If it is determined that further interventions will be needed, inservices will be provided to staff reflecting the interventions.... 7. A list of residents sustaining fall will be provided to each nurses station following the safety meeting. 8. The Pharmacist will be given a list of the residents' sustaining falls for review of these resident's medication to determine if there might be a contributing factor resulting from medications." This policy was not followed with R1's fall on 12-01-11.	F9999		

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