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F 329	Continued From page 14	F 329		
F9999	. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.610c)2 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 there under. 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. c) These written policies shall include, at a minimum the following provisions: 2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray). These requirements are not met as evidenced by: Based on interview and record review the facility failed to notify the Physician that tests for Prothrombin Time and International Normalized	F9999		

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Ratio had been missed for 2 of 9 residents (R3, R6) reviewed for Anticoagulant Monitoring in a sample of 10. This failure resulted in the hospitalization and ultimate death of R3.

Findings Include;

On 3/13/13 at 8:30 AM, an audit by E2 Registered Nurse, Director of Nurses (RN/DON) discovered that laboratory (lab) tests for Prothrombin Time (PT), and and International Normalized Ratio (INR), which are done to monitor bleeding times, had not been completed on R3 (originally ordered for 3/7/13). The same audit documents that R6 had a PT/INR ordered for 3/8/13. The 3/8 PT/INR for R6 had also been missed. The initial report written by E1 Administrator, was sent to the Department on 3/14/13 and documented as a medication error involving only R3.

The follow up report which was written by E2 DON, and is undated documents, that on 3/4/13 a PT/INR was drawn in the evening and results were received on 3/5/13, at 1:02 AM. The Physician was notified and ordered that the blood thinner, Coumadin be held for two days and the PT/INR should be rechecked in two days (3/7/13). The nurse placed the order into the electronic medical record but not into the laboratory system on the computer. This resulted in the PT/INR not being drawn on 3/7/13 and the Coumadin being administered from 3/7/13 through 3/13/13.

After the audit on 3/13/13, E2 RN/DON, put the lab tests that were missed, into the computer to be done on 3/14/13. She did not notify the physician. After Lunch on 3/13/13, R3 experienced a change in her condition, and

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F9999	Continued From page 16 started to vomit. The physician was notified of the vomiting and an order to "send to the emergency room if weak or unable to keep down liquids by morning." He was not informed about the missed laboratory tests. At 7:30 PM on 3/13/13, staff noted (R3) to be unresponsive with a blood pressure of 187/99 and pinpoint pupils. R3 was then transported to the local Hospital. The facility was notified on 3/14/13 at noon that R3 had expired. In an interview with E2 on 4/2/13 at 3:30PM, she stated she did not notify the doctor when she discovered that the labs had not been drawn, she just put the orders on the lab schedule for the next day. She did not look at the previous lab results. Review of the State of Illinois Death Certificate documents the cause of death to be "Hemorrhagic Stroke, Warfarin Overdose." Review of Nurses Notes for the Month of March document no Physician notification of the missed laboratory tests for either R3, or R6. 2. Review of the Physician orders dated 2/26/13 document that R6 was to have a repeat PT/INR drawn on 3/8/13, and to increase R6's coumadin dose to 10 MG daily. The Facility Anti-Coagulant Audit Log for the Month of March documents that R6 did not have her lab test drawn on 3/8/13 as ordered. The missed lab was not noticed until an audit was completed on 3/13/13. After the 3/13/13 audit, E2 RN/DON added R6 to the Laboratory test list to have a PT/INR drawn on 3/14/13. On 4/1/13 at 1:15PM, E 2 stated she did not notify the physician about the	F9999		

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missed labs. The lab results from the test completed on 3/14/13 document that both the PT and INR were Extremely elevated PT-54.9 (Normal 9.5-11.0 Seconds), INR 4.9 (Normal 2.5-3.5) for aggressive anticoagulation.

3. Review of the facility policy titled Anticoagulant Therapy and Dated 9/2010, documents under procedure; notify the Physician of laboratory results and 1. Obtain Orders for therapeutic lab monitoring from the Physician.

4. E2 DON stated in interview on 4/1/13 at 1:15 PM, that Anticoagulant Audits were previously done on a weekly basis, but since the incident we now do daily audits. There was an audit done 3/7/13 but the results would not have been back yet on (R3) for me to catch that the lab had not been done. I caught the missed labs for both (R3 and R6) during the audit on 3/13/13. During an interview on 4/2/13 at 3:30 PM E2 stated. I did not notify the doctor when I discovered that the labs had not been drawn, when I found the errors, I didn't get orders from the doctor on when he wanted the next labs to be drawn, I just put the residents on the lab schedule for the next day. I did not look back to check the previous lab results for myself or to let the Physician know.

(B)

300.1210a)
300.1210b)5)
300.1210c)
300.3240a
Section 300.1210 General Requirements for Nursing and Personal Care

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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)
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.
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or

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agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These requirements are not met as evidenced by:
Based on interview, observation and record review the facility failed to follow the Plan of Care and provide necessary supervision to prevent an accident with injury for 1 of 4 residents (R2) reviewed for falls in the sample of 10. This failure resulted in R2 falling and fracturing her left hip in January 2013. This fracture required surgery.
R2 fell again in March 2013 and re- fractured her left hip.

Findings include:

R2 was admitted to the facility on 11/16/12.
Review of the Facility Occurrence Log documents that R2 fell 17 times between 11/24/12 and 3/23/13. The fall investigation dated 1/5/13 documents that R2 fell from her wheelchair after attempting to stand, and was hospitalized, requiring surgery to repair a fracture to her left hip.

R2 has diagnoses which include Dementia, Insulin Dependant Diabetes, Orthostatic Hypotension and Psychosis.

Fall assessments dated 11/16/12 through 2/14/13 document that R2 is at high risk for falls. The Minimum Data Set dated 12/28/12 and 1/18/13 document that R2 is moderately cognitively impaired, requires extensive assistance with most activities of daily living including bed mobility , is unable to balance with out help and is frequently incontinent.

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Review of R2's Plan of Care which was last updated 2/29/13 documents that R2 has decreased ambulation listed as a problem. Under the approach area is documented, "do not leave resident unattended, high risk of falls."

Review of the facility Incident Investigation dated 3/23/13, documents under the summary area, " Resident noted to be laying on bathroom floor in front of toilet. Certified Nurses Aid (CNA) transferred resident to the toilet and left the bathroom for a few minutes." Another CNA discovered R2 when she attempted to take a second resident in to use the bathroom.

Review of the Emergency Room records for R2 document that R2 complained of pain at a level of 8-9/10, in both hips, left hand and foot. when seen in the emergency room. The left hip showed a, "Fracture Fragment at the lesser trochanter noted." " No superimposed acute fracture or dislocation is present in the left hip." R2 remained in the hospital for two days, then was transferred to another facility.

During an interview on 4/3/13 at 2:25 PM E11 Licensed Practical Nurse (LPN) stated, " You could not leave (R2) alone at any time. She could not walk by herself she was always falling and her balance was poor, we had to keep her out at the nurses station a lot to keep and eye on her. You could not trust her to be left alone."

E8, LPN stated during an interview on 4/3/13 at 2:25 PM, "(R2) could not be left alone at any time, she was not safe. At one point she had a 1:1 sitter when she was really agitated, no one was

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officially assigned for that."

During an interview on 4/3/13 at 3 PM, E9 the CNA who was caring for the resident when the fall occurred stated, "I took (R2) to the bathroom per wheelchair then transferred her to the toilet. I got her on the toilet then told the other CNA on the unit that I was going on break. When I came back I heard they found her on the floor. I had not been working that unit in a while."

(B)

300.610a)
300.610c)2
300.1210b
300.3240a

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.

c) These written policies shall include, at a minimum the following provisions:

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2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray).

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. Restorative measures shall include, at a minimum, the following procedures:

300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These requirements are not met as evidenced by:
Based on observation, interview and record review the facility failed to monitor laboratory test/bleeding times for the use of anticoagulant medications, and failed to notify the Physician of missed blood draws and test results for 2 of 9 residents (R6, R3) reviewed for anticoagulant therapy use in a sample of 10. This failure resulted R3 receiving an excessive dose of

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anticoagulant medication, suffering an acute cerebral hemorrhage, and death. This past Non-Compliance occurred from 3/7/13 to 3/15/13.

Findings include;

The facility's initial report of the incident to the Department was written by E1, Administrator, dated 3/14/13 at 7:40 PM. The report lists the incident as a medication error, and documents that on 3/13/13 at 8:30 AM, an audit by E2 Registered Nurse, Director of Nurses (RN/DON) discovered that Laboratory (lab) tests; a Prothrombin Time (PT), and and International Normalized Ratio (INR), which are done to monitor bleeding times, had not been completed on R3 (originally ordered for 3/7/13).

The follow up report which was written by E2 DON, and is undated documents that on 3/4/13 a PT/INR was drawn in the evening and results were received on 3/5/13, at 1:02 AM. The Physician was notified and ordered that the blood thinner, Coumadin be held for two days and the PT/INR should be rechecked in two days (3/7/13). The nurse placed the order into the electronic medical record but not into the laboratory system on the computer. This resulted in no PT/INR being drawn on 3/7/13 and the Coumadin being administered from 3/7/13 through 3/13/13. After the audit on 3/13/13, E2 RN/DON, put the lab test into the computer to be done on 3/14/13. After Lunch on 3/13/13, R3 experienced a change in her condition, and started to vomit. The physician was notified of the vomiting and an order to "send to the emergency room if weak or unable to keep down liquids by morning." At 7:30 PM on 3/13/13, staff noted (R3) to be

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unresponsive with a blood pressure of 187/99 and pinpoint pupils. R3 was then transported to the local Hospital. The facility was notified on 3/14/13 at noon that R3 had expired.

Review of Emergency Room records dated 3/13/13 document that (R3) is unresponsive. Laboratory tests were drawn and document a Prothrombin Time (PT) of >220.0 seconds; Normal range is (9.4-11.4). The INR result of >20; normal range is (0-1.3). A Computed Tomography scan was completed and documents, " a large subdural hemorrhage and a large intraparenchymal hemorrhage and an intraventricular hemorrhage." R3's condition is listed as "critical; with the Physicians primary impression being Cerebral Vascular Accident, Additional Impressions; Excessive anticoagulation."

Review of the State of Illinois Death Certificate dated 3/14/13, lists "Hemorrhagic Stroke and Warfarin Overdose," as the cause of death.

Review of R3's admission face sheet documents that R3 has diagnoses which include Atrial Fibrillation, Congestive Heart Failure, Dementia, and Cerebral Vascular Accident related to a blood clot. Review of R3's Physician Orders from March 1st through March 14th document that R3 was on a Coumadin Dose of 5 MG on Tuesday, Thursday, Saturday and Sunday, and 7.5 MG on Monday Wednesday and Friday.

A lab was drawn on 3/4/13, and the results were PT 110.2 Normal Range- (9.5-11.8), INR, 9.6 Normal Range for aggressive anticoagulation is- (2.5-3.5). These results were called to the

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facility on 3/5/13, at 1:02 AM, as a critical report. The Physician was called at 1:09 AM and gave orders to hold the coumadin for 2 days and repeat the lab tests again on 3/7/13. The lab test scheduled for 3/7/13 is the one that was missed.

A disciplinary action notice dated 3/14/13 documents that E4 Registered Nurse received the order on 3/5/13 to hold R3's coumadin and repeat PT/INR in 2 days. The medication hold order was entered into the computer, for two days, but the repeat lab order was not put into the computer.

The electronic medical record for the month of March documents that R3 received the dose of 5 MG alternating with 7.5 MG of coumadin from 3/7/13 through 3/12/13.

E2 DON stated in interview on 4/1/13 at 1:15 PM, that Anticoagulant Audits were done on a weekly basis. In an interview on 4/8/13, at 10:15 AM E2 stated, " There was an audit done 3/7/13 but the results would not have been back yet on (R3) for me to catch that the lab had not been done. I caught the missed lab during the audit on 3/13/13. Our computer system automatically takes off the "hold" order on a medication, after the number of days entered are finished, so the electronic medical record showed that the coumadin should be given on 3/7/13 after the hold order was finished. That is why (R3) received her coumadin 3/7-through-3/12. During an interview on 4/2/13 at 3:30 PM E2 stated. I did not notify the doctor when I discovered that the labs had not been drawn, I didn't get orders from the doctor, I just put the residents on the lab schedule for the next day. I did not look back to

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F9999	Continued From page 26 check the last lab results. During an interview on 4/1/13 at 2:25 PM E4 RN stated. I don't usually get lab results at night, but they called because the results were critical. I called the Physician during the night and he gave me orders to hold the Coumadin and repeat the labs in two days. I put the orders in the computer to hold the coumadin, but we had a new system and I didn't know how to put the orders in for the labs. I passed that information along in report the next day. I don't remember who that nurse was though. During an interview on 4/1/13 at 2:45 PM E 5 Licensed Practical Nurse, (LPN) stated, I was the nurse taking care of (R3) on 3/13, when she went to the hospital.. She had been vomiting on day shift, and when I got here she vomited two more times. It was dark brown but I would not call it coffee ground. She didn't have any other bleeding issues, when I assessed her. At 7:30 PM, I found her unresponsive and called the Doctor to get an order to send her to the Hospital. 2. R6 has diagnoses which include Cerebral Arterial Occlusion with infarction, Coronary Artery Disease, Lewy Body Dementia Thrombophlebitis, and Atrial Fibrillation. R6 receives ongoing anticoagulant therapy. Review of Ongoing Physicians Orders for PT/INR tests and Laboratory Results for R6 document that R6 had orders from the Physician to be drawn on 3/8/13. Review of the Facility Anticoagulant Audit log documents that no blood test was completed on 3/8/13. Per the same audit tool, the missing lab test was noticed on	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145508	A. BUILDING ______ B. WING ______	C 04/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HEALTH CARE CENTER	1450 26TH STREET HIGHLAND, IL 62249

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F9999	Continued From page 27 3/13/13. R6 was added to the Laboratory test list to have a PT/INR drawn on 3/14/13. The lab results from the test completed on 3/14/13 document that both the PT and INR were Extremely elevated PT-54.9 (Normal 9.5-11.0 Seconds), INR 4.9 (Normal 2.5-3.5) for aggressive anticoagulation. When the results of the 3/14/13 blood draw were sent to the Physician R6's Coumadin dose was decreased. During an interview on 4/1/13 at 1:15 PM. Yes we also missed the lab draw on (R6). It was supposed to be checked on 3/8/13. We didn't find the mix up until the chart audit on 3/13/14. We just put her on the lab draw for the next day. We didn't notify the Physician that the lab had been missed until we sent him the results of the 3/14/13 lab test. (AA)	F9999		