DEPARTMENT OF HEALTH AND HU **USERVICES** SERVICES SUPPLICABLE & MEDIC

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
	495244	B. WING	03/23/2017
		STREET ADDRESS, CITY, STATE, ZIP C	CODE

NAME OF PROVIDER OR SUPPLIER

AUTUMN CARE OF MADISON

ID PREFIX

NUMBER ONE AUTUMN COURT MADISON, VA 22727 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

COMPLETION DATE

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 000

TAG

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid abbreviated survey was conducted 3/21/17 through 3/23/17. One complaint was investigated during this survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities.

The census in this 84 certified bed facility was 77 at the time of the survey. The survey sample consisted of 3 current resident reviews (Residents #2 through #4) and 1 closed record review (Resident #1).

F 282 483.21(b)(3)(ii) SERVICES BY QUALIFIED SS=D PERSONS/PER CARE PLAN

- (b)(3) Comprehensive Care Plans The services provided or arranged by the facility as outlined by the comprehensive care plan. must-
- (ii) Be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced bv:

Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow the written plan of care for 1 of 4 residents in the survey sample; Resident #1.

The facility staff failed to monitor Resident #3's laboratory levels (PT / INR [Protime*/International Normalized Ratio**]) per the physician orders and comprehensive care plan for the use of and management of an anticoagulant(coumadin /

F282 – Services by qualified persons/per care plan

- 1. IDT reviewed residents #1- #4 care plans for accuracy and to reflect current problems and conditions, ensuring care plan is followed appropriately.
- 2. All residents receiving Coumadin, Lovenox, Heparin, Eliquis, Xarelto had care plans audited for appropriate monitoring of labs ordered and checks for bruising.
- 3. Education given to all nurses related to appropriate protocols for monitoring residents that are receiving anticoagulation medications as well as importance of updating and following the care plans that are written. Completed 3/6/17.
- 4. Audits of labs and audits of residents on Coumadin Lovenox, Heparin, Eliquis, Xarelto (as well as their care plans) are monitored 5 times/week for 12 weeks for accuracy.
- 5. Date of compliance 3/31/17.

ABORATORY DIRECTOR'S OR PROMPER SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined to the institution may be excused from correcting providing it is determined to the institution may be excused from correcting providing it is determined to the institution may be excused from correcting providing it is determined to the institution may be excused from correcting providing it is determined to the institution may be excused from correcting providing it is determined to the institution may be excused from correcting providing it is determined to the institution may be excused from correcting providing it is determined to the institution may be excused from correcting providing it is determined to the institution may be excused from correcting providing it is determined to the institution may be excused from correcting providing it is determined to the institution may be excused from the institution of the institution may be excused from the institution of the institution may be excused from the institution of the institution may be excused from the institution of the institution may be excused from the institution of the institutio other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing names, the findings stated above are disposable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings of polarization are disposable 14. days following the date these documents are made available to the facility. If deficiencies are ofted an approved dian of correction is requisite to continued program participation.



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F 282	12/31/16 and disch resident was admit not limited to stroke sided below the kno pressure, acute kid encephalopathy. T	e: dmitted to the facility on arged on 2/27/17. The ted with the diagnoses of but e, dysphagia, diabetes, left ee amputation, high blood ney failure, cataracts, and he most recent MDS) was a 5-day assessment	F 2	282	

A review of the resident's care plan revealed one for "Anticoagulant use" which was initiated on 1/31/17. The interventions included one for "Monitor labs per orders and notify MD of abnormalities." This intervention was dated 1/31/17.

rehospitalization) with an ARD (Assessment Reference Date) of 1/18/17. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total assistance for transfers; extensive assistance for hygiene, toileting, and dressing; supervision for eating; and as incontinent of bowel and bladder.

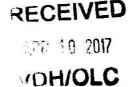
A review of the clinical record revealed an order dated 2/8/17 for a PT/INR (Protime*/International Normalized Ratio** blood tests used to monitor the effectiveness of Warfarin (Coumadin)) to be drawn on 2/9/17 or 2/10/17 (the order start date was 2/9/17 and end date was 2/10/17, indicating that during that time period, the laboratory tests were to be drawn.)

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: M38611

Facility ID VA0012

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F 282 SS=D	survey was conducted one complaint was survey. Corrections with 42 CFR Part 42 requirements and V for the Licensure of the Licensure of the Licensure of the Licensure of the succonsisted of 3 currer (Residents #2 through (Residents #2 through (Residents #1 483.21(b)(3)(ii) SER PERSONS/PER CAR (b)(3) Comprehension The services provides outlined by the comust- (ii) Be provided by concordance with earcare. This REQUIREMENT by:	34 certified bed facility was 77 creep. The survey sample ent resident reviews 19th #4) and 1 closed record 1. RVICES BY QUALIFIED ARE PLAN 1. The control of the control	F 28	.2	

review, and clinical record review, it was determined that the facility staff failed to follow the written plan of care for 1 of 4 residents in the survey sample; Resident #1.

The facility staff failed to monitor Resident #3's laboratory levels (PT / INR [Protime*/International Normalized Ratio**]) per the physician orders and comprehensive care plan for the use of and management of an anticoagulant(coumadin /

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

4-7-17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From pa	age 2	F 28	82		
	A review of the clini for these laboratory documentation of fa					
	Practical Nurse #2) stated that on 2/24/	ducted with LPN #2 (Licensed on 3/23/17 at 10:24 a.m., she /17 she realized the results of from the 2/10/17 draw and practitioner.				
	and labs for PT / IN check for blood clorordered. A review of that only the results obtained. The resu	se practitioner saw the patient IR and a D-Dimer (test used to ting problems (1)) were of the clinical record revealed for the D-Dimer were alts of the D-Dimer were 738. documented as being between				
	evidence that the fa	ne record failed to reveal any acility followed up with the lab ts of the PT / INR that were				
	on 3/23/17 at 10:24 was not followed; the	t was conducted with LPN #2 I a.m., she stated the care plan hat the facility should have results when they did not				
	Administrator and [oximately 3:00 p.m., the Director of Nursing ff Members #1 and #2) were				

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References:

notified of the concerns. No further information

*PT (Protime) is a blood test used in conjunction

was provided by the end of the survey.

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F 282	Warfarin (an antico Information obtaine	monitor the effectiveness of agulant medication)	Fź	282		
	test used to monitor (Coumadin). Inform	Normalized Ratio) a blood r the effectiveness of Warfarin nation obtained from e.org/understanding/analytes/				
	clotting problems. In https://medlineplus.	b test used to check for blood Information obtained from gov/ency/article/007620.htm DRUG REGIMEN IS FREE BARY DRUGS	F3	329		
	Each resident's dru	sary Drugs-General. g regimen must be free from . An unnecessary drug is any				
	(1) In excessive dos therapy); or	se (including duplicate drug				
	(2) For excessive d	uration; or				
	(3) Without adequa	te monitoring; or				
	(4) Without adequa	te indications for its use; or				
		of adverse consequences lose should be reduced or				
		ns of the reasons stated in				

Resident #1 was administered Coumadin (an anticoagulant medication) without adequate and timely monitoring of laboratory test for PT / INR (Protime/International Normalized Ratio) levels, for which dosing was dependent on. When the laboratory results were not received, the facility staff failed to follow up with the lab regarding the results, and Resident #1's Coumadin dose was not readjusted accordingly, resulting in toxic levels of the medication for the resident, that required hospitalization.

The findings include:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(3) DATE SURVEY COMPLETED C
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F 329 Continued From page 5

Resident #1 was admitted to the facility on 12/31/16 and discharged on 2/27/17. The resident was admitted with the diagnoses of but not limited to stroke, dysphagia, diabetes, left sided below the knee amputation, high blood pressure, acute kidney failure, cataracts, and encephalopathy. The most recent MDS (Minimum Data Set) was a 5-day assessment post readmission (1/11/17 after brief re-hospitalization) with an ARD (Assessment Reference Date) of 1/18/17. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring total assistance for transfers; extensive assistance for hygiene, toileting, and dressing; supervision for

Review of the hospital record for the hospitalization leading to the resident's initial admission of 12/31/16 revealed the following:

eating; and as incontinent of bowel and bladder.

A review of the hospital record dated 12/31/16 revealed a discharge summary which documented, "Principle Discharge Diagnosis: Acute Ischemic Stroke....Indication for Admission:....68 y.o. (year old) female with a history of poorly controlled DM (diabetes) c/b (complicated by) neuropathy and right BKA (below knee amputation), hypertension (high blood pressure), hyperlipidemia, breast cancer s/p (status post) lumpectomy in 2007, and recurrent DVT/PE (deep vein thrombosis, pulmonary embolism) on coumadin (anticoagulant medication (1)) who presented to the (hospital) ED (Emergency Department) after waking up with left sided weakness....No history F 329

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of stroke. Reports compliance with coumadin. Takes 4 mg (milligrams) nightly (at 6 pm) but had been off all medications, including coumadin, for a year due to insurance issues....Continue full anticoagulation for history of recurrent PEs with warfarin (also known as Coumadin (2)). Check INR (International Normalized Ratio (3)) in 1-2 days after discharge. Restart warfarin at 1 mg (milligram) daily once INR is between 2-3. Continue warfarin 1 mg daily for the duration of antibiotic therapy with Bactrim (an antibiotic (4)). After Bactrim is completed, would recommend close INR monitoring and readjustment of her warfarin to higher doses."

In addition, the above dated hospital record documented that on 12/29/16, the resident's INR was 2.9 (normal range was identified as 0.9 to 1.2). The Protime (PT) level was high at 32.9. Documented normal range was 9.8 to 12.6

A review of the facility physician's orders dated 12/31/16 and 1/1/17 revealed that, per the discharge summary above, Resident #1 was not yet started on the coumadin at the time of admission to the facility on 12/31/16.

On 1/3/17, the resident was sent from the facility to the hospital for suspected heart attack related to complaints of chest pain. The hospital record for this visit contained an INR result of 1.4, which was still elevated above the normal range. The PT was documented as 15.6, which was also still above the normal range. The resident was released back to the facility the same day. The discharge paperwork documented, "Warfarin 1 mg....please wait till INR is between 2 - 3 to resume."

F 329

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On 1/4/17 the facility obtained an INR level, which the results were 1.5. The facility's laboratory ranges for this documented normal range as being 0.80 to 3.50. A PT result was documented as 12.1. The facility's laboratory documented normal range as being 10.5 to 12.0. [NOTE: variances in normal ranges and results vary by laboratory, based on equipment used, procedures used, laboratory policy, and standard deviation. (6)]. The nurse practitioner notated the lab results on 1/5/17. There were no further labs or medication changes until 1/9/17. Up to this date, the facility had not ordered any coumadin / warfarin for the resident. In the approximately 10 days the resident was in the facility, the PT and INR had been checked twice (1/3/17 at the hospital and 1/4/17 at the facility).

Review of the clinical record revealed that on 1/9/17, Resident #1 was again sent to the hospital, for altered mental status related to hypoglycemia. Resident #1 was admitted, and was discharged back to the facility on 1/11/17. The hospital record documented the following: PT normal ranges 9.6 to 11.0. INR normal ranges (not provided). On 1/8/17 the resident's PT was 11.5 and INR was 1.12. On 1/10/17 the PT was 12.7 and the INR was 1.22. On 1/11/17 the PT was 13.9 and the INR was 1.34. The hospital record further documented, "Discussion:....5. DVT/PE (deep vein thromboses/pulmonary embolus) history. Patient not currently on anticoagulation despite being continued at discharge recently; will start a heparin (7) bridge to warfarin."

The resident was readmitted to the facility on 1/11/17.

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	F 329	Continued From pa	ige 8	F 32	29	
The same of the last		A physician's order "Warfarin 4 mg in the	dated 1/12/17 documented he evening."			
		Record) for the mothat Resident #1 re	R (Medication Administration nth of January 2017 revealed ceived Warfarin, 4 mg every 19/17. There were no further			

Review of the clinical record revealed that on 1/20/17 a PT / INR were drawn. The results were PT 12.8 and INR 1.22. The nurse practitioner documented on the lab results to check (labs) on Monday (1/23/17) and to increase the Coumadin to 6 mg every evening. A review of the physician's orders revealed one dated 1/20/17 for "Warfarin 6 mg in the evening." A review of the MAR for January 2017 revealed the resident received this medication as prescribed each evening from 1/20/17 through 1/26/17.

labs for PT / INR obtained until 1/19/17. On 1/19/17, a PT / INR were drawn. The results were: PT 13.5 (normal ranges 10.0 - 12.0) and

INR 1.28 (normal ranges 0.80 - 3.5).

On 1/23/17 a PT / INR were drawn. The results were: PT 14.0 and INR 1.33. The nurse practitioner documented on the results on 1/25/17 to check (labs) on Friday (1/27/17) and to increase the Coumadin to 8 mg. A review of the physician's orders revealed no new orders at this time. The medication dose did not change. Review of the MARs revealed the resident remained on the previous dose of 6 mg every evening through 1/26/17.

On 1/25/17 a PT / INR were drawn. The results were: PT 16.9 and INR 1.59. It was unclear as to why the results were drawn on this date as there

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DEPARTMENT OF HEALTH AND HUM SERVICES

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F 329	Continued From pa	ige 9	F 329			
		do so. However, the nurse				
		the results on 1/26/17 and				
		results was a notation to adin to 8 mg and recheck the				
		eview of the physician's orders				
		1/27/17 for Coumadin 4 mg				
	tabs, give 2 tabs (8	mg) every morning.				
	A review of Reside	nt #1's January MAR revealed				
		din was administered on				
		point, the medication was				
		at night. On 1/27/17, when				
		is written for 4 mg Coumadin, in the morning, it was before				
		ing dose was due, thus an				
	order for the medic	ation was not in effect for the				
		an evening dose for 1/27/17.				
		R for January 2017 revealed ed the 8 mg for the remaining				
	days of January 20					
		IR were drawn. The results				
		NR 1.28. The nurse the state of the results on 2/2/17 and				
		results was the notation for				
		/17), 10 mg Thurs (Thursday,				
		k the labs on Monday (2/6/17).				
		sician's orders revealed one oumadin 12 mg one time only"				
		dated 2/1/17 for Coumadin 10				
		' A review of Resident #1's				
İ	February MAR reve	ealed the resident received the				
		nd 10 mg on 2/2/17 through				
	2/8/17. It was note	d that this order was, once				

administration.

again, scheduling the medication for an evening

On 2/6/17 a PT and INR were drawn. The results were: PT 24.1 and INR 2.24. Hand written on the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

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F 329 Continued From page 10

results was "Now 10 mg Coumadin" and "check Wednesday (2/8/17). The nurse practitioner initialed the results on 2/8/17. There was no evidence of an order written for this one time dose, or evidence the resident received this one time dose. It was unclear if that was the intent of the notation, as the resident was already on 10 mg every evening at that time.

On 2/8/17 a PT / INR were drawn. The results were: PT 41.1 and INR 3.74. The nurse practitioner wrote on the results to decrease (Coumadin) to 8 mg and "hold x 2dy" (it was unclear if this meant "today" or for "2 days.) A review of Resident #1's physician's orders revealed one dated 2/8/17 that documented. "Coumadin 8 mg in the evening, start 2/10/17." A review of Resident #1's February 2017 MAR revealed the resident received 10 mg on 2/8/17, none on 2/9/17, and started the 8 mg dose on 2/10/17 as ordered; indicating that one day was held. The physician's orders did not specify to hold any doses even though the notation on the lab results documented to hold x 2 days. Further review of the MAR revealed Resident #1 continued to receive 8 mg of Coumadin through the date of discharge to the hospital on 2/27/17, each date from 2/10/17 through 2/27/17 contained initials indicating the medication was administered.

Review of the clinical record failed to reveal the results of the PT / INR that were to be drawn on 2/10/17. A review of the facility lab order sheet revealed that a PT / INR were ordered to be drawn on 2/10/17 and the lab tech (technician) initialed that the labs were drawn. However, to date of the survey (3/23/17), the results were never provided to the facility from the lab

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F 329	attempted to follow lab test results until discharged to the h 2/27/17. On 2/15/17 (a Wed saw the resident. In not document anyth PT/INR results that notation was made Wednesdays" indice performed on Wed orders written dated drawn, or for a dos. On 2/21/17 Reside different unit in the February 2017 MAI transfer, Resident of Coumadin every ordered to be takin no further PT / INR On 2/23/17 the NP documented, "(illeg	rige 11 ras no evidence the facility rup with the lab regarding this rafter Resident #1 was rospital for Warfarin toxicity on resday) the nurse practitioner The NP note dated 2/15/17 did ring regarding the missing rewere drawn on 2/10/17. A that documented "INR on rating that the lab was resdays. There were no red 2/15/17 for a PT/INR to be re change in the medication. Int #1 was transferred to a facility. Review of the R revealed that after the red ay that she was already red gince 2/10/17. There were red orders obtained until 2/24/17. In saw the resident. The note regible) INR still (illegible)." recicion's orders revealed one	F3	329	

dated 2/23/17 for "CBC (complete blood count (15)), BMP (basic metabolic panel (16)), Mag (magnesium (17)) level, Phos (phosphorous (18)) level and d-dimer (test used to check for blood clotting problems (8)) in A.M." Also dated 2/23/17 was an order for a "PT/INR Friday" (2/24/17).

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F 329	Continued From pa	age 12	F 3	329		
		actitioner saw the resident and T / INR and a D-Dimer (8).				
	the d-dimer could r problem with the sa redrawn. There was	s dated 2/24/17 revealed that not be performed due to a ample and was going to be as no evidence the PT/INR was er labs drawn the morning of				
		order slips revealed one dated nented "PT/INR, d-dimer,				
	note documented,	saw the resident again. The "INR (illegible)INR still not results (illegible) 2-3"				
	#3, she stated that regarding labs draw that there was som for the d-dimer and	p.m., in an interview with LPN the lab called her on 2/24/17 who that morning and reported tething wrong with the sample I PT/INR and that they would lay to redraw these labs.				

On 3/22/17 at 4:57 p.m., an interview was conducted with LPN #4. She stated that she worked evening shift on 2/24/17 and saw the lab tech in the building and going into Resident #1's room to redraw the labs. LPN #4 stated that she inquired of the lab tech about the labs she was drawing because she was not made aware from day shift, to be expecting any labs to be drawn that evening. She stated the lab tech was drawing a PT/INR and d-dimer.

A review of the labs drawn 2/24/17 revealed the d-dimer was 738. The normal range documented on the lab results was 0-243. Further review of



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F 329	that the facility follor the results of the P ² Review of the nurse following entries: - 2/25/17 at 11:00 a resident's skin tone dry, and that stool v - 2/26/17 at 10:30 a	ge 13 ailed to reveal any evidence wed up with the lab regarding I / INR that were drawn. es' notes documented the a.m., documented the was normal, and warm and was soft and formed. a.m., documented the was normal and skin was	F 329			

- 2/27/17 at 3:30 a.m., documented, "...Resident skin tone is normal. Skin is warm and dry....Last BM (bowel movement) 02/26/17. Stool appearance is soft and formed "
- 2/27/17 at 10:34 a.m., documented, "Resident c/o chest pain at 08:40 A.M. Crying out during the episode. V/S (vital signs) are 97.6 (temperature), 75 (pulse), 17 (respirations), 159/85 (blood pressure) with an 02 sat (oxygen saturation) of 95% on RA (room air). Took her meds and is calmer at this time.

A note by the nurse practitioner on 2/27/17 at 11:26 a.m., documented, "f/u (follow up) CP

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(complaints of pain), with elevated dimer, no inc [sic - fNR] as of yet, getting stat today as not returned prior per report to me, pt (patient) declining ED (emergency department) visit as I stated multiple times that she should be evaluated, is oriented and able to make decisions, ekg (electrocardiogram) looked ok, no nausea, no bleeding, no sob (shortness of breath)....Physical Exam:....Skin: no rash, turgor normal, warm, dry....A/P: (assessment/plan) 1. CP improved, pt awake and alert, could suspect PE (pulmonary embolus), need INR returned asap (as soon as possible), nurse to call me, pt (patient) declines ED visit and understands risks. CVA/debility, cont LTC (continue long term) care). 3. URI (upper respiratory infection), on antibiotic.

A nurse's note dated 2/27/17 at 6:15 p.m., documented the resident was given Tylenol 2 tabs for pain, and a follow up note documented that the medication was ineffective.

A routine weekly skin assessment completed on 2/27/17 at 4:14 p.m., documented no changes in skin condition or areas of concern.

A nurse's note dated 2/27/17 at 6:43 p.m., documented, "Lab called with PT INR results which the lab states are too high to read on their machine. (Nurse Practitioner) called and she gave an order to give 5 Mg Vit (vitamin) K (used to reverse the effects of blood thinning medications when too much is given (10)) IM stat (5 milligrams of Vitamin K, via intramuscularly injection immediately). Order written, noted and faxed to the pharmacy. Resident vomited coffee ground material (vomit having the appearance and consistency of coffee grounds because of

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F 329 Continued From page 15

blood mixed with gastric contents*) at 17:25 (5:25 p.m.). (Nurse Practitioner) notified. She gave an order to give 40 mg of Prilosec (used to treat reflux and ulcers (10)) stat (immediately) and then cont. (continue) the order BID (twice daily). Prilosec given as ordered. her daughter (name) was notified. Resident was instructed that if she had more emesis then she would need to go to the hospital. She stated that she didn't want to go to hospital as she didn't want to loose [sic] her bed."

A nurse's note dated 2/27/17 at 11:30 p.m., documented. "Staff notified writer that resident was not feeling well and acting differently. Writer assessed resident, found resident to be confused, disoriented, skin tone appeared light yellow all over, large purple bruises noted to Rt (right) upper arm, a large raised hematoma to Rt forearm. Resident c/o (complained of) Rt arm being weak, more than normal. Writer had received in report, resident had vomited x1 dark brown, coffee ground looking emesis earlier in the evening. CNA (certified nursing assistant) reported to writer that resident had vomited again, just before writer entered room, x2. CNA described emesis as dark brown coffee grounds. Resident said she was unable to eat any food, vomited from drinking a sip of water. Resident said she wanted to go to ER (emergency room). POA (Power of Attorney) notified of change, and agreed that she wanted her mom to be sent to the ER. Placed call to 911, resident sent via squad to (hospital).

A nurse's note dated 2/28/17 at 2:42 a.m., documented, "SBAR: Situation: Change in condition, symptoms or signs I am calling about is/are: Altered mental status Functional decline

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(X5) COMPLETION DATE

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(worsening function and/or mobility) Nausea/Vomiting. This started on 02/27/2017 and the time of day Afternoon. Background: Resident is in the nursing home for long term care... (resident diagnoses were listed). Medication changes in the past week: d/c (discontinue) coumadin, metoperolo [sic]. Assessment/Appearance: Vitals: BP (blood pressure) 107/54 - 2/27/17 00:48 (12:48 a.m.) Position: Lying r/arm. P (pulse) 85 - 2/27/2017 00:49 (12:49 a.m.) Pulse Type: Regular. R (respirations) 17 - 2/27/17 00:50 (12:50 a.m.). T (temperature) 99.4 - 2/27/2017 19:19 (7:19 p.m.) Route: Oral. W (weight) 210.8 lb (pounds) -2/15/2017 13:18 (1:18 p.m.) Scale: Lift Scale. O2 (oxygen) 94% - 2/27/2017 19:20 (7:20 p.m.) Method: Room air, BS (blood sugar) 271 -2/27/2017 00:51 (12:51 a.m.) Pain: 0. Resident has increased confusion (e.g. disorientation). Resident has general weakness, no behavioral changes observed. no [sic] respiratory changes observed. Resident noted to be Jaundice Blood [sic] noted in stool or vomitus c/o [sic] of nausea. Vomiting noted. appetite [sic] diminished No [sic] Urinary changes observed. Other neurological symptoms observed. Skin Changes: Discoloration. Disoriented, confused, c/o (complained of) weakness. Resident c/o not feeling well, asked to go to ER....Request: Reported to primary care clinician. No, d/t (due to) time of night, on. [sic] Orders obtained: (none listed). Name of Family/healthcare agent notified: (name) residents [sic] daughter. on 02/27/2017 11:30 PM."

A nurse's note dated 3/1/17, documented as a "Late entry for 2-23-17" documented, "NP (nurse practitioner) notified of resident not receiving PT/INR since 2-8-17 NP with order for PT/INR

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next day 2-24-17. Resident transferred to Unit 1 Lab slip taken down to south unit manager. Resident aware of lab orders for next day."

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

A review of the resident's care plan revealed one for "Anticoagulant use" which was initiated on 1/31/17. The interventions included one for "Monitor labs per orders and notify MD of abnormalities." This intervention was dated 1/31/17.

A review of the facility policy for "Anticoagulation Protocol" documented, "....b. The nurse will obtain an order from the physician for any pertinent labs for monitoring of the anticoagulant therapy"

Additional interviews conducted with staff as follows:

In an interview conducted on 3/22/17 at 1:18 with LPN (licensed practical nurse) #2, she stated that at the time of this resident (Resident #1), she was the unit manager for the skilled unit. LPN #2 stated that the nurses were responsible to ensure that labs were received and reported to the physician. She could not provide further explanation as to how it fell through the cracks that this resident's PT/INR that was drawn on 2/10/17 was never followed up on for the results.

In a follow up interview that was conducted with LPN #2 on 3/23/17 at 10:24 a.m., she stated that as the unit manager she should have ensured that the lab results were received. In addition LPN #2 stated that the care plan for monitoring the labs as ordered was not followed. LPN #2 stated that as the unit manager, she would bring to the morning meetings, any information

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 03/23/2017
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COMPLETION DATE

F 329 Continued From page 18

regarding abnormal labs, but that whether or not a lab result was actually received was not part of the process at the time. LPN #2 stated that aside from the nurses, the physician/nurse practitioner should also have followed up; asking about lab results that he/she had ordered was expecting to receive.

In an interview conducted 3/22/17 at 2:02 p.m., with LPN #1 (Licensed Practical Nurse) she stated that she received the resident from the other unit on 2/21/17 and that everything was going ok with the resident. LPN #1 stated that a couple days later, the unit manager from the other unit brought over the PT/INR flow sheet (which had not been initiated until 1/20/17) and that the unit manager told her she just realized that the resident had not had a PT/INR drawn since about 2/8/17. LPN #1 stated the nurse practitioner was notified and orders were obtained to get a PT/INR on "Friday" (which was 2/24/17). She stated that during the approximately 1 week the resident was on her unit, there were no noted issues with the resident until the events of 2/27/17.

On 3/22/17 at 5:00 an interview was conducted with OSM (Other Staff Member) #1, the pharmacist. She stated that until a resident is stable, that labs should be monitored frequently, at least weekly. She stated that if a resident has Coumadin toxicity, that the effects of that could be significant bleeding related issues (i.e., brain bleed, gastrointestinal bleed, etc.)

On 3/23/17 at 11:20 a.m., in an interview with the Director of Nursing (DON) (Administrative Staff Member #2 - ASM #2) she stated that ever since this situation occurred, she has been in contact

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F 329 Continued From page 19

with the lab and that results from Resident #1's PT/INR draw on 2/10/17 could not be located by the lab company either. She stated that the lab company followed up with the hospital laboratory facility that they utilize and that it would appear the hospital lab did not perform the testing. In addition, ASM #2 stated a similar scenario occurred with the stat testing that was done on 2/24/17 wherein the lab collected was for a D-Dimer and a PT/INR but the hospital laboratory failed to perform the PT/INR. Therefore, the lab company only had results for the D-Dimer to return to the facility. The facility had failed to follow up with the lab company regarding the results for the PT/INR for either of these dates Resident #1's levels went unchecked and Resident #1 continued to receive 8 mg of Coumadin without monitoring and was sent to the emergency room on 2/27/17 and was hospitalized for Coumadin/Warfarin toxicity.

On 3/23/17 at approximately 8:30 a.m., the Administrator stated that the nurse practitioner had been out sick but was expecting my call; and that the physician was expecting my call specifically at 10:00 a.m. On 3/23/17 at 9:58 a.m., and 10:05 a.m., attempts were made to contact the physician, without success. Attempts to contact the nurse practitioner were made on 3/23/17 at 10:11 a.m. and 10:20 a.m. The nurse practitioner did not answer the call.

A review of the hospital discharge summary dated 3/14/17 documented in part the following: "Acute blood loss anemia (source unknown), in setting of Warfarin toxicity/fluctuation (resolved)"

On 3/22/17 at approximately 3:00 p.m., the Administrator and Director of Nursing were



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notified of the concern for harm. The following plan of correction was presented:

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- 1. Incident: 2/27/17 resident with a high PT/INR [with a result of] (unable to read); bruising noted; emesis x1 coffee ground in color (inconsistency of labs)): resident evaluated by NP, labs ordered, PT/INR elevated; Vit K given; resident to hospital and admitted.
- 2. 100% audit of residents receiving Coumadin, Lovenox (12), Heparin, Eliquis (13), Xarelto (14) audited for pertinent labs and bruising/bleeding and relating care plans.
- 3. Education to nursing staff on anticoagulant policy to include signs and symptoms; education to licensed nurses on anticoagulant policy and lab process by DON/designee
- 4. Audits of labs and audits of resident on Coumadin, Lovenox, Heparin, Eliquis, Xarelto audited 5 times a week for 12 weeks for lab orders/completion/ MD/RP notification by DON/designee. Results of audits will be taken to QAPI monthly x 3 months for review and revision as needed.
- Date of compliance: March 6, 2017.

A review of the plan of correction revealed that 100% of the nursing staff was educated. Audits to date were reviewed. All current residents on Coumadin or Warfarin who were also in the facility at the time the resident was in the facility were reviewed by the surveyor. There were no discrepancies identified with these residents' labs and Coumadin dosing at the time Resident #1 was in the facility or since then up to the date of survey.

No further information was provided by the end of the survey.

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID M38611

Facility ID VA0012

If continuation sheet Page 21 of 45



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

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	References:							
	your blood from clo from	medication that helps keep otting. Information obtained s.gov/ency/patientinstructions/0						
	(2) Warfarin is and 1 above)	other name for Coumadin (see						
	test used to monito (Coumadin). Inform	nal Normalized Ratio) a blood or the effectiveness of Warfarin mation obtained from ne.org/understanding/analytes/						
	from	antibiotic. Information obtained s.gov/druginfo/meds/a684026.h						
	conjunction with the	a blood test used in e INR test to monitor the arfarin (see 3 above)						
	significantly evolved some lab-to-lab var differences in testin reagents used, and Consequently, for n	y of laboratory testing has dover the past few decades, riability can occur due to ng equipment, chemical danalysis techniques. most lab tests, there is no ble reference value.						

ef-ranges/

https://labtestsonline.org/understanding/features/r

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES



PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

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	(7) Heparin is used Information obtained	to prevent blood clots.					
	clotting problems.	b test used to check for blood Information obtained from gov/ency/article/007620.htm					
	pain. Information of	to relieve mild to moderate obtained from gov/druginfo/meds/a681004.h					
	blood thinning med given. Information	sed to reverse the effects of ications when too much is obtained from gov/druginfo/natural/983.html					
		ormation obtained from gov/druginfo/meds/a693050.h					
	legs of patients who having hip replacen stomach surgery. I	ed to prevent blood clots in the pare on bedrest, or who are ment, knee replacement, or information obtained from gov/druginfo/meds/a601210.h					
	clots in people who Information obtaine	to prevent strokes and blood have atrial fibrillation. d from gov/druginfo/meds/a613032.h					
		I to treat deep vein thrombosis					

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DEPARTMENT OF HEALTH AND HUMANSERVICES

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	https://medlineplus. ml	.gov/druginfo/meds/a611049.ht			
	Market A secretarion Market Lean E	A LILL DE LES E			
		losby's Medical Dictionary,			
	sixth edition, 2002.	St. Louis, MO: Mosby, Inc.			
		complete blood count) is a determine the number of red			
		ils per cubic millimeter of			
		f the most valuable screening			
	and diagnostic tech				
	and diagnostic teer	miques.			8
	(16) A BMP (Basic	metabolic panel) is a group of			
	blood tests that pro	vides information about your			
	body's metabolism.	This test can be used to			
		nction, blood acid/base			3
		evels of blood sugar, and			
	electrolytes. Deper	nding on which lab you use, a			890
		nel may also check your levels			
		otein called albumin.			
	Information obtained	ed from			
		gov/medlineplus/ency/article/0			
	03462.htm				
	(17) According to N	Mosby's Medical Dictionary,			
		St. Louis, MO: Mosby, Inc.			
		level (Magnesium) is "a blood			
		nine the level of magnesium,			
		s critical in nearly all metabolic			
		mal levels may indicate renal			

Information obtained from

insufficiency, chronic renal disease, uncontrolled diabetes, diabetic acidosis, Addison's disease, hypothyroidism, malnutrition, malabsorption, hypoparathyroidism, and alcoholism."

(18) Phosphorus tests are most often ordered along with other tests ...to help diagnose and/or monitor treatment of various conditions ..."

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F 502 SS=G	vomit 483.50(a)(1) ADMII (a) Laboratory Serv (1) The facility mus services to meet the facility is responsible of the services.	NISTRATION	F	502	
	by: Based on staff inte review, and clinical determined that the timely lab services	erview, facility document record review, it was e facility staff failed to provide to meet the resident's needs in the survey sample;		Past noncompliance: no plan of correction required.	
	timely results of a la levels, for which an dosing was depend results were not rec follow up with the la therefore, the media readjusted according	the facility staff failed to ensure aboratory test for PT / INR anticoagulant medication dent on. When the laboratory derived, the facility staff failed to ab regarding the results, and decation dose was not engly, resulting in toxic levels of the resident, that required			
	The findings include	e:			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

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F 502 Continued From page 25

F 502

Resident #1 was admitted to the facility on 12/31/16 and discharged on 2/27/17. The resident was admitted with the diagnoses of but not limited to stroke, dysphagia, diabetes, left sided below the knee amputation, high blood pressure, acute kidney failure, cataracts, and encephalopathy. The most recent MDS (Minimum Data Set) was a 5-day assessment post readmission (1/11/17 after brief re-hospitalization) with an ARD (Assessment Reference Date) of 1/18/17. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring total assistance for transfers; extensive assistance for hygiene, toileting, and dressing; supervision for eating; and as incontinent of bowel and bladder.

Review of the hospital record for the hospitalization leading to the resident's initial admission of 12/31/16 revealed the following:

A review of the hospital record dated 12/31/16 revealed a discharge summary which documented, "Principle Discharge Diagnosis: Acute Ischemic Stroke....Indication for Admission:....68 y.o. (year old) female with a history of poorly controlled DM (diabetes) c/b (complicated by) neuropathy and right BKA (below knee amputation), hypertension (high blood pressure), hyperlipidemia, breast cancer s/p (status post) lumpectomy in 2007, and recurrent DVT/PE (deep vein thrombosis, pulmonary embolism) on coumadin (anticoagulant medication (1)) who presented to the (hospital) ED (Emergency Department) after waking up with left sided weakness.....No history

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F 502 Continued From page 26

of stroke. Reports compliance with coumadin. Takes 4 mg (milligrams) nightly (at 6 pm) but had been off all medications, including coumadin, for a year due to insurance issues....Continue full anticoagulation for history of recurrent PEs with warfarin (also known as Coumadin (2)). Check INR (International Normalized Ratio (3)) in 1-2 days after discharge. Restart warfarin at 1 mg (milligram) daily once INR is between 2-3. Continue warfarin 1 mg daily for the duration of antibiotic therapy with Bactrim (an antibiotic (4)). After Bactrim is completed, would recommend close INR monitoring and readjustment of her warfarin to higher doses.

In addition, the above dated hospital record documented that on 12/29/16, the resident's INR was 2.9 (normal range was identified as 0.9 to 1.2). The Protime (PT) level was high at 32.9. Documented normal range was 9.8 to 12.6

A review of the facility physician's orders dated 12/31/16 and 1/1/17 revealed that, per the discharge summary above, Resident #1 was not yet started on the coumadin at the time of admission to the facility on 12/31/16.

On 1/3/17, the resident was sent from the facility to the hospital for suspected heart attack related to complaints of chest pain. The hospital record for this visit contained an INR result of 1.4, which was still elevated above the normal range. The PT was documented as 15.6, which was also still above the normal range. The resident was released back to the facility the same day. The discharge paperwork documented, "Warfarin 1 mg....please wait till INR is between 2 - 3 to resume."

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F 502 Continued From page 27

On 1/4/17 the facility obtained an INR level, which the results were 1.5. The facility's laboratory ranges for this documented normal range as being 0.80 to 3.50. A PT result was documented as 12.1. The facility's laboratory documented normal range as being 10.5 to 12.0. [NOTE: variances in normal ranges and results vary by laboratory, based on equipment used, procedures used, laboratory policy, and standard deviation. (6)]. The nurse practitioner notated the lab results on 1/5/17. There were no further labs or medication changes until 1/9/17. Up to this date, the facility had not ordered any coumadin / warfarin for the resident. In the approximately 10 days the resident was in the facility, the PT and INR had been checked twice (1/3/17 at the hospital and 1/4/17 at the facility).

Review of the clinical record revealed that on 1/9/17, Resident #1 was again sent to the hospital, for altered mental status related to hypoglycemia. Resident #1 was admitted, and was discharged back to the facility on 1/11/17. The hospital record documented the following: PT normal ranges 9.6 to 11.0. INR normal ranges (not provided). On 1/8/17 the resident's PT was 11.5 and INR was 1,12. On 1/10/17 the PT was 12.7 and the INR was 1.22. On 1/11/17 the PT was 13.9 and the INR was 1.34. The hospital record further documented. "Discussion:...5. DVT/PE (deep vein thromboses/pulmonary embolus) history. Patient not currently on anticoagulation despite being continued at discharge recently; will start a heparin (7) bridge to warfarin."

The resident was readmitted to the facility on 1/11/17.

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F 502

A physician's order dated 1/12/17 documented "Warfarin 4 mg in the evening."

A review of the MAR (Medication Administration Record) for the month of January 2017 revealed that Resident #1 received Warfarin, 4 mg every evening through 1/19/17. There were no further labs for PT / INR obtained until 1/19/17. On 1/19/17, a PT / INR were drawn. The results were: PT 13.5 (normal ranges 10.0 - 12.0) and INR 1.28 (normal ranges 0.80 - 3.5).

Review of the clinical record revealed that on 1/20/17 a PT / INR were drawn. The results were PT 12.8 and INR 1.22. The nurse practitioner documented on the lab results to check (labs) on Monday (1/23/17) and to increase the Coumadin to 6 mg every evening. A review of the physician's orders revealed one dated 1/20/17 for "Warfarin 6 mg in the evening." A review of the MAR for January 2017 revealed the resident received this medication as prescribed each evening from 1/20/17 through 1/26/17.

On 1/23/17 a PT / INR were drawn. The results were: PT 14.0 and INR 1.33. The nurse practitioner documented on the results on 1/25/17 to check (labs) on Friday (1/27/17) and to increase the Coumadin to 8 mg. A review of the physician's orders revealed no new orders at this time. The medication dose did not change. Review of the MARs revealed the resident remained on the previous dose of 6 mg every evening through 1/26/17.

On 1/25/17 a PT / INR were drawn. The results were: PT 16.9 and INR 1.59. It was unclear as to why the results were drawn on this date as there

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F 502	Continued From pa	age 29	F	502		
		do so. However, the nurse the results on 1/26/17 and				
	hand written on the	results was a notation to adin to 8 mg and recheck the				
i i	INR on 2/1/17. Are	eview of the physician's orders				
		1 1/27/17 for Coumadin 4 mg mg) every morning.				
	no dose of Coumac 1/27/17. Up to this being administered the above order wa give 2 tabs (8 mg) the resident's even order for the medic resident to receive A review of the MA	nt #1's January MAR revealed din was administered on point, the medication was Lat night. On 1/27/17, when as written for 4 mg Coumadin, in the morning, it was before ing dose was due, thus an eation was not in effect for the an evening dose for 1/27/17. R for January 2017 revealed ed the 8 mg for the remaining 117.				
	were PT 13.4 and it practitioner initialed handwritten on the "12 mg tonight (2/1 2/2/17) and rechect A review of the phy	IR were drawn. The results INR 1.28. The nurse of the results on 2/2/17 and results was the notation for /17), 10 mg Thurs (Thursday, ok the labs on Monday (2/6/17). It is cian's orders revealed one formadin 12 mg one time only"				

administration.

and an order also dated 2/1/17 for Coumadin 10 mg in the evening." A review of Resident #1's February MAR revealed the resident received the 12 mg on 2/1/17 and 10 mg on 2/2/17 through 2/8/17. It was noted that this order was, once again, scheduling the medication for an evening

On 2/6/17 a PT and INR were drawn. The results were: PT 24.1 and INR 2.24. Hand written on the

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F 502 Continued From page 30

results was "Now 10 mg Coumadin" and "check Wednesday (2/8/17). The nurse practitioner initialed the results on 2/8/17. There was no evidence of an order written for this one time dose, or evidence the resident received this one time dose. It was unclear if that was the intent of the notation, as the resident was already on 10 mg every evening at that time.

On 2/8/17 a PT / INR were drawn. The results were: PT 41.1 and INR 3.74. The nurse practitioner wrote on the results to decrease (Coumadin) to 8 mg and "hold x 2dy" (it was unclear if this meant "today" or for "2 days.) A review of Resident #1's physician's orders revealed one dated 2/8/17 that documented. "Coumadin 8 mg in the evening, start 2/10/17." A review of Resident #1's February 2017 MAR revealed the resident received 10 mg on 2/8/17, none on 2/9/17, and started the 8 mg dose on 2/10/17 as ordered; indicating that one day was held. The physician's orders did not specify to hold any doses even though the notation on the lab results documented to hold x 2 days. Further review of the MAR revealed Resident #1 continued to receive 8 mg of Coumadin through the date of discharge to the hospital on 2/27/17, each date from 2/10/17 through 2/27/17 contained initials indicating the medication was administered.

Review of the clinical record failed to reveal the results of the PT / INR that were to be drawn on 2/10/17. A review of the facility lab order sheet revealed that a PT / INR were ordered to be drawn on 2/10/17 and the lab tech (technician) initialed that the labs were drawn. However, to date of the survey (3/23/17), the results were never provided to the facility from the lab

F 502

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	attempted to follow lab test results until	vas no evidence the facility of up with the lab regarding this il after Resident #1 was nospital for Warfarin toxicity on					
	saw the resident. T not document anyth PT/INR results that notation was made Wednesdays" indic- performed on Wedr orders written dated	dnesday) the nurse practitioner. The NP note dated 2/15/17 did hing regarding the missing to were drawn on 2/10/17. A set that documented "INR on cating that the lab was linesdays. There were no d 2/15/17 for a PT/INR to be e change in the medication.					
	different unit in the frebruary 2017 MAF transfer, Resident # of Coumadin every ordered to be taking	nt #1 was transferred to a facility. Review of the R revealed that after the #1 continued to receive 8 mg day that she was already g since 2/10/17. There were orders obtained until 2/24/17.					
	documented, "(illegi Review of the physi- dated 2/23/17 for "C (15)), BMP (basic m (magnesium (17)) le level and d-dimer (to clotting problems (8)	saw the resident. The note pible) INR still (illegible)." ician's orders revealed one CBC (complete blood count netabolic panel (16)), Mag evel, Phos (phosphorous (18)) test used to check for blood (3)) in A.M." Also dated 2/23/17 "PT/INR Friday" (2/24/17).					
		ducted with LPN #2 (Licensed on 3/23/17 at 10:24 a.m., she					

stated that on 2/23/17 she realized the results were never obtained from the 2/10/17 PT/INR lab draw and notified the nurse practitioner. LPN #2

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F 502	Continued From pa	ge 32	F :	502	
		actitioner saw the resident and 「/ INR and a D-Dimer (8).			
	the d-dimer could n problem with the sa redrawn. There wa	dated 2/24/17 revealed that ot be performed due to a imple and was going to be s no evidence the PT/INR was r labs drawn the morning of			
		order slips revealed one dated ented "PT/INR, d-dimer,			
	note documented, "	saw the resident again. The INR (illegible)INR still not esults (illegible) 2-3"			
	#3, she stated that regarding labs draw that there was some for the d-dimer and	p.m., in an interview with LPN the lab called her on 2/24/17 on that morning and reported ething wrong with the sample PT/INR and that they would ay to redraw these labs.			
	conducted with LPN worked evening shi	p.m., an interview was N #4. She stated that she ft on 2/24/17 and saw the lab and going into Resident #1's			

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drawing a PT/INR and d-dimer.

room to redraw the labs. LPN #4 stated that she inquired of the lab tech about the labs she was drawing because she was not made aware from day shift, to be expecting any labs to be drawn that evening. She stated the lab tech was

A review of the labs drawn 2/24/17 revealed the d-dimer was 738. The normal range documented on the lab results was 0-243. Further review of

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Facility ID VA0012

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CROSS-REFERENCED TO THE APPROPRIATE

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F 502 Continued From page 33

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the clinical record failed to reveal any evidence that the facility followed up with the lab regarding the results of the PT / INR that were drawn.

REGULATORY OR LSC IDENTIFYING INFORMATION)

Review of the nurses' notes documented the following entries:

- 2/25/17 at 11:00 a.m., documented the resident's skin tone was normal, and warm and dry, and that stool was soft and formed.
- 2/26/17 at 10:30 a.m., documented the resident's skin tone was normal and skin was warm and dry.
- 2/26/17 at 5:15 p.m., "Resident c/o pain dramatically crying out into hall. She c/o pain in ribs, neck, and arms. When I took the resident some Tylenol (9) down she refused it stating. "I am not going to even take it anymore, it doesn't help." She stopped crying out as soon as I left the room. Note left for MD (medical doctor) to evaluate her pain. Will continue to monitor "
- 2/27/17 at 3:30 a.m., documented. "...Resident skin tone is normal. Skin is warm and dry....Last BM (bowel movement) 02/26/17. Stool appearance is soft and formed...."
- 2/27/17 at 10:34 a.m., documented, "Resident c/o chest pain at 08:40 A.M. Crying out during the episode. V/S (vital signs) are 97.6 (temperature), 75 (pulse), 17 (respirations), 159/85 (blood pressure) with an 02 sat (oxygen saturation) of 95% on RA (room air). Took her meds and is calmer at this time.

A note by the nurse practitioner on 2/27/17 at 11:26 a.m., documented, "f/u (follow up) CP

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(complaints of pain), with elevated dimer, no inc [sic - INR] as of yet, getting stat today as not returned prior per report to me, pt (patient) declining ED (emergency department) visit as I stated multiple times that she should be evaluated, is oriented and able to make decisions, ekg (electrocardiogram) looked ok, no nausea, no bleeding, no sob (shortness of breath)....Physical Exam:....Skin: no rash, turgor normal, warm, dry....A/P: (assessment/plan) 1. CP improved, pt awake and alert, could suspect PE (pulmonary embolus), need INR returned asap (as soon as possible), nurse to call me, pt (patient) declines ED visit and understands risks. 2. CVA/debility, cont LTC (continue long term care). 3. URI (upper respiratory infection), on antibiotic.

A nurse's note dated 2/27/17 at 6:15 p.m., documented the resident was given Tylenol 2 tabs for pain, and a follow up note documented that the medication was ineffective.

A routine weekly skin assessment completed on 2/27/17 at 4:14 p.m., documented no changes in skin condition or areas of concern.

A nurse's note dated 2/27/17 at 6:43 p.m., documented, "Lab called with PT INR results which the lab states are too high to read on their machine. (Nurse Practitioner) called and she gave an order to give 5 Mg Vit (vitamin) K (used to reverse the effects of blood thinning medications when too much is given (10)) IM stat (5 milligrams of Vitamin K, via intramuscularly injection immediately). Order written, noted and faxed to the pharmacy. Resident vomited coffee ground material (vomit having the appearance and consistency of coffee grounds because of

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blood mixed with gastric contents*) at 17:25 (5:25 p.m.). (Nurse Practitioner) notified. She gave an order to give 40 mg of Prilosec (used to treat reflux and ulcers (10)) stat (immediately) and then cont. (continue) the order BID (twice daily). Prilosec given as ordered. her daughter (name) was notified. Resident was instructed that if she had more emesis then she would need to go to the hospital. She stated that she didn't want to go to hospital as she didn't want to loose [sic] her bed."

A nurse's note dated 2/27/17 at 11:30 p.m., documented, "Staff notified writer that resident was not feeling well and acting differently. Writer assessed resident, found resident to be confused, disoriented, skin tone appeared light yellow all over, large purple bruises noted to Rt (right) upper arm, a large raised hematoma to Rt forearm. Resident c/o (complained of) Rt arm being weak, more than normal. Writer had received in report, resident had vomited x1 dark brown, coffee ground looking emesis earlier in the evening. CNA (certified nursing assistant) reported to writer that resident had vomited again, just before writer entered room, x2. CNA described emesis as dark brown coffee grounds. Resident said she was unable to eat any food, vomited from drinking a sip of water. Resident said she wanted to go to ER (emergency room). POA (Power of Attorney) notified of change, and agreed that she wanted her mom to be sent to the ER. Placed call to 911, resident sent via squad to (hospital).

A nurse's note dated 2/28/17 at 2:42 a.m., documented, "SBAR: Situation: Change in condition, symptoms or signs I am calling about is/are: Altered mental status Functional decline

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(worsening function and/or mobility) Nausea/Vomiting. This started on 02/27/2017 and the time of day Afternoon. Background: Resident is in the nursing home for long term care... (resident diagnoses were listed). Medication changes in the past week: d/c (discontinue) cournadin, metoperolo [sic]. Assessment/Appearance: Vitals: BP (blood pressure) 107/54 - 2/27/17 00:48 (12:48 a.m.) Position: Lying r/arm. P (pulse) 85 - 2/27/2017 00:49 (12:49 a.m.) Pulse Type: Regular. R (respirations) 17 - 2/27/17 00:50 (12:50 a.m.). T (temperature) 99.4 - 2/27/2017 19:19 (7:19 p.m.) Route: Oral. W (weight) 210.8 lb (pounds) -2/15/2017 13:18 (1:18 p.m.) Scale: Lift Scale. O2 (oxygen) 94% - 2/27/2017 19:20 (7:20 p.m.) Method: Room air, BS (blood sugar) 271 -2/27/2017 00:51 (12:51 a.m.) Pain: 0. Resident has increased confusion (e.g. disorientation). Resident has general weakness, no behavioral changes observed. no [sic] respiratory changes observed. Resident noted to be Jaundice Blood [sic] noted in stool or vomitus c/o [sic] of nausea. Vomiting noted, appetite [sic] diminished No [sic] Urinary changes observed. Other neurological symptoms observed. Skin Changes: Discoloration. Disoriented, confused, c/o (complained of) weakness. Resident c/o not feeling well, asked to go to ER....Request: Reported to primary care clinician. No, d/t (due to) time of night, on. [sic] Orders obtained: (none listed). Name of Family/healthcare agent notified: (name) residents [sic] daughter, on 02/27/2017 11:30 PM."

A nurse's note dated 3/1/17, documented as a "Late entry for 2-23-17" documented, "NP (nurse practitioner) notified of resident not receiving PT/INR since 2-8-17 NP with order for PT/INR

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PRINTED: 03/30/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICA SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED. **IDENTIFICATION NUMBER** AND PLAN OF CORRECTION A. BUILDING 495244 R WING 03/23/2017 STREET ADDRESS CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER NUMBER ONE AUTUMN COURT **AUTUMN CARE OF MADISON** MADISON, VA 22727 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BF PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 502 F 502 Continued From page 37 next day 2-24-17. Resident transferred to Unit 1 Lab slip taken down to south unit manager. Resident aware of lab orders for next day." A review of the resident's care plan revealed one for "Anticoagulant use" which was initiated on 1/31/17. The interventions included one for "Monitor labs per orders and notify MD of abnormalities." This intervention was dated 1/31/17. A review of the facility policy for "Anticoagulation Protocol" documented, "....b. The nurse will obtain an order from the physician for any pertinent labs for monitoring of the anticoagulant therapy" Additional interviews conducted with staff as follows: In an interview conducted on 3/22/17 at 1:18 with LPN (licensed practical nurse) #2, she stated that at the time of this resident (Resident #1), she was the unit manager for the skilled unit. LPN #2

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stated that the nurses were responsible to ensure that labs were received and reported to the physician. She could not provide further explanation as to how it fell through the cracks that this resident's PT/INR that was drawn on 2/10/17 was never followed up on for the results.

In a follow up interview that was conducted with LPN #2 on 3/23/17 at 10:24 a.m., she stated that as the unit manager she should have ensured that the lab results were received. In addition LPN #2 stated that the care plan for monitoring the labs as ordered was not followed. LPN #2 stated that as the unit manager, she would bring

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regarding abnormal labs, but that whether or not a lab result was actually received was not part of the process at the time. LPN #2 stated that aside from the nurses, the physician/nurse practitioner should also have followed up; asking about lab results that he/she had ordered was expecting to receive.

In an interview conducted 3/22/17 at 2:02 p.m., with LPN #1 (Licensed Practical Nurse) she stated that she received the resident from the other unit on 2/21/17 and that everything was going ok with the resident. LPN #1 stated that a couple days later, the unit manager from the other unit brought over the PT/INR flow sheet (which had not been initiated until 1/20/17) and that the unit manager told her she just realized that the resident had not had a PT/INR drawn since about 2/8/17. LPN #1 stated the nurse practitioner was notified and orders were obtained to get a PT/INR on "Friday" (which was 2/24/17). She stated that during the approximately 1 week the resident was on her unit, there were no noted issues with the resident until the events of 2/27/17.

On 3/22/17 at 5:00 an interview was conducted with OSM (Other Staff Member) #1, the pharmacist. She stated that until a resident is stable, that labs should be monitored frequently, at least weekly. She stated that if a resident has Coumadin toxicity, that the effects of that could be significant bleeding related issues (i.e., brain bleed, gastrointestinal bleed, etc.)

On 3/23/17 at 11:20 a.m., in an interview with the Director of Nursing (DON) (Administrative Staff Member #2 - ASM #2) she stated that ever since this situation occurred, she has been in contact

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with the lab and that results from Resident #1's PT/INR draw on 2/10/17 could not be located by the lab company either. She stated that the lab company followed up with the hospital laboratory facility that they utilize and that it would appear the hospital lab did not perform the testing. In addition, ASM #2 stated a similar scenario occurred with the stat testing that was done on 2/24/17 wherein the lab collected was for a D-Dimer and a PT/INR but the hospital laboratory failed to perform the PT/INR. Therefore, the lab company only had results for the D-Dimer to return to the facility. The facility had failed to follow up with the lab company regarding the results for the PT/INR for either of these dates Resident #1's levels went unchecked and Resident #1 continued to receive 8 mg of Coumadin without monitoring and was sent to the emergency room on 2/27/17 and was hospitalized for Coumadin/Warfarin toxicity.

On 3/23/17 at approximately 8:30 a.m., the Administrator stated that the nurse practitioner had been out sick but was expecting my call; and that the physician was expecting my call specifically at 10:00 a.m. On 3/23/17 at 9:58 a.m., and 10:05 a.m., attempts were made to contact the physician, without success. Attempts to contact the nurse practitioner were made on 3/23/17 at 10:11 a.m. and 10:20 a.m. The nurse practitioner did not answer the call.

A review of the hospital discharge summary dated 3/14/17 documented in part the following: "Acute blood loss anemia (source unknown), in setting of Warfarin toxicity/fluctuation (resolved)"

On 3/22/17 at approximately 3:00 p.m., the Administrator and Director of Nursing were

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the survey.

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was in the facility or since then up to the date of

No further information was provided by the end of

PRINTED: 03/30/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICA SERVICES (X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A BUILDING С 495244 R WING 03/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER NUMBER ONE AUTUMN COURT **AUTUMN CARE OF MADISON** MADISON, VA 22727 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 502 F 502 Continued From page 41 Complaint Deficiency past noncompliance. References: (1) Coumadin is a medication that helps keep your blood from clotting. Information obtained from https://medlineplus.gov/ency/patientinstructions/0 00255.htm (2) Warfarin is another name for Coumadin (see 1 above) (3) INR (International Normalized Ratio) a blood test used to monitor the effectiveness of Warfarin (Coumadin). Information obtained from https://labtestsonline.org/understanding/analytes/ pt/tab/test (4) Bactrim is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a684026.h tml (5) PT (Protime) is a blood test used in conjunction with the INR test to monitor the

ef-ranges/

Information obtained from

effectiveness of Warfarin (see 3 above)

(6) While accuracy of laboratory testing has significantly evolved over the past few decades, some lab-to-lab variability can occur due to differences in testing equipment, chemical reagents used, and analysis techniques. Consequently, for most lab tests, there is no universally applicable reference value.

https://labtestsonline.org/understanding/features/r

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	05	d to prevent blood clots.				
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		b test used to check for blood				
		Information obtained from .gov/ency/article/007620.htm				
	pain. Information of https://medlineplus	to relieve mild to moderate obtained from .gov/druginfo/meds/a681004.h				
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	blood thinning med given. Information	ised to reverse the effects of lications when too much is obtained from .gov/druginfo/natural/983.html				
	The Control of the Co	formation obtained from .gov/druginfo/meds/a693050.h				
	legs of patients wh having hip replaces stomach surgery.	ed to prevent blood clots in the o are on bedrest, or who are ment, knee replacement, or Information obtained from agov/druginfo/meds/a601210.h				
	clots in people who Information obtains	d to prevent strokes and blood blave atrial fibrillation. ed from s.gov/druginfo/meds/a613032.h				

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(14) Xarelto is used to treat deep vein thrombosis or pulmonary embolism. Information obtained

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	sixth edition, 2002. Page 405, a CBC (blood test used to and white blood ce	Mosby's Medical Dictionary, St. Louis, MO: Mosby, Inc. (complete blood count) is a determine the number of red ills per cubic millimeter of of the most valuable screening hniques.				
	blood tests that probody's metabolism evaluate kidney fu balance, and your electrolytes. Deperbasic metabolic particular of calcium and a puriformation obtain	metabolic panel) is a group of ovides information about yourThis test can be used to nction, blood acid/base levels of blood sugar, and ending on which lab you use, a nel may also check your levels rotein called albumin. ed from .gov/medlineplus/ency/article/0				
	Page 1042, an MC test used to deterr an electrolyte that processes. Abnor insufficiency, chrodiabetes, diabetic hypothyroidism, m	Mosby's Medical Dictionary, . St. Louis, MO: Mosby, Inc. delevel (Magnesium) is "a blood mine the level of magnesium, is critical in nearly all metabolic mal levels may indicate renal nic renal disease, uncontrolled acidosis, Addison's disease, alnutrition, malabsorption. m, and alcoholism."				
	(18) Phosphorus t	ests are most often ordered				

Information obtained from

along with other tests ...to help diagnose and/or monitor treatment of various conditions ..."

DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 03/30/2017 FORM APPROVED OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF MADISON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 502 Continued From page 44 https://labtestsonline.org/understanding/analytes/phosphorus/tab/test *This information was obtained from the website:	117
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 502 Continued From page 44 https://labtestsonline.org/understanding/analytes/phosphorus/tab/test *This information was obtained from the website:	
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