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	345289	A. BUILDING _____ B. WING _____	C 03/21/2015

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on physician and staff interviews and review of medical records, the facility failed to hold a dose of Coumadin for 1 of 3 sampled residents (Resident #4) who had a critical laboratory value for Prothrombin (PT) and a critical laboratory value for the international normalized ratio (INR). Findings included:	F 329		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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The facility policy, titled, PT/INR Testing, revised 10/13/09, indicated a physician's order was needed to perform PT/INR testing. The policy further indicated in a non-orthopedic resident, Coumadin should be held if the INR exceeded 3.0 or if the INR was 5.0 or greater to repeat the test for verification and notify the physician.

Resident #4 was readmitted on 3/9/15 with hypertension, diabetes and history of pulmonary embolus.

Resident #4's care plan, reviewed on 11/17/14, indicated he was at risk for bleeding related to anticoagulant use. To keep the PT/INR within an acceptable level, staff were directed to administer the Coumadin as ordered, monitor for signs and symptoms of bleeding, monitor the PT/INR, make the physician aware of abnormal labs.

Review of physician's telephone orders indicated on 12/24/14, a PT/INR was drawn with the results reported to the physician. New orders were received to continue the same dose of Coumadin (an anticoagulant medication) at 10 milligrams (mgs) on Tuesday and 7.5 mgs the other six days. Orders also were received to recheck the PT/INR in 2 weeks.

Review of the January 2015 physician's orders and the January 2015 Medication Administration Record (MAR) indicated Resident #4 received his Coumadin as ordered.

The Coagulation Log (a facility form used to document the results of fingerstick PT/INR), dated 1/7/15 at 10:00 AM indicated a PT of greater than 96 and an INR greater than 8. Nurse

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#1 had signed the log as the one completing the test. Nurse #1 had written the word "HOLD" and repeat at 11:00 PM.

At 11:30 AM, Nurse #1 documented on the Coagulation log that Resident #4's PT/INR remained greater than 96/8. Physician orders, dated 1/7/15,, with no time, indicated she was to obtain blood from Resident #4 and sent for a PT/INR. Nurse's notes, dated 1/7/15 at 12:30 PM, written by Nurse #1 documented she had tested Resident #4's PT/INR twice using different fingers with the same result. She noted the physician was aware with new orders received and carried out (the orders received at 11:30 AM). The nurse documented blood was drawn from the right hand and sent for PT/INR testing.

Review of the Medication Administration Record revealed Resident #4 received his 6:00 PM scheduled dose of Coumadin 7.5 mg on 1/7/15 from Nurse #4.

At 7:20 PM on 1/7/15, Nurse #2 documented in the nurse's notes the lab had called a critical PT/INR of greater than 120 and greater than 9 to her. Nurse #2 documented she called the physician and received new orders were received. Physician telephone orders, not timed, written by Nurse #2 indicated Vitamin K 10 milligrams (mgs) was to be given and the PT/INR to be rechecked at 11:00 PM on 1/7/15. If the INR remained greater than 6.0, the physician ordered her to give Vitamin K 10 mg po for one dose. The Medication Administration Record (MAR) dated 1/7/15 at 7:20 PM revealed the resident received the ordered Vitamin K.

Review of the Coagulation Log indicated Resident

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#4's PT/INR was tested on 1/7/15 at 11:00 PM with a result of greater than 96/8. Review of the MAR revealed Resident #4 had received Vitamin K as ordered.

Nurse's notes for 1/8/15 at 7:00 AM indicated Nurse #3 had documented Resident #4 had no bleeding noted.

On 1/8/15 at 8:00 AM, the Registered Nurse Clinical Manager (RNCM) documented in the nurse's notes that Resident #4's PT/INR remained elevated. She documented the physician was aware and noted Resident #4 had no bleeding.

Review of physician's orders and the MAR indicated Vitamin K 10 mgs was ordered and given at 11:00 AM.

At 4:45 PM on 1/8/15, nurse's notes revealed Resident #4 complained of back pain. Blood was noted in his mouth. The nurse noted the resident's PT/INR remained elevated. The MD was notified and ordered Vitamin K 10 mgs to be given and also ordered the resident be transferred to the hospital.

On 3/20/15 at 2:00 PM a telephone interview was held with Nurse #1. . The nurse stated she remembered the resident. The surveyor read the note to Nurse #1. She stated she did Resident #4's fingerstick PT/INR twice on 1/7/15 and received the same results both times. Nurse #1 added the fingerstick machine for PT/INR testing only went to a certain reading and then would say greater than. The nurse stated she reported the PT/INR to the RNCM. Nurse #1 stated the RNCM re-educated her and told her she should

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have sent Resident #4 to the hospital. The nurse stated she reported the results to Resident #4's primary care physician (PCP) who ordered a venipuncture for a PT/INR. She stated she did that and sent the blood to the lab. Results were not reported until after the end of her shift. The nurse stated the resident had petichiae (small red colored areas) on his cheeks. She stated she did not know if the petichiae was from a high PT/INR or from being shaved earlier in the day by the Nursing Assistant (NA). Nurse #1 stated she could not remember if she told the PCP about the petichiae. The nurse also added at this facility licensed practical nurses (LPNs) could not write Coumadin orders. She stated at this time she believed the resident should have gone to the hospital and received Vitamin K or other treatment for the increased INR. At the time, she did not request he go out.

An interview was held with the RNCM for the 300 and 400 hall on 3/20/15 at 2:19 PM. The nurse stated orders for PT/INR testing for a resident on Coumadin came directly from the PCP based on the individual resident. After the hall nurses on the hall complete the PT/INR test, results are logged onto the PT/INR log and kept on the MAR. The results of PT/INR testing are reported to the RNCM who in turn reports the results to the PCP. Orders for change in the dosage of Coumadin or when to get the next level is reported back to the hall nurse, but written by the RN and not the LPN. The RNCM stated if the results of the PT/INR was above 5, the PCP would be notified and a venipuncture completed for the blood sent to the hospital lab for more accurate testing. On 1/7/15, the RNCM stated she was teaching a class and not available to the hall nurse. She added the RNCM for the other hall or any other RN in the building could have covered and

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answered any questions Nurse #1 may have had. The RNCM stated Nurse #1 came in while she was teaching her class and stated she had an elevated PT/INR. The nurse stated she instructed Nurse #1 to let the PCP know and follow the protocol. The RNCM stated Nurse #1 did not mention Resident #4 had petichiae on his cheeks, but added the resident's cheeks were usually rosy. The nurse identified herself as the author of the unsigned note for 1/8/15 at 4:45 PM and stated the back pain internal bleeding.. She stated the facility followed the PCP's orders, the PCP was aware the PT/INR remained elevated even after giving 3 doses of Vitamin K, there was no signs and symptoms of bleeding and bruising, so therefore, there was no reason to send Resident #4 to the hospital prior to the PCP's order to transfer.

A telephone interview was held with Nurse #3 on 3/20/15 at 3:20 PM. She had worked the 11-7 shift that started on 1/7/15. Nurse #3 stated she remembered the resident's PT/INR being elevated because she received the information in report to monitor the resident for bruising and bleeding. The nurse stated she received report from the 3-11 nurse.

A telephone interview was held with Nurse #2 on 3/20/15 at 3:22 PM. Nurse #2 stated she had been the 3-11 supervisor on 1/7/15. Nurse #2 stated she had not received report on Resident #4's elevated PT/INR; adding she only became aware when the lab called her with the critical value for the PT/INR around 7:00 PM on 1/7/15. The nurse added she immediately went to the hall to notify Nurse #4 not to give the resident his scheduled Coumadin. Nurse #4 told her she had given Resident #4 his Coumadin around 5:30 PM

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to 6:00 PM. Nurse #2 reported Nurse #4 stated she had not received information in report that Resident #4's PT/INR was elevated. Nurse #2 stated she assessed the resident and he had no bruising or bleeding and then notified the PCP he had received his Coumadin earlier in the shift. After finding out Resident #4 received his Coumadin, Nurse #2 stated she called the unit's RNCM and Nurse #1. The nurse stated when she spoke with the RNCM for the day shift, she was told the RNCM had taught a class and had forgotten to write the order to hold the Coumadin on the MAR. The nurse added when she spoke to Nurse #1, she had been told the nurse had told the Director of Nursing (DON) about the elevated Coumadin and was told to tell the RNCM. Nurse #2 stated Nurse #1 could not write an order to hold the Coumadin since LPNs were not allowed to write Coumadin orders. On 1/8/15, Nurse #2 stated she arrived for work between 2:30 and 3:00 PM. At that time, she observed Resident #4 had blood in his mouth. She stated that was when the PCP was notified and Resident #4 was sent to the hospital.

A telephone interview was held with Nurse #4 on 3/20/15 at 3:33 PM. She stated she had worked on 1/7/15 during the 3-11 shift and had been assigned to care for Resident #4. Nurse #4 stated she had not received information in report about the resident's PT/INR being elevated. She acknowledged she had given the Coumadin because the MAR did not say to hold the Coumadin. She stated after the Nurse #2 received the critical lab results, she immediately notified her along with orders to give Vitamin K, which was given. Nurse #4 stated after the incident, she was re-educated by the DON on what to do if a resident's PT/INR was elevated. The nurse stated she completed a medication

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F 329	Continued From page 7 error report. An interview with the RNCM on 3/20/15 at 3:57 PM. The RNCM stated someone, she was not sure who, called her at home to let her know the Coumadin had been given on 1/7/15. The RNCM stated she instructed the person to call the PCP since the Coumadin should not have been given. The nurse added the facility policy was to hold Coumadin if the INR was over 3 unless there was a specific order from the PCP directing otherwise. The RNCM stated if she had been working on the floor on 1/7/15 she would have been responsible to write the hold order for the Coumadin, but since she was teaching a class any other RN could have written the order. She was unaware if Nurse #1 had reported the elevated Coumadin to the 3-11 shift. Prior to this incident, the RNCM stated it had been put into policy that only RNs could write Coumadin orders. She stated after this incident with Resident #4 she had also in-serviced the nurses on the 300-400 halls. The RNCM stated it was done as a group meeting using the Coumadin policy and sign in sheets had not been used. The RNCM stated one clinical manager was expected to report to the on-coming clinical manager, but since she had been teaching she had not reported to the 3-11 clinical manager on 1/7/15. The nurse added with her absence it would have been Nurse #1's responsibility to give report to the 3-11 supervisor, who on 1/7/15, was Nurse #2. A telephone interview was held with Resident #4's PCP on 3/20/15 at 4:49 PM. He stated even if he had not given a direct order, he would have expected the Coumadin to be put on hold until the lab results were received. He stated he was unaware the resident received Coumadin 7.5 mg on 1/7/15 with staff having knowledge the	F 329		

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resident's INR was greater than 8. The MD stated the resident was already at risk of bleeding, so getting the extra Coumadin did not put him at a greater risk.

An interview was held with the DON on 3/20/15 at 5:55 PM. She stated Coumadin orders including testing schedule was determined by the PCP. The nurse that completed the PT/INR was responsible for logging the results on the Coagulation log. The results are then given to the RNCM who in turn reports to the PCP. The RN is then responsible to receive orders, transcribe and fax the new Coumadin orders. The DON stated facility policy indicated if the INR is above 3, then the Coumadin was held. Even if the PT/INR result was not given in report, the nurse giving the Coumadin was expected to read the notes on the Coagulation Log Sheet and hold the Coumadin if the INR was greater than 3. The DON stated Nurse #1 that worked on 1/7/15 could have written the order to hold the Coumadin, but added her preference was only RNs write Coumadin orders. If the RNCM was unavailable, she added Nurse #1 could have gotten any other RN to write the order. The DON added after she realized Resident #4 received the Coumadin with an elevated INR, she spoke with staff. Nurse #1 told her she gave report to Nurse #4, but Nurse #4 stated she had not received report. In addition to giving verbal reports, nurses are expected to log significant events on the 24 hour report sheet. The DON stated she spoke to the 2 nurse's involved and asked the RNCM to speak with the other nurses to make sure they understood the policy. The DON stated she had not audited other residents on Coumadin to assure no errors had been made. The DON stated she had recently done an in-service on

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shift report and communication. She added she had in-serviced because in reading the 24 hour shift report she could not get a clear idea of what had gone on during her absence.

On 3/20/15 at 8:41 PM, the PCP was again interviewed. He stated any resident with an increased INR is at risk of bleeding; adding that the higher the INR, the higher the risk. The PCP stated when a dose of Coumadin was changed, it took approximately 3 days for the effects to be noted. The effects of Vitamin K, he added, was not noted for 24 to 48 hours after being given. The PCP stated the critical lab value was reported around 7:00 PM on 1/7/15. He ordered Vitamin K to be given. He stated he could not remember ordering a repeat PT./INR at 11:00 PM since there would have been no expectation in a difference in the INR since Vitamin K takes at least 24 hours to work. The PCP stated while intramuscular (IM) Vitamin K worked faster, there was really no measurable difference between IM and Vitamin K taken orally. He stated on 1/8/15 at 8:00 AM when the order was given for Vitamin K STAT (now,quickly), it was not critical that it be done STAT, but he expected his orders to be followed within a reasonable time and 3 hours for a STAT order was not reasonable. The PCP stated he was unaware Coumadin 7.5 mg was given after 1/7/15 at 12:30 PM when an elevated PT/INR was identified. He stated there was no need to transfer the resident to the hospital as long as the resident was not actively bleeding Resident #4 could be managed in the facility with Vitamin K.

The DON presented the 24 hour report for 1/7/15. Information about the elevated PT/INR, the risk of bleeding or information about the Vitamin K

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F 329	Continued From page 10 Resident #4 received was not included. The DON acknowledged the lack of information about the PT/INR and stated it should have been included.	F 329		