STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345340	A. BUILDING _____ B. WING _____	09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LEAF HEALTH CARE	2640 DAVIE AVENUE STATESVILLE, NC 28625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide leg supports for one (1) of three (3) sampled residents. (Resident #34). The findings are: Resident #34 was admitted with diagnoses including Alzheimer's dementia and hypertension. Resident #34's most recent Minimum Data Set, a 30 day dated 07/02/12 assessment, coded her with long and short term memory impairments, severely impaired decision making skills, being nonambulatory and requiring extensive assistance for bed mobility, transfers, dressing, eating, toileting and hygiene. She was coded with balance problems and the need for human assistance to maintain balance when moving from a seated to standing position and during surface to surface transfers. An incident report dated 08/16/12 at 10:30 PM revealed Resident #34 was being pushed in her room by a nurse aide when the resident leaned	F 246	1. Foot and leg supports were issued to Residents #34. OT re-evaluated resident #34 for proper positioning in the Rock and Go Wheelchair and provided required treatment to maintain proper wheelchair positioning. 2. All residents have the potential to be affected by this alleged deficient practice. The OT, ADON and Unit Manager will complete an audit of all residents currently utilizing wheelchairs to verify proper wheelchair positioning. Therapy referrals were initiated for those residents in need of further therapy evaluation and treatment to maintain proper wheelchair positioning. This audit will be completed by October 18, 2012. 3. All Nursing and Therapy staff will be re-educated by the Rehab Manager or Designee on observation of proper wheelchair positioning, appropriate use of positioning devices and equipment including foot and leg supports and referrals to therapy for needs as identified. 4. The Rehab Manager will randomly observe 10 residents to verify proper wheelchair positioning weekly for 4 weeks, then monthly for 2 months, results will be documented on the Wheelchair Positioning audit tool. Opportunities identified as a result of these observations and reviews will be corrected by the Rehab Manager. The results of these observations and reviews will be reported during the monthly QAPI meeting by the Rehab Manager or Designee, the committee will evaluate and make recommendations as indicated. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	10/18/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sherrill Simon | TITLE: Senior Administrator | (X6) DATE: 10/11/12

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 246	Continued From page 1 forward and fell from her wheelchair. Review of her care plans revealed her fall care plan was updated 08/17/12 to include the recent addition for a rehabilitation referral for a rock and go wheelchair. An Occupational Therapy (OT) evaluation dated 08/22/12 noted that back in June 2012 Resident #34 had been in a wheelchair, which she propelled by using her hands and the hall handrails. She was referred to therapy following a fall which led to decreased activities of daily living skills. This evaluation noted Resident #34 was issued a rock and go wheelchair along with continuing therapy treatments. Resident #34 was observed as follows: *On 09/17/12 at 12:20 PM, resident in her room in a rock and go wheelchair with her feet dangling, not touching the floor. *On 09/18/12 at 9:53 AM, resident in her room in a rock and go wheelchair with her feet dangling, not touching the floor. *On 09/18/12 at 1:09 PM, resident in her room in a rock and go wheelchair with her feet dangling, not touching the floor while being fed by staff. *On 09/18/12 at 2:28 PM, resident in her room in a rock and go wheelchair with her feet dangling, not touching the floor. At this time, Nurse Aide (NA) #1 stated Resident #34 had not been in a rock and go wheelchair for very long. *On 09/19/12 at 7:55 AM, resident in her room in a rock and go wheelchair with her feet dangling, not touching the floor. *On 09/19/12 at 11:09 AM, resident in an activity in a rock and go wheelchair with her feet dangling, not touching the floor.	F 246		

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F 246	Continued From page 2 *On 09/19/12 at 12:02 PM, resident in a rock and go wheelchair with her feet dangling, not touching the floor. NA #1 stated at this time, Resident #34 had never had any leg rests on her rock and go wheelchair since she has had it. On 09/19/12 at approximately 1:00 PM, the Occupational Therapist (OT) stated that a rock and go wheelchair was implemented following a fall from her wheelchair. She stated that all rock and go wheelchairs come with foot pedals. She stated Resident #34 was still receiving OT therapy but was about to reach her maximum potential. When asked about the foot pedals, OT stated Resident #34 has had no problems with edema or foot drop. She then stated that at one time all rock and go wheelchairs were checked and foot rests were provided. On 09/19/12 at 1:29 PM, OT introduced the surveyor to a rehabilitation technician who checked and provided all the rock and go wheelchairs with foot rests. The rehabilitation technician was then interviewed and stated he made sure Resident #34 was provided foot rests when she was issued a rock and go wheelchair. At 1:34 PM the rehabilitation technician stated he again placed foot rests on Resident #34's rock and go wheelchair. When asked why she needed foot rests, he stated because her legs were dangling. On 09/19/12 at 1:35 PM, NA #1 was interviewed again. NA #1 stated Resident #34 always had foot rests on the regular wheelchair when she used it. NA #1 did not recall ever seeing foot rests on the rock and go wheelchair for Resident #34. She then checked the care guide, she kept	F 246		

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F 246	Continued From page 3 in her pocket. (The care guide is provided daily to nurse aides with individual information for each resident.) She explained that if Resident #34 needed foot rests on the rock and go wheelchair, it would be listed on the care guide and showed the surveyor there was nothing about foot rests for Resident #34. NA #1 stated most of the time, she reclined Resident #34 in the rock and go wheelchair. Interview with the hall Licensed Nurse (LN) #4 on 09/19/12 at 1:48 PM revealed she had never seen Resident #34 with foot rests when she was in the rock and go wheelchair. She further stated that she had noticed Resident #34's legs dangling when she was in the rock and go wheelchair. On 09/19/12 at 2:52 PM the Director of Nursing (DON) stated Resident #34 had problems with leaning when in she was in a regular wheelchair. The DON stated it was up to therapy to ensure the rock and go wheelchair was an appropriate fit for each resident. When asked about Resident #34's legs dangling, DON stated she was more comfortable in the rock and go wheelchair. She would not comment on whether or not Resident #34's legs should be unsupported. On 09/19/12 at 4:29 PM, NA #2 who worked evenings stated she saw foot rests on the rock and go wheelchair "maybe just one day" after Resident #34 was issued the rock and go wheelchair. She stated after that, the leg rests were not in the room so she figured they were not needed anymore. She stated she did not ask any one about the need for foot rests on the rock and go wheelchair.	F 246		

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F 246	Continued From page 4 On 09/20/12 at 1:49 PM, during an interview, the Administrator and DON stated the care guides would not necessarily be so specific as to include the need for foot rests. When asked how nurse aides would know that foot rests were needed, the Administrator and DON stated it would be communicated verbally but not necessarily written somewhere. Another interview was conducted with OT on 09/20/12 at 1:55 PM. During this interview, OT again stated there had been no edema or foot drop identified for Resident #34. OT stated they would not wait for edema or foot drop before issuing foot rests. OT was not specific as to whether Resident #34's legs needed to be supported when she was up in the rock and go wheelchair.	F 246		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow physician orders for one (1)of of twelve (12) sampled residents. Resident #155 did not receive Vitamin D daily as ordered. The findings are: Resident #155 was admitted to the facility with diagnoses including Vitamin D deficiency. The admission orders dated 09/05/12 included Vitamin D 1000 international units (IU) to be	F 281	1. The Medication Administration Record (MAR) was corrected for Resident #155. A medication variance report was completed for Resident #155. The physician and responsible parties were notified by the Unit Manager. 2. All residents have the potential to be affected by this alleged deficient practice. The DON, ADON and Unit Manager will conduct an audit of all Physician orders for current residents to ensure orders are transcribed correctly by October 18, 2012. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	10/18/12

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F 281	Continued From page 5 administered by mouth daily. The admission orders were signed by Nurse #3 and the Assistant Director of Nursing (ADON). The Minimum Data Set dated 09/12/12 coded Resident #155 with long and short term memory impairment and moderately impaired decision making skills. Review of the September Medication Administration Record (MAR) revealed Vitamin D was not included on the MAR for September and there was no record of Vitamin D being administered to Resident #155 since admission 09/05/12 through 09/19/12. Interview with LN #4 on 09/20/12 at 7:50 AM revealed she had not been administering the Vitamin D as it was not listed on the MAR. LN #4 stated the Vitamin D was ordered and should have been on the MAR and been administered daily since admission. She further stated that two nurses check the orders for accuracy and the nurse who took the orders transcribed them to the MAR. On 09/20/12 at 8:48 AM the ADON stated she checked the transcribed orders from the hospital records to ensure accuracy. She further stated that she did not necessarily check the MAR for accuracy, however, the nurse transcribing the medications to the MAR should have gotten another nurse to recheck and sign off the MAR for accuracy. The ADON also stated the next day, the entire admission would be reviewed the next day by an administrative nurse, one of a team that shared this responsibility, as a double check to catch mistakes. The ADON confirmed	F 281	3. All Licensed Nurses will be re-educated by the Director of Nursing or Designee regarding receiving and transcribing physician orders by October 18, 2012. 4. The Director of Nursing and Designee will randomly review 5 admission or re-admission physician's orders and 10 physician's orders weekly for 4 weeks then monthly for 2 months to verify accuracy of transcription, results will be documented on the audit tool. Opportunities identified as a result of these audits will be corrected daily by the ADON and Unit Manager. The results of these audits will be reported during the monthly QAPI meeting by the Director of Nursing, the committee will evaluate and make recommendations as indicated. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	10/18/12

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F 281	Continued From page 6 there were no initials on the MAR indicating administrative nursing staff rechecked the MAR for accuracy. LN #3 who transcribed the admission orders for Resident #155 was interviewed via phone on 09/20/12 at 10:13 AM. She stated she verified the orders with the physician and transcribed the orders to the MAR. She stated that usually the ADON came behind her and rechecked both the orders and the MAR. She thought they shared this particular admission, each completing part of the admission routine. She stated she just "overlooked" the Vitamin D order when filling out the MAR. On 09/20/12 at 2:12 PM the Director of Nursing stated two nurses were to review each new admission and verify accuracy of the orders and the MAR.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide nail care to one (1) of four (4) sampled residents. (Resident #136). The findings are:	F 312	1. Resident #136 received nail care. 2. All residents have the potential to be affected by this alleged deficient practice. ADON, Unit Manager and Designees will complete an audit of all residents and provide nail care for those residents identified. 3. All Nursing Staff will be re-educated by the ADON and Unit Manager on providing nail care and ADL assistance including hand hygiene during bathing and showering by October 18, 2012. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	10/18/12

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F 312	Continued From page 7 Resident #136 diagnoses included paralysis agitans, anemia, paroxatrial tachycardia, hypertension, pressure ulcer, dementia, depressive disorder, acute renal failure, tube feeding placement and Parkinson's Disease. The Minimum Data Sets (MDS), a quarterly dated 08/02/12 coded Resident #136 as having moderately impaired cognition and requiring extensive assistance with bed mobility, dressing, and hygiene. A care plan was last updated on 08/02/12 for the problem of requiring extensive to total assistance to complete activities of daily living skills (adls). The goal was to have adls needs met with staff assistance while maintaining independence to wash face, brush teeth, and brush hair. The current September 2012 computerized physician order sheet included for Resident #136 to receive nail care every Monday during the 7 AM - 3 PM shift to include checking fingernails and toenails and trimming and cleaning them as needed. Resident #136 was observed in bed with black residue under all ten fingernails, some long some short as follows: *On 09/18/12 at 9:12 AM; *On 09/18/12 at 1:36 PM; and *On 09/19/12 at 8:10 AM. On 09/19/12 at 9:03 AM, Resident #136 was observed receiving morning care by Nurse Aides (NA) #3 and #4. He was washed with a wash cloth and no rinse spray soap. His fingernails	F 312	4. The Director of Nursing and designee will randomly observe 10 residents weekly for 4 weeks and then monthly for 2 months to verify nail care and ADL assistance has been provided, results will be documented on the audit tool. Opportunities identified as a result of these observations and reviews will be corrected daily by the ADON and Unit Manager. The results of these observations and reviews will be reported during the monthly QAPI meeting by the Director of Nursing, the committee will evaluate and make recommendations as indicated. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	10/18/12

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F 312	Continued From page 8 were observed with black residue under them and his nails were not cleaned during this care observation. Resident #136's fingernails remained with black residue under them on 09/19/12 at 11:45 AM and on 09/19/12 at 2:45 PM. NA #3 was interviewed on 09/19/12 at 2:45 PM. NA #3 stated Resident #136 did not receive showers but instead received a complete bed bath on shower days. She stated she cleaned his nails yesterday using a nail stick to extract the black residue but only used a wash cloth today. She gave no reason why she did not ensure his nails were clean this date. On 09/19/12 at 5:00 PM, the Director of Nursing (DON) was interviewed. She stated nails should be clean and trimmed. She related that Resident #136 tended to dig in his incontinent brief at times. The DON stated Resident #136 had clean nails last Thursday and she observed NA #3 cleaning them this date. She stated Resident #136's nails also needed trimming.	F 312		
F 329 SS=E	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.	F 329	1. Medication variance reports were completed for Residents # 6, 68, and 113. The physicians and responsible parties were notified by the Unit Managers. A clarification order for Coumadin dosage was obtained as well as orders for PT/INR monitoring. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	10/18/12

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F 329	Continued From page 9 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 record review, policy review, and staff interviews, the facility failed to monitor anticoagulant laboratory results as ordered and obtain physician consultation to ensure the anticoagulation medication dosage was appropriate for three (3) of four (4) sampled residents. (Residents #6, #68 and #113). The findings are: Review of the facility's policy titled Anticoagulation Therapy revised June 2008 read in part, "Effectively monitor residents receiving anticoagulant therapy and reduce the risk of bleeding by maintaining therapeutic blood levels in accordance with physician orders. · Initiate and order anticoagulant therapy labs per physician's order. · Document lab result, current dosage, and physician orders on the Anticoagulant Therapy	F 329	2. All residents receiving Coumadin have the potential to be affected to be by this alleged deficient practice. The DON, ADON and Unit Manager completed an audit of all residents receiving Coumadin and verified current ordered dose, obtained clarification orders for PT/INR monitoring and initiated the Anticoagulant Tracking Log for each resident on 9/20/12 3. All Licensed Nurses will be re-educated by the ADON and Unit Manager on the Coumadin management guideline including obtaining and transcribing physician orders for Coumadin and PT/INRs, utilizing the Anticoagulant Tracking Log to monitor lab results and track Coumadin doses, timely notification of physicians when PT INR results are received, and obtaining and processing physician's orders for labs according to the Lab Management guideline by October 18, 2012. 4. The Director of Nursing or Designee will monitor residents receiving Coumadin utilizing the Anticoagulant Tracking Log daily during the morning Stand Up meeting. The Log will be reviewed to verify accurate Coumadin dosages, timely completion of PT/INRs . timely physician notification of lab results and obtaining orders for ongoing monitoring of PT/INRs. Opportunities identified as a result of these observations will be corrected daily by the ADON and Unit Manager. The results of these audits will be reported during the monthly QAPI meeting by the Director of Nursing, the committee will evaluate and make recommendations as indicated. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	10/18/12

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F 329	Continued From page 10 Flow Sheet" 1. Resident #68 was admitted to the facility with diagnoses including deep vein thrombosis and chronic Coumadin anticoagulation use. On 05/29/12 physician telephone orders included to decrease Coumadin to 5 milligrams (mg) every day with the Prothrombin Time with International Normalized Ratio (PT/INR) to be rechecked in one week. On 06/04/12 the PT/INR results were 32.5 / 3.16. A physician's telephone order dated 06/28/12, taken by Nurse #3, included "clarification from 6/4" to continue Coumadin 5 mg every night and recheck PT/INR in four (4) weeks. Review of the June 2012 Medication Administration Record (MAR) revealed Coumadin was administered 5 mg daily as ordered. In addition, the MAR included a section for "PT/INR weekly info only" that was blank with no indication of any lab testing being completed. This section was crossed out with the handwritten note that it was discontinued on 06/28/12. Review of the medical record and laboratory testing revealed there was no PT/INR completed after 06/04/12 until 08/02/12. Interview with the Director of Nursing (DON) on 9/19/12 at 3:04 PM revealed the new order dated 06/04/12 for the PT/INR to be drawn in four weeks was not transcribed to the laboratory calendar and therefore not completed as ordered. The pharmacy review dated 07/25/12 questioned the need for PT/INR testing which, according to	F 329		

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F 329	Continued From page 11 the corporate nurse resulted in the PT/INR being drawn 08/02/12. The July 2012 MAR reflected that Coumadin 5mg was administered every day. The PT/INR dated 08/02/12 results were 21.2 / 1.77. Review of physician telephone orders revealed an order on 08/06/12 which did not specify any orders for Coumadin dosages (i.e. to keep the same or to change dosages) but did include repeating the PT/INR in one week on 08/09/12. The August 2012 MAR reflected Coumadin 5mg was administered at 5mg per day 08/01/12 through 08/09/12. The PT/INR dated 08/09/12 results were 20.3 / 1.67. Physician telephone orders dated 08/10/12 included changes to Coumadin dosages (6 mg on Tuesday and Thursday and 5 mg the other days) and to recheck the PT/INR in one week. The August MAR included printed instructions for PT/INR to be checked weekly and hand written note dated 08/10/12 to recheck PT/INR in one week. Both entries were blank indicating no nurse signed that the lab draw was completed. The PT/INR on 08/16/12 was 34.6 / 3.30. Although there was evidence that this was faxed to the physician on 08/16/12, there were no new orders to continue the Coumadin or change the dosage or to repeat the PT/INR until 09/07/12. The MAR reflected Coumadin was administered as ordered on 08/10/12 from 08/10/12 until 09/08/12. Review of the laboratory results in Resident #68's record revealed blood draws for PT/INR were	F 329		

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F 329	Continued From page 12 obtained as follows: *on 08/30/12 PT/INR was 31.7 / 5.9 and there was no physician order to continue or change coumadin therapy. *on 09/06/12 PT/INR was 16.3/ 1.7 and a physician's telephone order dated 09/07/12 changed the Coumadin dosage (5mg Tuesday, Thursday and Saturday and 6 mg Monday, Wednesday, Friday and Sunday) and recheck PT/INR in one week on 09/13/12. *on 09/13/ 12 PT/INR was 20.2 / 2.5 with physician's telephone orders to continue current Coumadin orders and recheck PT/INR in one week on 09/20/12. Review of the September 2012 MARs revealed printed instructions for PT/INR to be checked weekly and hand written entries dated 09/07/12 and 09/13/12 to recheck the PT/INR in one week. These entries were blank indicating no nurse signed that the lab draw was completed. On 9/19/12 at 3:04 PM the DON stated that PT/INRs were drawn only as the physician orders them. She further stated that here was no physician's order for routine PT/INR draws for Resident #68 since 06/04/12. On 09/20/12 at 10:17 AM Nurse # 3 was interviewed via phone. She stated that once an order for PT/INR was issued, the PT/INR was placed in the lab book to make sure it was drawn as ordered as well as being placed on the MAR. Nurse #3 then stated once the results were received, they were faxed to the physician. The physician then should fax back the response to include the Coumadin dosage and next planned lab draw. If the physician did not respond, the	F 329		

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F 329	Continued From page 13 nurses followed up with the physician within the day. If the physician failed to provide the next lab date, the nurses would obtain clarification from the physician. She stated she may have missed placing the lab orders per the physician order of 06/04/12 in the lab book. She stated the mistake should be caught at the end of the month when orders are rechecked for accuracy. On 09/20/12 at 10:31 AM the Assistant Director of Nursing stated the physician orders were checked monthly ensure labs are completed timely. On 09/20/12 at 1:20 PM interview with the DON and Administrator revealed the problem with the laboratory was identified in June or July and a change was made in lab companies. There were still problems being worked out and training needed to be ongoing as not all nurses had been trained in the new lab software. 2. Resident #113 was admitted to the facility on 01/26/12 with the diagnoses of dementia, osteoarthritis, and a history of deep vein thrombosis. Review of Resident #113's most recent Quarterly Minimum Data Set (MDS) dated 06/25/12 revealed he was assessed as having long and short term memory loss as well as difficulty with daily decision making. Review of Resident #113's care plan dated 04/03/12 revealed he was at risk for increased bleeding, bruising, and injury related to use of anticoagulant therapy, he receives Coumadin. Interventions in place for Resident #113 among others was to monitor labs as ordered.	F 329		

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F 329	Continued From page 14 Physician orders dated 08/01/12 revealed an order for Prothrombin Time/International Normalizing Ratio (PT/INR) to be drawn on the next lab day, then monthly due to continued use of Coumadin. The previous PT/INR had been done on 05/31/12 with no orders to recheck PT/INR. Review of physician orders dated 08/03/12 revealed an order to increase the Coumadin dose, alternate 9 mg with 10 mg daily and to recheck PT/INR in one week (08/10/12). Review of Resident #113's Medications Administration Record (MAR) for the month of August 2012 revealed he received Coumadin 9 milligrams (mg) alternating with 10 mg every other day starting 08/03/12. This dose continued through 08/31/12. Review of Resident #113's medical record revealed there were no laboratory results for PT/INRs dated after 08/03/12. On 09/18/12 at 4:20 PM an interview was conducted with Nurse #2. Nurse #2 reported she noted the physician's order dated 08/03/12 for the PT/INR that was to be drawn on 08/10/12. She stated their process for labs was that a lab that was due was written in the Lab Book calendar. She stated she continued to give the Coumadin as ordered 9 mg alternating with 10 mg daily. She stated she would not know the results of the PT/INR or if the dose had been changed unless it was written as a physician's order in the medical record. During an interview on 09/18/12 at 4:50 PM with	F 329		

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F 329	Continued From page 15 the Director of Nursing (DON) she stated the process for labs is after the order is received from the doctor the nurse puts the order in the lab book. If the lab was not put in the lab book no one knows to draw the lab. She stated the lab for 08/03/12 was not written into the Lab book by the nurse. She was unable to say if there was a system in place to make sure the lab was drawn. An interview was conducted with the Unit Manager in charge of labs on 09/18/12 at 4:50 PM. When asked if there is a process to check to make sure the labs were drawn she stated there was not. She further stated the current Anticoagulant Therapy policy had been in effect since June of 2008. She stated the facility had not been using the Anticoagulant Therapy Flow Sheet. During an interview on 09/20/12 at 2:00 PM with the DON she stated it was her expectation that the nurse should have written in the Lab Book the PT/INR that was to be drawn on 08/10/12. Review of physician orders dated 08/01/12 revealed an order to check PT/INR (Prothrombin Time and International Normalized Ratio) on the next lab day (08/03/12), then monthly (09/03/12) due to continued use of Coumadin. Review of Resident #113's medical record revealed no indication that the lab was drawn or received on 09/03/12. Review of MARs dated September 2012 revealed Resident #113 continued to receive 9 mg of Coumadin alternating with 10 mg every other day until 09/18/12.	F 329		

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F 329	Continued From page 16 An interview was conducted on 09/18/12 at 4:20 PM with Nurse #1. She stated she had called the lab on 09/18/12 to find out when the last PT/INR was drawn. She reported the girl at the lab stated the blood sample that had been collected on 09/03/12 was an inadequate sample. Nurse #1 further reported the lab girl stated she had called the facility on 09/03/12 and was put on hold for an extended period and eventually hung up. An interview was conducted on 09/20/12 at 9:18 AM with the Unit Manager in charge of labs. She stated the facility had a new laboratory they are using to process labs. She stated not all nurses had been trained on the new system. She stated at the time there was not a process in place to that would have caught the PT/INR result not coming back to the facility. An interview was conducted with the DON on 09/20/12 at 2:00 PM. She stated she would have expected the Lab Book to be checked daily to make sure the results of the PT/INR that was drawn 09/03/12 came back to the facility. 3. Resident # 6 was admitted 09/09/08. Diagnoses included atrial fibrillation with Coumadin anticoagulation use. Review of care plan dated 07/05/12 identified bleeding risk related to anticoagulant therapy. Care plan approaches included monitoring labs as ordered. Review of Physician Order Sheets (POS) for June 2012 revealed Coumadin 2.5 mg	F 329		

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F 329	Continued From page 17 (milligrams) by mouth daily. Review of POS also revealed orders for monthly Prothrombin Time with International Normalized Ratio (PT/INR). Review of PT/INR labs dated 06/11/12 revealed PT of 23.7 and INR of 2.04. Physician order dated 06/13/12 indicated to recheck PT/INR in 1 month with no indication to change Coumadin dosage. Medication Administration Record (MAR) dated June 2012 indicated Coumadin 2.5 mg by mouth every evening was continued. Review of the medical record and laboratory calendar revealed there was no PT/INR completed after 06/11/12 until 08/02/12. The pharmacy review dated 07/25/12 questioned the need for monthly PT/INR testing for July 2012. Interview on 09/20/12 at 8:20 AM with the Director of Nursing (DON) stated review of pharmacy recommendations resulted in the PT/INR being drawn 08/02/12. Review of PT/INR labs dated 08/02/12 revealed PT of 39.5 and INR of 3.9. Physician order dated 08/03/12 indicated to hold Coumadin 08/03/12 through 08/05/12, then begin Coumadin 2mg every evening and recheck PT/INR in 1 week. Review of PT/INR labs dated 08/10/12 revealed PT of 15.2 and INR of 1.15. Physician order dated 08/10/12 indicated to give Coumadin 4mg tonight then start Coumadin 3mg every evening and recheck PT/INR in 2 weeks. PT/INR labs dated 08/24/12 through 09/11/12 were completed as ordered with Physician orders for changes to Coumadin dosage as indicated.	F 329		

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F 329	Continued From page 18 On 09/19/12 at 11:04 AM an interview was conducted with the Unit Coordinator. The Unit Coordinator stated nurses took orders from the Physician and wrote labs due on the laboratory calendar. Night shift nurses would complete lab requisitions for each days scheduled lab work for the lab tech to draw blood work. The Unit Coordinator stated during daily morning meetings she assisted to review all orders from the previous day to make sure labs ordered were written on the calendar. Review of the lab calendar for July 2012 revealed no documentation of monthly PT/INR scheduled for Resident #6. The Unit Coordinator stated the orders for the monthly PT/INR was not transcribed to the calendar and must have been missed when verifying daily Physician orders dated 6/13/12 for Resident #6 to have PT/INR to be drawn for July 2012. On 09/20/12 at 10:20 AM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that she verified the July 2012 monthly Physician Order Sheets for Resident # 6. The ADON stated that when she verified the MARs for July 2012 she would normally check to make sure labs ordered were written on the laboratory calendar as indicated. The ADON stated the monthly PT/INR was not transcribed to the calendar for July 2012 and that she must have missed that when verifying the MARs. On 09/20/12 at 1:20 PM an interview was conducted with the Director of Nursing (DON). The DON stated that she would have expected	F 329		

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F 329	Continued From page 19 orders for monthly PT/INR lab work to be completed as ordered.	F 329		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain a physician's order before doing laboratory testing on one (1) of twelve (12) sampled residents. (Resident #68). The findings are: Resident #68 was admitted to the facility with diagnoses including deep vein thrombosis and chronic Coumadin anticoagulation use. A physician's order dated 05/29/12 included to decrease Coumadin to 5 milligrams (mg) per day and recheck Prothrombin Time with International Normalized Ratio (PT/INR) in one week. Review of the laboratory results in Resident #68's medical record revealed a PT/INR was drawn on 06/01/12 without a physician's order. A PT/INR was also drawn on 06/04/12 per the physician's order of 05/29/12. PT/INRs were drawn without physicians' orders as follows: *08/02/12; *08/30/12;	F 502	1. A medication variance report was completed for Residents # 68. The physician and responsible party were notified by the Unit Managers. A clarification order for Coumadin dosage was obtained as well as orders for PT/INR monitoring. 2. All residents receiving Coumadin have the potential to be affected to be by this alleged deficient practice. The DON, ADON and Unit Manager completed an audit of all residents receiving Coumadin and verified current ordered dose, obtained clarification orders for PT/INR monitoring and initiated the Anticoagulant Tracking Log for each resident on 9/20/12 3. All Licensed Nurses will be re-educated by the ADON and Unit Manager on the Coumadin management guideline including obtaining and transcribing physician orders for Coumadin and PT/INRs, utilizing the Anticoagulant Tracking Log to monitor lab results and track Coumadin doses, timely notification of physicians when PT INR results are received, and obtaining and processing physician's orders for labs according to the Lab Management guideline by October 18, 2012. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	10/18/12

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F 502	Continued From page 20 *09/06/12; and *09/14/12. A pharmacy review dated 07/25/12 identified a missed PT/INR in July 2012. There was no new order for the PT/INR that was completed 08/02/12. A PT/INR was completed on 08/16/12 as ordered by the physician on 08/10/12. Although the results were faxed to the physician on 08/16/12, there were no physician orders for the PT/INRs drawn on 08/30/12 and on 09/06/12. Following the PT/INR drawn on 09/06/12 the physician ordered PT/INR to be drawn in one week on 09/13/12. This was completed, however, review of the laboratory results revealed Resident #68 also had a PT/INR drawn on 09/14/12 without a physician's order. After reviewing the laboratory results, interview on 09/20/12 at 1:20 PM with the Administrator, Director of Nursing and the corporate nurse confirmed PT/INR laboratory testing was completed on Resident #68 without physician's order. Staff confirmed PT/INR testing should only be completed with a physician's order. Staff further stated they changed laboratory companies due to identified problems. According to staff, Resident #68's name was placed in the new computer system provided by the new laboratory company for routine PT/INRs based on the existing facility's lab book and not necessarily the physician's orders. When the physician ordered another PT/INR, the existing routine orders were not changed and so extra laboratory draws were completed in August.	F 502	4. The Director of Nursing or Designee will monitor residents receiving Coumadin utilizing the Anticoagulant Tracking Log daily during the morning Stand Up meeting. The Log will be reviewed to verify accurate Coumadin dosages, timely completion of PT/INRs . timely physician notification of lab results and obtaining orders for ongoing monitoring of PT/INRs. Opportunities identified as a result of these observations will be corrected daily by the ADON and Unit Manager. The results of these audits will be reported during the monthly QAPI meeting by the Director of Nursing, the committee will evaluate and make recommendations as indicated. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	10/18/12

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