STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009260	A. BUILDING: _____ B. WING _____	C 03/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANDALIA REHAB & HEALTH CARE C	1500 WEST ST LOUIS AVENUE VANDALIA, IL 62471

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S 000	Initial Comments Complaint Investigation 2151434/IL131457	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 a) 300.1210 b) 300.1220 b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs.	S9999		

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Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These regulations were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to develop and implement a plan of care for monitoring warfarin (Coumadin) for 1 (R14) of 4 residents, failed to implement and include resident specific information for anticoagulation therapy for 3 residents(R1, R5, R15), failed to follow physicians' orders to obtain repeat labs on 2/19/21 after receiving elevated PT/INR (pro time)/(international rate) levels, and/or failed to notify the physician of PT/INR results to obtain further orders for monitoring for 4 (R1, R5, R14, R15) of 4 residents reviewed for monitoring in regard to the use of blood thinning medications in a sample of 41. This failure has the potential to cause serious physical harm (uncontrolled bleeding), and the possibility of death for R1, R5, R14 and R15, all who receive blood thinning medication.

These failures have the potential to affect all 4 residents (R1, R5, R14, R15) residing in the facility, who receive blood thinning medication.

The Findings Include:

1. R1's Profile Face Sheet documents that R1

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S9999	Continued From page 3 re-admitted to this facility most recently on 4/01/20, with diagnoses in part of acute respiratory failure with hypoxia, morbid obesity due to excess calories, need for assistance with personal care, cardiomyopathy, atrial fibrillation, and atrial flutter. R1's February 2021 Physician's Order Sheet (POS) contains an order for Coumadin 5 mg (milligram) tablet po (by mouth) once a day, with a start date of 4/02/20. R1's care plan did not contain any documentation regarding the drug Coumadin (Anti Coagulant therapy), how to monitor this drug for potential side effects, or have any interventions in place. On 3/12/21 at 4:05 PM, V1 (Administrator) verified that R1's care plan does not contain any documentation regarding Coumadin, how to monitor for side effects, or any interventions that may be necessary. On 3/19/21, V28 (Floating MDS/CPC Minimum Data Set/Care Plan Coordinator) stated the current care plan for R1 referenced dates between 4/01/20 - 3/16/20 in the computer, but they were unable to include these dates on the printed copies. This surveyor observed R1's care plan to be dated 4/01/20 - 3/16/20 as documented on the facility computer. R1's lab result dated, 2/04/21, documents a PT (pro time) level at 19.3 (normal range - 9.6 - 12.2) and INR (international rate) level at 1.8 (normal range - 0.9 - 1.1). Handwritten orders on this form indicated R1's PT/INR lab was to be repeated on 2/19/21 to re-check these elevated levels. R1's record did not have any PT/INR results for	S9999		

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S9999	Continued From page 4 2/19/21. On 3/11/21 at 9:18 AM, R1 is alert and oriented. R1's room has a blood-soaked hand towel on the floor next to his bed. When asked, R1 stated this is where he puts things that need to go to laundry. R1 continued to state he had a nose bleed through the night that took two hours to get stopped. R1 stated he had also blown out two large clots of blood on the bathroom floor when he was trying to get his nose to stop bleeding, which were also still present on R1's bathroom floor. R1 stated he wasn't sure what caused his nose bleed, guessed it might be dry, stating he felt fine. R1 added when V19 (CNA - Certified Nursing Assistant) came in to his room this morning, she said, "Eeww, I'm not touching that," referring to the bloody towel and blood spots on the floor. R1 stated the housekeeper would take care of the dirty towel and blood when she gets to his room this morning. When asked if he had pushed his call light or called anyone to help during his nose bleed, he stated, "No. It wouldn't have done any good anyway." On 3/11/21 at 11:18 AM, V2 (Resident Care Coordinator - RCC) confirmed V22 (Primary Care Physician - PCP) gave an order on 2/04/21 to repeat R1's PT/INR on 2/19/21, and this lab had documentation from three different LPNs and was still not followed up and completed. On 3/11/21 at 11:03 AM, V20 (Licensed Practical Nurse - LPN) stated she was not aware of R1's nose bleed and did not know if R1's lab was drawn on 2/19/21, but would try and find out. On 3/11/21 at 11:20 AM , V2 (Licensed Practical Nurse) stated staff were overwhelmed with changes in staffing, roles had recently changed, and this order for R1 "just got missed." V2	S9999		

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S9999	Continued From page 5 confirmed R1's lab was not drawn on 2/19/21, and has not been drawn since. On 3/11/21 at 12:30 PM, V2 confirmed she was getting ready to call V22 back and get the order for R1. The process of the facility obtaining a STAT PT/INR lab for R1, from the time V2 was notified of the missed lab on 3/11/21 at 12:30 PM until the time the lab was drawn on 3/12/21 at 3:27 PM, took an additional 15 hours. On 3/11/21 at 11:28 PM, V18 (CNA) stated R1 does not have a history of nose bleed, but R1 did have one yesterday. V18 stated she did not notify anyone else about this. On 3/11/21 at 12:03 PM, V22 (PCP/Medical Director) stated, "The facility obviously messed up by not following up on R1's PT/INR on 2/19/21 as ordered. It sounds like his nose bleed was significant, however, without a lab result to compare his levels, I cannot say whether this is a serious result at this point. His labs were trending down, but if the repeat comes back high, then we have a serious problem. I need to speak with the DON (Director of Nursing) now and order a STAT PT/INR." V22 was re interviewed on 3/16/21 at 8:00 AM, regarding the results of the PT/INR drawn on 3-12-21. V22 stated he was notified of R1's critical lab result on 3/12/21. V22 confirmed this was a serious oversight on the nursing home's part, having had the potential to be a life-threatening situation. On 3/11/21 at 12:03 PM, V22 confirmed he had not been notified by any staff in the facility R1 had a nose bleed. On 3/12/21 at 11:40 AM, V26 stated she was told	S9999		

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the lab was unable to draw blood on R1 last night (3/11/21) and this had not been done. V26 stated she re-ordered a STAT (immediately) lab (within 2 hours) at 11:30 AM.

The PT/INR results dated, 3/12/2021 at 18:00, show a "PT of 70.6 (Normal range 10.2-12.9 seconds) and an INR of 6.0 (Normal range 0.9-1.1) CRITICAL RESULT. Read back to V26 (LPN) at the facility on 3-12-21 at 1759."

On 3/12/21 at 6:19 PM, V26 notified this surveyor of a critical lab result on R1 of INR - 6.0 and PT - 70.6. V26 stated V22 was informed and orders were given to administer Vitamin K 5mg po (by mouth), hold all Coumadin, and repeat CBC (complete blood count), BMP (basic metabolic panel), and PT on Monday, 3/15/21.

On 3/16/21 at 11:55 AM, V20 (Licensed Practical Nurse, LPN) stated she saw blood on R1's nasal cannula and the bloody towel in his room on the morning of 3/11/21 between 6:00 AM and 9:00 when she was passing medication. She stated he told her he had a nose bleed and she thought it might have been from a dry nose and oxygen and could be seasonal allergies. She confirmed she did not document this in R1's chart or call the physician regarding the nose bleed. V20 stated it did not occur to her this may be a side effect of Coumadin. When asked if anyone from the previous night shift had mentioned R1's nose bleed to her, she stated, "Yes, V24 (LPN) saw it."

On 3/17/21 at 11:18 AM, V24 (LPN) stated R1 had told her he had a nose bleed, but she did not see any blood. When asked if any other staff had mentioned this to her, she stated they might have, but she could not really remember.

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S9999	Continued From page 7 V20 and V24 both stated they did not notify V22 (PCP/Medical Director) of R1's nose bleed. 2. On 3/17/21, R14's record was reviewed. R14's Profile Face Sheet documents an admission to this facility on 8/18/18. R14's March 2021 POS documents the following diagnoses in part - History of myocardial infarction with stent placement, congestive heart failure, history of head injury, and atrial fibrillation. R14's March 2021 POS documents an order for Coumadin 3 mg 1 tablet by mouth once a day and Coumadin 1 mg tablet, take ½ tablet by mouth once a day for a total of 3.5 mg daily. R14's care plan was not in the care plan binder, was unable to be located, and at 4:05 PM on 3-12-21, V1 (Administrator) stated R14 did not have a care plan. R14 did not have any monitoring in place in regard to anticoagulant therapy. R14's most recent lab result, dated 3/03/21, documents an elevated PT/INR result of - PT - 20.8 (H) (normal range - 9.6 - 12.2 seconds) and INR - 1.9 (H) (normal range - 09.1 - 1.1). This lab report indicates the facility received these results via fax on 3/03/21 at 2:03 PM. There is no documentation in R14's record indicating V22 (PCP) was notified of the elevated lab values. The facility schedule documents V20 and V26 were working on 3/03/21 from 6:00 AM to 6:00 PM. On 3/17/21 at 12:07 PM, V20 (LPN) stated she did not notify V22 of R14's elevated lab work.	S9999		

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S9999	Continued From page 8 V26 has not returned this surveyor's call at this time. On 3/17/21 at 12:10 PM, V4 (Licensed Practical Nurse - LPN) stated, "The lab has been a problem since we switched. If the lab was not in the chart, we probably didn't get it called to the doctor. V2 (Acting DON - Director of Nursing) tracks the residents on Coumadin and she is not here." V4 confirmed V22 (Primary Care Physician - PCP) was not notified of R5 or R14's abnormal lab results. On 3/17/21 at 12:15 PM, V22 stated he would expect the facility to notify him of any abnormal labs they receive. V22 stated for R14 he would have instructed the facility to continue with the current treatment and dose of Coumadin and repeat PT/INR in 1-2 weeks. On 3/17/2021 at 12:24 PM, when asked if he had been notified of R5 and R14's abnormal lab results, V22 stated, "I was not. If I was notified, they should have made an entry in the resident's record documenting the date and time and reported the results." V22 stated he would have given an order to maintain or change the Coumadin depending on the results, and repeat the PT and INR in one week. 3. R5's Face sheet documents diagnoses in part as Left Above Knee Amputation, Peripheral Vascular Disease, Type 2 Diabetes, and Hypertension. R5's Profile Face Sheet documents admission date of 7/13/2017. R5's March 2021 POS documents the following in part-diagnosis of peripheral vascular disease. An order for Coumadin 5 mg tablet po once a day, with start	S9999		

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S9999	Continued From page 9 date of 12/10/2020. R5's care plan does not contain any documentation regarding Coumadin, how to monitor for side effects, or any interventions that may be necessary. R5's Physician Telephone Orders, dated on 1/19/2021, documents, "Continue same dose of coumadin and recheck Protime in 2 weeks." On 3/17/2021 At 10:00 AM, V1 and V4 were unable to find the 2/2/2021 follow up lab result in R5's chart, and finally called the reference lab to obtain a copy. R5's chart did not reference if the lab was done or if the physician was notified of the results. R5 has no current order for PT/INR follow up. Once this 2/2/21 lab report was obtained the resuts are as follows: PT 26.8 (H) (Normal range 9.6-12.2) INR 2.6 (H) (Normal Range 0.9-1.1.) . R5's Quarterly Minimum Data Set, dated 12/7/20220, documents his Brief Interview for Mental Status (BIMS) of 14, indicating cognitively intact. R5's Care Plan, last entry dated 9/3/2020, does not reference any monitoring in regard to anticoagulant therapy. On 3/17/2021 at 11:15 AM, R5 stated, "I don't know if I take a blood thinner or not. Yes, they were checking my blood weekly for a while but it has been like 3 to 4 weeks since they checked it last. No, I don't have any abnormal bleeding or bruising." On 3/17/2021 at 12:10 PM, V4, "The lab has been a problem since we switched. If the lab was	S9999		

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not in the chart, we probably didn't get it called to the doctor. (V2) tracks the residents on coumadin and she is not here. We don't have a standing order for PT/INR here, we call the doctor each time to get the orders. I don't see anything in the nurse's notes, or physician orders that documents the doctor was notified."

On 3/17/2021 at 12:24 PM, V22 stated, "The facility is having issues with the lab they use. I should have been notified. If I was notified, they should have made an entry in the resident's record documenting the date and time and reported the results. After reading the results of R5's 2/02/21 lab to V22, V22 further stated even though he would consider R5's INR to be within his desired therapeutic range, he should have been notified and would give the order to adjust or maintain the same Coumadin dose, and repeat the PT and INR in week."

4. R15's Profile Face Sheet documents re-admission to this facility on 3/27/18. R15's March 2021 POS documents the following in part - diagnoses to include history of coronary artery bypass graft, deep vein thrombosis (DVT). An order for Coumadin 4 mg 1 po at bed time daily, with a start date of 01/19/21. An updated order dated 2/05/21 to include Coumadin 6 mg 1 tablet po daily.

R15's care plan, dated 4/01/17 does not contain any documentation regarding Coumadin, how to monitor for side effects, or any interventions that may be necessary.

On 3/9/2021 at 2:45 PM, V2 (Acting Director of Nursing - DON/RCC - Resident Care Coordinator) stated, "We don't have updated care plans and MDS's right now because the MDS

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S9999	Continued From page 11 nurse quit in November. Corporate is doing them now." On 3/12/21 at 4:05 PM, V1 (Administrator) verified that, "R1, R5, and R14's current care plans do not contain any documentation regarding Coumadin, how to monitor for side effects, or any interventions that may be necessary." On 3/17/21 at 11:00 AM, V20 (Licensed Practical Nurse - LPN) stated she has not accessed any resident care plan since she started work in the facility 6 weeks ago. On 3/17/21 at 11:03 AM, V4 (LPN) stated, "I don't access the care plans much at all because they are in the Director of Nursing's (DON) office. With them being in there, we don't see them much. They need to be in our office or in the resident charts." On 3/17/21 at 11:12 AM, V28 (Floating Minimum Data Set Coordinator - MDSC) stated she was the floating MDS person who is here to try and keep them caught up, but this is "not my permanent building." She stated V2 is supposed to be in the role of Care Plan Coordinator, but her other duties as DON have kept her busy, and to her knowledge, no one is doing the care plans at this time. V28 stated she had not yet been able to work on updating resident care plans. On 3/17/21 at 11:15 AM, V1 stated we have two books with care plans kept in the DON's office. V1 confirmed resident care plans are not readily available to staff and stated it's been that way since I started in December 2020. We need to come up with a better system and we are going through lots of changes. V2 will take over her	S9999		

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S9999	Continued From page 12 role of RCC (Resident Care Coordinator) to include the care planning when we hire a new DON. A facility policy titled, "Laboratory Tests", dated revised 1/16/17, documents the following in part - "Policy: Appropriate laboratory monitoring of disease processes and medications requires consideration of many factors including concomitant disease(s) and medication(s), wishes of the resident and family and current standards of practice. "Responsibility: ...Licensed nursing personnel ...Procedure: 1) Laboratory testing will be completed in collaboration with Medicare guidelines, pharmacy recommendations and physician orders. 2) Obtain laboratory orders upon admission, readmission and PRN for medication and condition monitoring per the physician's order." Facility policy entitled, "Notification for Change in Resident Condition or Status", dated Revised 12/7/2017, documents in part, "The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, Director of Nursing, Physician, Guardian, Health Care Power of Attorney (HCPOA) of changes in the resident's medical/mental condition and/or status". Also documents, "Procedure: 1. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: m. Abnormal lab findings". Facility Policy entitled, "Comprehensive Care Planning", dated revised on 11/1/20217, documents in part, "It is the policy of (Facility) to comprehensively assess and periodically reassess each Resident admitted to this facility." "1. The Comprehensive Care Plan (CCP) shall be developed within 7 days of the completion of the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009260	A. BUILDING: _____ B. WING _____	C 03/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 Resident Assessment Instrument (RAI). A. The CCP shall be reviewed after each Annual, Significant Change, and Quarterly MDS and revised as necessary to reflect the resident's current medical, nursing, and mental and psychosocial needs as identified by the Interdisciplinary Team (IDT)." The drugs.com website documents the following regarding the drug Coumadin (Warfarin) - ..."Warning: Oral route (tablet) - Warfarin can cause major or fatal bleeding. Regular monitoring of INR should be performed on all treated patients. Drugs, dietary changes, and other factors affect INR levels achieved with warfarin sodium therapy. Instruct patients about prevention measures to minimize risk of bleeding and to report signs and symptoms of bleeding. Side Effects Requiring Immediate Medical Attention: Along with its needed effects, warfarin (the active ingredient contained in Coumadin) may cause some unwanted effects. Although not all of these side effects may occur, if they do occur they may need medical attention. Check with your doctor immediately if any of the following side effects occur while taking warfarin: ...nosebleeds ..." (B)	S9999		