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	IL6005722	A. BUILDING: _____ B. WING _____	C 11/08/2021

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LOFT REHABILITATION & NURSING	700 NORTH MAIN STREET EUREKA, IL 61530

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S 000	Initial Comments Original Complaint Investigation 2128169/IL139917 2128174/IL139932	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)1) 300.1210d)2) 300.3320f) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) These requirements were not met as evidenced by: Based on interview and record review the facility failed to accurately transcribe a physician order for a high-risk anticoagulant medication, failed to ensure residents received the correct dose of a high-risk anticoagulant medication, and failed to ensure a resident received anticoagulant medication for two of three residents (R1 and R2) reviewed for anticoagulant medication in the sample of three. These failures resulted in R1 receiving the wrong dose of a high-risk anticoagulant medication resulting in critical lab results and requiring R1 to receive an intramuscular injection of a reversal agent. R1 was transferred to the local area hospital for evaluation. Findings include: The facility's RN (Registered Nurse)/LPN (Licensed Practical Nurse) Charge Nurse Job Description, not dated, states, "Transcribes physician orders to medical record and carries out orders as written. Prepares and administers medications as per physicians' orders and observes for adverse effects."	S9999		

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S9999	Continued From page 2	S9999		

The facility's "Physician/Practitioner Orders" policy, revised 1/1/20, states, "Policy: The attending physician shall authenticate orders for the care and treatment of assigned residents. b. Follow facility procedures for verbal or telephone orders including: noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record."

The facility's "High Risk Medications-Anticoagulants" policy, not dated, states, "Policy: The facility recognizes that some medications, including anticoagulants, are associated with greater risks of adverse consequences than other medications. This policy addresses the facility's collaborative, systematic approach to managing anticoagulant therapy for efficacy and safety...1. Anticoagulants shall be prescribed by a physician or other authorized practitioner with clear indications for use...Risks associated with anticoagulants include: a. Bleeding and hemorrhage (bleeding gums, nosebleed, unusual bruising, blood in urine or stool) b. Fall in hematocrit or blood pressure c. Thromboembolism."

The facility's "Medication Error and Investigation Incident Report", not dated, states, "Description of Medication Error: An order for Warfarin (Coumadin) 10 mg po (by mouth) daily was placed on 10/21/21 in error and given to (R1) daily for four days (10/25/21). The medication was not given due to a missed medication administration on 10/26/21. The error was discovered on 10/27/21 and the medication was then held. A PT/INR result for (R2) was received with an order for 10 mg Warfarin po daily. (R2) is on the same hall as (R1). It is likely that the order was placed for (R1) by mistake. History indicates (R1) had never had a dose of Warfarin higher

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S9999	Continued From page 3 than 4 mg." The facility's "Quality Improvement Plan", dated 11/2/21, states, "(Regarding the 10/27/21 findings) Target Area: Med Errors. Analysis: Wrong input by nurse on wrong resident, wrong dose given." 1. R2's Facesheet documents R2 was admitted to the facility on 7/23/21 with diagnoses to include but not limited to: Cerebral Infarction, Acquired Coagulation Factor Deficiency, Surgical Aftercare Following Surgery on the Skin and Subcutaneous Tissue, and Parkinson's Disease. R2's current Care Plan documents R2 is on anticoagulant therapy for CVA (Cerebrovascular Accident) and documents an intervention as "Administer anticoagulant medications as ordered by physician." R2's Laboratory Results for PT/INR, dated 10/20/21, contains a written order signed by V7 (R1 and R2's Physician) stating "(Coumadin) 15 mg (milligram) today, then 10 mg q d (every day). Weekly Protime." This order is signed off as being completed by V9 (Registered Nurse). R2's Physician Order Sheet (POS) documents an order for Warfarin Sodium Tablet 4 mg Give one tablet by mouth one time a day related to Unspecified Sequelae of Cerebral Infarction, give with 5 mg to equal 9 mg start date 10/14/21 and Warfarin Sodium Tablet 5 mg Give one tablet by mouth one time a day related to Unspecified Sequelae of Cerebral Infarction. These medications have a start date of 10/14/21 and an end date of 11/4/21. R2's MAR documents orders for Warfarin Sodium	S9999		

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S9999	Continued From page 4 Tablet 4 mg Give one tablet by mouth one time a day related to Unspecified Sequelae of Cerebral Infarction, give with 5 mg to equal 9 mg start date 10/14/21 and Warfarin Sodium Tablet 5 mg Give one tablet by mouth one time a day related to unspecified Sequelae of Cerebral Infarction with a start date of 10/14/21. This same MAR documents Coumadin 9 mg was given 10/15/21-10/25/21. R2's medical record does not document that V7's written order for Coumadin 15 mg one-time dose or Coumadin 10 mg daily dose was transcribed into R2's medical record. 2. R1's Facesheet documents R1 was admitted to the facility on 9/10/21 with diagnoses to include but not limited to: Cerebral Palsy, Other reduced mobility, Paroxysmal Atrial Fibrillation, Presence of Prosthetic Heart Valve, Other Pulmonary Embolism without Acute Cor Pulmonale, and Chronic Diastolic (Congestive) Heart Failure. R1's POS on 10/21/21 documents V9 entered R2's above written order for Coumadin onto R1's POS. R1's POS states, Coumadin Tablet 5 mg (Warfarin Sodium) Give one tablet by mouth one time only related to Paroxysmal Atrial Fibrillation until 10/21/21 Take one tablet with 10 mg for 15 mg today only then 10 mg daily. This same POS documents R2's order for Coumadin Tablet 10 mg (Warfarin Sodium) Give one tablet by mouth one time a day related to Paroxysmal Atrial Fibrillation. R1's Medication Administration Record (MAR) documents R2's order for Coumadin Tablet 5 mg (Warfarin Sodium) Give one tablet by mouth one time only related to Paroxysmal Atrial Fibrillation until 10/21/21 Take one tablet with 10 mg for 15	S9999		

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mg today only then 10 mg daily. This same MAR documents R2's order for Coumadin Tablet 10 mg (Warfarin Sodium) Give one tablet by mouth one time a day related to Paroxysmal Atrial Fibrillation. These medications are marked as given to R1 on 10/21-10/25/21.

The facility's "Packing Slip Proof of Delivery" from the pharmacy documents the facility received seven Warfarin 10 mg tablets and one 5 mg tablet for R1 on 10/22/21 at 3:56 A.M.

R1's "Lab Results Report" dated 10/27/21 documents R1 with a PT (Prothrombin Time) result of greater than 196 seconds. PT normal reference range is documented as 20.3-29.9 seconds. This result is flagged as high. This same report documents R1 with an INR (International Normalized Ratio) of greater than 22.03. R1's lab results report documents a reference INR range of 2-3 is commonly followed for prevention of venous thrombosis and a reference INR range of 2.5-3.5 is commonly followed for treatment of mechanical heart valves. This same form documents R1's results as "critical."

R1's Nursing Note on 10/27/21 at 1:30 P.M., signed by V12 (Former Director of Nursing) states V7 was notified of R1's critical PT/INR results and orders for Vitamin K 5 mg IM (Intramuscular) were given.

R1's MAR, dated 10/1/21-10/31/21, documents R1 received a dose of Phytonadione Solution (Vitamin K/Reversal Agent) 5 mg intramuscularly one time on 10/27/21.

R1's Nursing Note on 10/27/21 at 4:45 P.M., signed by V12 (Former Director of Nursing),

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S9999	Continued From page 6 states, "Description of condition change: (R1's) PT/INR was critically high. (V7) initially ordered 5 mg IM Vitamin K that was immediately given by the primary nurse. After discussing the treatment and PT/INR level, (R1) made the decision that (R1) would like to go to the emergency department to be evaluated and observed for any complications that may arise from this critical level. EMS (Emergency Medical Service) contacted and will be transporting (R1) to (local area hospital)." The facility's "Admission/Discharge To/From Report" documents R1 was transferred to the local area hospital on 10/27/21. R1's EMS "Patient Care Record", dated 10/27/21, states, "Called to (Skilled Nursing Facility) for a patient (R1) with a critical lab value. EMS was met by the nursing home staff and led to patient (R1). Nursing home staff stated there was a medication error with this patient's Coumadin." R1's local area hospital Admission History and Physical documents R1 was admitted to the hospital for continuation of INR monitoring with diagnosis of supratherapeutic INR. On 11/6/21 at 10:27 A.M., V3 (Licensed Practical Nurse) stated, "(R1) received the wrong dosage of Coumadin. Someone else's (R2's) Coumadin order was placed in (R1's) chart. (R2) receives a large dose of Coumadin compared to what (R1) receives. The problem is we have a lot of agency nurses and they don't know the residents well." On 11/6/21 at 10:51 A.M. V2 (Assistant Director of Nursing) stated, "On 10/27/21, (V7) had called over to the facility and stated there was a transcription error on (R1's) Coumadin. We	S9999		

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investigated it and found the nurse (V9) put (R2's) order in on the wrong patient (R1). (R2's) 9 mg Coumadin order should have been increased according to (R2's) labs, but it wasn't. (V9) placed the order in the computer as a written order under (V7's name). (R1) was getting 10 mg, which (R1) usually gets 1-4 mg." V2 verified R1 had critical lab results which resulted in R1 needing an injection of a reversal agent.

On 11/6/21 at 12:03 P.M. V9 (Registered Nurse) verified entering the Coumadin order on 10/21/21 into R1's chart. V9 stated V9 copied the order from the lab results that came back from V7's office. V9 verified V9 did not realize V9 had entered the orders into the incorrect resident's chart.

R1's Laboratory (lab) Result form, dated 10/9/21, documents a handwritten order at the bottom that states, "(Coumadin) 1.5 mg (milligram) x (time) day. Next draw (PT/INR) 10/14/21 per (V8/R1's Physician).

R1's Physician Order Sheet (POS) documents an order for "Warfarin Sodium Tablet 1.5 mg by mouth one time a day related to Other Pulmonary Embolism without Acute Cor Pulmonale until 10/14/21." This order has a start date of 10/10/21 and an end date of 10/14/21.

R1's Medication Administration Record (MAR), dated 10/1/21-10/31/21, documents an order for "Warfarin Sodium Tablet 1.5 mg by mouth one time a day related to Other Pulmonary Embolism without Acute Cor Pulmonale until 10/14/21." This order has a start date of 10/10/21 and an end date of 10/14/21. This same MAR documents the ordered medication was given 10/10/21-10/14/21.

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S9999	Continued From page 8 R1's POS or MAR does not document R1 received any doses of Warfarin (Coumadin) from 10/14/21-10/20/21. On 11/6/21 at 1:29 P.M., V2 (Assistant Director of Nursing) verified R1 was not on any Coumadin from 10/14/21-10/20/21 and should have been. On 11/6/21 at 2:39 P.M. V7 (R1 and R2's Physician) stated R2's written anticoagulant order was placed incorrectly into R1's chart. V7 stated R1 received too high of doses of Coumadin (on 10/21/21-10/25/21) which caused R1's critical lab results on 10/27/21 and caused R1 to need an injection of a reversal agent. V7 stated the critical INR level put R1 at an increased risk of bleeding/hemorrhage. V7 verified R1 should not have gone seven days without receiving anticoagulant medication (10/14/21-10/20/21). V1 stated the nurse entered the 10/9/21 order with an end date of when the next lab draw was due and since the lab didn't get drawn (on 10/14/21), the medication (Coumadin) did not get continued. V7 stated this has been a "chronic problem" at the facility and V7 has had to take residents off of Coumadin and switch to a different anticoagulant due to lab testing and doses being missed. (A)	S9999		