Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003420	A. BUILDING: _____ B. WING _____	R-C 04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHAB & HC	5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614

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S 000	Initial Comments First Revisit to Complaint Investigation 2420595/IL169023	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1010h) 300.1210b) 300.1210d)1)2)3) 300.1610a)1) 300.1620c) 300.1630e) 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 of notification. 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	S9999		

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S9999	Continued From page 1 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. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Section 300.1620 Compliance with Licensed	S9999		

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S9999	Continued From page 2 Prescriber's Orders c) Review of medication orders: The staff pharmacist or consultant pharmacist shall review the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical experience and judgment, and Section 300.Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be documented in the clinical record. Portions of this review may be done outside the facility. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon. Section 300.1630 Administration of Medication e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report. These regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to fully monitor and implement the facility's recent plan of correction for monitoring of high-risk anticoagulant medications (Warfarin/Coumadin), failed to obtain physician orders to adjust a high-risk	S9999		

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S9999	Continued From page 3 medication (Anticoagulant/Coumadin) after a resident's PT (Prothrombin Time) and INR (International Normalized Ratio) laboratory (lab) values were resulted as subtherapeutic, failed to monitor laboratory values of a high-risk medication (Anticoagulant/Coumadin), and failed to ensure a resident received the physician ordered dose of Coumadin/Warfarin (high-risk anticoagulant) for one of nine residents (R47) reviewed for high-risk medications in the sample of 11. This failure resulted in R47 receiving a high-risk anticoagulant medication for over four months with no monitoring and R47 receiving incorrect dosages of a high-risk anticoagulant medication (Warfarin) putting R47 at risk for thrombosis or bleeding. Findings include: The facility's "Medication Administration" Policy revised 11/18/17 states, "Definition: Drug administration shall be defined as an act in which a single dose of prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given." "6. Medications must be identified by using the seven (7) rights of administration: right resident; right drug; right dose; right consistency; right time; right route; right documentation. 7. All medications must be labeled with the resident's name, the medication, the dosage, and instructions for administration. (If instructions have changed since the original order, medication	S9999		

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must contain an 'Order Change' label)." "16. After a drug is given, record the date, time, name of drug, dose, and route on the resident's individual Medication Administration Record (MAR)." "19. Document any medications not administered for any reason by circling initials and documenting on the back of the MAR the date, the time, the medication and dosage, reason for omission and initials." "21. If the medication is not available for a resident, call the pharmacy and notify the physician when the drug is expected to be available. 22. Notify the physician as soon as practical when a scheduled dose of medication has not been administered for any reason. 23. Report errors in medication administration immediately per policy."

The facility's "Adverse Drug Reactions and Medication Discrepancy" Policy revised 10/06 documents a medication discrepancy/error has been made when the wrong dose of a medication is given and when a medication is not administered.

The American Heart Association Website (https://www.heart.org/en/health-topics/arrhythmia/prevention--treatment-of-arrhythmia/a-patients-guide-to-taking-warfarin) states, "A Patient's Guide to Taking Warfarin: Warfarin (brand names Coumadin and Jantoven) is a prescription medication used to prevent harmful blood clots from forming or growing larger. Beneficial blood clots prevent or stop bleeding, but harmful blood clots can cause a heart attack, stroke, deep vein thrombosis or pulmonary embolism. Monitoring and Dosing Tips: The goal of warfarin therapy is to decrease the clotting tendency of blood, not to prevent clotting completely. The effect of warfarin must be monitored carefully with blood testing. Based on the results of the blood test, your daily

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dose of warfarin will be adjusted to keep your clotting time within a target range. The blood test used to measure the time it takes for blood to clot is referred to as a prothrombin time test, or protime (PT). The PT is reported as the International Normalized Ratio (INR). The INR is a standardized way of expressing the PT value. The INR ensures that PT results obtained by different laboratories can be compared. It's important to monitor the INR at least once a month and sometimes as often as twice weekly to make sure the level of warfarin remains in the effective range. If the INR is too low, blood clots will not be prevented, but if the INR is too high, there is an increased risk of bleeding. This is why those who take warfarin must have their blood tested so frequently. Unlike most medications that are administered as a fixed dose, warfarin dosing is adjusted according to the INR blood test results; the dose usually changes over time." "Side Effects: The major complications associated with warfarin are clotting due to underdosing or bleeding due to excessive anticoagulation. The most serious bleeding is gastrointestinal or intracerebral (within the brain). Excessive bleeding can occur in any area of the body, and patients taking warfarin should report any falls or accidents, as well as signs or symptoms of bleeding or unusual bruising, to their health care professional."

The facility's "Laboratory Tests" Policy reviewed 9/27/17 states, "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." "Procedure: 1. Laboratory testing will be completed in collaboration with Medicare guidelines, pharmacy

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recommendations, and physician orders. 2. Obtain laboratory orders upon admission, readmission, and PRN (as needed) for medication and condition monitoring per the physician's order."

R47's current Admission Record documents R47 admitted to the facility on 5/31/23.

R47's Brief Interview of Mental Status dated 3/14/24 documents R47 as cognitively intact.

On 4/2/24 at 2:11 PM, R47 was sitting up on the side of the bed in R47's bedroom. R47 was alert and oriented and able to answer questions well. R47 stated that R47 is aware of being on the anticoagulant, Warfarin/Coumadin. R47 stated the medication was prescribed by V8 (R47's Cardiologist). R47 stated R47 did not know who was managing R47's medications (Warfarin) now. R47 stated R47 has not seen V8 since "last year". R47 stated R47 had an irregular heartbeat and developed "blood clots" in both of R47's legs. R47 stated, "That was the worst pain I ever felt in my life. I don't ever want to go through that again. I couldn't even walk. I was hurting bad." R47 denied refusing to have R47's PT/INR levels checked.

R47's Cardiology Office Visit Note dated 10/25/23 and signed by V8 (R47's Cardiologist) documents R47 with diagnoses to include but not limited to: Nonischemic Cardiomyopathy; Persistent Atrial Fibrillation; Hypertension, End Stage Renal Disease with Hemodialysis; and Morbid Obesity. This same office note documents R47's Coumadin (Warfarin) was restarted on this date (10/15/23).

R47's medical record documents a laboratory PT

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S9999	Continued From page 7 (Prothrombin Time) and INR (International Normalized Ratio) value dated 11/22/23 as 13.6 seconds and 1.1, respectively. The target INR range is documented as 2-3 for treatment of prophylaxis of thrombosis or embolism. This laboratory result documents V7 (R47's Physician) as the ordering physician. As of 4/2/24, R47's medical record did not contain: orders for a PT/INR to be obtained; that a physician was notified of R47's 11/22/23 PT/INR result, or that a physician was notified of R47's lack of PT/INR monitoring. As of 4/2/24, R47's "Order Summary Report" of orders received for R47 since R47's admission to the facility documents an order for "Warfarin Sodium Oral Tablet 1 (one) MG (mg/milligram) (Warfarin Sodium). Give 3 (three) mg by mouth one time a day for prevention and treatment of blood clots." This order has an order start date of 11/11/23 and no end date. As of 4/3/24, R47's "Order Summary Report" documents an order for "Warfarin Sodium Oral Tablet 1 (one) MG (mg/milligram) (Warfarin Sodium). Give 4 (four) mg by mouth one time a day for prevention and treatment of blood clots." This order has an order start date of 4/3/24. This same report documents the previous 3 mg order was discontinued. As of 4/8/24, R47's "Order Summary Report" documents an order for "Warfarin Sodium Oral Tablet 1 (one) MG (mg/milligram) (Warfarin Sodium). Give 5 (five) mg by mouth one time a day for prevention and treatment of blood clots." This order has an order start date of 4/8/24. This same report documents the previous 4 mg order was discontinued.	S9999		

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S9999	Continued From page 8 Pharmacy Delivery Receipts document the pharmacy shipped 90-Warfarin Sodium One Milligram/MG tablets to the facility on 1/13/24. This same delivery receipt documents the pharmacy did not ship anymore Warfarin Sodium tablets again until 3/21/24. R47's Medication Administration Records/MAR documents between 1/14/24-3/20/24, R47 should have received a total of 183 Coumadin one milligram tablets (Three-one milligram tablets a day). Pharmacy Delivery Receipts document the pharmacy shipped 90-Warfarin Sodium One Milligram/MG tablets to the facility on 3/21/24. This same delivery receipt documents the pharmacy has not shipped anymore Warfarin Sodium tablets to the facility. R47's Medication Administration Records/MAR documents between 3/21/24 and 4/8/24, R47 should have received a total of 55 Coumadin tablets. On 4/9/24 at 12:30 PM, the medication cart containing R47's medications was observed alongside V13 (Director of Nursing). The medication cart contained three medication cards of R47's Warfarin Sodium one mg tablets. Two cards were unused, each containing 30 tablets (60 total tablets). A third medication card for Warfarin had one remaining tablet available for use. All three medication cards for Warfarin contained a total of 61 tablets available for use. R47's medication cards for Coumadin state, "MONITOR FOR BLEEDING. CHECK FOR BLEED W/ (with) MED CHANGES. NOTIFY DR. (doctor) IF BLEEDING NOTED." These	S9999		

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S9999	Continued From page 9 medication cards also state, "3 mg = (equals) 3 tablets. One of the three medication cards had crossed out "3 mg" in ink pen and 4 tabs was handwritten off to the side. On 4/9/24 at 1:05 PM, V14 (Pharmacy Technician) stated that medications at the facility are not refilled automatically; the facility has to request refills on medications. V14 stated the pharmacy sent 90 tablets to the facility on 1/13/24 and not again until 3/21/24. V14 stated on 4/3/24, the pharmacy received an order for R47's increased dose of Warfarin 4 mg tablets, but the order was sent to pharmacy as 1 mg tablets, give four tablets. V14 stated the pharmacy denied the request and a return fax was sent to the facility requesting the order be entered as 4 mg tablets versus 1 mg tablets. V14 stated no response was received back from the facility and the order was not completed. V14 stated on 4/8/24, the pharmacy received an order for Warfarin 5 mg tablets, but the facility marked "do not fill" on the order. V14 stated this order was also entered as one mg tablets, give five tablets. V14 stated 4 mg and 5 mg tablets should have been ordered, not one mg. On 4/9/24 at 2:35 PM, V13 (Director of Nursing) verified 61 Coumadin tablets were remaining for R47 in the medication cart. V13 stated if 90 tablets were delivered and 55 tablets are documented as "given", then 35 tablets would be remaining to administer to R47. At this time, V13 verified 61 tablets remained available for use for R47. V13 verified no other medication cards or deliveries have been made for R47's Coumadin. V13 stated a medication error had occurred and that V13 would start an "internal investigation." V13 stated that it is likely the nurses were not administering the correct amount of Coumadin	S9999		

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tablets since R47's Coumadin was delivered as one mg tablets and multiple tablets were ordered to be given at a time. V13 verified the pharmacy shipped a one-month supply (90 tablets) on 1/13/24 and not again until 3/2/24. V13 verified Coumadin doses between 1/14/24 and 3/20/24 were not given correctly as more medications are documented as given than what was on hand. With the three Warfarin medication cards sitting on V13's desk, V13 stated that ordering and delivering the medications in this way leaves room for too much error. V13 stated R47's Warfarin 4 mg and 5 mg doses should have been entered as new orders, so 4 mg and 5 mg tablets could have been sent from pharmacy.

On 4/8/24 at 5:06 PM, V9 telephone called this writer and expressed concern that V9 and V8's office did not think that R47 is getting correct doses of Warfarin at the facility. V9 stated R47 returned to V8's office on 4/8/24 for an INR check and R47's INR result was again 1.1. V9 stated, "I know the facility and (R47) say (R47) is getting his (Warfarin), but we just don't see how that could be. (R47's) INR is not moving. We'll check (R47's INR) again on 4/12/24."

On 4/3/24, 4/8/24, and 4/12/24, attempts were made to speak with V8 (R47's Cardiologist) directly. V8 refused to comment directly on R47's Warfarin concerns with lack of PT/INR monitoring or R47's medication discrepancies.

R47's Plan of Care Note dated 4/12/2024 at 8:29 AM states, "QA (Quality Assurance) Note: (R47) on Coumadin therapy requiring monitoring of PT/INR, unclear what dose (R47) had been previously receiving compared to doctor's order, MD (Medical Doctor/V8) has been notified of potential discrepancy."

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S9999	Continued From page 11 R47's "Medication Discrepancy Report" dated 4/9/24 documents R47 was administered the "wrong dose" of Coumadin. This form documents the discrepancy was discovered by reviewing PT/INR logs and counting remaining supply. This form documents the reason for discrepancy was "transcription, miscalculation, and five rights." Possible affects to the resident (R47) is documented as "change in PT/INR, non-therapeutic range." R47's Pharmacy Consultation Report dated 10/27/23 and signed by V11 (Pharmacist) states, "Comment: ***CLINICAL PRIORITY RECOMMENDATION: PROMPT RESPONSE REQUESTED.***" These same reports document that R47 was started on Warfarin and has no orders for a PT/INR and contains a recommendation to see when the prescriber would like to check a PT/INR. "Rationale for Recommendation: Warfarin has a BOXED WARNING describing the potential for major, sometimes fatal, bleeding. To avoid adverse consequences (e.g., bleeding, thrombosis), individuals should be closely and continually assessed both clinically and through appropriate INR monitoring." This form is blank with no Director of Nursing or Physician response. R47's Pharmacy Consultation Report dated 11/21/23 and signed by V11 (Pharmacist) states, "Comment: ***CLINICAL PRIORITY RECOMMENDATION: PROMPT RESPONSE REQUESTED.*** (R47) was started on Warfarin for blood clots, has no PT/INR results on file from the lab and no orders for a PT/INR to be drawn. Recommendation: Please clarify PT/INR orders for (R47) and make sure one is drawn. Rationale for Recommendation: Warfarin has a BOXED	S9999		

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S9999	Continued From page 12 WARNING describing the potential for major, sometimes fatal, bleeding. To avoid adverse consequences (e.g., bleeding, thrombosis), individuals should be closely and continually assessed both clinically and through appropriate INR monitoring." This form is blank with no Director of Nursing or Physician response. R47's Pharmacy Consultation Report dated 1/23/24 and signed by V12 (Pharmacist) states, "Comment: ***CLINICAL PRIORITY RECOMMENDATION: PROMPT RESPONSE REQUESTED.*** (R47) receives Warfarin and the most recent INR documented in the medical record is 1.1 on 11/22/23. Recommendation: Please consider monitoring an INR on the next convenient lab day and at least monthly thereafter, increasing the frequency when clinically appropriate (e.g., acute illness, dose adjustments, change in interacting medication or diet, signs of bleeding). Rationale for Recommendation: Warfarin has a BOXED WARNING describing the potential for major, sometimes fatal, bleeding. To avoid adverse consequences (e.g., bleeding, thrombosis), individuals should be closely and continually assessed both clinically and through appropriate INR monitoring." This form is blank with no Director of Nursing or Physician response. R47's Pharmacy Consultation Report dated 2/27/24 and signed by V11 (Pharmacist) states, "Comment: ***CLINICAL PRIORITY RECOMMENDATION: PROMPT RESPONSE REQUESTED.*** (R47) receives Warfarin and the most recent INR documented in the medical record is 1.1 on 11/22/23. Recommendation: Please consider monitoring an INR on the next convenient lab day and at least monthly thereafter, increasing the frequency when	S9999		

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clinically appropriate (e.g., acute illness, dose adjustments, change in interacting medication or diet, signs of bleeding). Rationale for Recommendation: Warfarin has a BOXED WARNING describing the potential for major, sometimes fatal, bleeding. To avoid adverse consequences (e.g., bleeding, thrombosis), individuals should be closely and continually assessed both clinically and through appropriate INR monitoring." This form is blank with no Director of Nursing or Physician response.

On 4/3/24 at 1:00 PM, V1 (Administrator in Training) verified that there are no signed responses to V11 and V12's recommendations for R47 to have a PT/INR obtained. V1 stated the reports should have been acknowledged.

On 4/3/24 at 12:18 PM, V7 (R47's Physician) stated that V7 was made aware by facility staff yesterday (4/2/24) that R47 is on Coumadin and R47 has not had a PT/INR drawn since November 2023. V7 stated V7 immediately gave an order for a CBC/Complete Blood Count and PT/INR to be drawn "STAT". V7 stated, "They (facility staff) have a form (Protime Flowchart) that monitors Coumadin doses, and when the next labs are due to be drawn. They just stopped doing them." V7 stated that when V7 is ordering Coumadin, V7 does not like to go longer than two weeks without having PT/INR values checked. V7 stated, "The residents get put on antibiotics and so many other medications that interfere with Coumadin, so I won't go longer than two weeks." V7 stated Protime Flowsheets should be used especially if V7's office is managing the Coumadin. V7 stated that V7 was under the impression that R47's Cardiologist (V8) was managing R47's Coumadin dosing and lab ordering. V7 stated that if R47's Coumadin dosing

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and PT/INRs are not being checked, R47 is at risk for a thrombosis or bleed. V7 denied being notified of Pharmacy's repeated requests for a PT/INR to be drawn on R47. V7 denied being aware that R47 was on Coumadin without having a PT/INR drawn since November 2023. V7 denied ever being notified that R47 refused PT/INR levels to be drawn. V7 stated V7 should have been notified immediately. V7 stated, "There are multiple issues there (skilled nursing facility), especially with such a high (staff) turnover."

The facility's "Protime Flowchart" contains the following documentation: Resident Name, Resident Physician; Diagnosis for Coumadin; Date; INR result; Current Coumadin Dose; New Dose; Next PT date; Date MD (Medical Doctor) Notified; Side Effects Noted and Nurse Initials. R47's Protime Flowchart provided by the facility on 4/2/24 was blank containing no documentation.

On 4/3/24 at 12:35 PM, V6 (Licensed Practical Nurse) stated that V6 never sent any orders with R47 to R47's dialysis treatments for a PT/INR to be drawn. V6 stated V6 did not obtain a physician order that labs were ok to be drawn during R47's dialysis treatments. V6 was asked who was monitoring R47's PT/INR levels and who the staff should be calling PT/INR levels to and V6 responded, "That is a good question."

On 4/3/24 at 8:38 AM, V10 (Registered Nurse at R47's Dialysis Center) stated that the dialysis center has not been able to draw "courtesy labs" for "years." V10 stated that unless the nephrologist was managing the Coumadin; PT/INR levels would not be able to be drawn during dialysis treatments. V10 denied being aware that the facility was attempting to have

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S9999	Continued From page 15 R47's PT/INR levels drawn during R47's dialysis treatments. V10 stated, "We do not do that here." On 4/3/24 at 9:24 AM, V3 (Resident Care Coordinator/Licensed Practical Nurse) stated that on 4/3/24, V8's office was called regarding getting R47 scheduled to have a PT/INR drawn. V3 stated R47 is out of the facility having these lab results obtained now. V3 verified: R47's medical record does not contain any PT/INR results since November 2023; the facility is not able to provide documentation that a physician was notified of R47's lack of PT/INR monitoring since November 2023; and that no documentation could be provided to show that R47's Coumadin (Warfarin)/PT/INR levels were being monitored by the facility. V3 stated, "There is so much different management in and out here. The ball was definitely dropped. Even with all the management changes, as a nurse, I would want to know my resident's PT/INR results before I go giving Coumadin. (R47's) labs (PT/INR) should have been checked regularly and were not. There is a lot of agency nurses here too and they aren't held accountable by their agencies." V3 stated that 4/2/24 was V3's first day working in the facility and V3 was not aware of the facility's recent Immediate Jeopardy related to the lack of Coumadin/PT/INR monitoring. On 4/3/24 at 9:41 AM, V9 (V8's Registered Nurse) stated that V8's office thought the skilled nursing facility and V7 were managing R47's PT/INR levels for R47's Coumadin dosing. V8 stated that PT/INR levels are needed to be frequently checked to ensure R47's PT/INR is in therapeutic range. V8 stated therapeutic range for R47 is between two to three (2-3). V9 stated that when R47's INR was noted as 1.1 in November 2023, R47's Coumadin should have been	S9999		

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increased at the time. V9 denied that V8's office was notified of R47's November 2023 PT/INR result. V9 stated a physician should have been notified immediately. V9 stated R47 called V8's office on 4/2/24 asking to switch to another anticoagulant medication that did not require blood draws. V9 stated that V8 (R47's Cardiologist) said Coumadin is the only option for R47 due to R47's kidney function. V9 stated V8's office is aware that R47 is a difficult stick for lab draws and offered that R47 could come to V8's office to get finger sticks instead. V9 denied that R47 has come to V8's office any time after October 2023 to have this done. V9 denied that R47's office has been made aware that R47 was refusing lab draws. V9 stated R47 should not have been on Coumadin since November 2023 without having a PT/INR checked as the PT/INR levels determine R47's correct dosage of Coumadin/Warfarin.

On 4/3/24 at 4:20 PM, a follow-up telephone interview with V9 stated that R47 came to V8's office the morning of 4/3/24 to have a PT/INR fingerstick obtained. V9 stated that R47's 4/3/24 INR result of 1.1 required R47's Coumadin dose to be increased (4 mg daily) and a repeat PT/INR was ordered for 4/8/24. V9 stated the lack of R47's PT/INR levels being monitored resulted in R47 being on incorrect doses of Coumadin. V9 stated, "If (R47) has been taking Coumadin daily as the facility says, R47's levels are not anywhere near where they should be." V9 stated R47's Coumadin dose should have been increased in November 2023 after R47's INR result of 1.1 on 11/22/23. V9 stated that due to R47's obesity and R47's dialysis status, R47's levels are difficult to manage, further leading to the importance of having PT/INR levels checked frequently. V9 stated R47's PT/INRs can be "unpredictable".

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S9999	Continued From page 17 On 4/2/24 at 3:33 PM, V2 (Regional Nurse Consultant) stated the following: R47's PT/INR levels should have been monitored and were not; a resident cannot be on Coumadin without having PT/INRs monitored; and R47's medical record should have been audited as a result of the facility's Plan of Correction and was not. V2 stated, "The person in charge didn't do it." At this time, V2 could not state who that "person in charge" was. V2 verified R47's medical record did not contain: audits; documentation of physician notification related to Coumadin; or lab orders or lab results for PT/INR since November 2023. On 4/5/24 at 11:17 AM, V5 (Resident Care Coordinator/Licensed Practical Nurse) stated V5 did not know if V7 or V8 was to be monitoring R47's Coumadin dosing and labs. V5 stated V5 knew V6 spoke with dialysis about drawing R47's labs and V5 assumed dialysis was ordering them. V5 stated, "We shouldn't have assumed." V5 verified dialysis had stated they could not draw PT/INRs for R47. V5 stated a resident should "never" be on Coumadin without PT/INRs being monitored. V5 stated, "There is a risk of bleeding and a number of other things." V5 denied calling a physician regarding pharmacy's requests to obtain a PT/INR for R47. On 4/9/24 at 2:35 PM, V13 (Director of Nursing) stated, "A prudent nurse would know that you don't give Coumadin without knowing the labs (PT/INR). There are certain medications that you don't mess around with and one of them is Coumadin." V13 stated Coumadin orders should be entered with stop and start dates based off the ordering of PT/INR levels as a reminder to the nurse to check the lab result. V13 stated	S9999		

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S9999	Continued From page 18 residents should not be on Coumadin without frequent orders to monitor PT/INR levels. On the survey date 2/27/24, the facility was cited at an Immediate Jeopardy at F760 for not monitoring PT/INR levels or adjusting Coumadin dosing for R11. The facility's Plan of Correction (POC)/Abatement Plan for F760 with a completion date of 2/25/24 states, "1. The corrective action for the alleged deficient practice has been achieved by the following: c. All nursing staff including agency nurses in-serviced on facility policy and protocol for lab monitoring of high-risk medications on 2/24/24." "e. The Regional Clinical Director and/or designee will follow the Quality Assurance Monitoring Program of high-risk medications and labs twice weekly x (times) 3 (three) months. f. All nursing staff including agency educated on notification to physician and conformance with physician orders by Regional Clinical Director." This same POC documents that due to the implemented interventions, deficient practice will not recur. "4. The following Quality Assurance Programs have been implemented to monitor and ensure the alleged deficient practice will not recur: c. Facility IDT (Interdisciplinary Team) to review currently admitted residents for completeness of medical record by 3/1/24." As of 4/2/24, the facility was unable to produce documentation that R47's medical record was being audited/monitored for R47's high-risk medication, Warfarin as part of the facility's Plan of Correction. (A)	S9999		