STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009294	A. BUILDING: _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE SKILLED NUR & REHAB	333 SOUTH WRIGHTSMAN STREET VIRDEN, IL 62690

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S 000	Initial Comments Complaint Survey: 2544322/IL192481	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)2 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 2) All treatments and procedures shall be administered as ordered by the physician. These Requirements were NOT MET as evidenced by:	S9999		

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S9999	Continued From page 1	S9999		

Based on interview and record review, the facility failed to obtain physician ordered laboratory testing in 1 of 3 residents (R2), reviewed for medication monitoring in the sample of 9. This failure resulted in R2 being admitted to the hospital on 5/8/25, where he remains. R2 was diagnosed in the hospital with Supratherapeutic INR (Initial Normalized Ratio) with a level greater than 10 (target range is between 2-3) and had to receive medication to reverse the effects from the anticoagulant, Warfarin, that R2 was receiving in the facility for a diagnosis of Pulmonary Embolism.

Findings include:

On 5/20/25 at 10:30 AM, V5, R2's Sister, stated R2 is currently in the hospital preparing for surgery to remove a large cancerous mass in his intestines. V5 stated she is concerned about R2's Coumadin not being checked at the facility like it is supposed to be, it is to be checked weekly and hasn't been checked since March 2025. V5 stated when R2 was in the ER (Emergency Room) his blood count was 3 and his INR which is supposed to be between 1-2 was greater than 10. V5 stated this is not acceptable and whoever is to be checking to make sure his INR is being checked failed, the bedside care and the nurses are good at the facility and have saved R2's life a few times, but this is unacceptable.

R2's ER (Emergency Room) Notes, dated 5/8/25, document R2's INR was greater than 10, R2 was started on Vitamin K and Kcentra (medication used to reverse the effects of Warfarin). Admit to ICU (Intensive Care Unit) for multiple problems, critically ill patient. Impression: Sepsis, Leukocytosis, GI (Gastrointestinal) Bleed, Elevated Lactic Acid Level, Elevated INR.

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S9999	Continued From page 2	S9999		

R2's History and Physical, dated 5/8/25, documents the following: Impression - Acute Blood Loss Anemia, Probable GI Bleed, Supratherapeutic INR, Hx of PE. Reversal of Coumadin with Kcentra.

R2's Hospital Laboratory Results, dated 5/8/25, document R2's Hgb (Hemoglobin) level was 3.8 (normal range is 14 - 18); PT (Prothrombin Time) level of greater than 80 seconds (normal range is 11.6-14.5); INR level of greater than 10 (normal range is 0.9-1.1 with a suggested therapeutic range of 2-3); FOB (Fecal Occult Blood) was positive. R2 received four blood transfusions on 5/9/25 and one on 5/13/25.

R2's Final pathological diagnosis from the colon biopsies, dated 5/15/25, documents a colon/cecal mass that is an invasive moderately differentiated adenocarcinoma, the colon showed fragments of tubulovillous adenoma.

R2's Colorectal Surgery Consult, dated 5/15/25, documents R2 has a history of DVT(Deep Vein Thrombosis)/PE on Warfarin, Hgb 3.8, Supratherapeutic INR greater than 10, reversal with Kcentra. Admitted to ICU. EGD (Esophagogogastroduodenoscopy) and colonoscopy revealed a large cecal mass as well as a foreign body within the cecum, likely a bone.

R2's Cardiology Consult, dated 5/17/25, documents R2 has a history of subsegmental PE (Pulmonary Embolism), admitted for acute blood loss anemia with a Supratherapeutic INR greater than 10. Continue holding Coumadin (Warfarin).

R2's Face Sheet, Undated, documents R2 has a diagnosis of Pulmonary Embolism and

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Atherosclerosis of the Arteries of the Bilateral Lower Extremities.

R2's Physician Order Sheet (POS), has the following orders: 3/6/25 Warfarin 6 mg (milligrams) every evening for Pulmonary Embolism and 4/23/25 Check a PT/INR (Prothrombin Time/Initial Normalized Ratio) weekly on Mondays.

R2's Care Plan, dated, 9/23/22, documents R2 is at high Risk For Abnormal Bruising or Bleeding Related to Anticoagulant Therapy with Warfarin and an intervention to conduct therapeutic lab monitoring and report results as ordered by physician or anticoagulant clinic.

R2's last PT/INR was completed on 3/26/25. There were no other PT/INR results completed after this date.

A fax to V6, R2's Physician, dated 4/23/25, from V2, DON (Director of Nurses), documents that R2 had not had a PT/INR since 3/26/25 and V6 ordered a PT/INR to be completed weekly.

On 5/20/25 at 11:50 AM, V6, R2's Physician, stated verified that he gave an order on 4/23/25 to check R2's PT/INR weekly. V6 stated R2 is on Warfarin and a residents therapeutic INR level is dependent on what they are on it for. V6 stated he would need to re-evaluate R2's Warfarin. V6 stated an INR of 10 is not ideal because it allows bleeding and could lead to a person bleeding to death.

V7, RDO (Regional Director of Operations), stated V2, DON, identified a problem with the PT/INR's not being drawn so they did a past non-compliance, have in-serviced and are

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completing audits.

On 5/20/25 at 12:49 PM, V2, DON, stated R2's PT/INR's should have been drawn weekly after 4/23/25 as they were routine. V2 stated R2 should have been drawn on 5/5/25 and wasn't. V2 stated she called the lab and was told that it wasn't drawn because there was no carbon copy with the lab requisition, but that it still should have been drawn.

The Anticoagulant Policy/Procedure, dated 11/4/20, documents the following: The facility shall provide anticoagulation medications and perform surveillance as directed by the primary care physician and/or facility medical director. The Physician should adjust the anticoagulant dose or stop, taper, or change medications that interact with the anticoagulant, and/or monitor the PT/INR very closely while the individual is receiving Warfarin, to ensure that the PT/INR stabilizes within a therapeutic range. They physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications; for example, periodically checking hemoglobin/hematocrit, platelets, PT/INR, and stool for occult blood. If Warfarin is used the staff should use a Warfarin flow sheet or come comparable means to follow trends in anticoagulant dosage and response in individuals on Warfarin.

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