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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2011
NAME OF PROVIDER OR SUPPLIER LINCOLN MEADOWS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 3rd St, Lincoln, CA 95648-1576 PLACER COUNTY	

(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) COMPLETE DATE
<i>Do begin immediately and be corrected by 3/27/13. CRC letter given on 3/21/13.</i>	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:</p> <p>CLASS AA CITATION – PATIENT CARE 03-2171-0009792-F Complaint(s): CA00274673</p> <p>Representing the Department of Public Health Surveyor ID # 26663, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>F-279 483.20 Develop Comprehensive Care Plan (d) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under section 483.25, and any services that would otherwise be required under section 483.25 but are not provided due to the resident's exercise of rights under section 483.10, including the right to refuse treatment under section 483.10(b)(4).</p>			

Event ID: 025J11

3/21/2013

11:38:51AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

NHA

TITLE

RN, DON

(X6) DATE

3/21/13

4/4/13

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 11

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. Except for nursing homes, the findings 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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	<p>F329 483.25 Drug Regimen is Free from Unnecessary Drugs</p> <p>(I) 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.</p> <p>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.</p> <p>An unannounced visit was made on 7/11/11 to initiate an investigation of Complaint #CA00274673 concerning quality of care and treatment. The reports identified allegations Resident 1 had [redacted] sustained a [redacted] injury and [redacted]. As a result of the investigation, it was determined that the facility failed to:</p> <p>1. Ensure the resident was free from unnecessary drugs when Coumadin/warfarin was ordered and administered for 17 days without monitoring which</p>		<p>This Plan of Correction is prepared as part of the Quality Assurance process for the provider. This Plan of Correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such is protected from discovery.</p> <p>This Plan of Correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes and/or guidelines. As this transmission is required by law, it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes.</p> <p>Plum Healthcare was not the management company at the time of this occurrence. None of the management team is currently employed at the facility. Multiple attempts were made to reach the previous management team but were unsuccessful. The DSD and DON looked for any Licensed Nursing in-services concerning this event from the time period of May 2011 through August 2011 but were unable to be located.</p> <p>Resident 1 was discharged to acute care on [redacted] 11 and did not return.</p>	

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3/21/2013

12:46:10PM

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	<p>contributed to his [redacted] from [redacted] in the [redacted] and [redacted] y [redacted].</p> <p>2. Revise a care plan for anticoagulant treatment when Coumadin was ordered.</p> <p>Resident 1 was originally admitted to the facility on [redacted] 06 with diagnoses which included a prior [redacted] with [redacted] of [redacted] and [redacted] [redacted] [redacted] (the [redacted]) and recurrent [redacted] [redacted]. Resident 1's most recent readmission was [redacted] /11, following treatment of recurring [redacted] [redacted]. In the event of a cardio-pulmonary arrest (loss of heart and/or lung function), Resident 1 was to be fully resuscitated (Full.Code).</p> <p>The last full MDS (minimum data set, an assessment tool) dated 10/6/10, described Resident 1 as being [redacted] [redacted], but he used signs and gestures to enable staff to understand his needs. Resident 1 was described as having [redacted] [redacted] [redacted] problems and modified [redacted] skills. The resident was not able to [redacted], but used a [redacted] to move himself around the facility.</p> <p>Review of the clinical record initiated on [redacted] /11 for Resident 1 revealed the following:</p> <p>Readmission physician's orders dated [redacted] 11 included [redacted] [redacted] [redacted] [redacted] s. PT stands for Prothrombin Time. INR stands for International Normalized Ratio, a test which measures blood</p>		<p>F 279</p> <p>It is the policy of Lincoln Meadows to develop, review and revise the resident's comprehensive plan of care. Care plans will include measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The Director of Nursing completed a house wide audit on 3-21-2013 on all residents receiving anticoagulants medications to verify that a comprehensive care plan's are in place. There were no other residents that have been affected by the alleged deficient practice.</p>	

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	<p>clotting time) monitor for Coumadin." (Coumadin is a medication to prevent clot formation), "Coumadin, start when bleeding stops - review by PCP" (primary care physician).</p> <p>A laboratory report dated [redacted] 11 at 1:30 p.m. documented INR level of [redacted] and indicated the level was normal for someone not receiving anti-coagulation therapy. The INR lab report dated [redacted] /11 contained a hand written note "Resident currently not on any dosage of Coumadin, please decide dosage." To the right of this note, in different handwriting was "D/C [discontinue] I&R (INR) if not on Coumadin [redacted] /11 per [MD name] at 1345 (1:45 p.m.)." A third written note was below the first and it documented: "Resident new admit from hospital. Came with order for Coumadin but no dosage. PT/INR done to set parameter. Please advice (sic)!"</p> <p>A physician's order dated [redacted] /11 for "Verbal order from NP (nurse practitioner) to start Coumadin 3 mg. (milligrams, a unit of measure for medications) orally every evening for prophylaxis (prevention measure)." The order was written at 4 p.m.</p> <p>The Medication Administration Record (MAR) for [redacted] 2011 included an entry for Coumadin 3 mg orally, at bed time each day. The medication was documented as given daily starting [redacted] 11. The MAR also had an entry for PT/INR every Monday and Thursday. There were no signatures on any dates indicating a lab test result was available or checked. The clinical record contained no other laboratory reports documenting PT/INR values after</p>		<p>All licensed nurses will be in-serviced by the DON/Designee regarding the policy and procedure on "comprehensive care plan development" by 3/27/2013. The care plan will include: the medication order; and a observation for S/S of bleeding and if present to have Licensed Nurse evaluate and notify the DON or Designee in the event of which an RN is not available to assess, then notify the MD/NP for further orders; and Lab tests (PT/INR) as ordered with abnormal results reported to MD/NP based on the INR protocol (see attached); and identification of other medications that can potentially affect PT/INR readings and communicate with MD/NP for further orders.</p> <p>IDT will review any new resident's or any new prescriptions of anticoagulant medication for proper care planning.</p>	

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	<p>5/12/11.</p> <p>Review of LexiComp.com, an on-line drug information source revealed the following information (in part) about warfarin, the generic name for Coumadin:</p> <p>"Warfarin is used for chronic oral anticoagulation in a variety of clinical settings. Monitoring warfarin therapy by adjusting the INR to lie within the recommended range for the disorder treated (e.g., 2.0-3.0) is recommended. Dosing warfarin is more complex than with many drugs.</p> <p>High alert medication. The Institute for Safe Medication Practices (ISMP) includes this medication among its list of drugs which have a heightened risk of causing significant resident harm when used in error.</p> <p>Genatric Considerations: Before committing an elderly resident to long-term anticoagulation therapy, the risk for bleeding complications secondary to falls, drug interactions, living situation, and cognitive status should be considered. A risk of bleeding complications has been associated with increased age.</p> <p>Adverse Reactions - Bleeding is the major adverse effect of warfarin. Hemorrhage may occur at virtually any site. Risk is dependent on multiple variables, including the intensity of anticoagulation and resident susceptibility.</p> <p>Warnings/Precautions Hemorrhage: Possible</p>		<p>The DON or Designee will be completing a QA audit on all resident receiving anticoagulant medication monthly for the next 3 months. The DON/Designee will report any non-compliance to the QA/QI committee for the next three months. The QA/QI committee will provide further recommendations as needed.</p> <p>The QA/QI Committee will make a determination as to the frequency of the ongoing monitoring for compliance based on the outcome of the reviews.</p> <p>Completion date: 3/27/2013</p>	

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	<p>massive hemorrhage involving the GI (gastrointestinal) tract, spinal cord, GU (genitourinary tract), cerebral, pericardial, pulmonary, adrenal, or hepatic (liver) sites. Hemorrhagic (bleeding) complications may be manifested by signs or symptoms that do not indicate obvious bleeding, such as paralysis; headache; pain in the chest, abdomen, joints, muscles, or other areas; dizziness; shortness of breath; difficulty breathing or swallowing; unexplained swelling; weakness; hypotension (low blood pressure); or unexplained shock. Results principally from overdosage. Careful clinical management, including frequent PT or INR determinations, is required."</p> <p>The Coumadin product information provided by the manufacturer with the medication validated the above reference. In the section titled, Highlights of Prescribing Information, (in part) stated: "WARNING: BLEEDING RISK. Coumadin can cause major or fatal bleeding. Perform regular monitoring of INR in all treated patients...Monitoring: Obtain daily INR determinations until stable in the therapeutic range. Most common adverse reactions to COUMADIN are fatal and nontatal hemorrhage from any tissue or organ...An INR of greater than 4 appears to provide no additional therapeutic benefit in most patients and is associated with a higher risk of bleeding. Patients 60 years or older appear to exhibit greater than expected INR response to the anticoagulant effects of warfarin...Therefore, as patient age increases, a lower dose is usually required to produce a therapeutic level of</p>		<p>F 329</p> <p>It is the policy of the facility to ensure that each resident's drug regimen is 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.</p> <p>The DON and Consultant Nurse completed chart audits on 3-21-2013, 3-28-2013 and on 3-29-2013 of all residents receiving anticoagulant medication to ensure that all residents have an appropriate diagnosis for use, PT/INR's are ordered, and that all results that are out of normal range are called to MD/NP in a timely manner. On 3-29-2013 during a visit from DPH, one resident out of 11 residents on Coumadin therapy was noted to have an incorrect order transcribed on the electronic health record, which was also reflected on the printed MAR "medication administration record".</p>	

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	<p>anticoagulation..." The product insert also included specific guidelines for monitoring</p> <p>On [redacted] 11 (Day #7 of his anticoagulation therapy), Resident [redacted] from his [redacted] without apparent injury. Neurological assessments were done but there was no documented evidence that a bleeding risk was considered or anticoagulation monitoring ordered.</p> <p>A Fax Notification Form dated 5/26/11 at 3:30 p.m. (Day #14 of his anticoagulation therapy) documented, "Resident had an unwitnessed and unassisted [redacted] at [redacted] (military time for [redacted] p.m.). Resident was sitting in [redacted] and [redacted] to floor [redacted] to upper [redacted] and to [redacted] [redacted] due to rug burn, no S/T (skin tear) observed. [redacted] eye [redacted] and purple discoloration. Observed VS (vital signs) [redacted], [redacted] (pulse), [redacted] (respirations), [redacted] (temperature in Fahrenheit). [Complains] to [redacted]. No swelling or discoloration noted to [redacted]s. Will continue to observe." The physician documented "noted" and signed the form and returned it to the facility on [redacted]/11. There was no acknowledgement of an elevated temperature, and no orders were given. This note was signed by a Licensed Vocational Nurse (LVN). There was no documented evidence that anticoagulation monitoring was considered or ordered.</p> <p>A Nurse's Note dated [redacted] 11 at 9:30 p.m. included, "DON (Director of Nursing) notified and will do an assessment tomorrow." A Nurse's Note dated [redacted] 11 at 2:53 a.m. documented the</p>		<p>A QA plan of action was immediately completed by the DON on all residents receiving Coumadin therapy, comparing electronic health record orders of Coumadin to the written order on the MAR "medication administration record". No other residents have been found to have been affected by the alleged deficient practice. Effective immediately beginning 3-29-2013 the admission nurse and another licensed nurse, will complete a comparison of admission orders from the acute hospital with the electronic health record order and MAR "medication administration record" order on every new admission and every new order for Coumadin for any existing patient at Lincoln Meadows. We will monitor this by tracking the signatures of both licensed nurses on the printed physician order. The signed printed physician order will be kept in the plan of correction binder.</p>	

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	<p>resident had a temperature of [redacted] to [redacted] side of face. [redacted] "The note was not signed. A Nurse's Note dated [redacted]/11 at [redacted] a.m. included "Right is [redacted] and [redacted] side of face has two [redacted] and [redacted]." The note was not signed. On the same day at [redacted] p.m. the notes indicated [redacted] refused to get out of bed, [redacted] bruised [redacted], generalized [redacted]"</p> <p>There was no documentation in the record that Resident 1 was assessed by a Registered Nurse (RN) following his [redacted]. During an interview with the DON on [redacted]/11 at [redacted] p.m. she stated "I came in on the night shift and assessed [Resident 1]...I have no note...I was concerned his [redacted] was [redacted]." The DON stated there was not an x-ray done of the resident's [redacted]. The DON was not able to locate an RN assessment of Resident 1 following the fall.</p> <p>On [redacted]/11 at 1:35 p.m., there was an indication that the family member "wanted to speak to Hospice to decide if that is the next step..." An untimed and unsigned order for a Hospice Consult was in the clinical record</p> <p>On [redacted]/11 Resident 1 was transferred to the emergency room of a General Acute Care Hospital (GACH) following a change in condition. The resident's condition was described in a [redacted]/11 Nurse's Note at 5:56 p.m. as "Alert and responsive...rapid respirations and low BP (blood pressure)" The resident's blood pressure was [redacted] (normal range was 100/60 to 140/90) and</p>		<p>The facility DON or Unit Coordinators at Lincoln Meadows will review all PT/INR results and Coumadin dosages daily for the next 30 days. Post 30 days a Licensed Nurse will review the PT/INR results upon receipt with notification to MD/NP. Medical Records or DON will audit PT/INR orders and Coumadin orders weekly for the next 30 days. On 3-29-2013, Consultant Pharmacist completed an audit on all residents receiving Coumadin therapy for appropriateness of dosage, adequate monitoring, and the potential for drug to drug interaction. No recommendations were given.</p> <p>The facility DON completed an in-service for all Licensed Nurses on 3/27/2013 on anticoagulant medication use, necessary lab tests, INR protocol, and when to notify MD/NP for S/S of side effects and necessary interventions.</p> <p>IDT will review any new resident admitted with Coumadin orders or any existing resident with any new prescription for Coumadin for appropriate indication of use, dosage and lab tests.</p>	

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	<p>his respiratory rate was [redacted] per minute (normal range was 16-20 per minute).</p> <p>Review of the GACH clinical record for Resident 1's admission on [redacted]/11 revealed: A History and Physical report dated [redacted]/11 which included: "Assessment (1) [redacted] with [redacted] (2) [redacted] (inside the [redacted] with [redacted]. This is probably secondary to his [redacted] and his coagulopathy. (3) [redacted] due to medical treatment). The resident probably is on Coumadin, and his INR is more than [redacted]. I do not think the resident is going to survive this episode." A laboratory report dated [redacted]/11 included an INR result of "[redacted]" ([redacted] times normal).</p> <p>On [redacted]/11, Resident 1 was transferred from the GACH to another skilled nursing facility for comfort care. He died there on [redacted]/11 at [redacted] a.m.</p> <p>The Death Certificate for Resident 1 listed the following diagnoses: 1. [redacted] and [redacted]; 2. [redacted] between the [redacted]; 3. Probably secondary to Coumadin."</p> <p>Review of undated facility policy titled "INR Coumadin Protocol" included (in part) "Notify the attending physician of PT/INR results of 3.0 or greater. 3. If INR is greater than 3.0 a. hold Coumadin."</p>		<p>DON or Unit Coordinators will complete a monthly record review on 10% of resident's and report on any non-compliance to the QA/QI committee for the next 3 months.</p> <p>The QA/QI committee will make a determination as to the frequency of the ongoing monitoring for compliance based on the outcome of the reviews.</p> <p>Completion date: 4/04/2013</p>	4/4/13

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12:46:10PM

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	<p>During an interview with LN 4 on 9/16/11 at 3:25 p.m. LN 4 stated "Before giving Coumadin I want to know the INR results. Monday and Thursday INRs are routine for our residents. All Coumadin is given on PM shift, PM nurses know to get the INR every Monday and Thursday."</p> <p>During an interview with the Director of Nursing (DON) on 7/13/11 at 3:30 p.m. she stated they had reviewed the record and were unable to locate the lab tests following the [REDACTED]/11 test. The DON stated "We're following up with the lab, they didn't come and draw blood, they received the order but never came out." The DON stated "The evening shift nurse is responsible for ensuring the INR is done when they give the medication." The DON verified the PT/INR tests ordered twice weekly on Mondays and Thursdays after Coumadin was started were not done for Resident 1 on the following scheduled days: [REDACTED]/11, [REDACTED]/11, [REDACTED]/11, [REDACTED]/11 and [REDACTED]/11.</p> <p>Resident 1 had received Coumadin 3 mg. daily for 17 days without any laboratory monitoring. An INR of [REDACTED] was six times the therapeutic range for prevention of blood clots.</p> <p>Further review of the clinical record revealed for Resident 1 revealed:</p> <p>A 9/23/10 Care Plan for Risk for bruising and/or abnormal bleeding referenced the use of Plavix, a blood thinner which was no longer administered to the resident after his discharge on [REDACTED]/11. The care plan included a goal of "will have therapeutic levels</p>			

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2011
NAME OF PROVIDER OR SUPPLIER LINCOLN MEADOWS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 3rd St, Lincoln, CA 95648-1576 PLACER COUNTY		
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	<p>of medications [without signs and symptoms] of abnormal bleeding and excessive bruising daily [through] 7/6/11." No other blood thinner care plan was in the record and no revision was documented when the Coumadin was ordered.</p> <p>In an interview with the DON on 10/18/11 starting at 1:15 p.m. she stated the anticoagulant care plan "should have been changed when he went on Coumadin."</p> <p>As a result of the investigation, it was determined that the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure the resident was free from unnecessary drugs when Coumadin/warfarin was ordered and administered for 17 days without monitoring which [redacted] to [redacted] from [redacted] in the [redacted] 2. Revise a care plan for anticoagulant treatment when Coumadin was ordered. <p>These violations presented either (1) imminent danger that death or serious harm to the patients or residents of the long-term health care facility would result therefrom, or (2) substantial probability that death or serious physical harm to patients or residents of the long-term health care facility would result therefrom and were a direct proximate cause of death of the patient or resident.</p>			

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