



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/31/2012
NAME OF PROVIDER OR SUPPLIER  ROSEWOOD POST ACUTE REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 6041 Fair Oaks Blvd, Carmichael, CA 95608-4816 SACRAMENTO COUNTY		
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	<p>72311 - Nursing Services - General (b) All attempts to notify licensed healthcare practitioners acting within the scope of his or her professional licensure shall be noted in the patient's health record including the time and method of communication and the name of the person acknowledging contact, if any. If the attending licensed healthcare practitioner acting within the scope of his or her professional licensure or his or her designee is not readily available, emergency medical care shall be provided as outlined in Section 72301(g).</p> <p>72523 - Patient Care Policies and Procedures (a) Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved.</p> <p>72547 - Content of Health Record (a) A facility shall maintain for each patient a health record which shall include: (5) Nurses' notes which shall be signed and dated. Nurses' notes shall include: (D) Justification for the results of the administration of all PRN medications and the withholding of scheduled medications.</p> <p>Unannounced visits were made to the facility on 12/13/12 and 12/31/12 to investigate an Entity Reported Incident #CA00103216.</p> <p>As a result of the investigation, the Department determined the facility failed to:</p>		<p>PT/INR's are drawn every Monday and Thursday by the facility contracted laboratory. The nurse responsible for residents on warfain prints the results from the drawn PT/INR's prior to additional administration of warfain dose. Results are documented in the body of the order in the E-mar, if results are not within the desired PT/INR range for diagnosis the responsible nurse will contact the physician for instructions.</p> <p>All residents on anti-coagulation therapy will have an individualized written care plan developed and implemented with updates completed as necessary to reflect needs.</p> <p><b>What measures will be put into place or what are the systemic changes the facility will make to ensure that the deficient practice does not recur:</b></p> <p>Licensed staff have been re-educated on the policy and procedure for residents on warfain therapy.</p>	

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11/13/2013

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*Cynthia White Pulans 11/21/13*

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	<p>1) Ensure an individualized written patient care plan was developed and implemented for Patient A,</p> <p>2) Notify Patient A's physician of an administration of a medication which was life threatening and presented a risk to the patient,</p> <p>3) Ensure written policies and procedures were implemented,</p> <p>4) Maintain clinical records in accordance with professional standards.</p> <p>These failures resulted in Patient A sustaining an acute subdural hematoma (a collection of blood between the brain and the membrane lining the skull) subsequent to an over dose of Warfarin (an anti-coagulant or "blood thinner"). The bleeding resulted in Patient A's death.</p> <p>Review of Patient A's clinical record indicated she was admitted to the facility on [REDACTED] 06 and her diagnoses included femur fracture requiring surgery, chronic renal insufficiency (decrease in kidney function), high blood pressure, and dementia. According to her record Patient A had lived at a board and care facility where she had a fall that required surgery and was admitted to the facility for rehabilitative therapy.</p> <p>Patient A's Admission Nursing Assessment dated [REDACTED] 06, described her as alert, friendly and cooperative, as being disoriented to place and person and unable to answer questions appropriately.</p> <p>Review of Patient A's record indicated the following physician's orders were recorded:</p>		<p>All residents on warfain therapy will have their PT/INR blood drawn by the contracted laboratory on Monday and Thursday and PRN. The results of the PT/INR are documented in the body of the order on the E-Mar. If results are not within the desired range for diagnosis the nurse will contact the physician for instructions and document the conversation with the physician in the EHR.</p> <p>If any warfain dose is with held the nurse will document the reason in the EHR and notify the physician and document the conversation with physician in the EHR.</p> <p><b>How will the facility plan to monitor its performance to make sure that solutions are sustained and integrated into the QA program:</b></p> <p>The medical records department will audit the PT/INR results twice weekly for compliance with prescribed dose of warfain, physician notification and that follow up has been implemented.</p>	

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	<p>1. Warfarin (an anticoagulant or "blood thinner") 5 milligrams (mg) to be given one time on [REDACTED] 12.</p> <p>2. A laboratory blood test called <b>PT// NR</b> (Prothrombin Time/International Normalized Ratio) was to be checked weekly on Monday (the first Monday after the order was written was [REDACTED] 06) to monitor the effectiveness of the Warfarin.</p> <p>PT is a blood test that measure how long it takes blood to clot and is used when patients receive a blood thinner, such as Warfarin, to measure the effectiveness of the drug. INR-International Normalized Ratio measures the time it takes for blood to clot and standardizes the PT by comparing it to an average. The normal INR reference range is 0.90 to 1.10, and the reference range to prevent post-surgical DVT (Deep Vein Thrombosis, a blood clot in a deep vein, usually in the legs) is 2.0 to 3.0.</p> <p>The manufacturer's labeling information for Warfarin includes a "black box" warning (the strongest adverse effect information required by the Food and Drug Administration) indicating the medication has the potential to cause major or fatal bleeding. Risk factors include high intensity of anticoagulation (INR greater than 4.0), high blood pressure and renal insufficiency.</p> <p>3. Nursing staff was to call Patient A's physician for further Warfarin orders on [REDACTED] 06 after the facility received the PT/INR results. On [REDACTED] 06 the physician ordered Warfarin 5 mg daily to prevent DVT and PT/INR on Thursday [REDACTED] 06.</p>		<p>All residents on warfarin therapy will have a current working care plan that will be revised as necessary. Quarterly the chart will be reviewed by the IDT and by MDS coordinators for compliance. Results of these audits will be reviewed at the quarterly quality assurance committee. Results of the audits will be used as coaching, education and counseling licensed staff.</p> <p>Persons responsible for the corrections are the DON, ADON, and medical records staff.</p> <p><b><u>The date when corrective action will be completed:</u></b></p> <p>Date of compliance is 11/19/2013 1159 p.m.</p>	

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	<p>A laboratory report dated [REDACTED] 06 indicated Patient A's INR was 2.09 (reference range for DVT prevention 2.0-3.0), and therefore within the acceptable range to prevent DVT.</p> <p>A laboratory report dated [REDACTED] 06 indicated Patient A's INR was 2.92 and therefore within the acceptable range to prevent DVT. Review of Patient A's record revealed no documentation that the physician was notified of the laboratory results.</p> <p>A laboratory report dated [REDACTED] 06 indicated Patient A's INR was 5.48 HP (HP next to the lab value indicated the result was high at panic level) (reference range for DVT prevention 2.0-3.0). There was no documented evidence that Patient A's physician was notified of the high (panic level) results.</p> <p>Review of a policy titled, "Lab Work, Ordering of," dated 3/95, indicated "Purpose: To ensure all laboratory tests are performed as ordered, on a timely basis and that all test results are reported to the physician when received by the facility." The policy also indicated that "5. A licensed nurse may take phone reports of lab results and record it on a preliminary telephone report form.. 6. A licensed nurse will phone the lab results to the physician and make notation on the report of the date, time, and who the results were given to, one report will be filed in the chart until replaced by a printed report. A licensed progress note will be made of lab results, physician notification and any new orders. 7. A licensed nurse will review the reports and initiate appropriate measures when indicated.</p>			

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	<p>including infection control procedures."</p> <p>During an interview with the DON (Director of Nursing), on 12/13/12 at 11:45 a.m., she confirmed there was no documented evidence that the physician was notified of Patient A's PT/INR results on [REDACTED] 06 and [REDACTED] 06, per the facility's policy. She further confirmed she would expect some type of documentation to be in the chart.</p> <p>Review of a fax from the laboratory dated [REDACTED] 07 at 11:16 a.m., with Patient A's PT/INR results dated [REDACTED] 06, indicated the PT/INR results were called and "accurately" read back by Licensed Nurse (LN) 1.</p> <p>The facility supplied an example of a pre-printed care plan titled, "Risk for bleeding due to use of anticoagulant therapy," dated January 1995. Review of Patient A's record revealed no evidence that this care plan or any other care plan related to Patient A's anticoagulation therapy was developed for Patient A.</p> <p>During an interview with the DON, on 12/13/12 at 11:45 a.m., she confirmed there was no care plan regarding Patient A's anticoagulation therapy.</p> <p>Review of Patient A's Daily Medicare Note, dated [REDACTED] 07 AM Shift (no exact time), indicated Patient A had a "large bruise on the left hip. Bleeding from surgery staples."</p> <p>Resident A's Nurse's Notes dated [REDACTED] 07 at 9:40 a.m. indicated Patient A was noted at</p>			

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	<p>approximately 9:15 a.m. with a decreased level of consciousness (LOC). Patient A was described as "non-verbal" at the time with "some moaning," "movement responsive to touch." Patient A's physician was notified. Patient A required transfer to the Emergency Room (ER) of a general acute care hospital (GACH) for evaluation, admission and treatment.</p> <p>Review of Patient A's Medication Sheet, for December 2006, indicated that Warfarin 5 mg was given once daily from [REDACTED] 06. The Medication Administration Record (MAR) indicated that from [REDACTED] 06 the licensed nurses initials were circled. There was no entry for [REDACTED] 06.</p> <p>During an interview with the DON, on 12/13/12 at 11:10 a.m., she confirmed initials with a circle around them indicated the patient did not take or refused the medication.</p> <p>Review of the facility's policy titled, "Refused Medication or Drugs not Given," undated, indicated "1. Licensed Nurse initials and circles the medication record and documents the reason for omission on the back of the medication record. 2. The Licensed Nurse shall promptly notify the physician of the inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies or services as prescribed under conditions which present a risk to the health, safety, or security of the resident. 3. Documentation shall include all attempts to notify the physician, method of communication and name of person</p>				

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	<p>acknowledging contact"</p> <p>During an interview with the DON, on 12/13/12 at 11:45 a.m., she confirmed there was no documentation, on the back of the medication record, of the reason why the Warfarin was charted as not given to Patient A by LNs from [REDACTED] 06. The DON also confirmed there was no documented evidence the LNs notified the physician of the inability to obtain or administer Warfarin, per the facility's policy.</p> <p>Review of a facility document titled "Investigation Report of Incident" with the "Date of incident: [REDACTED] 07" indicated Patient A was "found with change in LOC." The "Investigation Report of Incident," indicated the facility reviewed Patient A's chart and laboratory reports and noted that Patient A's PT/INR were at "panic level" and that "this was not acted upon by the nurse on duty who then gave Warfarin in error."</p> <p>Review of a facility document titled, "Investigation of [Patient A]," dated [REDACTED] 07, indicated that Patient A's labs were reviewed and "it was noted that the labs on [REDACTED] 06 were unanswered by the in house nursing staff. The lab was a critical PT/INR out of range" The facility's investigation report indicated the facility's Administrator called the lab company to see if the lab called or faxed the report to the facility. The lab indicated they spoke to LN 1 on [REDACTED] 06 who read back the PT/INR report. LN 1 was assigned to Patient A on [REDACTED] 06. The investigation report indicated that LN 1 gave the Warfarin on [REDACTED] 06 and that LN 1 indicated he did</p>			

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	<p>not look to see if a lab had come back. Other nurses were questioned and they indicated they gave the Warfarin on the days following the date of the lab (■■■■/06-■■■■06). The facility's investigation report indicated Patient A's MAR had circles around the Warfarin doses for ■■■■-■■■■06. The facility investigative report indicated when the facility questioned some of the nurses about the circled initials, they said they gave the Warfarin as ordered (■■■■■■06) and they did not know about the circles around the initials and did not know of an order to hold (not give) the Warfarin.</p> <p>Review of a facility's document titled, "Incident/Accident Report," with a "Date of incident/accident" as ■■■■07. The document indicated Patient A was given Warfarin without verification of the lab results (which was a critical lab value) that was called by the laboratory to LN 1.</p> <p>Review of Patient A's GACH Emergency Room Report, with a "Date of Treatment: ■■■■07" indicated Patient A's INR was greater than 13 [reference range for DVT prevention 2.0-3.0]."</p> <p>Review of Patient A's laboratory results from ■■■■07 showed her RBC (Red Blood Cell Count) was extremely low at 1.61 (reference range 4.00-5.40 M<sup>ul</sup>), indicating significant anemia. RBCs carry oxygen from the lungs to the rest of the body. If the RBC count is low (anemia) the body may not be getting the oxygen it needs. Patient A's HGB (Hemoglobin) was 5.2 C ("C" indicates critical) (reference range 12.0-16.0 g/dl) Hemoglobin</p>			

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	<p>measures the blood's ability to carry oxygen throughout the body. Patient A's HGT (Hematocrit) was significantly decreased at 14.9 L ("L" indicates low) (reference range 36.0-47.0%). Hematocrit shows the amount of blood volume that is made up of red blood cells.</p> <p>Review of Patient A's GACH History and Physical (H &amp; P) dated [REDACTED] 07 indicated (in part) in the section "Physical Examination" under "General" that Patient A "was unresponsive even to painful stimuli" In the "Neurologic" section Patient A was described as "unresponsive and appeared to be posturing [abnormal body positions commonly seen with brain injury or swelling]." According to the H &amp; P a CT scan [a computerized scan of body parts] of the head was done and revealed an "Acute subdural hematoma." The H &amp; P indicated Patient A had an "Acute subdural hematoma secondary to supratherapeutic (above the therapeutic level) INR" and "profound anemia (when the number of healthy red blood cells in the body is too low)."</p> <p>A subdural hematoma is a collection of blood between the brain and the skull. As blood accumulates it compresses the brain. The pressure on the brain causes the symptoms of the subdural hematoma. If pressure inside the skull rises to very high level, a subdural hematoma can lead to unconsciousness and death.</p> <p>According to the H &amp; P dated [REDACTED] 07, Patient A was not a likely surgical candidate secondary to her multiple medical problems. The GACH discharge summary documented "Admitted with</p>			

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	<p>acute subdural hematoma. Evidence of uncal herniation (a result of pressure from bleeding or any expanding lesion, portions of the brain push against the section of the brain that controls blood pressure, heart rate and respiration. If not corrected, the increased pressure will result in death.) on CT. Patient continued to decline and expired." Patient A expired on █07. No autopsy was performed.</p> <p>Patient A had laboratory tests that indicated the amount of Warfarin she was receiving was too high. Facility nursing staff did not respond to the abnormal lab reports but continued to administer the anticoagulant Warfarin, which exposed Patient A to the potential of abnormal bleeding. Facility staff did not develop a care plan indicating the goals of the Warfarin therapy and the interventions necessary to safely administer the drug. Facility staff did not notify the physician of Patient A's abnormal laboratory results. Facility staff documented Patient A's Warfarin was not given █, █06, but the facility's investigation of the incident indicated the LNs involved gave the Warfarin █, █06 and did not know why the MAR showed documentation that the medication was not given. There was no entry for Warfarin on █06 so it was not clear if the medication was given or not. The laboratory reports at the GACH indicated a "supratherapeutic" PT/INR. On █07, Patient A died due to increased brain pressure from bleeding into the skull</p> <p>The Department determined the facility failed to:</p>				

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	<p>1) Ensure an individualized written patient care plan was developed and implemented for Patient A.</p> <p>2) Notify Patient A's physician of an abnormally high PT/INR which was life threatening and presented a risk to the patient.</p> <p>3) Ensure written policies and procedures were implemented.</p> <p>4) Maintain clinical records in accordance with professional standards.</p> <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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