<table>
<thead>
<tr>
<th>Facility Management of Personal Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</td>
</tr>
<tr>
<td>The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</td>
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<tr>
<td>The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</td>
</tr>
<tr>
<td>The facility must establish and maintain a system that assures a full and complete separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</td>
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<tr>
<td>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</td>
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<td>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</td>
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<td>The facility must notify each resident that receives Medicaid benefits when the amount in the</td>
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</table>

This Plan of Correction is submitted as required under State and Federal Law. The submission of this plan does not constitute an admission on the part of NHC HealthCare, Chattanooga as to the accuracy of the Surveyors' findings nor the conclusions drawn therefrom. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.

F 159 SS=F
See next page...
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 159</td>
<td>SS=F</td>
<td>...</td>
<td>Corrective Action: 1. Interest for January 1, 2011 through April 30, 2011 will be applied to all eighty eight resident trust accounts. To be completed by: Identifying Other Patients: 1. All residents were identified during the survey as not having interest applied to their trust account. There were no other residents with trust accounts. Measure &amp; Changes to be taken: 1. Bank charges will be reimbursed to the trust account monthly to ensure that interest accrued can be allocated to each resident account monthly. To be effective with all accounts beginning May 2011.</td>
<td>6/15/11</td>
</tr>
<tr>
<td>F 281</td>
<td>SS=E</td>
<td>...</td>
<td>...</td>
<td>6/30/11</td>
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**F 159 Continued From page 1**

Resident’s account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act, and that, if the amount in the account, in addition to the value of the resident’s other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:

Based on review of resident trust accounts and interview, the facility failed to apply interest to eighty-eight of eighty-eight resident trust accounts reviewed.

The findings included:

Review of eighty-eight pooled resident trust accounts revealed no interest was applied to the trust accounts January 1, 2011, through April 30, 2011. Review of the bank account statement for the trust account for the statement period from March 1-31, 2011, revealed the average balance was $45,382.93.

Interview on May 18, 2011, at 1:00 p.m., with the Business Office Manager (BOM), in the BOM’s office, confirmed interest was not applied to the resident trust accounts from January 1, 2011, through April 30, 2011.

**F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS**

The services provided or arranged by the facility must meet professional standards of quality.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 281</td>
<td>Continued From page 2This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to follow physician's orders for four residents (#18, #20, #15, #25) of twenty-eight residents reviewed. The findings included: Resident #18 was admitted to the facility on January 27, 2000, with diagnoses including Late Effects CVA (Cerebral Vascular Accident), Chronic Renal Insufficiency and Peripheral Vascular Disease. Medical record review revealed the resident received dialysis for chronic renal insufficiency at the dialysis clinic three times a week on Monday, Wednesday, and Friday. Continued medical record review revealed the resident had a vascular catheter (vas cath) placed in the upper right chest wall for dialysis access. Review of the physician's order dated May 9, 2011, revealed, &quot;...Monitor for S/S (signs and symptoms) of bleeding at vas cath Q (every) shift...&quot; Continued review of facility documentation revealed no evidence the facility had followed the physician's order and monitored the catheter site every shift. Interview with Licensed Practical Nurse #1 on May 18, 2011, at 4:00 p.m., at the 200 hall nurses station confirmed the physician's order had not been followed.</td>
<td>F 281</td>
<td>1. Licensed Nurses will be inserviced on monitoring the vascular catheter site for Resident #18 as ordered by the physician. To be completed by:</td>
<td>6/30/11</td>
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<td></td>
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<td>2. Licensed Nurses will be inserviced on the importance and procedures in following physician orders for obtaining blood pressures when ordered on all dialysis residents which includes Residents #20 and #15. To be completed by:</td>
<td>6/30/11</td>
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<td>3. Licensed Nurses will be inserviced on the importance of taking blood pressures prior to the administration of Clonidine for Resident #25 and other Residents who have anti-hypertensive medications where prior to administration of the medication, blood pressures are ordered. To be completed by:</td>
<td>6/30/11</td>
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<td>Identifying Other Patients: 1. All Dialysis patients records will be reviewed from 5/30/11 to 6/4/11 to ensure no other Residents were affected and that we are following Physicians orders for obtaining blood pressures. To be completed by:</td>
<td>6/15/11</td>
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<td></td>
<td>2. All residents with blood pressure medications will be reviewed from 6/1/11 to 6/6/11 to ensure that no other Residents were affected and that we are following Physicians orders for obtaining blood pressures when ordered. To be completed by:</td>
<td>6/15/11</td>
</tr>
</tbody>
</table>
Resident #20 was admitted to the facility on May 4, 2010, with diagnoses including Nephrosclerosis, Hypertension and Alzheimer's Disease. Medical record review revealed the resident received dialysis treatment three days a week on Tuesday, Thursday and Saturday.

Review of the physician's order dated May 9, 2011, revealed, "Obtain BP (blood pressure) prior to leaving for dialysis & (and) upon return from dialysis on Tues (Tuesday), Thurs (Thursday), Sat (Saturday)."

Review of the resident's dialysis treatment schedule revealed the first dialysis treatment after the order had been written on was on May 10, 2011. Review of the facility's documentation for May 10, 2011, revealed no evidence the blood pressures had been obtained.

Interview with RN #1 on May 19, 2011, at 8:30 a.m., at the 300 hall nurses station confirmed the physician's order had not been followed.

Resident #15 was admitted to the facility on February 26, 2008, with diagnoses including End Stage Renal Disease, Hypertension and Diabetes.

Medical record review of the physician's orders dated April 1, 2011, through April 30, 2011, and May 1, 2011, through May 31, 2011, revealed, "Obtain vitals (vital signs) before dialysis and upon returning from dialysis..."

Medical record review of the vital signs record revealed no documentation of vital signs were...
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tr>
<td></td>
<td>Interview on May 18, 2011, at 9:10 a.m., with the Assistant Director of Nursing, in the conference room, confirmed the vital signs had not been obtained upon return from dialysis on April 8, 18, 20, 22, 2011, May 4, and May 9, 2011.</td>
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<td></td>
<td>Resident #25 was admitted to the facility on December 7, 2005, with diagnoses including Hypertension, Hemiplegia, Cardiomegaly, and Late Effect Cerebral Vascular Accident.</td>
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<td>Medical record review of a Physician's Telephone Order dated May 10, 2011, revealed &quot;...1.) Stop HCTZ (Hydrochlorothiazide-a diuretic medication used to control blood pressure) 2.) Clonidine (a medication used to control blood pressure) 0.1 mg. (milligram) TID (three times per day) PO (by mouth); hold for SBP (systolic blood pressure) &lt;100 (less than 100)...&quot;</td>
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<td>Medical record review of the May, 2011, Medication Administration Record revealed no blood pressure had been checked prior to administration of the Clonidine from the May 10, 2011, 8:00 p.m. dose through the May 18, 2011, 2:00 p.m. dose.</td>
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<td></td>
<td>Interview with LPN #2 on May 18, 2011, at 3:50 p.m., in nursing station three, confirmed the blood pressure had not been checked prior to Clonidine administration.</td>
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<tr>
<td>F 287</td>
<td>483.20(f) ENCODING/TRANSMITTING  SS=D RESIDENT ASSESSMENT</td>
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</tbody>
</table>
F 287 Continued From page 5

(1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:

(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

(2) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

(i) Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an

F 287 SS=D  
Corrective Action:
1. An MDS was completed and transmitted on resident #11. To be completed by: 6/1/11

Identifying Other Patients:
1. All Resident MDS's were reviewed from 1/1/11 to 5/25/11 to identify any other MDS's as not having been completed or submitted to the State. No other Residents were affected. Completed by: 6/1/11

Measure & Changes to be taken:
1. On or before the 10th of each month, a completed assessment report will be printed for the previous 3 months to review for timely assessments and submission of each to the State. To be effective with all residents beginning June 2011.

Monitoring Performance:
1. The DON or designee will do a QA study monthly x 2 on all resident MDS's to verify that an MDS was completed and submitted to the State. Results will be reported monthly to the QA Committee consisting of Med Dir, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by: 6/30/11
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<tr>
<th>ID</th>
<th>PREMIS</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREMIS</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 287</td>
<td>Continued From page 6</td>
<td>Initial transmission of MDS data on a resident that does not have an admission assessment.</td>
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<td>(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure timely submission of the MDS (Minimum Data Set) information for one resident (#11) of twenty-eight residents reviewed.</td>
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<td>The findings included: Resident #11 was admitted to the facility on November 5, 2011, with diagnoses including Bladder Cancer, Paraplegia, Osteopenia, Scoliosis, Degenerative Joint Disease and Pressure Ulcer.</td>
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<td>Medical record review revealed no MDS available to review after December 30, 2010.</td>
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<td>Interview with the MDS Coordinator on May 17, 2011, at 4:30 p.m. at nursing station three, revealed the MDS with an assessment reference date of March 25, 2011, had not been locked or submitted to the state.</td>
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<td>F 323</td>
<td>483.25(h) FREE OF ACCIDENT HAZARDS/SUPervision/DEVICES</td>
<td>The facility must ensure that the resident environment remains as free of accident hazards</td>
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</tbody>
</table>
F 323 Continued From page 7
as is possible; and each resident receives
adequate supervision and assistance devices to
prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation
and interview, the facility failed to ensure a safety
device was in place for one (#22) of twenty-eight
residents reviewed.

The findings included:

Resident #22 was admitted to the facility on July
30, 2010, with diagnoses including Hypertension,
Chronic Airway Obstruction, Hypothyroidism and
Malnutrition.

Medical record review of the Minimum Data Set
(MDS) dated April 14, 2011, revealed the resident
required extensive assistance with transfers,
limited assistance with walking, and had
experienced a fall since the prior assessment.

Medical record review of the Complete Patient
Care Plan reviewed on April 21, 2011, revealed
the resident was at risk for falls and a tab alarm
was to be applied when in the chair or bed.

Observation on May 18, 2011, at 4:53 p.m.,
revealed the resident seated in a wheelchair in
the resident's room. Continued observation
revealed the alarm box was located on the back
of the wheelchair, however, the tab alarm was not
attached to the resident.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>445013</td>
<td>A. BUILDING</td>
<td>05/10/2011</td>
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<tr>
<td></td>
<td>B. WING</td>
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</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

**NHC HEALTHCARE, CHATTANOOGA**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2700 PARKWOOD AVE  
CHATTANOOGA, TN 37404

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<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X2) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 8</td>
<td>F 323</td>
<td>F 323 SS-D (continued)</td>
<td>6/30/11</td>
</tr>
<tr>
<td></td>
<td>Observation and interview, on May 18, 2011, at 4:57 p.m., with Licensed Practical Nurse (LPN) #3, revealed the resident seated in the wheelchair, and confirmed the tab alarm was not attached to the resident.</td>
<td></td>
<td>Monitoring Performance:</td>
<td></td>
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<td>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</td>
<td></td>
<td>1. The DON or designee will do a QA Study monthly x 2 on 10+ Residents with safety devices that will include a visual inspection to ensure that staff followed the care plan safety instructions on each resident. Visual inspections will ensure that alarms and safety interventions are in place and working properly. Results will be reported monthly to the QA Committee consisting of Med Dir, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2 month monitoring, QA frequency may be reduced depending on results. To be completed by:</td>
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<tr>
<td>F 425</td>
<td>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</td>
<td>F 425</td>
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<td>SS-D</td>
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This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of pharmacy delivery records, observation, and interview, the facility failed to ensure timely pharmacy services for one (22) of twenty-eight residents reviewed.
NHC HEALTHCARE, CHATTANOOGA

F 425
Continued From page 9

The findings included:

Resident #22 was admitted to the facility on July 30, 2010, with diagnoses including Hypertension, Chronic Airway Obstruction, Hypothyroidism and Malnutrition.

Medical record review of a physician's order dated February 21, 2011, at 4:40 p.m., revealed "Gentamycin (antibiotic) ophthalmic (ophthalmic) ointment 1/2 inch Rt (right) eye TID (three times a day) X (times) 5 days."

Medical record review of the nursing notes revealed the following: February 21, 2011, at 8:00 p.m., "...ABT (Antibiotic) for conjunctivitis. Gentamycin to begin to Rt. Eye..."; February 21, 2011, at 11:00 p.m., "Med (Medication) from pharmacy Gentamycin ophthalmic did not come in from pharmacy"; February 22, 2011, at 11:00 p.m., "ABT eye ointment still did not arrive..."; February 23, 2011, at 1:00 p.m., "ABT eye ointment still not in facility. Pharmacy has been notified..."

Review of the pharmacy Delivery Sheets revealed the Gentamicin Ophthalmic Ointment was delivered to the facility February 23, 2011, (no time documented).

Observation on May 18, 2011, at 7:15 a.m., revealed the resident lying on the bed sleeping.

Interview on May 19, 2011, at 7:35 a.m., with the Director of Nursing (DON), in the conference room, confirmed the delay in obtaining the Gentamicin ophthalmic ointment.

F 502
483.75(1)(1) ADMINISTRATION

F 425
Incorrect Action:
1. The Gentamycin ophthalmic arrived on 2/23/11 for resident #22 and was administered as ordered from that date.

2. Nurses will be reinserviced about procedures on what to do if medication does not arrive timely from the Pharmacy. Completed by:

Identifying Other Patients:
1. To identify any other Residents affected, all medications ordered from 6/2/11 to 6/8/11 will be reviewed to ensure that all medications were delivered and dispensed timely as ordered by the physician. To be completed by:

Measure & Changes to be taken:
1. Medications that are not delivered when scheduled as ordered by the Physician are to be put on the 24 hr Nursing Report. The Charge Nurse is to call the On-Call Pharmacist and report. The Pharmacist is to make arrangements to have the medication dispensed and delivered as ordered by the Physician. If the medication is not available or not here after 24 hrs, the Physician will be notified.

2. The Pharmacy Consultant is to report on any medications not delivered and dispensed timely, as ordered by the Physician, monthly to the DON and quarterly to the QA Committee consisting of Med Dir, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. To be completed by:
Continuing From page 10

**SS-D**

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This **REQUIREMENT** is not met as evidenced by:

Based on medical record review and interview, the facility failed to ensure laboratory tests were completed as ordered for three residents (#21, #25, #27) of twenty-eight residents reviewed.

The findings included:

- Resident #21 was admitted to the facility on January 29, 2011, with diagnoses including Anemia, Diabetes Mellitus and Restless Leg Syndrome.

Medical record review of Physician's Telephone Orders dated April 1, 2011, revealed "...CBC (Complete Blood Count) in 1 week..." Continued review revealed an order on April 8, 2011, "...Hgb A1c (blood test done to assess blood sugar levels over a three month period) to be obtained (with CBC see order 4/1/11)...."

Medical record review of the resident’s chart revealed no documentation the CBC and Hgb A1c were completed on April 8, 2011.

Interview with the Director of Nursing on May 19, 2011, at 8:45 am. in nursing station three, confirmed the CBC and Hgb A1c were not completed on April 8, 2011.

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**F 425 SS-D** (Continued)

Monitoring Performance:

1. The DON or designee will do a QA Study monthly x 2 on 10+ Residents that will include a record review to ensure that medications ordered were received and administered within 24 hrs of ordering unless otherwise ordered by the Physician. Results will be reported monthly to the QA Committee consisting of Med Dir, DON or Designee, ADM or Asst ADM, SW, Dietician and other team members. After initial 2-month monitoring, QA frequency may be reduced depending on results. To be completed by: 6/30/11

Corrective Action:

1. Resident #21 had a CBC lab completed on 5/8/11 and reviewed by the Nurse Practitioner. Resident #25 had a BMP lab completed on 4/4/11 and was reviewed by the Physician’s Asst. Resident #27 had a PT/INR completed prior to discharge. Results were obtained and the resident was seen by the Nurse Practitioner.

2. Nurses will be reinserviced about the procedures on the ordering and follow through of Physician ordered labs. Completed by: 6/30/11

3. We are changing lab providers effective June 1st, 2011.
Resident #25 was admitted to the facility with diagnoses including Hypertension, Hemiplegia, Cardiomegaly and Late Effect Cerebral Vascular Accident.

Medical record review of Physician's Telephone Orders dated March 10, 2011, revealed "...BMP (Basic Metabolic Profile-blood test to assess blood chemistry) Dx.(Diagnosis) HCTZ (Hydrochlorothiazide-diuretic drug used to treat Hypertension) Rx. (prescription)...".

Medical record review of the Medication Administration Record dated March 1-31, 2011, revealed the blood test was documented to be completed on March 11, 2011.

Continued medical record review revealed a BMP had not been completed on March 11, 2011.

Interview with the Assistant Director of Nursing on May 19, 2011, at 10:05 a.m., in the conference room, confirmed the BMP order on March 10, 2011, was not completed.

Resident #27 was admitted to the facility on January 3, 2011, with diagnoses including Atrial Fibrillation, Dysphagia, Malnutrition and Congestive Heart Failure. Medical record review revealed the resident was discharged on March 14, 2011.

Medical record review of a Nurse Practitioner's order dated March 7, 2011, revealed "1. Increase Coumadin (anticoagulant) 6 mg (milligrams) PO (by mouth) daily. 2. PT/INR (test to check coagulopathy) on 3-11-11"
Continued From page 12

Medical record review revealed no documentation the PT/INR was completed on March 11, 2011.

Medical record review of the Nurse Practitioner's (NP) orders dated March 14, 2011, revealed "1. Discharge to...4. Home Health to manage Coumadin therapy...5. PT/INR now before discharge. 6. Call NP with results before discharge for PT/INR/Coumadin orders..."

Medical record review of the PT/INR results dated March 14, 2011, revealed the PT was 12.6 and the INR was 1.3 (no reference range noted). Continued review of the PT/INR results revealed the Nurse Practitioner was notified of the results and an order was obtained to increase the Coumadin to 7 mg daily.

Interview on May 18, 2011, at 8:40 a.m., with the Assistant Director of Nursing, in the conference room, confirmed the PT/INR was not completed as ordered on March 11, 2011.

Interview on May 18, 2011, at 9:55 a.m., with the Nurse Practitioner, in the conference room, revealed the resident received the Coumadin due to Atrial Fibrillation and the optimal range for the resident's INR was 2.0-3.0. Continued interview revealed the Nurse Practitioner had discovered the PT/INR was not completed as ordered on March 11, 2011, and re-ordered the PT/INR on the day of discharge (May 14, 2011).