(F 000) INITIAL COMMENTS

During the annual Recertification survey conducted on March 29, 2011, through April 1, 2011, at Ridgetop Haven Health Care Center, no deficiencies were cited in relation to complaint #27225 under 42 CFR PART 482.13, Requirements for Long Term Care.

During the annual Recertification survey conducted on March 29, 2011, through April 1, 2011, at Ridgetop Haven Health Care Center, with an extended survey on April 1, 2011. Tags F-157, F-278, F-309 (Substandard Quality of Care), and F-428 were cited at the scope and severity level of "J". The facility failed to follow physician's orders to obtain laboratory (lab) studies for one resident (#11) receiving anticoagulant therapy.

The facility's failure to ensure labs were obtained as ordered, notify the physician the labs were not obtained, care plan for anticoagulant therapy and possible side effects, and the pharmacy consultant performed an accurate and thorough review of the medical record, was likely to cause serious injury, harm, impairment, or death to resident #11 from uncontrolled bleeding related to critically high blood clotting times.

The Interim Administrator, new Administrator (first day March 28, 2011), Director of Nursing (DON), Assistant Director of Nursing (ADON), Regional Compliance Nurse, and Compliance Nurse, were notified of the Immediate Jeopardy on March 31, 2011, at 8:15 a.m., in the conference room.

The Immediate Jeopardy was effective November 30, 2010 and is ongoing for F-157, F-279, F-309 (Substandard Quality of Care) and F-428.

LABORATORY DIRECTORS OR PROVIDERS/SUPPLIER REPRESENTATIVES SIGNATURE

[Signature]

APR 29 2011
A revisit was conducted at RidgeTop Haven Health Care Center on April 18, 2011, following an Acceptable Allegation of Compliance to remove the Immediate Jeopardy for F-157, F-279, F-309, and F-428. The revisit revealed the corrective actions implemented on April 8, 2011, removed the Immediate Jeopardy at F-157, F-279, F-309, and F-428, but noncompliance continues at a "D" level citation at F-157, F-279, F-309, and F-428. The "D" level citations for F-226, F-323, F-333, F-483, and F-602 also remain outstanding. The facility is required to submit a plan of correction for all outstanding tags.

F-157 Notify of Change: 5/01/2011

The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an incident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either the event of conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or an action to transfer or discharge the resident from the facility, as specified in §483.12(a).
Continued From page 2

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

- Based on medical record review, facility document review, facility policy review, review of a Standard Precaution Reference, Consultant Pharmacist Medication Regimen review, and interview, the facility failed to notify the physician of not obtaining a monthly laboratory (lab) study on November 2010, and a lab on December 20, 2010, as ordered by the physician; failed to notify the physician the lab specimen was clotted on December 17, 2010; failed to notify the responsible party of critically high laboratory results for one resident (f11) receiving anticoagulant therapy for four resident's reviewed receiving anticoagulant therapy.  

A revisit was conducted at Ridge Top Haven Health Care Center on April 18, 2011 following an acceptance of the Allegation of Compliance to remove the Immediate Jeopardy for F-157. The revisit revealed the corrective actions completed on April 6, 2011, removed the Immediate Jeopardy at F-157, but noncompliance continues at a "D" level as evidence by the

1. Resident #11 was affected by the deficient practice. Resident #11 was transferred on 12/22/2010 to another out of state skilled nursing facility to protect the resident from alleged harassment by one of the resident’s family members.

2. On 4/3/2011 the Director of Nursing (DON) and Assistant Director of Nursing (ADON) did a 100% Lab audit to determine if any other residents were affected by the deficient practice. It was determined that no other residents were affected by this deficient practice.

3. On 3/30/2011, the Resource Director of Compliance (the Consultant RN) inspected the DON and the ADON on the Lab Protocol and responsible party/physician notification. On 3/31/2011 and 4/1/2011, the Consultant RN and DON inspected all licensed nursing staff on physician and responsible party notification of significant changes, including missed labs and/or abnormal lab values. The licensed nurses were also taught on the Facility Lab Protocol by the Consultant RN and DON. The Licensed Nurses were not allowed to work on the floor until they were in-service or received a one-on-one “rostrum education” on the above topics. The facility does not use any agency staffing.
<table>
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<tr>
<th>(F 157)</th>
<th>Continued From page 3 findings at F-157.</th>
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<td></td>
<td>The facility remained out of compliance at a Scope and Severity level of &quot;D&quot;, no actual harm with potential for minimal harm that is not immediate jeopardy. The facility will remain out of compliance until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and review of the facility corrective measures by the Quality Assurance Committee.</td>
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<tr>
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<td>The findings included;</td>
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<td>The Facility provided an acceptable Credible Allegation of Compliance with a compliance date of April 8, 2011. An onsite visit was completed on April 18, 2011, to validate compliance. The Credible Allegation of Compliance was validated on April 18, 2011, at 12:00 p.m. Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, and interview with Licensed Nurse's and Certified Nursing Assistants and residents. The facility provided evidence of in-service and records for all nursing Staff, and nurse aide related to management of anticoagulation (blood thinner), clinical test values reporting, communication and documentation. Included in the validation process was the review of facility tools used to document ongoing monitoring of obtaining lab work, physician and chart audit.</td>
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<tr>
<td></td>
<td>Interview with the two licensed nurses confirmed the nurses had received training on anticoagulation therapy, physician notification, and documentation.</td>
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On 3/31/2011 the Consultant RN reviewed the laboratory policy with no changes. On 3/31/2011, the Attending Physician (the former Medical Director) for Resident #11, and the current Medical Director/Attending Physician for all other residents, were notified by the DON of the deficient practice and the corrective action that the Facility began to implement upon notification of the deficient practice. No other residents were affected by this deficient practice. On 12/9/10, the former pharmacy vendor was notified that the contract with the facility was being terminated effective 2-16-11 for non-performance. The current pharmacy consultant will conduct a 100% review of all resident labs on his monthly review and notify the DON of any missed lab tests/abnormal values when such findings are noted. The 3/22 – 3/23/2011 pharmacy consultant report includes the results of this review. On 3/31/2011, ADCN was given a written progressive disciplinary action plan by the DON for failure to follow the Facility’s laboratory protocol specific to Resident #11.
Continued from page 4

The new pharmacy consultant on March 23, 2011, completed a review of all residents' medication regimes. Based on pharmacy consultant recommendation and physician agreement all residents requiring anticoagulation therapy have been changed to a new medication that does not require on going laboratory monitoring.

Resident #11 was discharged from the facility and no corrective action could be taken for this resident.

Medical record review revealed three residents (#4, #5, #10) have been changed to a new medication (anticoagulant) after notification of the physician and family that does not require laboratory monitoring of therapeutic blood levels or medication dose changes.

483.15(c) DEVELOPMENT/IMPLEMENT ABUSE/NEGLECT, ETC. POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, review of facility policy, and interview, the facility failed to investigate injuries of unknown origin for two (#10, #4) of nineteen residents reviewed.

The findings included:

Resident #10 was admitted to the facility on April 7, 2010, with diagnoses including Pneumonia.
On 4/1/2011 LPN #5 was terminated.

The resident's attending physician will be notified by phone of all critical lab values within two hours of receiving lab results. Lab values that are noted to be within normal limits will be managed in accordance to each physician's preference.

On 4/3/2011, a 100% audit of the current resident lab orders was completed by the designated Lab Coordinator to ensure that all current laboratory testing has been obtained per the physician orders.

On 3/31/2011, the ADON communicated by phone with the facility's lab company to inform them of the current citations and verbally reviewed the facility laboratory protocol. No recommended changes to the lab protocol were noted.

4. The designated Lab Coordinator or designee will utilize the Lab Draw Log monitoring sheet to ensure that labs are obtained as ordered. The Lab Coordinator or designee will then bring a copy of the Lab Draw Log to the daily (Monday through Friday) QA Morning Meeting (consisting of Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Social Services Director, Dietary Manager, Activities Director, Maintenance Director, Rehab Therapy Representative, Business Office Manager), which is
conducted by the Administrator. In the absence of the Lab Coordinator (DON), the ADON or designee will be responsible for this daily review.

By utilizing the Lab Draw Log, the DON/Lab Coordinator or designee will be responsible for conducting weekend reviews of lab orders and results for the next 30 days. The weekend reviews will be conducted thereafter by the weekend RN on an ongoing basis. Results will be reported on the Lab Draw Log by the weekend RN for the DON to review on Monday morning. The DON will report these findings at the QA morning meeting each Monday.

The DON or designee will review the 24-Hour/Changes of Condition Report during the daily (Monday through Friday) QA Morning Meeting (Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Social Services Director, Dietary Manager, Activities Director, Maintenance Director, Rehab Therapy Representative, Business Office Manager) for notations that require immediate physician and/or family notification. The DON or designee will be responsible for reviewing documentation to ensure that the responsible party and physician are notified as needed.

The Lab Coordinator, or designee, will perform weekly audits of the lab log and physician orders to monitor timely completion of lab tests and that the physician/responsible party is notified of missed or rejected labs and abnormal lab values. The findings of these audits will be presented by the Lab Coordinator and reviewed in the daily (Monday through Friday) QA Morning meeting x 30 days and weekly x 2 month.

In addition, the Resource Director of Compliance or designee will conduct random audits (at least 10%
F-157 of the current residents) of physician orders and the Lab Log. The audits will be done weekly for the next 90 days and monthly thereafter. The findings of these audits will be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director) for review and further recommendations.

The QA Committee Chairperson, which is the facility Administrator, will ensure that the findings of the audits are reviewed and that the Lab Coordinator or designee follows up recommendations in the QA morning meeting.

The Administrator will ensure that findings are accurate for presentation to the QA Committee by reviewing the Lab Draw Log daily (Monday through Friday). The Administrator will also do a random chart audit on a weekly basis for the next 4 weeks and monthly thereafter to ensure that the findings are accurate.

The QA Committee will meet daily (Monday through Friday) in QA Morning Meeting and will meet quarterly with the Medical Director in attendance. The Consultant RN will attend the QA Meeting monthly to ensure compliance with the Lab Protocol for the next three months and quarterly thereafter.

The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.
Continued From page 5

Dementia, History of Right Hip Fracture, and Hypothyroidism.

Medical record review of the Minimum Data Set (MDS) dated January 11, 2011, revealed the resident wandered and was independent for ambulation.

Medical record review of the nursing notes dated January 27, 2011, at 4:00 p.m., revealed "(spouse) came & (and) got me to show me (resident's) left forearm. BIG Bruise; unsure of how ras (resident) received it. No c/o (complaints) of pain associated with bruise."

Observation on April 1, 2011, at 8:56 a.m., with Licensed Practical Nurse (LPN) #2, revealed the resident lying on the bed. Continued observation revealed LPN #2 exposed the resident's forearms and a small bruise was noted on top of the left wrist area.

Review of the facility's Abuse Program policy revealed "...The facility will thoroughly review, under the direction of the administrator, all injuries of unknown origin to determine if abuse or neglect was involved."

Interview on March 31, 2011, at 4:05 p.m., with LPN #1 (nurse who wrote the nursing note dated January 27, 2011), in the conference room, revealed the resident's spouse was concerned about the bruise on the left forearm. Continued interview revealed the bruised area was large and on top of the forearm. Continued interview revealed there did not appear to be fingerprint marks surrounding the bruise. Continued interview revealed LPN #1 had completed a report and the report was sent to the Director of

2. On 4/15/2011, a 100% audit of all skin assessments was completed by the Director of Nursing. There were no current identified areas of concern. All residents have the potential to be affected by this deficient practice. No other residents were affected by this deficient practice.

3. An additional investigative form has been included with the occurrence report. All licensed nursing staff have been interviewed on the utilization of this form by the Director of Nursing on 4/16/2011. Director of Nursing/designee will monitor occurrence reports and the investigative form daily (Monday through Friday) and any occurrence reports will be reviewed in the QA morning meeting (consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Social Services Director, Dietary Director, Activities Director, Rehab Representative, Maintenance Director, and Business Office Manager) to ensure thorough and complete occurrence investigations.
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<td><strong>Nursing (DON).</strong></td>
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Interview on March 31, 2011, at 4:26 p.m., with the DON, in the DON's office, confirmed a report related to the bruise the resident sustained on January 27, 2011, had been completed. Continued interview revealed the bruise the resident sustained on January 27, 2011, was an injury of unknown origin. Continued interview with the DON confirmed the cause of the bruise was not investigated and confirmed the facility's policy was not followed.

Resident #4 was admitted to the facility on June 8, 2010, with diagnoses including Dementia with Lewy Bodies, Hypertension, Paralysis Agitans, and Parkinson's Disease.

Medical record review of the nurse's note dated January 4, 2011, revealed, "Resident has a 4 cm (centimeter) x (by) 3 cm x 0.1 cm open area to (right) forearm..."  

Medical record review of a physician's order dated January 4, 2011, revealed, "...Cleanse (right) forearm with NS (normal saline). Apply polysporin and dry drg (dressing) daily (and) pm (as needed)..."  

Medical record review of the nurse's note dated March 16, 2011, revealed, "...(left) forearm skin tear..."  

Medical record review of a physician's order dated March 16, 2011, revealed, "...Skin tear (left) forearm NS...cover dry drg (dressing)..."  

Medical record review of the nurse's notes dated March 21, 2011, revealed, "...while CNA (certified
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<th>(F 220)</th>
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<tr>
<td>nursing assistant was taking resident to room...arm slipped off geri-chair and hit the door frame...causing 2 skin tears to...right forearm...</td>
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Medical record review of a physician’s order dated March 21, 2011, revealed, “...Cleanse right forearm (with) NS. Apply (triple antibiotic ointment) and cover (with) dry drsg (dressing) daily...”

Observation on March 30, 2011, at 2:00 p.m., of the dressing changes to the right forearm and left forearm with LPN (Licensed Practical Nurse) #3, revealed a skin tear to the right forearm with a small amount of serosanguinous drainage and a skin tear to the left forearm with no drainage.

Interview on March 30, 2011, at 8:55 a.m., with the Director of Nursing, in the conference room, confirmed the wound on the right forearm on January 4, 2011, and the skin tear on the left forearm on March 18, 2011 had not been investigated.

(F 279) 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care.

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.

The care plan must describe the services that are

(F 279) Develop Comprehensive Care Plans

The facility will initiate, monitor and revise the care plans in order to attain or maintain the resident’s highest practicable physical, mental and psychosocial wellbeing.

1. Resident #11 was affected by deficient practice. Resident #11 was transferred on 12/22/2010 to another out of state skilled nursing facility to protect the resident from alleged harassment by one of the resident’s family members.
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<th>ID</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F279</td>
<td>Continued From page 8</td>
<td>to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</td>
<td>F279</td>
<td>2. On 4/1/2011 the Minimum Data Set Coordinator (MDS Coordinator) did a 100% audit on care plans of residents receiving anticoagulant therapy to determine if any other residents were affected by the deficient practice. It was determined that no other residents were affected by this deficient practice. On 4/3/2011, the MDS Coordinator completed a 100% audit of all resident charts to assure care plans are in place and accurate and appropriate for each resident and their ordered care.</td>
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This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of the care plan, and interview, the facility failed to initiate, monitor and revise a care plan for anticoagulant therapy for one resident (#11) receiving anticoagulant therapy of four resident's reviewed receiving anticoagulant therapy.

A revisit was conducted at Ridgetop Haven Health Center on April 18, 2011 following an acceptance of the Allegation of Compliance to remove the Immediate Jeopardy for F-279. The revisit revealed the corrective actions completed on April 8, 2011, removed the Immediate Jeopardy at F-279, but noncompliance continues at a "D" level as evidence by the findings at F-279.

The facility remained out of compliance at a Scope and Severity level of "D", no actual harm with potential for minimal harm that is not immediate jeopardy. The facility will remain out of compliance until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and review of the facility corrective measures by the Quality Assurance Committee.
The findings included:

The facility provided an acceptable Credible Allegation of Compliance with a compliance date of April 8, 2011. An onsite visit was completed on April 10, 2011, to validate compliance. The Credible Allegation of Compliance was validated on April 18, 2011, at 12:00 p.m. Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, and interview with licensed nurse's and certified nursing assistants and residents. The facility provided evidence of in-service and records for all nursing staff, and nurse aides related to management of anticoagulation (blood thinner), clinical test values reporting, communication and documentation. Included in the validation process was the review of facility tools used to document ongoing monitoring of obtaining lab work, physician and chart audit.

Interview with the two licensed nurses confirmed the nurses had reviewed training on anticoagulation therapy, physician notification, and documentation, and updating care plans.

Interview with three certified nursing assistants confirmed the certified nursing assistants had reviewed training on the side effects of anticoagulant therapy and the resident's ADL information sheet/CNA care plan are updated to reflect the use of anticoagulant therapy.

Resident #11 was admitted to the facility on

currently have three residents receiving FRADAXA.

On 4/7/2011 and 4/8/2011 all of the certified nursing assistants (CNA's) were instructed by the DON in regard to the side effects of anticoagulant therapy, including FRADAXA, as they relate to precautions exercised while giving care. CNAs will be informed of residents receiving anticoagulant therapy via their ADL information sheet/CNA care plan reviewed by the CNA every shift. The MDS Coordinator is responsible for updating the ADL information sheet/CNA care plan monthly and as needed.

The attending physician has changed all of the current residents receiving anticoagulants (Coumadin) to a new medication, FRADAXA, which does not require lab monitoring.

On 4/6/2011, all of the licensed nurses were in-services by the consultant pharmacist regarding the potential side effects of FRADAXA. On 4/7/2011 and 4/8/2011, all CNAs were in-services by the DON on the potential side effects of this new anticoagulant medication.

4. The DON or designee will attend the care plan meeting and review the comprehensive care plans of those residents on anti-
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<td>October 19, 2010, with diagnoses including Stage IV Lung Cancer, Chronic Pain, Chronic Obstructive Pulmonary Disease, Dementia with Behavior Disturbances, Lack of Coordination, and Deep Vein Thrombosis. Further medical record review revealed the resident was discharged to another long term care facility on December 22, 2010.</td>
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Medical record review revealed three residents (#4, #5, #10) were receiving anticoagulants and care plans for the three residents indicated the name of the anticoagulant and the necessary monitoring for each resident.

The facility remained out of compliance at a Scope and Severity level of "D", no actual harm with potential for minimal harm that is not immediate jeopardy. The facility will remain out of compliance until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and review of the facility corrective measures by the Quality Assurance Committee.

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<th>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
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<td>coagulant therapy on a weekly basis for 90 days to ensure that the comprehensive care plan includes measurable objectives and timelines related to anti-coagulant therapy and to ensure the comprehensive care plan is reviewed as needed. The comprehensive care plan will be reviewed at least quarterly thereafter and revised as needed.</td>
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The DON or designer will report findings of the review of the comprehensive care plan for anti-coagulant therapy, and recommendation to the QA Committee weekly for 90 days and quarterly thereafter.
The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.

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<th>(F 309)</th>
<th>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</th>
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<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
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Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
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<tr>
<td>(F 309)</td>
<td>Continued From page 11 Based on medical record review, review of National Institute of Health reference, review of a Standard Precaution Reference, facility document review, facility policy review, Consultant Pharmacist Medication Regimen review, and interview, the facility failed to follow physician's orders, obtaining laboratory (lab) studies for one resident (#11) receiving anticoagulant therapy of 4 resident's reviewed receiving anticoagulant therapy. A revisit was conducted at Ridgetop Haven Health Center on April 18, 2011 following an acceptance of the Allegation of Compliance to remove the Immediate Jeopardy for F-309. The revisit revealed the corrective actions completed on April 8, 2011, removed the Immediate Jeopardy at F-309, but noncompliance continues at a &quot;D&quot; level as evidence by the findings at F-309. The facility remained out of compliance at a Scope and Severity level of &quot;D&quot;, no equal harm with potential for minimal harm that is not Immediate Jeopardy. The facility will remain out of compliance until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and review of the facility corrective measures by the Quality Assurance Committee. The findings included: The Facility provided an acceptable Credible Allegation of Compliance with a compliance date</td>
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| (F 309)      | The facility will follow physician orders for obtaining laboratory (lab) tests for the monitoring of side effects of anticoagulant therapy. 1. Resident #11 was affected by deficient practice. Resident #11 was transferred on 12/22/2010 to another out of state skilled nursing facility to protect the resident from alleged harassment by one of the resident's family members. 2. On 4/3/2011 the Director of Nursing (DON) and Assistant Director of Nursing (ADON) did a 100% Lab audit to determine if any other residents were affected by the deficient practice. It was determined that no other residents were affected by this deficient practice. 3. On 3/30/2011, the Resource Director of Compliance (the Consultant RN) interviewed the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on responsibility to follow physician orders, lab protocol, and responsible party/physician notification. On 3/31/2011 and 4/1/2011, the Resource Director of Compliance (the Consultant RN) and Director of Nursing (DON) in-serviced all
Continued From page 12

of April 8, 2011. An onsite visit was completed on April 10, 2011, to validate compliance. The Credible Allegation of Compliance was validated on April 18, 2011, at 12:00 p.m. Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, and interview with Licensed Nurse's and Certified Nursing Assistants and residents. The facility provided evidence of in-service and records for all nursing Staff, and nurse aides related to management of anticoagulation (blood thinner), clinical test values reporting, communication and documentation. Included in the validation process was the review of facility tools used to document ongoing monitoring of obtaining lab work, physician and chart audit.

Interview with the two licensed nurses confirmed the nurses had received training in anticoagulation therapy, family notification, physician notification, and documentation.

The new pharmacy consultant on March 23, 2011, completed a review of all residents' medication regimes. Based on pharmacy consultant recommendation and physician agreement all residents requiring anticoagulation therapy have been changed to a new medication that does not require going laboratory monitoring.

Resident #11 was admitted to the facility on October 19, 2010, with diagnoses including Stage IV Lung Cancer, Chronic Pain, Chronic Obstructive Pulmonary Disease, Dementia with Behavior Disturbances, Lack of Coordination, and Deep Vein Thrombosis. Further medical record review revealed the resident was discharged to another long term care facility

Licensed Nursing Staff on their responsibility to follow physician orders to ensure that lab results are obtained as ordered for each resident, especially those residents receiving anti-coagulant therapy that requires monitoring for abnormal lab values. The licensed nurses were also retrained by the DON and Consultant RN at that time on the Facility Lab Protocol and Lab Documentation Protocol and their responsibility to ensure that the residents are provided with timely laboratory services. The Licensed Nurses were not allowed to work on the floor until they were in-service or received a one-on-one "roadside education" on the above topics. The facility does not use any agency staffing.

On 3/31/2011 and 4/7/2011 the Director of Nursing (DON) in-serviced the Minimum Data Set (MDS) Coordinator on initiating, monitoring, and revising a care plan for anticoagulant therapy and comprehensive assessment for all residents receiving blood thinners. We currently have three residents receiving FRAXAXA.

On 3/31/2011, all the Licensed Nursing Staff were in-serviced by the DON and Resource Director of Compliance (RN) on the facility's anti-coagulant therapy policy and on 4/6/2011 all Licensed Nursing Staff were in-
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<tr>
<td>(F 309)</td>
<td>Continued From page 13 on December 22, 2010. Medical record review revealed three residents (#4, #6, #10) have been changed to a new medication (anticogulants) after notification of the physician and family that does not require laboratory monitoring, or therapeutic blood levels or medication dose changes. Medical record review of ten residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10) revealed laboratory fact were done as ordered by the physician. The facility remained out of compliance at a Scope of Severity level of &quot;D&quot;, no actual harm with potential for minimal harm that is not immediate jeopardy. The facility will remain out of compliance until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and review of the facility corrective measures by the Quality Assurance Committee.</td>
<td>serviced by the consultant pharmacist regarding the side effects of anticoagulant therapy to include PRADAXA. On 4/7/2011 and 4/8/2011 all of the Certified Nursing Assistants (CNA's) were involved by the DON in regard to the side effects of anticoagulant therapy including PRADAXA as they relate to precautions exercised while giving care. On 3/31/2011, the Attending Physician (the former Medical Director) for Resident #11 and the current Attending Physician/Medical Director for all of the other residents, were notified by the DON of the deficient practice and the corrective action that the</td>
</tr>
<tr>
<td>(F 323)</td>
<td>483.25(m) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</td>
<td>5/01/2011</td>
</tr>
<tr>
<td>(F 323)</td>
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<td>E323 Free Of Accident Hazards/Supervision/Devices: The facility will ensure safety devices and implement safety interventions. 1. Residents #3, #6 and #10 were affected by the deficient practice. On 4/1/2011, bed alarms were placed on the beds of resident #3 and #10. Resident #6 has not had a fall that required a new interventions in a three month period since 1/16/2011.</td>
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</tbody>
</table>
Facility began to implement upon notification of the deficient practice. No other residents were affected with this deficient practice.

On 12/9/10 the former pharmacy vendor was notified that the contract with the facility was being terminated effective 2/16/11 for non-performance. The facility signed an agreement with a new pharmacy on 12/22/10 to begin services on 2/16/11 (the earliest date that the new pharmacy could transition the facility).

The current pharmacy consultant will conduct a 100% review of all resident labs on his monthly review and notify the DON of any missed lab tests/abnormal values when such findings are noted. The 3/22 - 3/23/2011 pharmacy consultant report includes the results of this review.

On 3/31/2011, Assistant Director of Nursing (ADON) was given a written progressive disciplinary action plan by the Director of Nursing (DON) for failure to follow the Facility's laboratory protocol specific to Resident #11.

On 3/31/2011, Resource Director of Compliance retrained the DON and ADON on the Facility laboratory protocol to ensure that the appropriate systems and forms were in place. The DON, as designated Lab Coordinator, was given additional training at that time by the Resource Director of Compliance on monitoring the Lab Logs in order to provide additional oversight to the ADON.

The DON will compare lab logs to the physician's orders daily (Monday through Friday) x four weeks and weekly thereafter. The lab log/order comparison will be reviewed by the Consultant RN during the monthly compliance visit.
On 4/1/2011 LFN #3 was terminated.

The resident's attending physician will be notified by phone of all critical lab values within two hours of receiving lab results. Lab values that are noted to be within normal limits will be managed in accordance to each physician's preference.

On 4/3/2011, a 100% audit of the current resident's lab orders was completed by the designated Lab Coordinator to ensure that all current laboratory testing has been obtained per the physician's orders.

On 3/31/2011, the ADON communicated by phone with the facility's lab company to inform them of the current citations and verbally reviewed the facility laboratory protocol. No recommended changes to the lab protocol were noted.

4. The designated Lab Coordinator or designee will utilize the Lab Draw Log monitoring sheet to ensure that labs are obtained as ordered. The Lab Coordinator or designee will then bring a copy of the Lab Draw Log to the daily (Monday through Friday) QA morning meeting (consisting of Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Activities Director, Maintenance Director, Rehab Therapy Representative), which is conducted by the Administrator. In the absence of the Lab Coordinator (DON), the ADON or designee will be responsible for this daily review.

By utilizing the Lab Draw Log, the DON/Lab Coordinator or designee will be responsible for conducting weekend reviews of lab orders and results for the next 30 days. The weekend reviews will be conducted thereafter by the weekend RN on an ongoing basis. Results will be
reported on the Lab Draw Log by the weekend RN for the DON to review on Monday morning. The DON will report these findings at the QA morning meeting each Monday.

The DON or designee will attend the care plan meeting and review the comprehensive care plans of those residents on anti-coagulant therapy on a weekly basis for 90 days to ensure that the comprehensive care plan includes measurable objectives and timelines related to anti-coagulant therapy and to ensure the comprehensive care plan is revised as needed. The comprehensive care plan will be reviewed at least quarterly thereafter and revised as needed.

The DON or designee will review the 24-Hour/Changes of Condition Report during the QA Morning Meeting (Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Activities Director, Maintenance Director, Rehab Therapy Representative), for notations that require immediate physician and/or family notification. The DON or designee will be responsible for reviewing documentation to ensure that the responsible party and physician are notified as needed.

The Lab Coordinator, or designee, will perform weekly audits of the lab log and physician orders to monitor timely completion of lab tests and that the physician/responsible party is notified of missed or rejected labs and abnormal lab values. The findings of these audits will be reviewed in the daily QA Morning meeting (held Monday through Friday) X 30 days and weekly x 2 months.

In addition, the Resource Director of Compliance or designee will conduct random audits (at least 10% of the current residents) of physician
orders and the Lab Log. The audits will be done weekly for the next 90 days and monthly thereafter. The findings of these audits will be reported to the QA Committee (consisting of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director) for review and further recommendations in the monthly QA meeting.

The QA Committee Chairperson, which is the facility Administrator, will ensure that the findings of the audits are reviewed and that the Lab Coordinator or designee follows up recommendations in the QA morning meeting.

The Administrator will ensure that findings are accurate for presentation to the QA Committee by reviewing the Lab Draw Log daily (Monday through Friday). The Administrator will also do a random chart audit on a weekly basis for the next 4 weeks and monthly thereafter to ensure that the findings are accurate.

The QA Committee will meet daily (Monday through Friday) in QA Morning Meeting and will meet quarterly with the Medical Director in attendance. The Consultant RN will attend the QA Meeting monthly for the next three months and quarterly thereafter to ensure compliance with the Lab Protocol.

The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.
**NAME OF PROVIDER OR SUPPLIER**
RIDGETOP HAVEN HEALTH CARE CENTER

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG 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>
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</thead>
<tbody>
<tr>
<td>(F 323)</td>
<td>Continued from page 14 devices were in place for two (#10, #3), and failed to implement safety interventions after a fall for one (#8) of nineteen residents reviewed.</td>
<td>(F 323)</td>
<td>2. Residents who require bed alarms have the potential to be affected by this deficient practice. The post occurrence reports and care plans will be updated to reflect individualized specific interventions.</td>
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<td>The findings included:</td>
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<td>3. 100% audit of all residents’ medical records was completed by the Minimum Data Set Coordinator (MDS Coordinator) on 4/1/2011 to identify residents utilizing and/or requiring bed/chair alarms. The audit revealed six chair alarms and eight bed alarms.</td>
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<td>Resident #10 was admitted to the facility on April 7, 2010, with diagnoses including Pneumonia, Dementia, History of Right Hip Fracture, and Hypothyroidism.</td>
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<td>On 4/1/2011, bed/chair alarms were purchased and placed on beds/chairs of residents whose care plans indicated utilization.</td>
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<td>Medical record review of the Minimum Data Set (MDS) dated January 11, 2011, revealed the resident transferred and ambulated independently.</td>
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<td>Residents utilizing bed/chair alarms were screened by rehab on 4/1/2011 and 4/5/2011 to determine appropriateness of alarm usage.</td>
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<td>Medical record review of a Fall Risk Assessment dated February 25, 2011, revealed the resident was at moderate risk for falls.</td>
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<td>Oui 4/1/2011 a current list of bed/chair alarms was placed in the CNA book and at the nurses’ station for staff reference. This list will be updated as needed by the MDS Coordinator/designee. Use of bed/chair alarms is now listed on the CNA ADLs/care plan sheets.</td>
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<td>Medical record review of the Care Plan review on January 13, 2011, revealed the resident was at risk for falls and a bed alarm was to be used.</td>
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<td>Observation and interview with Licensed Practical Nurse (LPN) #2 on March 30, 2011, at 1:40 p.m., revealed the resident lying on the bed, in the resident’s room, and confirmed the bed alarm was not in place.</td>
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<td>Observation and interview with LPN #2 on April 1, 2011, at 8:56 a.m., revealed the resident lying on the bed, in the resident’s room, and confirmed the bed alarm was not in place. Continued observation and interview with LPN #2 revealed the facility was trying to locate a bed alarm to place on the resident’s bed.</td>
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<td>(F 323) Continued From page 15</td>
<td>(F 323)</td>
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<td>Resident #3 was admitted to the facility on July 29, 2010, with diagnoses including Altered Mental Status, Psychosis, Dementia, Motor Vehicle Accident with Severe Head Injury. Medical record review of the Minimum Data Set dated February 2, 2011, and March 2, 2011, revealed 0 out of 16 and 3 out of 15 respectively on the Brief Interview for Mental Status, with 0 = severe cognitive impairment and 15 = no cognitive impairment. Further review revealed limited assistance of one person was required for transfers, ambulation, and bathing. Further review revealed no falls since admission. Medical record review of the care plan dated March 8, 2011, revealed the resident was at risk for falls with an approach of &quot;...bed alarm in place...&quot; Observation on March 29, 2011, at 6:47 a.m., and 11:30 a.m., revealed the resident in bed, head of bed was elevated, and the left side rail by the head was in the up position. Continued observation on March 29, 2011, at 11:30 a.m., revealed the resident in bed, and at the request of Certified Nurse Aide #2, the resident grabbed the left head side rail, set up, placed the foot on the floor, stood while holding the side rail, pivoted while holding the side rail, lowered self to a locked wheelchair next to the bed while holding onto the side rail. Continued observation revealed the resident checked the brakes on the wheelchair to ensure they were locked, held onto the wheelchair arms with both hands and stood up, one hand on the wheelchair arm as the other hand grasped the side rail, stood upright and held a bed/chair alarm audit will be performed by the MDS Coordinator/designee to ensure placement and functionality daily x 30 days, weekly x 4 weeks and randomly thereafter. All post occurrence reports will be reviewed by the Director of Nursing and any individualized specific interventions will be discussed and care planned at that time. Findings will be reviewed in the QA meeting (consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Social Services Director, Dietary Director, Activities Director, Rehabilitation Supervisor, Maintenance Director, and Business Office Manager) and the MDS Coordinator will be updating care plans with any additional interventions as needed. 4. All findings will be reported by the Director of Nursing and the MDS Coordinator to the QA committee monthly/quarterly for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.</td>
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Continued from page 16:

onto the side rail, pivoted toward the bed while
holding the side rail, sat on the side of the bed
while holding the side rail, layed down on the bed
while holding onto the side rail.

Interview with Certified Nurse Aide (CNA) #2, on
March 29, 2011, at 11:30, in the resident’s room,
confirmed there was no alarm on the bed. The
CNA requested the resident transfer out of bed to
demonstrate the resident could do so safely.

Interview with the care plan coordinator, on March
28, 2011, at 11:35 a.m., at the nursing station,
confirmed the care plan coordinator was not
aware the bed alarm was not on the bed.

Interview with Licensed Practical Nurse (LPN) #2
on March 29, 2011, at 11:40 a.m., in the nursing
station, confirmed “(resident) had one (bed
alarm) but not for awhile now since (resident)’s
appetite improved, ambulation improved,
(resident) just improved...” Further interview and
observation revealed LPN #2 holding a bed alarm
pad with a severed cord and confirmed the bed
pad alarm had just been removed from resident
#3 bed. Continued interview revealed the
resident “...don’t get up without our help...”

Interview with CNA #7 on March 29, 2011, at
12:38 p.m., at the dining room, confirmed the
CNA was not aware resident #3 had a bed alarm
“...since I been here and I been here about three
months now...”

Interview with the Interim Administrator and the
new Administrator (first day March 28, 2011) on
March 30, 2011, at 8:00 a.m., in the
administrative building, confirmed the facility had
no alarm policy.
Resident #6 was admitted to the facility on September 24, 2010, with diagnoses including Atrial Fibrillation, Congestive Heart failure, Edema of Lower Extremities, Hypertension, Morbid Obesity, Chronic Degenerative Arthritis, and Chronic Renal Failure.

Medical record review of the Minimum Data Set dated January 1, 2011, revealed 7 out of 15 on the Brief Interview for Mental Status, with 0 = severe cognitive impairment and 15 = no cognitive impairment. Further review revealed the resident required extensive assistance with one person for transfers, ambulation, dressing, toileting, personal hygiene, and bathing.

Medical record review of the “Fall Risk Assessment” dated September 24, 2010, October 28, 2010, January 5, 2011 and January 12, 2011, revealed the resident was at moderate risk for falls.

Medical record review of the physical therapy documentation revealed the resident received physical therapy from September 25, 2010 through November 1, 2010; December 3, 2010 through January 3, 2011, and was evaluated on January 12, 2011 with recommendations for five times per week for 30 days and a renewal for another thirty days in February 2011.

Medical record review of the nursing note dated October 23, 2010, at 6:30 p.m., revealed "...Res (Resident) tried getting in bed by...self; (Resident) had locked...wheel) chair, stood up and dropped something. When (resident) bent over to pick it up and (resident) fell over. No
Continued From page 18

obvious injuries noted...

Review of the facility document "Post Occurrence Investigation Report" dated October 23, 2010, revealed the immediate intervention put in place was "...repeated use of call light and not stand by...self..."

Medical record review of the nursing note dated November 2, 2010, at 13:40 revealed "...Resident in room yelling "help". Upon entering room, observed resident sitting on floor beside (resident's) bed. Resident status...transferred...self from wheelchair to bed and while trying to slide further up onto bed...slid to the floor. Resident status did not hit...head. No c/o (complaint) on pain at this time..."

Review of the facility document "Post Occurrence Investigation Report" dated November 2, 2010, revealed the immediate intervention put in place was "...Explained to resident to always call for help before trying to get up out of bed or wheelchair..."

Medical record review of the nursing note dated January 16, 2011, at 9:30 a.m. revealed "...resident observed on the floor today. (Resident) had extreme agitation since shift started. (No) injuries present from fall..."

Review of the facility document "Post Occurrence Investigation Report" dated January 16, 2011 revealed the immediate intervention put in place was "...Verbal cue to use call light for assistance. Call light in reach. Checked frequently throughout the remained (sic) of the shift, reminding resident to call for assistance..."
Continued From page 19

Interview with the Director of Nursing (DON) on March 30, 2011, at 10:15 a.m., in the conference room, confirmed the facility did not initiate any additional interventions after the November 23, 2010, fall or the fall on January 16, 2011 in order to prevent future falls.

483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of the pharmacy delivery records, and interview, the facility failed to ensure one resident (#15) was free of a significant medication error of nineteen residents reviewed.

The findings included:

Resident #16 was admitted to the facility on December 8, 2008, and readmitted to the facility on March 24, 2009, with diagnoses including Chronic Kidney Disease, Atrial Fibrillation, Hypertension, and Mental Disorder.

Medical record review of a laboratory report dated February 22, 2011, revealed, "...Protime with INR (international normalized ratio) 17.2...reference range 8.8-11.8...INR 1.6...reference range 0.8-1.1..."

Medical record review of a physician's order dated February 3, 2011, revealed, "...Warfarin (coumadin) 7.5mg (milligrams) po (by mouth) qd (everyday)..." Medical record review of the...
On 4/1/2011, LPN #1 was subsequently terminated. On 4/3/2011 resident #15 began a PRADAXA drug regimen.

2. On 4/3/2011, a 100% audit of the residents' medical records receiving anticoagulant therapy was done by the Director of Nursing. No other residents on the anticoagulants were affected by this deficient practice.

3. On 4/6/2011, the Director of Nursing and RN Consultant inserviced licensed nursing staff on medication administration. On 4/6/2011 the consultant pharmacist inserviced licensed nurses on proper medication administration and anticoagulant therapy.

On 4/14 – 4/16, 2011, the pharmacy RN consultant conducted random medication pass observations audits with licensed nursing staff.

On 4/22/2011, the Director of Nursing conducted random medication pass observation audits with licensed nursing staff. The DON/designee will continue to conduct random medication pass observation audits weekly x 2 weeks, monthly x 2 and randomly thereafter.

The Pharmacy Consultant will audit medication passes on a monthly basis and as needed.
All findings will be reported by the Director of Nursing to the QA committee monthly/quarterly for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: RIDGETOP HAVEN HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 2002 ORRER ROAD
GOODLETTSVILLE, TN 37072

[F 428] DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, facility document review, review of pharmacist consultant's report, and interview, the facility pharmacist consultant failed to identify PT/INR laboratory (lab) studies ordered by the physician had not been completed for one resident (#11) receiving anticoagulant therapy of four resident's reviewed receiving anticoagulant therapy.

A revisit was conducted at Ridgetop Haven Health Center on April 16, 2011 following an acceptance of the Allegation of Compliance to remove the Immediate Jeopardy for F-428. The revisit revealed the corrective actions completed on April 8, 2011, removed the Immediate Jeopardy at F-428, but noncompliance continues at a "D" level as evidence by the findings at F-428.

The facility remained out of compliance at a Scope and Severity level of "D", no actual harm with potential for minimal harm that is not


The facility will ensure that a licensed pharmacist reviews the drug regimen of each resident at least once a month. The pharmacist must report any irregularities to the attending physician and the director of nursing, and these reports must be acted upon.

1. Resident #11 was affected by the deficient practice. Resident #11 was transferred on 12/22/2010 to another out of state skilled nursing facility to protect the resident from alleged harassment by one of the resident's family members.

2. On 4/3/2011 the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) did a 100% Lab audit to determine if any other residents were affected by the deficient practice. It was determined that no other residents were affected by this deficient practice.

3. On 12/9/10, the former pharmacy vendor was notified that the contract with the facility was being terminated effective 2-16-11 for non-performance. The facility signed an agreement with a new pharmacy on 12/22/10 to begin services on 2/16/11 (the earliest date that the new pharmacy could transition the facility).
**Ridgetop Haven Health Care Center**

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<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F428</td>
<td>Continued From page 22</td>
<td>Immediate jeopardy. The facility will remain out of compliance until it provides an acceptable plan of correction. To include continued monitoring to ensure the deficient practice does not recur and review of the facility corrective measures by the Quality Assurance Committee.</td>
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<tr>
<td>The current pharmacy consultant, who is contracted by the new pharmacy vendor, conducts monthly medication regimen reviews on all residents to ensure that the appropriate laboratory testing has been completed, according to the physician orders. The pharmacy consultant will notify the DON of any missed or rejected lab tests and abnormal lab values when such findings are noted. The 3/22 – 3/23/2011 pharmacy consultant report includes the results of this review.</td>
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On 3/31/2011, Resource Director of Compliance remained the DON and ADON on the facility's laboratory protocol to ensure that the appropriate systems and forms were in place. The DON, as the designated Lab Coordinator, was given additional training at that time by the Resource Director of Compliance on monitoring the Lab Logs in order to provide additional oversight to the ADON.

The DON will compare lab logs to the physician's orders daily (Monday through Friday) x 4 weeks and weekly thereafter. The lab log/order comparison will be reviewed by the Consultant RN during the monthly compliance visit.
Resident #11 was admitted to the facility on October 19, 2010, with diagnoses including Stages IV Lung Cancer, Chronic Pain, Chronic Obstructive Pulmonary Disease, Dementia with Behavior Disturbances, Lack of Coordination, and Deep Vein Thrombosis. Further medical record review revealed the resident was discharged to another long term care facility on December 22, 2010.

Medical record review revealed three residents (#4, #5, #10) have been changed to a new medication that does not require on-going laboratory monitoring.

The facility remained out of compliance at a Scope and Severity level of "D", no actual harm with potential for minimal harm that is not immediate jeopardy. The facility will remain out of compliance until it provides an acceptable plan of correction to include continued monitoring to ensure the deficient practice does not recur and review of the facility corrective measures by the Quality Assurance Committee.

The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.

This REQUIREMENT is not met as evidenced.

The resident's attending physician will be notified by phone within two hours of receiving critical lab values. Lab values that are noted to be within normal limits will be managed in accordance to each physician's preference.

On 4/3/2011, a 100% audit of the current resident lab orders was completed by the designated Lab Coordinator to ensure all current laboratory testing has been obtained per the physician's orders.

On 3/31/2011, the ADON communicated by phone with the facility's lab company to inform them of the current citations and verbally reviewed the facility laboratory protocol. No recommended changes to the Lab Protocol were noted.
4. The Pharmacy Consultant will provide the facility DON with the monthly Medication Regimen Review. The DON or designee will ensure that the recommendations are followed up on with the Attending Physician for any medication changes.

The Consultant RN or designee will review the Pharmacist’s Medication Regimen Review on a monthly basis for 90 days and quarterly thereafter to ensure that the Facility has followed up on the recommendations. The findings of these audits will be reported to the QA Committee for review and further recommendations.

The Administrator will ensure that findings are accurate for presentation to the QA Committee by reviewing the Lab Draw Log daily (Monday through Friday). The Administrator will also do a random chart audit on a weekly basis for the next 4 weeks and monthly thereafter to ensure that the findings are accurate.

The QA Committee will meet daily (Monday through Friday) in QA meeting (consisting of Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Managers, Activities Director, Maintenance Director, Rehab Therapy Representative) and will meet quarterly with the Medical Director in attendance. The Consultant RN will attend the QA Meeting monthly for the next three months and quarterly thereafter to ensure compliance with the Lab Protocol.

The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Managers, Social Services Director and Activities Director. The Pharmacy Consultant will attend the QA meeting on a quarterly basis to ensure compliance with the Medication Regimen Review.
<table>
<thead>
<tr>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Providers Plan of Correction</th>
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<tbody>
<tr>
<td>F 463</td>
<td>Continued From page 24 by: Based on observation and interview, the facility failed to maintain the resident communication system for one resident (#8) of nineteen residents reviewed. The findings included: Observation on March 29, 2011, at 5:23 a.m., revealed Resident #8 in bed and pressing the call light. Further observation revealed the call light did not activate in the resident's room, the hallway light, or at the nursing station panel. Interview with Maintenance Director on March 30, 2011, at 12:52 p.m., in the conference room, confirmed the call light was not operating due to the plug was loose in the wall. Further interview revealed after the plug was pushed into the socket the call light was functional.</td>
<td>2. All residents have the potential to be affected by this deficient practice. No other resident were affected by this deficient practice. 3. On 5/31/2011 the Maintenance Director performed a 100% audit on all call lights in the facility to assure proper function. Call lights will be checked daily by the Maintenance Director/designee for 30 days, then randomly thereafter. All staff will randomly check the call light system for proper functioning. Any finding will be reported to the Maintenance Director.</td>
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<tr>
<td>F 502</td>
<td>483.75(i)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY 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. The findings included: Resident #9 was admitted to the facility on</td>
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**Footnotes:**

- **F 463**: Provides the details of the deficiency, including observations and actions taken.
- **F 502**: Provides the requirements for laboratory services, including the findings and actions taken.

**Notes:**

- The facility must ensure that laboratory services are provided in a timely and quality manner to meet the needs of residents.
- All residents are reviewed and any issues are addressed immediately.
- Any findings are reported and corrective actions are taken.

**Timeline:**

- 5/01/2011: Final completion date for the action plan.
On 4/5 and 4/6, 2011, QI services were done by the Consultant RN and the Maintenance Director for all staff regarding the call light system.

All findings will be discussed in QA morning meeting (consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Social Services Director, Dietary Director, Activities Director, Rehab Representative, Maintenance Director, and Business Office Manager).

4. All findings will be reported by the Maintenance Director/designee to the QA committee monthly/quarterly for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.
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<td>(F 502)</td>
<td>Continued from page 25</td>
<td>determined to be affected by deficient practice.</td>
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<td>December 2, 2009, and readmitted to the facility on March 4, 2010, with diagnoses including Alzheimer's Disease, Epilepsy, and Angina.</td>
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<td>Medical record review of a physician's order dated February 10, 2011, revealed, &quot;...Depakote and Dilantin level in 2 wks (weeks) (due February 24)...&quot;</td>
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<td>Medical record review of a laboratory report dated March 1, 2011, (5 days later) revealed, &quot;...Valproic Acid (Depakene) 43.6...reference range 50-100...Phenytoin (Dilantin) (less than) 2.6...reference range 10-20...&quot;</td>
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<td>Interview on March 31, 2011, at 1:30 p.m., in the conference room, with the Assistant Director of Nursing, confirmed the lab was not obtained as ordered.</td>
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<td>3. On 4/3/2011, a 100% audit of the current resident lab orders was completed by the designated Lab Coordinator to ensure that all current laboratory testing has been obtained per the physician orders.</td>
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<td>On 3/31/2011, the licensed nurses were instructed on the Facility Lab Protocol by the Resource Director of Compliance and DON. The licensed nurses were not allowed to work on the floor until they were instructed or received a one-on-one &quot;roadside education&quot; on the Facility Lab Protocol. The facility does not use any agency staffing.</td>
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|               | The Lab Coordinator or designee will utilize the Lab Draw Log monitoring sheet to ensure that labs are obtained as ordered. The Lab Coordinator or designee will then bring a copy of the Lab Draw Log to the daily (Monday through Friday) QA Morning Meeting (consisting of Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Social Services Director, Dietary Manager, Activities Director, Maintenance Director, Rehab Therapy Representative, Business Office Manager), which is conducted.
by the Administrator. In the absence of the Lab Coordinator (DON), the ADON or designee will be responsible for this daily review.

4. All findings will be reported by the Lab Coordinator/designee to the QA committee monthly/quarterly for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.