

**Iowa Department of Inspections and Appeals**  
**Health Facilities Division**  
**Citation**

Citation Number: <b>#6799</b>		Amended 5/23/18	Date: <b>May 18, 2018</b>		
Facility Name: <b>Arbor Court</b>		Survey Dates: <b>April 15-19, 23-24, 2017</b>			
Facility Address/City/State/Zip  <b>701 East Mapleleaf Drive Mount Pleasant IA 52641</b>		JKM			
Rule or Code Section	Nature of Violation		Class	Fine Amount	Correction date
58.20(1)	<p><b>Duties of health service supervisor.</b> Every nursing facility shall have a health service supervisor who shall:</p> <p><b>58.20(1) Direct the implementation of the physician's orders; (I, II)</b></p> <p><b>DESCRIPTION:</b></p> <p>Based on record review, and staff, pharmacist, physician and responsible party interviews, the facility failed to follow physician orders when an order was not transcribed from the hospital physician orders to the facility's physician orders. When the lab was drawn several days afterwards, it was found to be critically elevated (Resident #8). The facility identified a census of 40 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) Assessment tool dated 3/21/18 revealed Resident #8 admitted to the facility on 3/15/18 with diagnoses that included atrial fibrillation (irregular heart beat), hypertension (high blood pressure), pneumonia, and congestive heart failure. The MDS documented the resident scored 7 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated the resident experienced cognitive impairment. The MDS revealed Resident #8 required extensive assistance of at least 2 staff for transfers to</p>		I	\$9,500 <b>(held in suspension)</b>	Upon Receipt

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	<p>and from bed and chair, ambulation (walking), bathing, dressing, toilet use and personal hygiene, and remained continent of bowel and bladder.</p> <p>Physician orders dated 3/15/18 for the resident's hospital discharge and nursing home admission directed staff to administer medications that included:</p> <ol style="list-style-type: none"> <li>1. Warfarin (Coumadin, a blood-thinning, anticoagulant medication) 2 milligrams (mg) administered oral daily (hospital staff did not administer prior to discharge on 3/15/18)</li> <li>2. Aspirin 81 mg delayed release tablet orally 1 time daily (last dose administered at the hospital on 3/15/18).</li> </ol> <p>The orders also directed the facility to perform an INR blood test (International Normalized Ratio, a test that quantifies the anticoagulation effects of Warfarin), on 3/16/18, the physician to dose the Warfarin from the INR result. The resident's hospital records, included with the discharge orders, revealed INR results of 4.2 on 3/13/18, 4.0 on 3/14/18 and 4.1 on 3/15/18 (normal INR results are 1.1 or less, and 2.0 to 3.0 is the desired therapeutic range for people that take Warfarin for disorders that include atrial fibrillation) and a hemoglobin of 12.2 on 3/2/18, and 11.7 on 3/14/18 (hemoglobin is the part of the red blood cell that contains iron and transports oxygen, normal range is 12.0 to 16.0, a decreased hemoglobin could be a sign of blood loss).</p>				

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	<p>The physician orders, transcribed at the facility by the director of nursing (DON) and dated 3/15/18, directed staff to administer Warfarin 2 mg oral daily and Aspirin 81 mg oral daily (the orders transcribed at the facility did not specify delayed release Aspirin), and the 3/16/18 INR test was not transcribed on the facility physician orders. The orders also included physical therapy and occupational therapy services.</p> <p>Medication Administration Records (MAR's) revealed staff administered 2 mg Warfarin and 81 mg of chewable Aspirin to the resident daily from 3/16/18 through 3/20/18.</p> <p>The nursing care plan, dated as implemented on 3/15/18, included a bleeding risk problem due to anticoagulant medication, and directed staff to perform lab work as ordered by the physician, assess for signs or symptoms of bleeding, and notify the physician.</p> <p>An INR performed 3/21/18 at 5:25 a.m., with critical lab value results telephoned to Staff A, registered nurse (RN), on 3/21/18 at 8:00 a.m., reported a 14.4 INR result.</p> <p>Physician orders transcribed after admission included:</p> <ol style="list-style-type: none"> <li>1. Administer oxygen at 2 liters (per minute) per nasal cannula to keep oxygen (saturation) above 90 percent (normal value 95 to 100 percent without oxygen), transcribed on 3/16/18 at 4:00 p.m.</li> <li>2. A facsimile (fax) to the physician on 3/20/18 at 9:49 a.m. described the resident ambulated to the bathroom</li> </ol>			

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	<p>without assistance, and the staff requested an order for a floor alarm to alert staff due to the resident's orthostatic hypotension (sudden drop in blood pressure upon standing), with order received on 3/20/18 at 2:27 p.m.</p> <p>3. Vitamin K (medication administered as an antidote for blood clotting problems) 5 mg administered now by intramuscularly (IM) injection, for critical INR value, repeat INR on 3/22/18, hold Warfarin and aspirin indefinitely, with order transcribed on 3/21/18 at 10:21 a.m.</p> <p>Nurse's Notes revealed the following entries:</p> <p>3/16/18 at 4:00 p.m. - oxygen saturation 65 percent during assessment, physician notified with order for oxygen at 2 liters per nasal cannula as needed to keep saturation above 90 percent. Oxygen started at 2 liters.</p> <p>3/17/18 at 1:10 p.m. - in recliner all day, sleeping most of the time. Oxygen on at 2 liters, saturation 89 percent, no signs of dyspnea or any respiratory distress, appetite poor.</p> <p>3/18/18 at 10:35 a.m. - very tired this morning. An oxygen saturation of 96 percent recorded on 3/18/18 evening shift with vital signs.</p> <p>3/19/18 at 11:00 p.m. - small amount reddish brown stool reported by certified nursing assistants (CNA's). Physician on call notified of bloody appearance of</p>				

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	<p>bowels, vital signs, Warfarin 2 mg daily with INR test scheduled on 3/21/18, physician directed staff to monitor for any adverse change in blood pressure or pulse, and call if any change. An oxygen saturation of 91 percent recorded on the evening shift with vital signs.</p> <p>3/21/18 at 12:16 p.m. - lab phoned facility to notify of a high 14.4 INR. Faxed and called physician notified of INR results. Physician's office called back with order for Vitamin K 5 mg IM for critical INR value, repeat INR on 3/22/18, hold aspirin and Warfarin indefinitely, Vitamin K administered.</p> <p>3/22/18 at 9:30 a.m. - staff summoned nurse to the resident's room at 6:10 a.m., resident on toilet and too weak to stand, skin pale, respirations slow and deep, and no response to verbal stimuli. Staff transported the resident to bed. The resident's oxygen saturation measured 80% percent, and the nurse left to obtain a stethoscope and blood pressure cuff. Upon her return to the room, nurse unable to obtain blood pressure or oxygen saturation, no pulse or respirations for 2 minutes at 6:20 a.m.</p> <p>Physical and Occupational Therapy notes revealed the following entries:</p> <p>By Staff B, physical therapy assistant (PTA): 3/19/18 at 4:34 p.m. - unable to stand longer than 62 seconds (with walker) on 1st attempt, 51 seconds on</p>				

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	<p>2nd attempt and 22 seconds on 3rd attempt, with substantial rest breaks required between attempts.</p> <p>3/20/18 at 1:40 p.m. - resident reports she felt extremely tired, doesn't have much pep. Unable to stand with assist from recliner, recliner elevated to approximately 45 degrees and able to stand with 50 percent assist by therapist, stood 65 seconds on 1st attempt, 42 seconds on 2nd attempt, and 15 seconds on 3rd attempt, immediate loss of trunk control upon 2 steps with wheeled walker.</p> <p>3/21/18 at 1:51 p.m. - resident found in the restroom unattended last night, now alarmed with a pressure mat. Resident constantly complained of being too cold throughout the entire treatment, oxygen saturation 85 percent on 2 liters nasal cannula. Resident unable to sit unsupported for more than 40 seconds before fatigued, 20 seconds on 2nd attempt and 15 seconds on 3rd attempt. Frequent rest breaks required.</p> <p>By Staff C, occupational therapy assistant (COTA): 3/16/18 at 2:16 p.m. - maximal assistance required to stand from lift chair, transfer to wheel chair, and to don and doff clothes.</p> <p>3/19/18 (documented on 3/20/18 at 8:41 a.m.) - maximal assist for sit to stand and pivot to recliner, therapist allowed the resident to rest. Upon return, increased time required to wake resident and get her to open her eyes. Staff assistance required and extra time for resident to sit to stand from recliner, stood 90</p>				

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	<p>seconds with walker before sitting rest break required due to fatigue.</p> <p>3/20/18 at 2:35 p.m. - increased time required to wake resident and to sit forward in recliner, did not tolerate sitting forward longer than 30 seconds, 3 attempts, with increased rest breaks required after each attempt.</p> <p>Staff, physician, pharmacist and resident responsible party (RP) interviews revealed:</p> <p>4/16/18 at 2:56 p.m., Staff E, CNA, stated the resident wasn't short of breath or use oxygen and required only 1 staff assist for ambulation when she was first admitted, but after a few days became short of breath, used oxygen, and required 2 staff to assist with ambulation. Staff E reported Resident #8 bled from bowels or bladder (could not tell which one) that started a couple days after admission. She said she informed the nurse, Staff F, licensed practical nurse (LPN).</p> <p>4/17/18 at 6:23 a.m., Staff D, CNA, stated the resident was supposed to have 1 staff assist for the toilet but the resident self-transferred and didn't alert staff; she was short of breath, although she didn't have oxygen at first. Staff D reported the resident had bleeding from her bowels or bladder; she couldn't really tell but saved it in the toilet and reported it to the nurse each time she observed it. Staff D stated the day the resident passed she had walked very slowly to the bathroom</p>			

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	<p>and was too weak to stand from the toilet, so the CNA called for help. It took 3 staff to carry the resident to bed, there was blood in the toilet, and the resident was non-responsive.</p> <p>4/16/18 at 3:48 p.m., Staff F, LPN, stated staff reported the resident had blood in her stool, observed reddish brown stool in the toilet, called the physician on call and was directed to monitor her blood pressure. An INR was already scheduled for the next lab day. During another interview on 4/19/18 at 10:41 a.m., Staff F stated she had contacted the physician on call at approximately 9:00 p.m., the doctor asked what the INR was, and she looked through the chart and couldn't find an INR result. She then looked in the lab book and it was scheduled on the next lab day (3/21/18). When asked, she confirmed she was not aware the INR ordered for 3/16/18 had not been done.</p> <p>4/17/18 at 6:06 a.m., Staff G, LPN, stated he worked on the night shift, the resident self-transferred to the bathroom and wasn't supposed to, had dark stools on 3/19/18, there was a fax from the doctor to get an INR if indicated. He said there wasn't one set up and scheduled it for the next lab day on 3/21/18. Staff were supposed to watch her blood pressure. The night before she died her blood pressure had dropped 10 points. During another interview on 4/19/18 at 11:52 a.m., Staff G stated he knew to schedule the INR because of the fax from the physician on 3/19/18 that ordered the INR if warranted. Staff G felt a nurse couldn't make that determination so he scheduled the</p>			

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	<p>INR for the next lab day. He was not aware the INR ordered for 3/16/18 was not completed.</p> <p>4/16/18 at 5:19 p.m., Staff H, registered nurse (RN), stated she had not observed bleeding, but the resident had to be carried out of the bathroom the day she died.</p> <p>4/17/18 at 10:20 a.m., Staff B, PTA, and Staff C, COTA, were interviewed together and in agreement of their responses. Staff B stated the resident's endurance decreased during the time she was at the facility, instead of the number of repetitions per exercise, the normal protocol of therapists, they modified the resident's exercise program to the number of seconds that she could tolerate an activity. The resident was oxygen dependent and short of breath with any exertion, and this was reported to nursing staff. Staff C stated on 3/21/18, the resident was in a recliner chair with several blankets on and said she was cold; they were informed by the nurse that day of the resident's high INR.</p> <p>4/17/18 at 8:09 a.m., Staff A, RN, stated she worked the day shift on 3/21/18 and lab notified of the high 14.4 INR from lab by phone. She reported it to the physician with order obtained to administer Vitamin K injection; she had looked through the Nurse's Notes and found something about bleeding but the information had not been passed on in report prior to the call from the lab. The resident was very weak, had not improved since admission to the facility and therapy had not advanced her activity level. On the</p>			

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	<p>day she died (3/22/18), there was blood in the toilet and she was 1 of the 3 staff that transferred the resident from the bathroom to bed, an described it as an "emergency." Staff A reported she did not observe blood in the toilet or on the floor.</p> <p>4/16/18 at 3:41 p.m., Staff J, registered pharmacist (RPh) from the facility's pharmacy, stated delayed-release aspirin is not the same as chewable aspirin. Staff J reported the pharmacy would have provided delayed-release aspirin if specified by the facility but it was not transcribed on the orders. Staff J stated chewable aspirin would affect actions of the Warfarin.</p> <p>4/16/18 at 2:35 p.m., the director of nursing (DON), confirmed she transcribed the resident's physician orders for facility admission, she saw the INR lab order for 3/16/18, it was not transcribed on the orders she wrote and was not performed. Since then, the facility initiated a process where a 2nd nurse manager proof read all transcribed physician orders to ensure all orders were accurate. During another interview on 4/18/18 at 1:15 p.m., the DON stated she became aware the 3/16/18 INR order was missed when she returned to work on 3/22/18, the facility aware on 3/21/18 when INR results performed that day were called to the facility with critical value.</p> <p>4/17/18 at 7:16 a.m., the assistant director of nursing (ADON), stated she admitted the resident on 3/15/18, saw the order for the INR on 3/16/18 but it was missed on the orders, the aspirin order was for delayed-</p>				

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	<p>release and chewable aspirin was not delayed-release. She reported orders were now double checked, sometimes triple checked by either the DON, QA (quality assurance) nurse or herself.</p> <p>4/17/18 at 11:50 a.m., Staff L, physician assigned to the resident with admission to the facility, stated staff should have followed physician orders as written or communicated when changes were needed, they should have performed the INR on 3/16/18 and contacted the office with results, Warfarin orders would have been directed by the physician at that time, and staff shouldn't have administered the Warfarin without the resident's INR results. Staff L reported he never saw the resident because she died the day she had an appointment to see him.</p> <p>4/30/18 at 3:18 p.m., the nurse at Staff L's office, stated there was no documentation in the resident's record of notification of resident condition from the facility between 3/17/18 and 3/20/18. She reported the office did not record communication with on-call physicians and it is not recorded in the record unless the on-call physician wrote it.</p> <p>4/17/18 at 12:35 p.m., Staff K, physician, the facility's medical director, stated the facility informed him that a resident's INR order was missed and a critical high INR result obtained. He stated it was an oversight and was not aware of the action taken by the facility because the quality assurance committee had not met since the event.</p>				

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	<p>4/18/18 at 12:06 p.m., Staff M, the resident's primary physician prior to admission to the facility, stated she was unaware the resident was admitted to a nursing home, she was notified the resident would discharge from the hospital to home and was to follow-up with an appointment with her in 1 week, in correspondence she received from the hospital. Staff M stated she didn't have information related to the resident's condition at the time of her death or when she completed the death certificate, other than information from her Emergency Room visit on 3/2/18. Staff M stated it is required for the death certificate to be completed within 72 hours.</p> <p>During another interview on 4/30/18 at 4:07 p.m., Staff M stated she was not aware of the resident's 14.4 INR or symptoms of gastrointestinal/rectal bleeding when she completed the death certificate on 3/26/18, because didn't have other laboratory data or medical tests at the time of the resident's death and an autopsy was not performed.</p> <p>During an interview on 4/18/18, the resident's RP stated he/she arrived at the facility after staff notified him of the resident's death. The RP reported the resident was in bed, there were drops of blood on the floor between the bed and the bathroom, and red blood in the toilet.</p> <p>On 4/24/18 at 3:15 p.m., the administrator and DON stated the facility didn't have a policy or procedure for</p>				

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	following physician orders; it was a professional standard staff were expected to follow.			

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