

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 309 SS=J	<p>Complaint # 13010, substantiated (all or in part) with deficiencies cited at F309 and F490. Complaint #12924, unsubstantiated</p> <p>483.25 QUALITY OF CARE</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # 13010, substantiated (all or in part) with these findings.</p> <p>Based on record review and interview, the facility failed to ensure residents on anticoagulation therapy received test to monitor therapeutic blood levels and recognized and implemented timely interventions when bleeding occurred for 1 (Resident # 7) of 7 case mix residents on anticoagulation therapy (Residents # 3, 4, 5, 6, 7, 9, and 10). This failed practice resulted in Immediate Jeopardy which caused or could have caused serious illness, injury or death for 1 (Resident #7) and had the potential to affect 9 residents on anticoagulation therapy. The Immediate Jeopardy was removed by the facility and the scope and severity reduced to a "G" when Resident #7 was transferred to the hospital for treatment on 10/11/07 and a plan of corrective action was initiated. The findings are:</p> <p>1. The facility's policy titled "Anticoagulation -</p>	F 309		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 1 Clinical Protocol" documented, "Assessment and Recognition: 1. As part of the initial assessment, the physician will help identify individuals who are currently anticoagulated... a. Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. b. Assess for evidence of effects related to the sub therapeutic or greater than therapeutic drug level related to that particular drug (for example, a resident with an above therapeutic level of an anticoagulation medication should be assessed for bleeding). 2. In addition, the nurse shall assess and document/report the following:... b. Recent labs, including therapeutic dose monitoring; c. Other current medications;... Treatment/Management:... 2. The physician will identify potentially serious medication interactions that interact with warfarin, for example, digoxin, dilantin, amiodarone, and many antibiotics. a. The physician should stop, taper, or change medications that interact with warfarin, or monitor the PT (Prothrombin Time)/INR (International Normalized Ratio) very closely while the individual is receiving warfarin, to ensure that the PT/INR stabilizes. 3. The staff and physician will identify and address potential complications in individuals receiving anticoagulation; for example, someone with a fall risk, a history of gastrointestinal bleeding, or poorly controlled hypertension... Monitoring and Follow-Up:... 4. The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant..."	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 2  2. Resident #7 had diagnoses of Gastrointestinal Hemorrhage, Gastritis and Atrial Fibrillation. The 30 day Medicare Minimum Data Set dated 10/4/07 documented the resident was independent in cognitive skills for daily decision making, and had no mood indicators or behaviors.  a. The hospital History and Physical dictated on 8/29/07 documented "Chief Complaint: Recurrent nausea and vomiting. History of Present Illness:... For the last two or three days she has been unable to hold her medications down. She has had multiple episodes of vomiting. Family members say that she did have some coffee ground emesis today. She was also seen in the past week to ten days by [physician] and evidently she has a Staph infection of her left forearm... She was seen in our emergency room where she was noted to have... BUN [blood urea nitrogen] 92... The patient was admitted for evaluation and treatment of recurrent nausea and vomiting and treatment of suspected dehydration. However, I do suspect that a good deal of her elevation of BUN is probably due to some upper GI bleeding. She has a previous history of gastritis and multiple gastric ulcers noted per EGD (Esophogastroduodenoscopy) dated February 2007. Past Medical History: ... 9. Chronic atrial fibrillation,... 10. Gastritis... Impression: 1. Recurrent nausea and vomiting, some coffee ground emesis, probably secondary to gastritis... 3. Anemia secondary to probable GI blood loss..."  b. The hospital Laboratory Results Report documented the following results on 9/3/07: Prothrombin Time 18.4 H (high), collection range 9.5 - 12.1; PT/INR 1.96 H, collection range 0.87 -	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 3 1.20.  c. The hospital Discharge Summary dictated on 9/4/07 documented, "...Final Diagnoses: 1. Staph cellulitis of the left forearm. 2. Anemia, multifactorial and due to a probable recurrent gastritis with bleeding and chronic disease, status post three units of packed red blood cells with interval correction... Discharge Instructions:... 9. Coumadin 3 mg (milligrams) tablets on Monday, Wednesday, Friday, Saturday and Sunday. 10. Coumadin 1.5 mg tablet on Tuesday and Thursday..."  d. The resident was admitted to the nursing facility on 9/4/07. The Admission Orders documented, "Section A:... Coumadin 3 mg tablets on M, W, F, S, (Monday, Wednesday, Friday, Saturday) and Sunday... Coumadin 1.5 mg tablets on Tuesday and Thursday... Section B: Diagnoses:... Gastritis... Chronic AFib (Atrial Fibrillation)..." There were no documented orders for any laboratory test to monitor the effects of Coumadin therapy.  e. The Admission Nursing Assessment written by Licensed Practical Nurse (LPN) # 3, dated 9/4/07 at 6:00 p.m. documented, "... Attending physician notified? No [box for No checked] Attempted..." (LPN # 3 was on medical leave and could not be reached.  On 10/18/07 at 2:25 p.m., the Director of Nurses (DON) was asked to describe the process of reviewing the discharge instructions from the hospital to become facility admission orders. The DON stated, "When we get this list of discharge medications we send them to the attending physician and they review it. They ok it and/or	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 4 make any changes. Then they call back and talk to the nurse who puts the meds on the Admission paperwork." The DON was asked to review the discharge instructions for Resident #7. The DON was asked if there were any orders for a PT/INR. The DON stated: "No, the attending was also the physician at the hospital so he had all the old results".  f. The physician Progress Notes dated 9/10/07 documented, "...Impression: 1. Cellulitis improved 2. Anemia stable Plan: 24 hour dsg (dressing) [change] [with] Neosporin until completely healed. Cont (continue) freq (frequent) labs..." There were no documented physician orders for any laboratory test to monitor the effects of Coumadin therapy.  g. The Care Plan dated 9/19/07 documented, "Problem/Need: 9/5/07 Risk for abnormal blood count d/t GI Bleed and Anemia et (and) anticoagulation therapy... Approaches:... Labs as ordered and report results to MD (medical doctor)... monitor for s/s (signs/symptoms) abnormal bleeding and report changes to MD."  h. A physician order dated 9/21/07 documented, "C&S (culture and sensitivity) wound [left] arm."  i. The Daily Skilled Nurses Notes written by Licensed Practical Nurse (LPN) #1, dated 9/24/07 at 9:00 a.m. documented, "Lab results recd (received) from culture. [Physician] office notified..."  j. A physician order dated 9/24/07 documented, "Bactrim DS (double strength) 1 po bid (twice a day) x [times] 10 days for wound".	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 5</p> <p>The Drug Information Handbook for Nursing 2007, 8th edition, page 1154, documented "Sulfamethoxazole and Trimethoprim: U.S. Brand Names: Bactrim; Bactrim DS... Pharmacologic Category:... Sulfonamide Derivative... Increased Effect/Toxicity:... Sulfamethoxazole/trimethoprim may increase the levels/effects of... warfarin..."</p> <p>k. The Daily Skilled Nurses Notes and Daily Skin Integrity Assessment from 9/4/07 through 10/7/07 documented the dressing on the left forearm was dry and intact.</p> <p>l. The Daily Skin Integrity Assessment dated 10/8/07 and signed by LPN #1 documented, "S/T (skin tear) top [left] hand with bruising - two open area remain on left arm bleed easily on Coumadin..."</p> <p>m. The Daily Skilled Nurses Notes dated 10/9/07 and signed by LPN #4 documented, "...Family concerned about her cognitive status... and wants her changed to a soft mechanical diet if @ (at) all possible. Dressing to arm changed x (times) 1 @ 3:15 p.m..."</p> <p>n. The Daily Skilled Nurses Notes dated 10/10/07 for the 7:00 a.m. - 3:00 p.m. shift and signed by LPN #2 documented, "... Pulse: 88 B/P (blood pressure) 98/54... PT/INR ordered for a.m. d/t (due to) bleeding from wound and receiving Coumadin..."</p> <p>On 10/17/07 at 2:35 p.m. LPN #2, the 7:00 a.m. to 3:00 p.m. nurse, was asked what happened on 10/10/07. LPN #2 stated, "Family here and requested diet change because resident not alert. Resident had dressing on left forearm and it bled</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 6 through. It had to be changed twice and she [treatment nurse] told me to call doctor. I called the doctor because of the bleeding and because of no current INR."  o. The Daily Skin Integrity Assessment dated 10/11/07 and signed by LPN #1 documented, "S/T top [left] hand with bruising to hand and arm. Excessive bleeding. Remain on Coumadin..."  p. The Daily Skilled Nurses Notes dated 10/11/07 at 10:00 a.m. and signed by LPN #2 documented, "Resident lethargic and coloring very pale. Unable to eat or take meds d/t lethargic..."  q. The Daily Skilled Nurses Notes dated 10/11/07 at 11:20 a.m. and signed by LPN #2 documented, "[Ambulance] here to transport resident."  r. The [Ambulance] Paramedic Report dated 10/11/07 at 11:05 a.m. documented, "...Chief complaint: Transfer - [decreased] LOC (Level of Consciousness)... NH (nursing home) staff states [decreased] LOC, [decreased] food/fluid intake x 2 days... Vital signs: B/P 82 palpated... Extremities: Wound [left] arm... fingers [left] hand appear purplish/green/bruised..."  s. The laboratory results reported on 10/11/07 at 4:45 p.m. documented Prottime 47.9 H, normals 10.8 to 13.9, INR 12.9 H, normals 0.8 - 1.2... INR Prophylaxis range 2.0 - 3.0.  t. The [hospital] Emergency Physician Record documented, "...Chief Complaint: Pt (patient) sent for ER (emergency room)... with several day [decreased] responsiveness and hypotension. Voided yellow urine on arrival but grossly bloody urine noted promptly on Foley placement... Labs,	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 7 EKG and X-rays:... Hbg 6.5 Hct 19.3... Clinical Impression: Anemia, Gross Hematuria, Sepsis... Emergency Department Physician's Orders:... Fresh Frozen Plasma - 4 units IV (intravenous) Aqua Mephyton - 10 mg slow IV..." The hospital laboratory results of the PT/INR drawn 10/11/07 at 12:17 p.m. documented Prothrombin time greater than 120 (normal range 9.5 - 12.1) INR could not be read."  u. On 10/18/07 at 11:05 a.m. LPN # 1, the Treatment Nurse, was asked what does 'bleed easily' mean on the skin audit done 10/8/07. LPN #1 stated, "Oozing red blood... changed bandage 2 times that day, it had bled through bandage." LPN #1 was asked where it had bled from. LPN #1 stated, "Left forearm". LPN #1 was asked if the treatment record documented that the treatment was done twice that day. LPN #1 stated "No, didn't document it. She had some blood on outside of bandage. The first time... quite a bit... Telfa saturated, through the 4 x 4 and on Kling." LPN #1 was asked how long before you had to go back and change the dressing again. LPN #1 stated, "All of them happened in the morning. I had to go to other halls to do treatments." LPN #1 was asked how much blood was on the dressing the second time you changed it. LPN #1 stated "Three inches by 2 inches approximately... covered all the Telfa pad... on top of the dressing... nothing underneath, on bottom." LPN #1 was asked did you check back again. LPN #1 stated, "Yes, and so did [LPN # 2] - her nurse that day." LPN #1 was asked what kind of dressing did you use/remove. LPN #1 stated, "Telfa, three 4 x 4s on top then wrapped with Kling... a whole roll on the forearm." LPN #1 was asked what did you do. LPN #1 stated, "Asked [LPN #3] if the	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 8 resident was on blood thinners, Coumadin..." LPN #1 was asked where was the resident bleeding from. LPN #1 stated, "Hand and forearm... forearm was bleeding more than hand. Lesion on forearm had not bled like that before... never had any bleeding until after resident hurt her hand on 10/5/07. I was curious as to why it was bleeding more when it hadn't done that before. That's why I asked about blood thinners." LPN #1 was asked was there any bleeding on 10/9/07. LPN #1 stated, "Yes". LPN #1 was asked how many times was the dressing changed by you on 10/9/07. LPN #1 stated, "Two times that day." LPN #1 was asked, "How much blood was there that day." LPN #1 stated, "Bled through dressing, bright red... Telfa, 4 x 4s and Kling." LPN #1 was asked, "What did you do on 10/9/07?" LPN #1 stated, "Nothing more than usual." LPN #1 was asked how many times the bandage was changed on 10/10/07. LPN #1 stated, "Maybe I've got my day wrong... I had to change the dressing two times on two days... I don't remember what days." LPN #1 was asked if there was any bleeding on 10/11/07... "you charted 'excessive bleeding'." LPN #1 stated, "I cleaned it and wrapped it... some bleeding... not a lot. She hadn't eaten, I fed her... tried milk and juice... couldn't get resident to eat." LPN #1 was asked was there blood on the dressing at the forearm. LPN #1 stated, "Some blood on dressing dark red on dressing... wasn't as much as day before... a spot about size of quarter." LPN #1 was asked if there had been any bleeding from the skin lesions between 9/4/07 and 10/8/07. LPN #1 stated, "No except for some serosanguinous oozing from the biggest lesion." LPN #1 was asked did you document any problems with the treatment on 10/11/07. LPN #1 stated, "No, I just did one that day." LPN #1 was	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 9</p> <p>asked did you document any where when the treatment was done more than once or what the wound looked like, any bleeding, etc. LPN #1 stated, "No".</p> <p>v. On 10/18/07 at 12:00 p.m., LPN # 4, the 3:00 p.m. to 11:00 p.m. nurse on 10/9/07, was asked what can you tell me about the dressing on the resident's arm on 10/9/07. LPN #4 stated, "I came in at 3:00 p.m... in report they said they had changed the dressing 3 or 4 times that day. I went down and it was kind of saturated... it had bled through on the upper part of the dressing... a pinkish red color. I put on a new dressing and didn't have to change it again." LPN #4 was asked did you notify the physician. LPN #4 stated, "No, because they said it had been bleeding all day and they notified the physician." LPN #4 was asked were you concerned that the resident was on Coumadin and bleeding from an old surgery site. LPN #4 stated, "Yes but they had just been changing the dressing and they said they told the doctor." LPN #4 was asked did you give the Coumadin dose as ordered on 10/9/07. LPN #4 stated, "Yes".</p> <p>w. On 10/18/07 at 12:45 p.m., LPN #2 was asked what can you tell me about the bleeding from [Resident #7's] arm. LPN #2 stated, "[Resident # 7] had saturated dressing after [LPN #1], Treatment Nurse, changed it that morning... so I told her and changed it again." LPN #2 was asked what day was that. LPN #2 stated, "I think it was 10/8/07, maybe the 9th because it was when [LPN #4] worked... she worked on 10/9/07." LPN #2 was asked how many times on 10/9/07 was the dressing changed. LPN #2 stated, "Two times on days [7:00 a.m. to 3:00 p.m.]". LPN #2 was asked did you notify the physician on</p>	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 10</p> <p>10/9/07. LPN #2 stated, "No". LPN #2 was asked was there any bleeding on 10/10/07. LPN #2 stated, "No". LPN #2 was asked why wait until 10/10/07 to call the physician. LPN #2 stated, "I've no answer for that". LPN #2 was asked what exactly did you tell the doctor's office when you did call. LPN #2 stated, "I told them the wound on the left forearm was bleeding and had to change the dressing twice that day because it bled through the first time and the resident was on Coumadin." LPN #2 was asked did you tell them about the low blood pressure. LPN # 2 stated, "No".</p> <p>x. On 10/18/07 at 2:25 p.m., the Director of Nurses (DON) was asked are you concerned about the lack of PT/INR with this resident who was on Coumadin with a recent history of gastrointestinal bleeding and gastritis. The DON stated "Yes, it was brought to my attention on 10/11/07 and I pulled the chart and started going through it. We developed a plan of action and reviewed all our residents on Coumadin then."</p> <p>y. On 10/18/07 at 3:00 p.m. the DON presented the facility's action plan which documented, "Problem: PT/INR not ordered by MD. Action:</p> <p>1) Order obtained from MD. Date completed 10/11/07.</p> <p>2) Audit of all residents with anti-coagulant therapy in place. Date completed 10/16/07. Weekly PT/INRs established for each resident on anti-coagulant therapy.</p> <p>3) Inservice Nursing on anti-coagulant therapy and need for frequent monitoring. No completion date indicated.</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11	F 309		
F 490 SS=J	<p>4) Magnet system updated to include symbol for Coumadin therapy (i.e., abnormal bruising - bleeding). No completion date indicated.</p> <p>z. The DON was asked have you finished the audit of all residents on anticoagulant therapy. The DON stated, "Still working on finalizing it". The DON was asked when will you begin inservices. The DON stated "Next Tuesday".</p> <p>483.75 ADMINISTRATION</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # 13010, substantiated (all or in part) with these findings.</p> <p>Based on record review and interview, the facility failed to ensure Nursing Administration had a system in place to ensure nursing staff monitored anticoagulation therapy through lab testing, promptly identified complications, and developed/implemented timely interventions when excessive bleeding occurred for 1 (Resident # 7) of 7 case mix residents on anticoagulation therapy (Residents # 3, 4, 5, 6, 7, 9, and 10). This failed practice resulted in immediate jeopardy which caused or could have caused serious illness, injury or death for 1 (Resident #7) and had the potential to affect 9 residents on anticoagulation therapy. The Immediate Jeopardy was removed by the facility and the</p>	F 490		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	Continued From page 12 scope and severity reduced to a "G" when Resident #7 was transferred to the hospital for treatment on 10/11/07 and a plan of corrective action was initiated. The findings are:  1. The facility's job description for the Director of Nursing documented "General Purpose: To manage the overall operations of the Nursing Department in accordance with Company policies, standards of nursing practices and governmental regulations so as to maintain excellent care of all residents' needs... Administrative Functions:... Plan, develop, organize, implement, evaluate and direct the nursing services department as as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the long-term care facility..."  2. On 10/18/07 at 6:15 p.m., the DON was asked how were residents on coumadin therapy monitored to ensure PT/INRs were drawn and were within therapeutic limits. The DON stated, "I have a part time nurse who is assigned to review labs and report to me with any concerns." The DON was asked, "How are you monitoring residents who are on Coumadin with no labs ordered." The DON stated. "...Part time nurse audits weekly and would report any problems and we'd make corrections. I guess we didn't do very well." The DON was asked did anyone note that [Resident # 7] was on Coumadin. The DON stated, "I wasn't aware of it until the 12th [10/12/07] and I grabbed the chart and started going through the chart." The DON was asked do you do any spot checks of the part time nurses work. The DON stated, "I monitored lab results and I can go through and monitor orders. I get Pharmacy Consultant reports." The DON was	F 490			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	Continued From page 13 asked did anyone pick up that [Resident #7] was on Coumadin. The DON stated "No". 3. The facility's policy titled "Anticoagulation - Clinical Protocol" documented, "Assessment and Recognition: 1. As part of the initial assessment, the physician will help identify individuals who are currently anticoagulated... a. Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. b. Assess for evidence of effects related to the sub therapeutic or greater than therapeutic drug level related to that particular drug (for example, a resident with an above therapeutic level of an anticoagulation medication should be assessed for bleeding). 2. In addition, the nurse shall assess and document/report the following:... b. Recent labs, including therapeutic dose monitoring; c. Other current medications;... Treatment/Management:... 2. The physician will identify potentially serious medication interactions that interact with warfarin, for example, digoxin, dilantin, amiodarone, and many antibiotics. a. The physician should stop, taper, or change medications that interact with warfarin, or monitor the PT (Prothrombin Time)/INR (International Normalized Ratio) very closely while the individual is receiving warfarin, to ensure that the PT/INR stabilizes. 3. The staff and physician will identify and address potential complications in individuals receiving anticoagulation; for example, someone with a fall risk, a history of gastrointestinal bleeding, or poorly controlled hypertension... Monitoring and Follow-Up:... 4. The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or	F 490			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	Continued From page 14 other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant..." 4. Resident #7 had diagnoses of Gastrointestinal Hemorrhage, Gastritis and Atrial Fibrillation. The 30 day Medicare Minimum Data Set dated 10/4/07 documented the resident was independent in cognitive skills for daily decision making, and had no mood indicators or behaviors.  a. The hospital History and Physical dictated on 8/29/07 documented "Chief Complaint: Recurrent nausea and vomiting. History of Present Illness:... For the last two or three days she has been unable to hold her medications down. She has had multiple episodes of vomiting. Family members say that she did have some coffee ground emesis today. She was also seen in the past week to ten days by [physician] and evidently she has a Staph infection of her left forearm... She was seen in our emergency room where she was noted to have... BUN [blood urea nitrogen] 92, ... The patient was admitted for evaluation and treatment of recurrent nausea and vomiting and treatment of suspected dehydration. However, I do suspect that a good deal of her elevation of BUN is probably due to some upper GI bleeding. She has a previous history of gastritis and multiple gastric ulcers noted per EGD (Esophogastroduodenoscopy) dated February 2007. Past Medical History: ... 9. Chronic atrial fibrillation,... 10. Gastritis... Impression: 1. Recurrent nausea and vomiting, some coffee ground emesis, probably secondary to gastritis... 3. Anemia secondary to probable GI blood loss..."  b. The hospital Laboratory Results Report	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	<p>Continued From page 15</p> <p>documented the following results on 9/3/07: Prothrombin Time 18.4 H (high), collection range 9.5 - 12.1; PT/INR 1.96 H, collection range 0.87 - 1.20.</p> <p>c. The hospital Discharge Summary dictated on 9/4/07 documented, "...Final Diagnoses: 1. Staph cellulitis of the left forearm. 2. Anemia, multifactorial and due to a probable recurrent gastritis with bleeding and chronic disease, status post three units of packed red blood cells with interval correction... Discharge Instructions:... 9. Coumadin 3 mg (milligrams) tablets on Monday, Wednesday, Friday, Saturday and Sunday. 10. Coumadin 1.5 mg tablet on Tuesday and Thursday..."</p> <p>d. The resident was admitted to the nursing facility on 9/4/07. The Admission Orders documented, "Section A:... Coumadin 3 mg tablets on M, W, F, S, (Monday, Wednesday, Friday, Saturday) and Sunday... Coumadin 1.5 mg tablets on Tuesday and Thursday... Section B: Diagnoses:... Gastritis... Chronic AFib (Atrial Fibrillation)..." There were no documented orders for any laboratory test to monitor the effects of Coumadin therapy.</p> <p>e. The Admission Nursing Assessment dated 9/4/07 at 6:00 p.m. and signed by Licensed Practical Nurse (LPN) # 3, documented, "... Attending physician notified? No [box for No checked] Attempted..." (LPN # 3 was on medical leave and could not be reached.</p> <p>On 10/18/07 at 2:25 p.m., the Director of Nurses (DON) was asked to describe the process of reviewing the discharge instructions from the</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	<p>Continued From page 16</p> <p>hospital to become facility admission orders. The DON stated, "When we get this list of discharge medications we send them to the attending physician and they review it. They ok it and/or make any changes. Then they call back and talk to the nurse who puts the meds on the Admission paperwork." The DON was asked to review the discharge instructions for Resident #7. The DON was asked if there were any orders for a PT/INR. The DON stated "No, the attending was also the physician at the hospital so he had all the old results".</p> <p>f. The physician Progress Notes dated 9/10/07 documented, "...Impression: 1. Cellulitis improved 2. Anemia stable Plan: 24 hour dsq (dressing) [change] [with] Neosporin until completely healed. Cont (continue) freq (frequent) labs..." There were no documented physician orders for any laboratory test to monitor the effects of Coumadin therapy.</p> <p>g. A physician order dated 9/21/07 documented, "C&amp;S (culture and sensitivity) wound [left] arm."</p> <p>h. A physician order dated 9/24/07 documented, "Bactrim DS (double strength) 1 po bid (twice a day) x [times] 10 days for wound".</p> <p>The Drug Information Handbook for Nursing 2007, 8th edition, page 1154, documented "Sulfamethoxazole and Trimethoprim: U.S. Brand Names: Bactrim; Bactrim DS... Pharmacologic Category:... Sulfonamide Derivative... Increased Effect/Toxicity:... Sulfamethoxazole/trimethoprim may increase the levels/effects of... warfarin..."</p> <p>i. The Daily Skin Integrity Assessment dated</p>	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	<p>Continued From page 17</p> <p>10/8/07 and signed by LPN #1 documented, "S/T (skin tear) top [left] hand with bruising - two open area remain on left arm bleed easily on Coumadin..."</p> <p>j. The Daily Skilled Nurses Notes dated 10/9/07 and signed by LPN #4 documented, "...Family concerned about her cognitive status... and wants her changed to a soft mechanical diet if @ (at) all possible. Dressing to arm changed x (times) 1 @ 3:15 p.m..."</p> <p>k. The Daily Skilled Nurses Notes dated 10/10/07 for the 7:00 a.m. - 3:00 p.m. shift and signed by LPN #2 documented, "... Pulse: 88 B/P (blood pressure) 98/54... PT/INR ordered for a.m. d/t (due to) bleeding from wound and receiving Coumadin..."</p> <p>On 10/17/07 at 2:35 p.m. LPN #2, the 7:00 a.m. to 3:00 p.m. nurse, was asked what happened on 10/10/07. LPN #2 stated, "Family here and requested diet change because resident not alert. Resident had dressing on left forearm and it bled through. It had to be changed twice and she [treatment nurse] told me to call doctor. I called the doctor because of the bleeding and because of no current INR."</p> <p>l. The Daily Skin Integrity Assessment dated 10/11/07 and signed by LPN #1 documented, "S/T top [left] hand with bruising to hand and arm. Excessive bleeding. Remain on Coumadin..."</p> <p>m. The Daily Skilled Nurses Notes dated 10/11/07 at 10:00 a.m. and signed by LPN #2 documented, "Resident lethargic and coloring very pale. Unable to eat or take meds d/t lethargic..."</p>	F 490			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	Continued From page 18  n. The Daily Skilled Nurses Notes dated 10/11/07 at 11:20 a.m. and signed by LPN #2 documented, "[Ambulance] here to transport resident."  o. The [Ambulance] Paramedic Report dated 10/11/07 at 11:05 a.m. documented, "...Chief complaint: Transfer - [decreased] LOC (Level of Consciousness)... NH (nursing home) staff states [decreased] LOC, [decreased] food/fluid intake x 2 days... Vital signs: B/P 82 palpated... Extremities: Wound [left] arm... fingers [left] hand appear purplish/green/bruised..."  p. The laboratory results reported on 10/11/07 at 4:45 p.m. documented Prottime 47.9 H, normals 10.8 to 13.9, INR 12.9 H, normals 0.8 - 1.2... INR Prophylaxis range 2.0 - 3.0.  q. The [hospital] Emergency Physician Record documented, "...Chief Complaint: Pt (patient) sent for ER (emergency room)... with several day [decreased] responsiveness and hypotension. Voided yellow urine on arrival but grossly bloody urine noted promptly on Foley placement... Labs, EKG and X-rays:... Hbg 6.5 Hct 19.3... Clinical Impression: Anemia, Gross Hematuria, Sepsis... Emergency Department Physician's Orders:... Fresh Frozen Plasma - 4 units IV (intravenous) Aqua Mephyton - 10 mg slow IV..." The hospital laboratory results of the PT/INR drawn 10/11/07 at 12:17 p.m. documented Prothrombin time greater than 120 (normal range 9.5 - 12.1) INR could not be read."  r. On 10/18/07 at 2:25 p.m., the Director of Nurses (DON) was asked are you concerned about the lack of PT/INR with this resident who was on Coumadin with a recent history of	F 490			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045408</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/18/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRACE HEALTHCARE OF BENTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3300 ALCOA ROAD</b> <b>BENTON, AR 72015</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	Continued From page 19 gastrointestinal bleeding and gastritis. The DON stated "Yes, it was brought to my attention on 10/11/07 and I pulled the chart and started going through it. We developed a plan of action and reviewed all our residents on Coumadin then."  s. On 10/18/07 at 3:00 p.m. the DON presented the facility's action plan which documented, "Problem: PT/INR not ordered by MD. Action:  1) Order obtained from MD. Date completed 10/11/07.  2) Audit of all residents with anti-coagulant therapy in place. Date completed 10/16/07. Weekly PT/INRs established for each resident on anti-coagulant therapy.  3) Inservice Nursing on anti-coagulant therapy and need for frequent monitoring. No completion date indicated.  4) Magnet system updated to include symbol for Coumadin therapy (i.e., abnormal bruising - bleeding). No completion date indicated.  s. The DON was asked have you finished the audit of all residents on anticoagulant therapy. The DON stated, "Still working on finalizing it". The DON was asked when will you begin inservices. The DON stated "Next Tuesday".	F 490			