

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Ascension Saint Anne Place		STREET ADDRESS, CITY, STATE, ZIP CODE 4405 Highcrest Road Rockford, IL 61107	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38488</p> <p>Based on interview and record review, the facility failed to ensure a resident was free of significant medication errors for 1 of 3 residents (R2) reviewed for medications.</p> <p>The findings include:</p> <p>R2's facesheet showed he was admitted to the facility on [DATE], with diagnoses to include Parkinson's Disease, Type 2 Diabetes, hypertension, chronic kidney disease, Paroxysmal atrial fibrillation, and presence of prosthetic heart valve.</p> <p>R2's care plan, with problem onset 9/4/2017, showed, [R2] has alteration in blood clotting related to use of anticoagulant medications . Administer anticoagulants per physician orders . labs as ordered. Inform physician for dosage changes .</p> <p>R2's March eMAR (electronic Medication Administration Record) showed his anticoagulant (blood thinner) medication was administered on 3/10/24, and then not again until 3/19/24 (8 days without receiving his anticoagulant medication).</p> <p>R2's 3/18/24 nursing note showed, Writer notified on call Nurse Practitioner that resident has no order for Coumadin in [the electronic health record] and does not seem to have had Coumadin since 3/10/24 . order to recheck INR in the morning and have NP address results. Unit Manager notified. Resident notified. POA (Power of Attorney) notification endorsed to morning shift .</p> <p>R2's 3/19/24 nursing note showed, Call placed to POA (Power of Attorney) this morning and informed of resident missing Coumadin. Told that on call Nurse Practitioner was called last night and PT/INR was drawn this morning. I told POA that I would call her with the results of the PT/INR and orders that were received. Answered all question and informed her vital signs would be taken every shift for 72 hours.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/2/24 at 12:56 PM, V6 said when she was assigned to work R2's hall, she noticed he did not have an order for Coumadin. V6 said she knew R2 was on Coumadin because she has worked at the facility for 7 years and is pretty familiar with the resident's medications. V6 said when Coumadin orders are put into the system, they have a stop date that coincides with the resident's lab draw that monitors the residents blood. V6 said the nurse would report the results of the resident's lab to the nurse practitioner and get a new order for Coumadin at that time. V6 said the new order was not entered into the system, so the Coumadin was not given. V6 said it is important for R2 to receive Coumadin so his artificial heart valve functions properly.</p> <p>On 4/2/24 at 12:40 PM, V3 (Unit Nurse Manager) said R2 takes anticoagulants because he has an artificial heart valve. V3 said R2 had a medication error. V3 said everything was brought forward except the order for R2's Coumadin.</p> <p>The facility's policy and procedure reviewed 1/2024 showed, . Procedure: Anticoagulant . Treatment/Management: A. The physician will prescribe anticoagulation therapy (for example, low molecular weight heparin or warfarin [Coumadin]) appropriately, in accordance with recognized guidelines . Monitoring and Follow-Up: A. The physician will order appropriate lab testing to monitor anticoagulant therapy and potential complications; . 1. The associates should use a warfarin flow sheet or comparable monitoring tool to follow trends in anticoagulant dosage and response.</p>		