

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145911	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2024
NAME OF PROVIDER OR SUPPLIER  Goldwater Care Gibson City		STREET ADDRESS, CITY, STATE, ZIP CODE  620 East First Street Gibson City, IL 60936	

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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702</b></p> <p>Based on interview and record review the facility failed to follow physician orders for a resident's anticoagulant medication (Warfarin/Coumadin) resulting in the resident receiving an increased anticoagulant dosage for 24 days. The facility also failed to monitor the resident's anticoagulant medication as recommended by the drug manufacturer guidelines. These failures affect one (R1) resident reviewed for anticoagulation therapy on a sample list of three residents. These failures resulted in R1 experiencing internal bleeding and dying.</p> <p>Findings include:</p> <p>The Immediate Jeopardy began on [DATE] when the facility failed to follow the physician orders to decrease R1's Warfarin dosage from 3mg to 2.5mg and failed to obtain a PT/INR (Prothrombin Time/International Normalized Ratio (measures blood clotting time)). Twenty four days later, R1's PT/INR were at critical levels, R1 was bleeding internally and was sent to the hospital for Warfarin toxicity where he subsequently died . V1 Administrator was notified of the immediate jeopardy on [DATE] at 3:37PM.</p> <p>The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on [DATE] but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.</p> <p>The undated Warfarin package insert documents, The dosage and administration of warfarin sodium tables must be individualize for each patient according to the patient's (International Normalized Ratio) INR response to the drug. Adjust the dose based on the patient INR and the condition being treated. Monitoring: Obtain daily INR determinations upon initiation until stable in the therapeutic range. Obtain subsequent INR determination every ,d+[DATE] weeks.</p> <p>The National Institute of Health (NIH) report on Warfarin (Coumadin) anticoagulant dated [DATE] documents, Close monitoring of a patient's INR is a strong recommendation when initiating Warfarin. The INR requires more frequent monitoring when starting Warfarin. More frequent monitoring is necessary for patients with supratherapeutic or subtherapeutic INR to evaluate safety and efficacy. Also, the INR requires assessment when initiating, discontinuing, or changing doses of medications known to interact with Warfarin. Patients also require close monitoring for signs and symptoms of active bleeding throughout their treatment. Close monitoring for signs and symptoms of bleeding, such as dark tarry stools, nosebleeds, and hematomas, is necessary.</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's census report dated [DATE] documents admission to the facility.</p> <p>R1's undated diagnoses sheet includes the following diagnoses: Transient Cerebral Ischemic Attack, Non-Rheumatic Aortic Valve Stenosis, Hypothyroidism, Hypertension, Chronic Respiratory Failure, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Aneurysm of the Ascending Aorta Without Rupture, Depression, Dementia, Anxiety, and the Presence of a Prosthetic Heart Valve.</p> <p>R1's January, February and [DATE] physician order sheet documents Plavix (antiplatelet) 75 milligrams (mg) to be given daily.</p> <p>R1's [DATE] medication administration record documents R1's Plavix was discontinued and Warfarin (anticoagulant), 4mg daily was started.</p> <p>R1's Anticoagulant Monitoring Flow Sheets do not document target INRs.</p> <p>R1's Prothrombin Time (PT) and International normalized ratio (INR) results sheet dated [DATE] documents a target range PT of 9XXX,d+[DATE].7 and a target range INR of 2XXX,d+[DATE].0.</p> <p>R1's first documented PT/INR in the medical record is dated [DATE] with PT results of 16.4 and INR results of 1.7 (Both out of range).</p> <p>R1's next documented PT/INR in the medical record is dated [DATE] with PT results of 14.3 and INR results of 1.5 (Both out of range).</p> <p>R1's next documented PT/INR in the medical record is dated [DATE] with PT results of 15 and INR results of 1.5 (Both out of range).</p> <p>R1's next documented PT/INR in the medical record is dated [DATE] with PT results of 19.4 and INR results of 2.0 (PT results out of range).</p> <p>R1's [DATE] physician orders document to administer Warfarin 2mg from [DATE]-[DATE] and to administer Warfarin 3mg from [DATE]-[DATE].</p> <p>R1's next documented PT/INR in the medical record is dated [DATE] with PT results of 24.8 and INR results of 2.6 (PT results out of range).</p> <p>R1's next documented PT/INR in the medical record is dated [DATE] with PT results of 51.3 and INR results of 5.4 (Both out of range).</p> <p>R1's next documented PT/INR in the medical record is dated [DATE] with PT results of 35.8 and INR results of 3.7 (Both out of range).</p> <p>R1's [DATE] physician orders document Warfarin 3mg to administer from [DATE]-[DATE], [DATE]-[DATE] and from [DATE]-[DATE].</p> <p>R1's next documented PT/INR in the medical record is dated [DATE] with PT results of 116 and an INR greater than 10 (Both critically out of range high results).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's physician orders dated [DATE] document to hold the Warfarin for three days, obtain two PT and INRs, the first on [DATE] and the second on [DATE] and to restart Warfarin at 2.5mg on [DATE].</p> <p>R1's June and [DATE] medication administration records document that the facility continued to administer 3mg of Warfarin from [DATE] until discharge on [DATE] (24 days) and that a PT/INR was not completed until [DATE], rather than as ordered on [DATE] and [DATE].</p> <p>After the critical PT/INR value on [DATE] and the recheck on [DATE]; the facility, the physician, nor the pharmacy requested another PT/INR until [DATE] when the results are documented as a PT of 120 and an INR of greater than 10 (critically high results). At this time R1 was sent to the local hospital.</p> <p>R1's local hospital notes dated [DATE] document that R1 was sent to the local hospital with Warfarin toxicity and was admitted with lethal bleeding requiring frozen fresh plasma to reverse his INR and then R1 was sent to a tertiary care center for critical care.</p> <p>R1's tertiary care center notes dated [DATE] document a left hemothorax, right lung with alveolar hemorrhage, increased size of the ascending aortic aneurysm, and a subcutaneous right gluteal hematoma measuring 7.8 centimeters (cm) x 5.7cm x 7.9cm.</p> <p>R1's death certificate dated [DATE] documents R1's cause of death as cardiopulmonary arrest with acute respiratory failure and a left hemothorax.</p> <p>On [DATE] at 10:30AM, V2 Director of Nursing (DON) said that the facility was not administering the Warfarin as ordered and not monitoring R1's labs as they should have done.</p> <p>On [DATE] at 9:10AM, V13 Medical Director said that the facility should have followed the correct Warfarin order and that R1 was at risk for increased bleeding and that R1 clearly died from the hemothorax.</p> <p>On [DATE] at 10:30AM, V12 Consultant Pharmacist said that she was unaware that R1 had out of target range or critical Prothrombin (PT) and International normalized ratio (INR) times.</p> <p>On [DATE] at 1:15PM, V3 Pharmacist stated that collaboration with the pharmacy when PT/INRs are inconsistent is the standard of care and that given R1's inconsistent results, closer laboratory monitoring should have been done. Failure to do so could result in increased bleeding and possibly death.</p> <p>The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy:</p> <p>1. All licensed and direct care staff was educated on Administration Procedures for All Medications including but not limited to: medications are administered in accordance with physician order, and physician notification including monitoring and adverse reactions by the Director of Nursing (DON) and the Administrator on [DATE]. Licensed staff and Direct Care Staff who are on leave or vacation and all agency staff will be serviced prior to returning to the facility by the Director of Nursing/Designee or the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. All licensed and direct care staff was educated on referencing and following drug manufacturing guidelines for monitoring of drug side effects, labs, and possible adverse reactions by the Director of Nursing and the Administrator on [DATE]. Licensed staff and Direct Care Staff who are on leave or vacation and all agency staff will be inserviced prior to returning to the facility by the Director of Nursing/Designee or the Administrator.</p> <p>3. All licensed staff was educated on utilizing the Coumadin Tracking Log to ensure medication dosage, order, and follow-up PT/INR are reviewed and to ensure physician's orders are carried out by the Director of Nursing and the Administrator on [DATE]. Licensed staff who are on leave or vacation and all agency staff will be inserviced prior to returning to the facility by the Director of Nursing/Designee or the Administrator.</p> <p>4. All licensed and direct care staff was educated on anticoagulant administration, effects, precautions, and monitoring by the Director of Nursing and the Administrator on [DATE]. Licensed staff and Direct Care Staff who are on leave or vacation and all agency staff will be inserviced prior to returning to the facility by the Director of Nursing/Designee or the Administrator.</p> <p>5. All licensed staff was educated on the facility process to monitor/review/follow-up/coordinate and administer safe use of anticoagulant medications by the Director of Nursing and the Administrator on [DATE]. Licensed staff who are on leave or vacation and all agency staff will be inserviced prior to returning to the facility by the Director of Nursing/Designee or the Administrator.</p> <p>6. An impromptu QAPI (Quality Assurance Performance Improvement) meeting was held with the medical director and staff IDT (Interdisciplinary Team) to discuss deficiency and facility action plan.</p> <p>7. The facility will audit the Coumadin Tracking Log and review resident charts to ensure anticoagulant medication orders were followed, monitoring for anticoagulant side effects, the physician was notified of changes in condition(s) of residents, and that abnormal lab results were reported to the physician within a timely manner. A QA (Quality Assurance) tool -will be completed to verify this practice has occurred. The QA tool will be completed by the DON or designee, daily for 6 weeks. There will be oversight of the QA tool by the RNC (Registered Nurse Certified).</p> <p>8. The facility will audit all residents currently receiving an anticoagulant to ensure physician orders are being followed, and monitoring is in place including monitoring side effects, labs, and adverse reactions. A QA tool will be completed to verify this practice has occurred. The QA tool will be completed by the DON or designee, daily for 6 weeks. There will be oversight of the QA tool by the RNC.</p> <p>9. Nursing Management will audit all newly admitted and readmitted residents within 24 hours of admission to ensure residents receiving anticoagulant medication are being monitored for side effects and adverse reactions, laboratory orders are in place, and the physician is notified of any change in condition. A QA tool -will be completed to verify this practice has occurred. The QA tool will be completed by the DON or designee, daily for 6 weeks. There will be oversight of the QA tool by the RNC.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility presented an abatement plan to remove the immediacy on [DATE]. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility on [DATE] for revisions. The facility presented a revised abatement plan on [DATE] and the survey team accepted the abatement plan on [DATE].</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702</b></p> <p>Based on interview and record review the facility failed to utilize data to put a quality improvement program in place that would identify, intervene, and improve resident outcomes to address significant medication errors after learning of a significant medication error that resulted in resident harm. This failure has the potential to all 51 residents who reside in the facility.</p> <p>Findings include:</p> <p>The facility provided census dated [DATE] documents 51 residents reside in the facility.</p> <p>The facility Quality Assurance Performance Improvement Program Policy dated [DATE] documents that quality of care will be monitored and evaluated in areas of resident care and services at each quality meeting including but not limited to adverse resident events and medication errors.</p> <p>R1's census report dated [DATE] documents admission to the facility.</p> <p>R1's [DATE] physician order sheet documents Plavix (anticoagulant) 75 milligrams (mg) to be given daily.</p> <p>R1's [DATE] medication administration record documents that R1 was started on Warfarin (anticoagulant) 4mg on [DATE].</p> <p>On [DATE], R1's laboratory results documents a PT of 116 and an INR of greater than 10 (critical levels) with physician orders to repeat the PT and INR on [DATE] and again on [DATE] and to begin Warfarin 2.5mg on [DATE].</p> <p>R1's June and [DATE] medication administration records document that the facility continued to administer 3mg of Warfarin from [DATE] until discharge on [DATE] (24 days) and a PT/INR was not completed until [DATE], rather than as ordered on [DATE] and [DATE]. Subsequently, the facility, nor a physician, nor the pharmacy requested another PT/INR until [DATE] when the results documented as a PT of 120 and an INR of greater than 10 (critical levels).</p> <p>R1's local hospital notes dated [DATE] document that R1 was transferred to the local hospital at approximately 10:00PM for hypoxia and Warfarin toxicity with dried blood in and around the mouth. Upon admission to the local hospital, R1 was determined to be bleeding internally and was given fresh frozen plasma to reverse the anticoagulant effect. R1 was then sent to a tertiary care center for critical care where he died as a result of Warfarin toxicity, causing a left hemothorax.</p> <p>The facility provided quality committee minutes dated [DATE] document attendees including: V1 Administrator, V2 Director of Nursing, V12 Pharmacy Consultant and V13 Medical Director. The [DATE] quality minutes do not reflect any discussion of medication errors.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On [DATE] at 9:10AM, V13 Medical Director said that he was not made aware of the Warfarin errors at the quality meeting in September and that [DATE] was the first time he had been apprised of the whole picture of what happened with R1.</p> <p>On [DATE] at 11:14AM, V12 Consulting Pharmacist said that she did not know about R1's medication error or concerns with the management of R1's anticoagulant therapy until just now.</p> <p>On [DATE] at 9:05AM, V1 stated, We had a quality meeting on [DATE] and our pharmacy (representative) attended but we didn't discuss Coumadin (Warfarin) or medication errors. In the future, I would expect that this will be a part of the quality process and discussed weekly.</p>		