STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165436	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IVY AT DAVENPORT	**800 EAST RUSHOLME STREET DAVENPORT, IA 52803**

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)
F 0757 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to monitor [MEDICATION NAME] Time and International Ratio (PT/INR) levels for 1 of 3 sampled (Resident #5) on [MEDICATION NAME] (blood thinner). Resident #5 re-admit to the facility on [DATE] and received [MEDICATION NAME]. On 2/28/20, the physician debrided Resident #5's wound which bled profusely and resulted in hospitalization . The staff failed to identify no lab orders to monitor the [MEDICATION NAME] and failed to notify the physician to clarify the orders. The facility reported a census of 69. Findings include: 1. Resident #5 admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE], documented the resident required extensive assistance with transferring, dressing, bathing and toileting and did not ambulate. Nurse notes dated 12/2[DATE]9, documented the resident entered the facility at 12:29 p.m., Progress notes dated 12/25/19, documented the resident complained of chest pain and was sent to the hospital at 1:05 p.m. The resident was readmitted to the facility on [DATE] after being hospitalized . Physician orders dated 1/6/20, directed staff to administer [MEDICATION NAME] 10 milligram (mg) one tablet every day related to personal history of [MEDICAL CONDITION] embolism. Documentation in the Medication Administration Record [REDACTED]. The plan of care identified a focus area of anticoagulant therapy. The plan directed staff to implement the following interventions: a. administer anticoagulant medication as ordered by physician. Monitor for side effects and effectiveness every shift. b. Daily skin inspection. Report abnormalities to the nurse. c. Labs as ordered. Report abnormal lab results to the physician. d. Monitor/document/report as needed, adverse reactions of anticoagulant therapy. Facility policy updated September 2019, indicated Resident's on [MEDICATION NAME] therapy will be monitored for therapeutic dosing. The facility procedure indicated All residents on [MEDICATION NAME] therapy will have pertinent labs drawn per MD orders. All abnormal labs will be reported to MD promptly. New orders regarding dosage adjustment and further lab draws will be followed up on promptly. Nurse notes dated 2/18/20 at 11:55 p.m., documented the first shift nurse reported the wound doctor came and did a wound debridement on the resident. The resident was taking [MEDICATION NAME] and was having episodes of heavy bleeding. The In-house physician ordered a stat INR (International normalized ratio) and Vitamin K administration. The wound doctor was able to stop the bleeding but not for long due to the resident moving. The wound doctor stayed around and monitored the resident until approximately 10:30 p.m., when the in house physician ordered the resident be sent out. The resident's blood pressure was low, reading 70/60. Medics arrive at 11:00 p.m. and transported the resident. The Emergency Department Physician note documented the resident presented with increasing gluteal bleeding after wound debridement earlier. The resident was chronically on [MEDICATION NAME] and the INR was found to be greater than 9. The bleeding was unable to be stopped and thus the resident was transferred to the emergency room . While in the emergency room the bleeding could not be controlled effectively and the resident was given FFP (fresh frozen plasma) as well as vitamin K via IV (intravenous). The resident's hemoglobin was found to be much lower than it had been previously in the 7 range, where the residents baseline was in the 12-13 range. Clinical record review revealed the resident's INR was 2.1 when readmitted to the facility on [DATE]. Clinical record review revealed no further INR's were completed until 2/18/20. There was no physician order for [REDACTED]. During interview on 3/3/20 at 3:10 p.m., the physician stated he visited the resident every week and reviewed the resident's wounds. On 2/1820 the buttock wound had eschar separating and started bleeding on its own and was debrided and kept bleeding. The physician did not have supplies available as he would if at the hospital. The physician stated he asked if the resident was on [MEDICATION NAME] and when saw the bleeding ordered a stat INR. The physician stated if a resident does not come with an order for [REDACTED]. During interview on 3/4/20 at 12:34 p.m., the Nurse Practitioner (NP) stated the resident was admitted on [DATE] and the physician wrote admit orders. The NP addresses acute incidents. If [MEDICATION NAME] a wound the physician should know if the resident is on [MEDICATION NAME] and what the INR was. She would have checked on the INR if doing any procedure. The NP stated protocol in the nursing home is to check the INR every 4-6 weeks. The NP never saw the wound until the physician asked her about the bleeding, however she thought it was usual after a debridement. The NP ordered an INR after seeing the bleeding and it was 9 and the resident needed to be sent out.

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.